PSYCHOLOGY AND EDUCATION (2021) 58(5), ISSN 1553 - 6939
Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

Personal and Social Corerelates of Quality of Life in Institutionalized and Non-Institutionalized Elderly

Sangeeta Trama[1] and Roopsi Mehta[2]

Abstract

As the world's population ages and people live longer, it is becoming increasingly important to ensure that older people enjoy a good quality of life Advancing age seems to bring meaningless misery mainly because the elderly have generally been neglected and been considered as "unimportant" by the modern society. Majority of the older populations are now being institutionalised due to various reasons - be it neglect, abuse or changing trends in youngsters who don't consider them as "worthy of importance". Thus, there is a need to study quality of life of elderly in institutionalized and non-institutionalized settings as keeping the elderly healthy has to be high on the list of priorities in this age, where ageing research is clearly gaining momentum.

Thus, the present research was designed to examine the predictors of quality of life of elderly in institutionalized and non-institutionalized settings, viz., affect, hope, spirituality, resilience, socio-economic status, and social support. The sample for institutionalized elderly (N=160; males=80 and females=80) comprised those who were living in old age homes (for at least 6 months) in and around Patiala and Chandigarh. The sample for non-institutionalized elderly (N=160; males=80 and females=80) comprised those who were living with their families in their homes. All participants living in urban cities of Patiala and Chandigarh were taken in the present investigation. Quality of Life Scale by Flanagan (1978), Panas-SF by Watson, Clark, and Tellegen (1988), Spiritual Well-Being Scale by Paloutzian and Ellison (2009), Adult Hope Scale by Snyder, Irving, and Anderson (1991), Resilience Scale by Wagnild and Young (1993), Socio-Economic Status Scale by Aggarwal, Bhasin, Sharma, Chhabra, Aggarwal, and Rajoura (2005), and PGI Social Support Questionnaire by Nehra and Kulhara (1995) *were used to collect the data. Inter-correlations were computed and stepwise multiple regression analyses were applied to examine the predictors of QOL in institutionalized and non-institutionalized elderly.*

The major findings of the study revealed that for institutionalized and non-institutionalized elderly, quality of life was positively related with positive affect, agency, pathways, religious well-being, existential well-being, and social support whereas, it was negatively related with negative affect. Positive affect predicted quality of life of institutionalized elderly whereas, existential well-being and resilience emerged as (negative and positive respectively) predictors of quality of life in non-institutionalized elderly. Positive affect and agency emerged as the positive predictors of quality of life in the total sample of the elderly. Overall, such findings indicate towards advancing more research and intervention efforts for improving the quality of life of institutionalized and non-institutionalized elderly.

Keywords: Quality of life, positive affect, negative affect, existential well-being, religious well-being, resilience, socio-economic status, and social support

Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

INTRODUCTION

With increase in the number of the aged in the present day, the Indian society is characterized by a dilution of a traditional support system. In the earlier times, the elderly got enough opportunities to satisfy various needs. Moreover, it was regarded as the *moral duty* of the children to provide financial and physical security to their parents in old age. As such, even deteriorating health was not an obstacle in leading a comfortable life. They were given leadership roles and powerful positions of decision makers and advisors in the family.

In the present times however, the family structure as well as relations are drastically changing from joint families to smaller/nuclear families with little scope for social networking, leading to isolation and disintegration of the family as well as the social structure. As a result, elderly people are typically facing problems, such as empty nest, lack of autonomy, paucity of economic and social resources, alongwith the biological effects of aging. Thus, the need of studying quality of life in institutionalized and non-institutionalized has become of utmost importance today especially with the increasing stresses and strains in life.

According to Ferrans (1990), QOL is a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her. Ferran's conceptual model is composed of four QOL domains: health and functioning, socio-economic, psychological/spiritual, and family.

Quality of life can be conceived of as a composite of *positive affect* (Medvedev & Landhuis, 2018). Rathee (2004) found that cultivated positive emotions not only reduce negative emotions but also broaden one's habitual modes of thinking, and build one's personal resources for coping. In a study by Khosla & Hangal (2004), it has been found that participants experiencing positive affect report more coping resources to deal with stress. Although the detrimental influences of *negative affect* (NA) on health are well-known, an increasing number of studies have revealed that positive affect (PA) plays a crucial and beneficial role in health (see Pressman & Cohen, 2005).

Apart from affect, another variable which can have an impact on quality of life of institutionalized and non-institutionalized elderly is

hope. Hope is a positive motivational state that is based on an interactively derived sense of successful agency and pathways, with agency referring to goal-directed energy, and pathways referring to the planning that is required in meeting one's goals (Snyder, Irving, & Anderson, 1991). Optimistic and hopeful people are therefore, happier and healthier; they have more effective immune systems, cope better with stress, and have better social support networks (Peterson, 2000; Snyder, 2000; Schneider & Stevenson, 1999).

Another important personal resource that could effect QoL of the elderly is *spirituality.* Spirituality is viewed as a basic human need, and is important because it has the potential to promote quality of life especially in the elderly, whether ill or well, since it does exist across the lifespan. As one ages, there is a need to hold onto something that has a meaningful purpose in their life - whether this basic need is family, friends, or religion. Several studies have investigated the relationship between religious involvement and mental health. In most cases, they have found that higher levels of religious involvement are associated with greater well being and mental health (Moreira-Almeida & Koenig, 2006). Positive religious coping has been associated not only with better physical and mental outcomes in medically ill patients (Pargament Koenig, Tarakeshwar, & Hahn, 2004), but also among trauma survivors, such as people affected by large-scale floods (Smith, Brooks-Gunn, & Jackson, 2000). On similar grounds, it was proposed to examine the contribution of spirituality towards QoL of the elderly

Apart from affect, hope, and spirituality, another variable which can have an impact on quality of life of institutionalized and non-institutionalized elderly is *resilience*. Resilient individuals believe that they can directly influence the events that occur in their lives and translate their beliefs into actions (Reivich & Shatte, 2002). Resilience helps to overcome day-to-day stressors and move towards opportunities. Coping with stress is a part of living, but how one beholds stressful life events and moves on is the basis of the resilience framework (Flach, 1988), which the present investigation proposes to unravel.

There are some social variables which have significant effect on QoL of both, instutionalized and non-

instutionalized elderly. Amongst them, one variable that comes forefront is *socio-economic status*. Wealth is related to many positive life outcomes (Furmham & Argyle, 1998). For example, people with a higher income have better health and mental health, can afford improved health care services, have greater longevity, lower rates of infant mortality, are less frequently the victims of violent crime, have access to better social services, and experience fewer stressful life events (Mayer, 1997; Smith, Brooks-Gunn & Jackson, 1997; Wilkinson, 1996).

Another variable which may contribute towards enhancing quality of life in institutionalized and non-institutionalized elderly people is *social support.* The benefit of social support for individuals confronted with life crises has been the subject of research for more than two decades. It has been shown, for instance, that greater social integration during periods of high life stress may not only provide sustenance for the psychological well-being of an individual, but might also have a positive impact on a variety of discrete health outcomes which will improve one's quality of life.

A limited number of studies have been concerned with the comparison of the elderly persons residing in old age homes versus those residing with their families on quality of life and its diverse correlates. The present investigation is therefore, a significant step in this direction as it proposes to explore the differential role of diverse factors in predicting QoL of institutionalized and non-institutionalized elderly. It is expected that the results of the study may provide empirical evidence regarding the same that may help psychologists, sociologists, social workers and other professionals as well as policy makers of our nation to seek ways to enhance QoL of the elderly.

INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED ELDERLY:

Let us now unravel the difference in institutionalized versus non-institutionalized elderly on quality of life, affect, hope, spirituality, resilience, socioeconomic status, and social support.

A study was conducted on elderly residing in old age home and those in family setting in Tripura. Data was collected by personal interview method - 60 samples from the old age homes and 60 samples from the family setting. Elderly

living in family setting were found to have higher subjective well-being and level of satisfaction scores as compared to elderly living in old age homes. Mean level of satisfaction scores of elderly living in family setting was 116, median 117, and standard deviation 5.07. Mean level of satisfaction scores of elderly living in old age homes was 107, median 108, standard deviation 3.71 (Chakrabarti, 2009).

Antonelli, Rubini, & Fassone (2000) found that the institutionalized elderly have more negative affect, lower levels of self-esteem, and have a more restricted interpersonal self when compared to the non-institutionalized elderly.

A study conducted by Tejal (2010) on psychological wellbeing of elderly found that institutionalized aged experience poor sense of psychological well being than the non-institutionalized aged. Another research finding indicates that aged persons living in old age homes lag behind in hopefulness and mental health (Joseph & George, 2011).

Non-institutionalized participants scored significantly higher than did the institutionalized participants on self-esteem and spiritual well-being (Roh, Lee, & Yoon, 2013).

Kaplan (2002) conducted a study to find out resilience of 50 senior citizens living in home for aged and 50 senior citizens living in the family set-up in Erode district. The findings indicated that majority of senior citizens in the home for aged had moderate resilience. Over all, mean score regarding resilience was found to be higher in senior citizens living in family set-up than the senior citizens living in home for the aged. Results arrived at in a study by Saroj, Punia, Singh, & Saroj (2007) indicated that overall, institutional facility provided to residents of old age home had positive and significant relationship with positive attitude towards their well-being status.

Previous studies have shown that predictors of institutionalization include being an older woman, being single, not having family or neighbourhood support, being illiterate, and having cognitive or physical impairment (Lopes, Mateu, & Rosati, 2020). Thus, institutionalized elderly were more likely to have lower socioeconomic status and to be widowed or single, uninsured, malnourished, and suffering from chronic diseases that made them dependent in their daily lives (Lopes, Mateu, & Rosati, 2020). Trama & Mehta (20202a) found that perceived stress emerged

as the sole (positive) predictor of QoL in instutionalized elderly women whereas, in case of instutionalized elderly men, planful problem solving was found to do so positively. So, institutionalized seem to differ in their QoL; they may face problems differentially, and may use different resources to fight stresses and achieve better QoL.

A study by Chadha, Shah, & Mahajan (1991) reported that institutionalized elderly exhibit significantly smaller social networks than non-institutionalized elderly. The institutionalized elderly were found to have greater feeling of loneliness, depression, and hopelessness. Moreover, the lack of support and assistance to the elderly during daily activities is suggested as an aggravating factor for stimulating elderly's institutionalization (Luppa, Luck, Weyerer, König, Brähler, & Riedel-Heller, 2010).

Trama & Mehta (2020b) too, found that institutionalized elderly men reported higher scores on QoL; confrontive coping, self controlling, planful problem solving; strength use, and resilience as compared with institutionalized elderly women. On the other hand, instutionalized elderly females reported higher levels of perceived stress; seeking social support, escape avoidance, and positive reappraisal (being different aspects of coping) in comparison to institutionalized eldery males. Since perceived stress seemed to play an important role in the lives of the elderly, and two variables pertaining to stress are the socio-economic status of the elderly, and one's social support, it was considered worthwhile to examine both these resources in the present investigation (viz., socio-economic status and social support).

In sum, it may be said that there is scanty research evidence regarding the contribution of personal and social correlates of quality of life in institutionalized and non-institutionalized elderly, which the present investigation proposes to examine.

OBJECTIVES

The following objectives were formulated in the present investigation:

1. To examine the predictors of QOL of institutionalized and non-institutionalized elderly.
2. To examine the inter-correlations of quality of life with affect, hope, spiritual well-being, resilience, socio-economic status, and social

support in institutionalised and non-institutionalised elderly.

HYPOTHESES

Keeping in view the objectives of the study as well as the Indian socio-cultural context, the following hypotheses have been framed:

1. There would be differential predictors of quality of life in institutionalized and non-institutionalized elderly.
2. Quality of life of institutionalized and non-institutionalized elderly would be positively related with positive affect, hope, spirituality, resilience, socio-economic status, and social support whereas, it would be negatively related with negative affect.
3. Even after controlling for negative affect, positive affect would be positively related with quality of life of institutionalized and non-institutionalized elderly.
4. Positive affect would be positively related with hope, spirituality, resilience, socio-economic status, and social support whereas, negative affect would be negatively related with hope, spirituality, resilience, socio-economic status, and social support in the elderly.
5. Hope would be positively related with spirituality, resilience, socio-economic status, and social support in the elderly.
6. Spirituality would be positively related with resilience and social support in the elderly.
7. Resilience would be positively related with social support in the elderly.

METHODOLOGY

SAMPLE:

The sample of the present investigation comprised 320 (160 males and 160 females) institutionalized and non-institutionalized elderly aged 60 to 75 years. The sample for institutionalized elderly (N=160; males=80 and females=80) comprised those who were living in old age homes (for at least 6 months) in and around Patiala and Chandigarh. The sample for non-institutionalized elderly (N=160; males=80 and females=80) comprised those who were living with their families in their homes. All participants living in urban cities of Patiala and Chandigarh were taken in the present

investigation. Convenience sampling was done as those elderly were taken who met the inclusion criteria, and were willing to participate in the investigation.

INCLUSION AND EXCLUSION CRITERIA USED IN THE STUDY

Inclusion criteria for elderly people living in old age home:

1) Educated up to fifth standard
2) Both males and females
3) Aged between 60-85 years
4) Living in old age home for at least past six months
5) Willing to participate in the study
6) Not involved in any occupation and profession

Exclusion criteria for elderly people living in old age home:

1) Those with prior history of major physical illness
2) Those with prior history of major psychiatric and neurological illness

Inclusion criteria for elderly people living within family setup:

1) Educated up to fifth standard
2) Both males and females
3) Aged between 60-85 years
4) Willing to participate in the study
5) Living with family members
6) Not involved in any occupation and professional work.

Exclusion criteria for elderly people living within family setup:

1) Those with no prior history of major physical illness
2) Those with no prior history major psychiatric and neurological illness

TOOLS USED:

For examining the personal and social correlates of quality of life in instutionalized and non-instutionalized elderly, the tools administered have been discussed below

1) QUALITY OF LIFE SCALE (FLANAGAN, 1978):

It is a self-administered questionnaire. It has 16 items. Items are rated on a seven-point scale ranging from "delighted" (7) to "terrible" (1). The instrument is scored by summing the items to make a total score (possible range of scores is 16 to 112). Higher score is indicative of better quality of life.

Estimates from the first study of 240 American patients with chronic illness (diabetes, osteoarthritis, rheumatoid arthritis, and post-ostomy surgery) indicated

that the 15-item QOLS Satisfaction Scale has adequate internally consistency (α=0.82 to 0.92), and has high test-retest reliability over 3-weeks in stable chronic illness groups (r=0.78 to r=0.84) (Burckhardt, Woods, Schultz, & Ziebarth, 1989). Other researchers too, have reported similar reliability estimates for the 16-item scale (Wahl, Burckhardt, Wiklund, & Hanestad, 1998). A study of content validity of the QOLS, in which Americans with chronic illness were asked open-ended questions about what the term "quality of life" meant to them and what was important to their QOL, generated words and phrases that were very similar to those used by the general population that Flanagan had studied (Bukardth, Woods, Schults & Ziebath, 1989). It has been adequately used on Indian samples (e.g., Trama & Mehta, 2013).

2) PANAS-SF (WATSON, CLARK, & TELLEGEN, 1988):

Trait pleasant and unpleasant affectivity was measured using the Positive Emotion and Negative Emotion subscales respectively of the Positive and Negative Affect Schedule (PANAS-SF) (Watson & Clark, 1999; Watson, Clark, &Tellegen, 1988). PANAS-SF is a shorter and more concise version of the original PANAS test. I-PANAS-SF is the international version of the short-form PANAS-test which allows all 10 concepts in each scale to be understood and interpreted in the same way by different nationalities, making it reliable and valid. In this test, all ambiguities and room for interpretation have been removed and replaced by words that have an unambiguous meaning. This has resulted in a reliable and efficient test that can be used at an international level. The short form was modified by Thompson (2007) to enhance content validity, and to establish an English-language short form that could be employed in international contexts. This version demonstrated a reasonable two-factor (PA, NA) structure, temporal stability, internal reliability, and invariant item loadings (Thompson, 2007). It has been adequately used on Indian samples (e.g., Sharma, 2016).

3) SPIRITUAL WELL-BEING SCALE (PALOUTZIAN & ELLISON, 2009):

This scale is a general indicator of perceived well-being which may be used for the assessment of both, individual and congregational spiritual well-being. It provides an overall measure of

the perception of spiritual quality of life as well as subscale scores for Religious and Existential Well-Being (EWB). The Religious Well-Being (RWB) subscale provides a self-assessment of one's relationship with God, while the Existential Well-Being subscale gives a self-assessment of one's sense of life purpose and life satisfaction.

The spiritual well-being, scale comprises twenty items, ten of which assess religious well-being, and ten of which assess existential well-being.

Each spiritual well-being scale item is scored from 1 to 6, with a higher number representing greater well-being. Negatively worded items are reverse scored. Summing up the scores for the positively worded items (11 items) and negatively worded items (9 items) will give the total score for spiritual well-being (SWB). A score in the range of 20–40 reflects a sense of low overall spiritual well-being, 41–99 reflects a sense of moderate spiritual well-being, a score in the range of 100 –120 reflects a sense of high spiritual well-being.

The religious well-being, existential well-being, and spiritual well-being scales/subscales have adequate reliability. For the religious well-being subscale, test-retest reliability coefficients across four studies, viz., Ellison (1983); Upshaw (1984); Brinkman (1989); and Kirschling & Pittman (1989), with 1-10 weeks between testings are 0.96, 0.99, 0.96, and 0.88 respectively. For the existential well-being subscale, the coefficients are 0.86, 0.98, 0.98, and 0.73 respectively. For total spiritual well-being, the coefficients are 0.93, 0.99, 0.99, and 0.82 respectively. Previous studies reported high construct validity and two-factor structure of the original scale (Ellison & Smith, 1991). It has been adequately used on Indian samples (e.g., Trama & Omna, 2019).

4) ADULT HOPE SCALE (SNYDER, IRVING, & ANDERSON,

1991):

Hope was measured using the Adult Hope Scale (AHS, Snyder, Irving & Anderson, 1991). It comprises 12 items; four agency items, four pathways items, and four filler items. Participants are asked to rate how much each statement describes them. Examples of agency items include ‘‘I energetically pursue my goals” and ‘‘I meet the goals that I set for myself”. Examples of pathways

items include ‘‘I can think of many ways to get out of a jam” and ‘‘I can think of many ways to get the things in life that are important to me”. Participants use an eight-point likert scale with one representing ‘‘definitely false” and eight representing ‘‘definitely true”. Internal consistency (alpha reliability) has been reported as ranging from 0.74 to 0.78, and a test–retest correlation over a 10-week period of 0.82 (Snyder et al., 1991). Total hope scale scores range from a minimum of 8 to a maximum of 64, while agency and pathway scores range from a minimum of 4 and a maximum of 32, with high scores reflecting high levels of hope.

Convergent and discriminant validity were documented, along with evidence suggesting that hope scale scores augmented the prediction of goal related activities and coping strategies beyond other self-report measures. Construct validitional support was provided in regard to predicted goal-setting behaviors; moreover, the hypothesized goal appraisal processes that accompany the various levels of hope were corroborated (Snyder et al., 1991). It has been adequately used on Indian samples (e.g., Ajitha, 2017).

5) RESILIENCE SCALE (WAGNILD & YOUNG, 1993):

It describes the psychological ability that allows a person to cope effectively with life stresses. It is a 25-items scale. Items are scored on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). Scores range from 25 to 175, with higher scores indicating greater resilience. Wagnild & Young (1993) have given the following scoring for the total score 25-100 = Very low, 101-115 = Low, 116-130 = On the low end, 131-145 = Moderate, 146-160 = Moderately high, and 161-175 = High. This scale has two major factors, viz., acceptance of self and life, and individual competence (Wagnild & Young, 1993). This scale is appropriate for younger individuals as well as middle-aged and older adults.

Cronbach's alpha coefficients have been found to range from 0.72 to 0.94 (Neill & Dias, 2001). Test-retest reliability has been reported to range between 0.67 to 0.84 by Killien & Jarretiss (1993). This scale has shown considerable construct validity with constructs, such as morale and life satisfaction (positively related), and depression and perceived stress (negatively related) as reported by Ahern,

Kiehl, Sole, & Byers (2006). It has been adequately used on Indian samples (e.g., Trama & Mehta, 2013).

6) SOCIO-ECONOMIC STATUS SCALE (SES SCALE; AGGARWAL, BHASIN, SHARMA, CHHABRA, AGGARWAL, & RAJOURA, 2005)

The present instrument is proposed to measure the socio-economic status of the family. The scale has 22 statements including financial, educational, family possessions, etc. of the family of the individual. This scale has been developed for all sections of the Indian society.

This scale consists of 22 items. The score range for this scale is 9-100. Score of 76 or above indicates upper high social status, score of 61-75 indicates high class, 46-60 score indicates upper middle class, score of 31-45 indicates lower middle class, score of 16-30 indicates poor class, and score of 15 or less indicates very poor class.

The internal consistency of items in the different scales was assessed by calculating Cronbach's alpha. All the 22 items of scale were divided among these four components called *prominence*, *paying capacity*, *assets* (parental support and land for cultivation) and *affordability* based on their factor loadings. Items under the first component (*prominence in society*) with strong factor loading were locality, education of husband/wife, occupation of husband/wife, family possessions, caste, and monthly per capita income. Intra class correlation (ICC) coefficients of the scale were estimated to be 0.786 (0.716, 0.838), 0.915 (0.888, 0.936), 0.92 (0.894, 0.94) and 0.952 (0.937, 0.964), respectively (Dudeja, Bahuguna, Singh, & Bhatnagar, 2015). Analysis narrowed down the 22 items of scale to six items e.g. locality, education of husband/wife, occupation of husband/wife, family possessions, caste and monthly per capita income. These 6 items together accounted for 49% of the variation and can be taken as a surrogate measure of SES of the family. It has been adequately used on Indian samples (e.g., Trama & Omna, 2019).

7) PGI SOCIAL SUPPORT QUESTIONNAIRE (NEHRA & KULHARA, 1995):

This scale was developed by Nehra & Kulhara in 1987, and adapted by the same authors in Hindi in 1995 based on “Social

Support Scale‟ by Pollock & Harris (1983) which consisted of 23 items. Based on the content analysis of these 23 items, 18 were adapted with modification of 7 items. Its concurrent validity has been found to be satisfactory. The scale measures "perceived social support". Out of total 18 items, 7 are positive worded and 11 are negatively worded. Each item is followed by a question "agree to what extent," and scored on seven-point scale from "fully agree" to "not at all". SSQ has a test–retest reliability of 0.59, and correlation with clinician's assessment at 0.80, and with items of social support from Family Interactions Pattern Scale Chubon (1987) at 0.65 of social support perceived by the individual. Higher score indicates more perceived social support.

PROCEDURE:

Participants for the present investigation were contacted in different old age homes of Chandigarh and Patiala district, viz., Shri Satya Sai Old Age Home, Sai Varidh Ashram, Senior Citizen Home, and Mata Khiwi Old Age Home. These aged people living with their families or institutions belonged to middle and upper class families of Chandigarh and Patiala district. Convenience sampling was done. For assessing quality of life, affect, hope, spirituality, resilience, socio-economic status, and social support, a set of questionnaires were given to the participants. A rapport was established with participants before beginning the investigation. All the above questionnaires were administered in two to three sittings. The participants were requested to co-operate and truthfully answer the items of each scale. They were assured that their personal information as well as their responses would be kept strictly confidential. The instructions for each questionnaire were given at the top of each scale. Scales measuring quality of life, affect, hope, spirituality, resilience, socio-economic status, and social support were administered, and scoring for each scale was done as mentioned in their respective manuals.

STATISTICAL ANALYSES:

The present investigation proposed to examine the personal and social correlates of quality of life in institutionalized and non-institutionalized elderly. Means, standard deviations, skewness, and kurtosis for quality of life, affect, spirituality, hope, resilience, socio-economic status, and social support were calculated (see appendix A). Inter-correlations were computed, and stepwise multiple regression

analyses were applied to examine the predictors of QoL in institutionalized and non-institutionalized elderly.

PSYCHOLOGY AND EDUCATION (2021) 58(5), ISSN 1553 - 6939
Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

APPENDIX A: SUMMARY TABLE SHOWING MEANS, S.D's, SKEWNESS, AND KURTOSIS FOR ALL THE VARIABLES FOR INSTITUTIONALIZED ELDERLY

	TOTAL (N=160)				MALES (80)				FEMALES (N=80)			
	MEAN	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**
QOL	76.32	20.52	-0.47	-0.12	82.96	21.20	-1.37	2.18	69.68	17.57	0.34	-0.87
PA	26.44	6.01	-0.10	-0.34	30.15	4.46	0.25	0.20	22.73	4.99	-0.07	-1.18
NA	30.31	8.78	-0.52	-0.60	32.26	8.65	-0.97	-0.05	28.36	8.52	-0.17	-0.47
AGENCY	16.36	4.93	0.81	0.16	16.89	6.06	0.55	-0.76	15.84	3.40	0.84	0.60
PATHWAY	14.89	3.54	0.54	-0.78	15.54	2.87	0.24	-0.83	14.25	4.02	0.90	-0.54
RWB	18.68	6.42	0.88	0.09	15.60	3.00	-0.19	-0.95	21.75	7.41	0.12	-1.05
EWB	21.48	6.27	0.08	-0.66	23.24	5.99	0.19	-0.61	19.71	6.09	0.03	-1.09
RESILIENCE	118.31	20.35	0.26	-1.09	123.19	20.31	-0.11	-0.98	113.43	19.30	0.66	-0.69
SES	45.71	6.19	-0.19	-1.11	44.66	6.28	-0.06	-1.31	46.75	5.95	-0.31	-0.84
SOCIAL SUPPORT	24.63	7.55	0.76	-0.18	25.91	7.66	0.77	-0.51	23.35	7.27	0.78	0.16

APPENDIX A: SUMMARY TABLE SHOWING MEANS, S.D's, SKEWNESS AND KURTOSIS FOR ALL THE VARIABLES FOR NON-INSTITUTIONALIZED ELDERLY

	TOTAL (N=160)				MALES (80)				FEMALES (N=80)			
	MEAN	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**
QOL	85.32	18.70	-0.93	0.78	91.78	15.06	-2.07	9.18	78.86	19.81	-0.27	-1.09
PA	31.63	5.70	0.34	-0.29	34.53	5.50	0.08	-0.51	28.74	4.27	0.09	-0.46
NA	30.61	6.66	0.14	-1.07	25.03	3.23	-0.05	-1.22	36.20	3.97	-0.05	-0.60
AGENCY	20.19	6.65	-0.04	-0.78	22.80	5.78	-0.09	-0.96	17.58	6.46	0.23	-0.62

PATHWAY	22.23	6.02	0.02	-1.06	24.63	5.40	-0.37	-0.91	19.84	5.67	0.50	-0.46
RWB	45.45	8.69	-0.54	-0.56	44.14	8.64	-0.78	-0.38	46.76	8.58	-0.33	-1.06
EWB	46.34	3.49	0.35	-0.28	47.46	3.47	0.42	-0.06	45.21	3.15	0.17	-1.31
RESILIENCE	111.88	24.69	0.54	-0.24	117.76	22.77	0.91	-0.53	106.00	25.26	0.50	-0.25
SES	44.75	6.39	-0.03	-1.29	43.86	6.44	0.16	-1.32	45.64	6.25	-0.21	-1.16
SOCIAL SUPPORT	29.54	8.75	0.31	-0.79	30.95	7.67	0.23	-1.13	28.14	9.56	0.52	-0.58

APPENDIX A: SUMMARY TABLE SHOWING MEANS, S.D's, SKEWNESS AND KURTOSIS FOR ALL THE VARIABLES IN TOTAL SAMPLE (N=360)

	TOTAL (N=160)				**MALES (80)**				**FEMALES (N=80)**			
	MEAN	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**	**MEAN**	**S.D.**	**SKEWNESS**	**KURTOSIS**
QOL	80.82	20.11	-0.68	0.11	87.37	18.86	-1.69	4.13	74.27	19.22	0.07	-1.14
PA	29.03	6.40	0.02	-0.02	32.34	5.46	0.32	-0.24	25.73	5.53	-0.18	-0.50
NA	32.53	6.34	-0.03	-0.76	28.64	7.45	0.10	-0.66	32.28	7.70	-0.85	0.42
AGENCY	18.28	6.15	0.43	-0.60	19.84	6.60	0.13	-1.05	16.71	5.22	0.60	0.29
PATHWAY	18.56	6.15	0.63	-0.58	20.08	6.27	0.48	-0.97	17.04	5.64	0.78	-0.06
RWB	32.06	15.43	0.17	-1.43	29.87	15.70	0.30	-1.59	34.26	14.88	0.08	-1.22
EWB	36.93	16.33	-0.13	-1.57	35.35	13.09	-0.18	-1.51	32.46	13.67	-0.20	-1.55
RESILIENCE	115.09	22.81	0.35	-0.55	120.48	21.68	0.43	-0.95	109.71	22.72	0.41	-0.29
SES	45.23	6.30	-0.11	-1.21	44.26	6.35	0.05	-1.32	46.19	6.11	-0.27	-1.01
SOCIAL SUPPORT	27.09	8.53	0.54	-0.57	28.43	8.05	0.42	-0.99	25.74	8.80	0.75	-0.08

PSYCHOLOGY AND EDUCATION (2021) 58(5), ISSN 1553 - 6939
Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

RESULTS

V.1 INTER-CORRELATIONS

TABLE 1: SUMMARY TABLE SHOWING THE INTER-CORRELATION+ MATRIX FOR INSTITUTIONALIZED ELDERLY (N=160; 80 MALES AND 80 FEMALES)

	QOL	PA	NA	Agency	Pathways	RWB	EWB	Resilience	SES	Social Support
QOL	-	**.25****	.08	**.17***	.03	**-.20***	.04	.00	-.06	.11
PA	-	-	**-.47****	**.16***	**.20***	**-.34****	.00	**.17***	-.11	**.21****
NA	-	-	-	.15	-.01	-.11	.00	.00	-.07	**.22****
Agency	-	-	-	-	-.05	-.05	.01	-.02	.08	**.26****
Pathways	-	-	-	-	-	**-.28****	.04	.01	-.03	.09
RWB	-	-	-	-	-	-	-.13	-.06	.15	-.11
EWB	-	-	-	-	-	-	-	.06	-.08	.02
Resilience	-	-	-	-	-	-	-	-	-.04	-.02
SES	-	-	-	-	-	-	-	-	-	-.13
Social Support	-	-	-	-	-	-	-	-	-	-

* $p < 0.05$

** $p < 0.01$

\+ one-tailed values

Since the pattern of correlations and regression analyses was similar for males and females in each sub-group, i.e., institutionalized and non-institutionalized elderly, therefore, the data was reported accordingly. The inter-correlations and stepwise multiple regression analyses for the *total sample* was done in order to examine the third hypotheses which stated that even after controlling for negative affect, positive affect would positively contribute towards QoL of the elderly.

The inter-correlation matrix (see table 1) for institutionalized elderly (N=160, Males=80;

Females=80) revealed that quality of life was positively related with positive affect (r=0.25, p<.01), and a subscale of hope, viz., agency (r=0.17, p<.05) whereas, it was negatively related with a subscale of spiritual well-being, viz., religious well-being (r=-0.20, p<.05). However, the inter-relations of quality of life with negative affect, pathways (a subscale of hope), existential well-being (a subscale of spiritual well-being), resilience, socio-economic status, and social support were found to be non-significant.

As far as the inter-correlations among predictor variables are concerned, it was found that for the sample of institutionalized elderly (N=160), positive affect was positively related with two subscales of hope [viz., agency (r=0.16, p<.05), and pathways (r=0.20, p<.05)], resilience (r=0.17, p<.05) and social support (r=0.21, p<.01) whereas, it was negatively related with negative affect (r=-0.47, p<.01) and religious well-being (r=-0.34, p<.01). However, the inter-relations of positive affect with existential well-being (a subscale of spiritual well-being), and socio-economic status were found to be non-significant.

Negative affect was found to be positively related with social support (r=0.22, p<.01) in institutionalized elderly. The relations of negative affect with two aspects of hope (viz., agency and pathways), two subscales of spiritual well-being (viz., religious well-being and existential well-being), resilience, and socio-economic status were found to be non-significant. Agency (a subscale of hope) was found to be positively related with social support (r=0.26, p<.01). The inter-relations of agency with two subscales of spiritual well-being (viz., religious well-being and existential well-being), resilience, and socio-economic status were found to be non-significant. Pathways (a subscale of hope) was found to be negatively related with religious well-being (r=-0.28, p<.05). The inter-relations of pathways with existential well-being (a subscale of spiritual well-being), resilience, and socio-economic status, and social support were found to be non-significant.

The inter-relations of two subscales of spiritual well-being (viz., religious well-being and existential well-being) with resilience, socio-economic status, and social support were not found to be significant. Moreover, no

Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

significant inter-relations were found among resilience, socio-economic status, and social support in case of institutionalized elderly.

TABLE 2: SUMMARY TABLE SHOWING THE INTER-CORRELATION+ MATRIX FOR NON-INSTITUTIONALIZED ELDERLY (N=160; 80 MALES AND 80 FEMALES)

	QOL	PA	NA	Agency	Pathways	RWB	EWB	Resilience	SES	Social Support
QOL	-	**.17***	**-.25****	.13	.15	-.08	**-.28****	**.24****	-.06	.14
PA	-	-	**-.33****	.08	**.22****	.05	**-.32****	.03	-.10	.13
NA	-	-	-	**-.37****	**-.35****	.15	**.63****	**-.20***	.07	-.07
Agency	-	-	-	-	**.21****	**-.22****	**-.27****	.02	-.04	.12
Pathways	-	-	-	-	-	.02	**-.31****	.15	-.11	.05
RWB	-	-	-	-	-	-	.02	-.03	.05	-.06
EWB	-	-	-	-	-	-	-	-.11	.07	-.11
Resilience	-	-	-	-	-	-	-	-	-.03	**.18***
SES	-	-	-	-	-	-	-	-	-	.04
Social Support	-	-	-	-	-	-	-	-	-	-

* p < 0.05

** p < 0.01

\+ one-tailed values

The inter-correlation matrix (see table 2) for non-institutionalized elderly (N=160; Males=80; Females=80) revealed that quality of life was positively related with positive affect (r=0.17, p<.05) and resilience (r=0.24, p<.01). Quality of life was negatively related with negative affect (r=-0.25, p<.01) and existential well-being (r=-0.28, p<.01). However, the inter-correlations of quality of life with two subscales of hope (viz., agency and pathways), a subscale of spiritual well-being, viz., religious well-being, socio-economic status, and social support were found to be non-significant.

As far as the inter-correlations among predictor variables are concerned, it was found that for non-institutionalized elderly (N=180), positive affect was positively related with pathways (r=0.22, p<.01) whereas, it was negatively related with negative affect (r=-0.33, p<.01) and existential well-being (r=-0.32, p<.01) (a subscale of spiritual well-being). However, the inter-correlations of positive affect with agency, religious well-being, resilience, socio-economic status, and social support were also found to be non-significant.

For non-institutionalized elderly, negative affect was found to be positively related with existential well-being (r=0.63, p<0.01) whereas, it was negatively related with two subscales of hope, viz., agency (r=-0.37, p<.01 and pathways (r=-0.35, p<.01), as well as resilience (r=-0.20, p<.05). The relations of negative affect with religious well-being, socio-economic status, and social support were found to be non-significant.

For non-institutionalized elderly, agency (a subscale of hope) showed a positive relation with pathways (a subscale of hope) (r=0.21, p<0.01) whereas, it was negatively related with two subscales of spiritual well-being, viz., religious well-being (r=-0.22, p<.01 and existential well-being (r=-0.27, p<.01). The inter-correlations of agency (a subscale of hope) with resilience, socio-economic status, and social support were found to be non-significant.

For non-institutionalized elderly, pathways (a subscale of hope) showed a negative relation with existential well-being (a subscale of spiritual well-being) (r=-0.31, p<0.01). The relations of pathways (a subscale of hope) with religious well-being (a subscale of spiritual well-being), resilience, socio-economic status, and social support were found to be non-significant.

The relations of two subscales of spiritual well-being (viz., religious well-being and existential well-being) with resilience, socio-economic status, and social support were not found to be significant.

Resilience was found to be positively related with social support (r=0.18, p<0.05), but no significant relation was found between resilience and socio-economic status in non-institutionalized elderly. Socio-economic status too, was not found to be significantly related with social support.

TABLE 3: SUMMARY TABLE SHOWING THE INTER-CORRELATION+ MATRIX FOR THE TOTAL SAMPLE OF ELDERLY (N=320)

	QOL	PA	NA	Agency	Pathways	RWB	EWB	Resilience	SES	Social Support
QOL	-	**.28****	**-.16****	**.21****	**.21****	**.13***	**.18****	.09	-.07	**.18****
PA	-	-	-.09	**.22****	**.39****	**.30****	**.34****	.03	**-.13***	**.26****
NA	-	-		**-.25****	**-.37****	**-.24****	**-.19****	-.07	.03	-.04
Agency	-	-	-	-	**.28****	**.19****	**.25****	-.04	-.01	**.25****
Pathways	-	-	-	-	-	**.49****	**.52****	-.01	-.11	**.22****
RWB	-	-	-	-	-	-	**.81****	**-.14***	-.02	**.21****
EWB	-	-	-	-	-	-	-	**-.14***	-.08	**.26****
Resilience	-	-	-	-	-	-	-	-	-.03	.05
SES	-	-	-	-	-	-	-	-	-	-.06
Social Support	-	-	-	-	-	-	-	-	-	-

* p < 0.05

** p < 0.01

\+ one-tailed values

For the total sample (of institutionalized and non-institutionalized elderly) (N=320; Males=160, Females=160), quality of life was positively related with positive affect (r=0.28, p<.01)], two subscales of hope [(viz., agency (r=0.21, p<.01) and pathways (r=0.21, p<.01)], two subscales of spiritual well-being [viz., religious well-being (r=0.13, p<.05) and existential well-being (r=0.18, p<.01)], and social support (r=0.18, p<.01). Quality of life was negatively related with negative affect (r=-0.16, p<.01). However, the inter-relations of quality of life with resilience and socio-economic status were found to be non-significant.

In the total sample (N=320) of the elderly, it was found that positive affect was positively related with two subscales of hope, viz., agency (r=0.22, p<.01) and pathways (r=0.39, p<.01), two subscales of spiritual well-being, viz., religious well-being (r=0.30, p<.01) and existential well-being (r=0.34, p<.01), as well as social support (r=0.26, p<.01) whereas, it was negatively related with socio-economic status (r=-0.13, p<.05). However, the inter-relations of positive affect with negative affect

and resilience were found to be non-significant.

Negative affect was found to be negatively related with two subscales of hope, viz., agency (r=-0.25, p<.01) and pathways (r=-0.37, p<.01), two subscales of spiritual well-being, viz., religious well-being (r=-0.24, p<.01 and existential well-being (r=-0.19, p<.01). However, the inter-relations of negative affect with resilience, socio-economic status, and social support were found to be non-significant.

In the total sample of the elderly, two subscales of hope, viz., agency and pathways, were found to be positively related with two subscales of spiritual well-being [viz., religious well-being (r=0.19, p<.01; r=-0.49, p<.01 respectively) and existential well-being (r=0.25, p<.01; r=0.52, p<.01 respectively)], and social support (r=0.25, p<.01; r=0.22, p<.01 respectively).

Two subscales of spiritual well-being, viz., religious well-being and existential well-being were found to be positively related with social support (r=0.21, p<.01; r=0.26, p<.01 respectively) whereas, both were negatively related with resilience (each r=-0.14, p<.05). The relations of two subscales of spiritual well-being, viz., religious well-being and existential well-being with socio-economic status were found to be non-significant. The inter-relations of resilience, socio-economic status, and social support were found to be non-significant.

V.2 REGRESSION ANALYSES

TABLE 4: SUMMARY SHOWING STEPWISE MULTIPLE REGRESSION ANALYSES FOR QUALITY OF LIFE IN INSTITUTIONALIZED ELDERLY (N=160)

VARIABLE		PA					
	a	b	β	R^2	F	$R^2\Delta$	F (for $R^2\Delta$)
PA	54.21	**0.84****	0.25	0.25	**10.99****	-	-

* p < 0.05

** p < 0.01

Stepwise multiple regression analyses (see table 4) revealed that 25% (R^2=0.25, p<0.01) of the variance in QoL of institutionalized elderly was being explained by positive affect, which emerged as a positive predictor of quality of life. In institutionalized elderly, positive affect emerged as the sole (positive) predictor of quality of life.

TABLE 5: SUMMARY TABLE SHOWING STEPWISE MULTIPLE REGRESSION ANALYSES FOR QUALITY OF LIFE IN NON-INSTITUTIONALIZED ELDERLY (N=160; MALES=80 AND FEMALES=80)

VARIABLE		EWB		RESILIENCE					
	a	b	β	b	β	R_2	F	$R^2\Delta$	F (for $R^2\Delta$)
EWB	145.89	-1.16	**-.28****	-	-	.08	**13.16****	-	-
RESILIENCE	122.76	-1.06	**-.32****	.16	**.06***	.12	**10.81****	.04	**7.79****

* p < 0.05
** p < 0.01

Stepwise multiple regression analyses revealed (see table 5) that 12% (R^2=0.12, p<0.01) of the variance in QoL in non-institutionalized elderly was being explained by existential well-being (a negative predictor) and resilience (a positive predictor).

In non-institutionalized elderly, 8% of the variance was being explained by existential well-being which emerged as a negative predictor. Resilience emerged as a positive predictor of quality of life in non-institutionalized elderly. It explained an additional 4% of the variance in QoL (over and above the contribution of existential well-being).

TABLE 6: SUMMARY TABLE SHOWING STEPWISE MULTIPLE REGRESSION ANALYSES FOR QUALITY OF LIFE OF ELDERLY (TOTAL SAMPLE; N=320)

VARIABLES		PA		AGENCY					
	A	b	β	b	β	R_2	F	$R^2\Delta$	F (for $R^2\Delta$)
PA	55.38	0.88	**0.28****	-	-	0.08	**26.84****	-	-
AGENCY	49.37	0.77	**0.25****	0.50	**0.15***	0.10	**17.57****	.02	7.72

* p < 0.05
** p < 0.01

Stepwise multiple regression analyses (see table 6) revealed that 10% (R^2=0.10, p<0.01) of the variance in QoL in the total sample was being explained by positive affect which emerged as a positive predictor, and agency (a subscale of hope) which too, emerged as a positive predictor.

In these elderly, 8% of the variance was being explained by positive affect which emerged as a positive predictor. Agency (a subscale of hope) emerged as a positive predictor of quality of life of the elderly (total sample). It explained an additional 2% of the variance in QoL (over and above the contribution of positive affect).

DISCUSSION

Now-a-days, the role of families in case of the elderly has declined due to structural changes which have taken place in the Indian society and the concomitant disintegration of the joint family system, which has resulted in the rejection or neglect of the aged. Life in institutions need not be bad, but it commonly is. This holds true everywhere in the world. Thus, life in an old age home can be very distressing and demoralizing.

The present investigation envisaged to examine personal and social correlates of quality of life in instutionalized and non-instutionalized elderly. In case of institutionalized elderly, stepwise multiple regression analyses revealed that 25% of the variance in QoL of institutionalized elderly was explained by positive affect, which emerged as a positive predictor of quality of life. In institutionalized elderly, positive affect emerged as the sole (positive) predictor of quality of life. For the total sample, stepwise multiple regression analyses revealed that 8% of the variance in QoL in the total sample was explained by positive affect which emerged as a positive predictor and 2% of the variance in QoL in the total sample was explained by agency (a subscale of hope) which too, emerged as a positive predictor and a correlate which is in line with the second hypotheses of the study stating that quality of life of institutionalized and non-institutionalized elderly would be positively related with positive affect and hope, As far as the correlation of positive affect with QoL is concerned, positive affect was found to be positively related with quality life for the elderly (institutionalized, non-institutionalized and for the total sample).

Being in homes, family bonds are there. The next generation is

busy earning their livelihood, and the grandparents have to cater to their grandchildren and because of that, grandchildren respond well to their grandparents. Thus, they feel important and satisfied which makes them feel happier, and enhances their ability to handle various stressors which is confirmed in a study by Adelmann (1994) who reported that there is a strong positive correlation between multiple roles and psychological wellbeing in the elderly population. Multiple roles (like spouse, parent, homemaker, grand parent, caregiver, employee, volunteer, etc.) are linked with higher life satisfaction and lower depressive symptoms.

A study by Charles & Almeida (2007) confirms that seniors experience more positive emotions and fewer (and less intense) negative emotions than young people and middle-aged adults. Generally, older adults are also more satisfied with their lives, and are more emotionally stable. Even with the losses that come with age, it is the happiest time of life for many people. This could be for a number of reasons. Elderly people have greater awareness of one's self and preferences; an ability to control desires, and have more realistic expectations – unrealistic expectations tend to foster unhappiness; moving closer to death may motivate people to pursue personal goals which leads to better QoL (Azeem & Naaz, 2015)

It was surprising to note that our third hypotheses of the research "*Even after controlling for negative affect, positive affect would be related with quality of life of institutionalized and non-institutionalized elderly" was supported by the present findings.* Such findings highlight the role that positive affect can play in one's life. Elderly develop positive view of life as they age, and these levels of positive affect can override the negative effects of negative affect in determining their quality of life. Thus, positive affect may independently contribute towards QoL,

Stepwise multiple regression analyses revealed (see table 5) that that 12% of the variance in *QoL of non-institutionalized elderly* was being explained by *existential wellbeing* which emerged as a negative predictor (as well as a correlate), and *resilience* which emerged as a positive predictor.

A possible reason could be that old age is generally considered as a disadvantageous stage in the life span of an individual. Due to urbanization and industrialization in

India, the traditional family system is weakening. Elderly persons are perceived by youth as obsolete and worthless because of their passive role in the society. As such, the elderly gradually lose things that previously occupied their time, and gave them life purpose. For example, their job may change, they may eventually retire from their career, their children may leave home, or other friends and family may move far away. Fan (2010) found that negative beliefs regarding aging, such as boredom and feelings of uselessness, directly challenged an individual's desires to search for a sense of meaning, purpose, and security later in life, and thus, appeared to contribute to the feelings of vulnerability.

As far as the correlation of existential well-being with QoL is concerned, it was found to be positively related with quality of life for the total sample which could be attributed to the fact that generally, our old generations have gone through so many things and they have this feeling of living and adjusting in any of the circumstances, which gave their life a meaning and purpose which led to quality of life which is also supported in a study by Panzini & Bandeira (2007) who found consistent evidence for the relations between QoL and spirituality.

However, this link was missing for the institutionalized elderly which could be due to the fact that after shifting to institutions, elderly accept their fate and they just start feeling that they are spending their last years of life. So, in their case, existential well-being was not related with quality of life.

Resilience emerged as a positive predictor (and a correlate) of quality in the life in the non-institutionalized elderly (but this correlation was non-significant for the institutionalized elderly as well as the total sample). The probable reason could be due to that elderly staying in homes usually have a less exposure to stress because being in homes, they take a back seat and give all the charge to their children, and elderly just focus on their self-care which is also supported in the study by Fan (2010). The contradicting evidence emphasizes that resilience factor comes in place where there is persistence of harsh life experiences (Azam & Naaz, 2015). The roots of research on resilience can be found in Warner's (1993) research on children born into poverty who faced difficult life circumstances. In these conditions, they not only faced problems but also flourished. Cognitive-

behavioural theory emphasizes that one's behaviour is determined by one's cognitive construction of the world, and this cognitive construction may promote or inhibit adaptation to stressful events (Beck, 1976). So, it can be said that resilience is influenced by the perception of situations and experiences. Living in families in a collectivistic culture as ours can be very challenging for the elderly, and hence, it was not surprising to find that being resilient turned out to be a potential positive predictor (and correlate) of QoL in non-institutionalized elderly.

However, the interrelation of QoL with resilience was found to be non-significant for the total sample as well as the institutionalized elderly. This could be due to this fact that being in institutions, elderly don't have that support system which they had earlier. Elderly accept every kind of treatment with a grace. Hence, being resilient was not leading to better QoL.

Further, the findings revealed that negative affect did not emerge as a predictor of quality of life (though quality of life was negatively related with negative affect in the total sample as well as for the non-institutionalized elderly). It can possibly be explained that elderly start loosing their physical fitness as they age. They face so many physical ailments due to which, sometimes, they are unable to perform their daily activities which makes them feel negative thus, affecting their quality of life which is confirmed in a study by Felton, Revenson, & Hinrichsen (1984) who found that negative emotional states lowered self-esteem thus, affecting one's QoL. But this link was missing for institutionalized elderly which could be attributed to the fact that being in old age homes may not have been a pleasurable experience for them. As such, their levels of negative affect were high, but this negative affect did not contribute towards their QoL.

Agency and pathways belief (subscales of hope) were found to be positively related with quality of life of elderly (total sample) which is in line with the first hypotheses stating that quality of life of institutionalized and non-institutionalized elderly would be positively related with hope. This might be due to the fact that elderly tend to have better problem solving skills because they have experienced a lot in their life and moreover, due to their wisdom and strength, they are always hopeful that everything will be fine. So this

will tend to enhance their QoL which is in line in a study by Theophil (2009) who found that hope strengthens our capacity to live which is partially in consonance with the second hypotheses of the present investigation stating that "quality of life of institutionalized and non-institutionalized elderly would be positively related with hope." However, this link was missing for the non-institutionalized elderly as well as the institutionalized elderly with the only exception of agency beliefs which were found to be positively related (with quality of life of institutionalized elderly). This could be due to the fact that being in institutions and following very strict regime could have been a very negative experience for the institutionalized elderly. So, in that particular environment, without the support of the family, it might have been very difficult for them to have any kind of hope which lead to diminished levels of QoL.

Moreover, even for non-institutionalized elderly, old age is a stage full of challenges. The disintegration of the traditional family in the Indian socio-cultural context also seem to be demoralizing where elderly are "forced to" or "compelled to" look after themselves inspite of their physical ailments and health constraints. As such, it was not surprising to find that even in the case of non-institutionalized elderly, both aspects of hope were unrelated with QoL.

Religious and existential well-being emerged as positive correlates of QoL in the total sample. Religious well-being was found to be negatively related with QoL in case of institutionalized elderly whereas, existential well-being was unrelated with it. This can be attributed to the fact that elderly tend to feel contended after participating in religious and spiritual practices. They feel happy while participating in these kind of practices because they get a kind of company there with whom they can share their joys and sorrows which is in line with a study by Wolf (1959) who found that religious practices fulfil the need for integration and affirmation of elderly thus, leading to better QoL. Religious well-being was found to be negatively related with QoL in case of institutionalized elderly whereas, existential well-being was unrelated with it. Religious well-being was found to be unrelated with QoL in case of non-institutionalized elderly whereas, but existential well-being was negatively with QoL of non-

imstitutionalized elderly. Religious well-being was negatively related with QoL in the case of institutionalized elderly only. This can be explained by the fact that different aspects influence how people appraise many facets of their life ranging from their happiness, self-worth to overall quality of life, and different individuals may have different valence and perception about religion, such as, for some, religion may act as a buffer against negative emotions whereas, for some, it could serve no purpose. Therefore, institutionalized elderly could have taken recourse to religion due to great levels of stress in their lives. As such, religious well-being was negatively related with QoL of institutionalized elderly. Another reason could be that the rigid routine of institutions made them feel negative because of which they have lost their interest in religious/spiritual activities.

For non-institutionalized elderly, religion was not associated with their quality of life, which is in line with a study by Fabricatore, Handal, & Fazel (2000) who failed to report a correlation between religiosity/spirituality and positive/negative affect. This could be due to the fact Indian elderly are by and large, religiously oriented. However, this religious well-being was not leading to better QoL of non-institutionalized elderly who face a lot of problems being in homes such as lack of authority, position, etc.

Socio-economic status did not emerge as a predictor (or as a correlate) of QoL in institutionalized elderly, non-institutionalized elderly, as well as the total sample. Infact, it was not related with any of the predictor variables considered in the present research (with the exception of the correlation between SES and PA which was found to be negative for the total sample). There is a paucity of research regarding this finding, but this is in line with the general observation which possibly explains that in the old age, material progression and money do not remain as important as they were in the adult life, and emotional needs of the elderly become of paramount significance. Thus, positive affect is not essentially affected by financial resources. This is supported by gerotranscendental theory which was originally expressed by Tornstam (1994). Based on this theory, gerotranscendental term points out to change in view of elderly, and a shifting in metaperspective, from a rational and materialistic view to a more transcendent and cosmic one.

Gerotranscendental term suggests to exceed developmental dynamic point of view in older adults. In contrast with materialistic theory, this theory believes that people have low attention to life material aspects by raising age, and become much more interested in communication with others. Based on this theory, all people are prone to be mature and become wise, and life crisis speeds the geotranscendental evolution. As such, it was not surprising to find that socio-economic status was unrelated with QoL as well as with almost all predictor variables in the present investigation.

Socio-economic status was however, negatively related with positive affect for non-institutionalized elderly. This reveals that living in homes is not sufficient in dealing with the elderly; even when they are having adequate socio-economic status, it may not lead to enhanced positive emotional status. In fact, the negative correlation obtained between positive affect and socio-economic status for non-institutionalized elderly in the present investigation reveals that elderly coming from higher socio-economic status families were having more diminished levels of positive affect and vice versa. Thus, having money and worldly possessions may not bring about happiness and contentment, especially so at an age when individuals are nearing the last stages of life. Hence, the findings clearly reveal that money and worldly possession cannot buy peace and satisfaction for the non-institutionalized elderly.

Moreover, social support was found to be positively related with quality of life only in the case of total sample (which is in line with the first hypotheses. This is in line with findings which revealed that elderly who received love and support of their age mates experienced positive emotions and happy moods (Diener, 1984), which could have led to better QoL.

However, inter-relations of quality of life and social support were found to be non-significant in case of institutionalized as well non-institutionalized elderly. Being in institutions, elderly don’t have the support of their loved ones, and elderly staying in their homes may be having the physical presence of loved ones but that support might not be adequate (functional support) in promoting their QoL.

Further, the results of the inter-correlations revealed that positive affect was negatively related with negative affect in case

of institutionalized and non-institutionalized elderly which is in line with the fourth hypotheses of the study stating that it would be negatively related with negative affect.

Elderly, whether institutionalized and non-institutionalized having adequate positive affect would have diminished levels of negative emotions. This is also in line with the findings of the study by Snyder (2000) who found that positive emotions are related to less anxiety. This possibly explains the negative correlation found between positive affect and negative affect for institutionalized and non-institutionalized elderly.

However, no correlation was found between PA and NA in case of the total sample. Few investigations recommend that positive and negative affect are independent factors (Diener & Emmons, 1985). Embracing this view, one expects that both of aspects affect can co-exist at a similar time without essentially offsetting one another. In view of this thought, it is then theoretically possible to elevate the levels of positive affect without fundamentally diminishing the levels of negative affect.

Further, the results of inter-correlations revealed that positive affect was positively related with hope (both, agency and pathways beliefs) in case of institutionalized elderly, non-institutionalized elderly as well as the total sample (with the only exception of the relation between positive affect and agency that was found to be missing in case of non-institutionalized elderly) which is in line with the fourth hypotheses stating that positive affect would be positively related with hope.

This might be due to that, these people, regardless of institutionalization or non-institutionalization, have a strong feeling of hope and survival because of their age, maturity and wisdom. However, in case of non-institutionalized elderly, positive affect was unrelated with agency beliefs which indicates that although these elderly living in homes had higher levels of positive affect, and lesser levels of negative affect as compared with the institutionalized elderly by and large, this positive affect was not leading to adequate effect of being able to produce outcomes. It is possible that these elderly were not able to produce desired outcomes or diminish undesired outcomes since

the agency beliefs were found to be unrelated with positive affect.

Further, the results of the inter-correlations revealed that positive affect was negatively related with religious well-being in case of institutionalized elderly (and negatively related with existential well-being of non-institutionalized elderly) (which is in contradiction with our fourth hypotheses of the study stating that positive affect would be positively related with spirituality). This possibly explains that the fear of God makes a person feel connected to religious faith. People fear God that they might fall ill or god will punish them if they fail to follow the religious norms which makes the elderly feel guilty sometimes, which is also in line with a study by Ellison & Levin (1998) who found that people, who violate religious norms, may experience feelings of guilt or shame, or they may fear punishment from God.

However, in case of non-institutionalized elderly, religious well-being was not related with positive affect whereas, existential well-being was negatively related with positive affect. This could be attributed to the fact that being in families, elderly continue to shoulder so many responsibilities because next generations are busy working for their careers, and elderly feel satisfied while helping them in the household activities. So, being religiously involved might not have had a positive impact on their sense of happiness and contentment. A study by Fabricatore, Handal, & Fazel (2000) found no correlation between religiosity/spirituality and positive/negative affect. Moreover, existential well-being was negatively related with positive affect for non-institutionalized elderly. Existential well-being and positive affect were more in non-institutionalized elderly than institutionalized elderly. However, these positive affect states were not leading to meaning in life and finding answers to existential issues. This possibly explains the negative correlation obtained between existential well-being and positive affect for non-institutionalized elderly.

However, in the case of the total sample positive affect was positively related with religious well-being and existential well-being which supported our fourth hypotheses. The reason might be that generally, aged people tend to be connected with religion. They spend most of their time in carrying out religious activities. They have this belief that by doing so, they have secured a good place in heaven

which gives meaning and pupose to their life which is in consonance with a study by Levin (2001), who found that spirituality and religion can enhance individuals' quality of life by positively contributing to greater life satisfaction, happiness, positive affect, morale, and hope.

Positive affect was positively related with resilience in institutionalized elderly which is in line with the fourth hypotheses of the study stating that positive affect would be positively related with resilience. These findings are also in line with a general observation that some individuals, who come from mediocre or impoverished backgrounds, tend to excel in academics as well in their personal lives. One often comes across such persons who have "started their life from scratch" and are leading very "well-off" lives in their later years. In such cases, one often observes that the stressors that these individuals faced were regarded by them as "challenges" rather than "constraints" which motivated them to put in an extra effort to excel in their lives, be it academically, socially or professionally. Hence, low socio-economic status acted as a catalyst for positive change and growth, facilitating the optimization of the potential of such individuals. This possibly explains as to why positive affect was positively related with resilience in instutionalized elderly.

However, no correlation was found between positive affect and resilience in case of non-institutionalized and the total sample. Elderly generally feel that they are in their reclining years of their life because of which positive affect may not lead to resilience. This effect can also be seen when elderly continue to have heavy responsibilities on their shoulder due to which non-institutionalized elderly showed lower levels of resilience than institutionalized elderly, though the former had higher levels of positive affect than the latter.

A positive correlation was found between positive affect and religious well-being/existential well-being in the total sample which could be due to the fact participating in religious/spiritual practices give elderly contentment and happiness which further helps them physical and mentally. This possibly explains the positive correlation obtained between religious well-being/ existential well-being and positive affect in the total sample.

Positive affect was found to be positively related with social support in the institutionalized

elderly as well as for the total sample (which is in consonance with our fouth hypotheses stating that positive affect would be positively related with social support.) This could be attributed to the fact that being in institutions, elderly are with like-minded people which gives them emotional support which helps them making feel more positive. Overall, one can say that elderly enjoy being with their age mates, which makes them feel positive.

However, the inter-relations of positive affect and social support were found to be non-significant in case of non-institutionalized elderly. Non- institutionalized elderly showed higher levels of positive affect and social support as compared with institutionalized elderly. However, it is possible that this "perceived support" was not leading to "functional support" for these elderly. Hence, social support was not leading to positive affective conditions in non-institutionalized elderly.

Negative affect was negatively related with agency and pathways in non-institutionalized elderly as well as the total sample. This, can be explained by the fact that in the Indian perspective, parents expect a lot from their children. They have very high hopes and are very positive that their children will also do something for them. This is supported in a study by Davey & Eggebeen (1998) who found that that parents expect more than the children can give. Children cannot reciprocate in an expected manner which affects the meaning and purpose of the life of the elderly. This leads elderly to have negative affect and beliefs which diminishes hope.

Negative affect was found to be was negatively related with religious well-being and existential well-being for the total sample (and positively related with existential well-being) for the non-institutionalized elderly which probably can be explained to the fact that in the Indian context, elderly tend to participate more in religious and spiritual practices which could also be a one big reason for their conflict in their homes because they tend to spend maximum time at religious institutions. This in turn, was diminishing their existential perspective of life. Thus, negative affect was found to be positively related with existential well-being for the non-institutionalized elderly.

Negative affect was found to be positively related with existential well-being in non-institutionalized elderly which could be attributed to

the fact that elderly, being in homes, face a lot of challenges and because of these hardships, they become quite negative as they become more and more aware of existential issues. This possibly explains as to why negative affect was found to be positively related with existential well- being in non-institutionalized elderly.

On the other hand, negative affect was negatively related with religious well-being/existential well-being for the total sample. This indicates that more negative affect was leading to diminished levels of spiritual well-being, and vice versa, high levels of spiritual well-being were leading to diminished levels of negative affect.

Negative affect was not related with spiritual well-being in institutionalized elderly because being in institutions, these elderly already had high levels of negative affect and poor levels of spiritual well-being, It is possible that negative affect did not allow them to focus on spiritual aspects of their life because they tend to feel that they are just passing through their last years of life. Moreover, spiritual well-being may be displayed by elderly high and low in negative affect. This possible explains the fact that negative affect was not related with spiritual well-being in institutionalized elderly.

Negative affect was found to be negatively related with resilience in case of non-institutionalized elderly. A study by Charles & Almeida (2007) also confirms that seniors experience more positive emotions and fewer (and less intense) negative emotions than young people and middle-aged adults. Generally, older adults are also more satisfied with their lives, and more emotionally stable. Even with the losses that come with age, it is the happiest time of life for many people which gives them a ray of hope thus, enhancing their resilience. Thus, negative emotional states may lead to diminished resilience in these elderly.

However, on the other hand, negative affect was not related with resilience in institutionalized elderly the reason being that being in instititutions is already leading to despair, making them more negative, which was not leading to making these elderly resilient.

Negative affect was found to be unrelated with social support in the institutionalized elderly as well as for the total sample which could be due to the fact since the sample on which the study based was urban, so, negative affect didn't have any effect on their social

support because urban people are conditioned to have an intrinsic support rather than having extrinsic support system. Moreover, this perceived social support may or may not have led to decrease in negative affect.

As such, negative affect was unrelated with social support in the total sample of the elderly and the non-institiutionalized elderly. Non-institutionalized elderly were found to have relatively lower levels of negative affect and higher levels of social support than institutionalized elderly. As such, this relatively lower level of negative affect was displayed by non-institutionalized elderly irrespective of whether they were getting "perceived" social support or not. Vice versa, they were getting adequate social support (as compared with institutionalized elderly) from significant others. However, this social support was being rendered to them whether or not they were high on positive affect or negative affect. As such, the relation of positive affect/negative affect with social support were found to be missing. In fact, the links of social support with all other predictor variables (except for socio- economic status) were found to be missing for the non-institutionalized elderly.

Negative affect was found to be positively related with social support in institutionalized elderly (but this link was missing for non-institutionalized and the total sample) which can be explained by the fact that sometimes, social support has negative effects on health and well-being of people. For example, in several studies, it has been found that high level of social support is associated with a high level of stress and low level of health and well-being which is in line with research stating that negative social interactions may, in fact, have more potent effects on psychological well-being than positive interactions (Abbey, Abramis, & Caplan, 1985).

Agency (a subscale of hope) was positively related with pathways in case of non-institutionalized elderly and the total sample. The perception of the elderly that they are capable of executing the means of attaining their desired goal moves hand-in-hand with their perception that they are capable of generating those means because they are in their comfort-zones being in their homes. They have almost all the facilities available which is also confirmed in a comparative study by Nandhini & Parvathi (1996). They conducted a study on the levels of depression

and sense of well-being of institutionalized and non-institutionalized senior citizens. A sample of 30 non-institutionalized and 21 institutionalized senior citizens were tested on Beck's Depression Scale and P.G.I Sense of Well-Being Scale, and these elderly were individually interviewed regarding their family, leisure activity, and living arrangements. Institutionalized senior citizens were found to be significantly more depressed than the retired individuals living at home. It was explained the non-institutionalized elderly usually live with their spouse and family members which provides them with emotional security that others are there to look after them whereas, the institutionalized individuals have no friends or family members to look up to; they had workers of institution to rely upon. Thus, agency was related with pathways in case of non-institutionalized elderly whereas, these variables were unrelated for institutionalized elderly which is also in line with a recent research by Trama and Mehta (2021) on differences between the quality of life of the institutionalised and non-institutionalised elderly revealed that non-institutionalized elderly scored higher on QOL, positive affect agency (subscale of hope), pathways (subscale of hope), religious well-being and existential well-being (subscales of spiritual well-being) and social support than the institutionalized elderly whereas, the latter scored more than the former on negative affect and resilience, by and large. Also, there were no differences between institutionalized elderly and non-institutionalized elderly on socio-economic status.

No correlation was found between agency and pathways in case of institutionalized and total sample because at this age, they have achieved almost everything and they feel satisfied. So, they were not so goal-oriented in the last years of their lives. Moreover, they might be high on self-efficacy (agentic beliefs), but it was not leading to pathways or alternate solutions to their problems. This possibly explained why there was no correlation between agency and pathways in institutionalized elderly as well as the total sample.

On the other hand, hope was negatively related with two subscales of spiritual well-being, viz., religious well-being and existential well-being in case of non-institutionalized elderly, by and large (with the exception of the correlation between pathways and

religious well-being which was found to be non-significant. It can be explained by the possibility that as spiritual awareness increases, hope decreases. As the elderly become aware of their self and their existence, their future hope decreases because they start realizing that they have experienced and seen many different things in their life. They just need inner peace and contentment which is also in consonance with gerotranscendental theory by Tornstam (1994).

However, in case of the total sample, hope (both agency and pathways was positively related with the two subscales of spiritual well-being, viz., religious well-being and existential well-being, and social support which can be attributed to the fact that when elderly get positive social support from their family, friends/relatives and other social institutions, they tend to feel more positive and hopeful towards their their life. Likewise, being spiritually enlightened also contributes positively in their future expectation which is also confirmed in a study by Wolf (1959) who reported that religious belief, prayer and faith in God all help the aged to overcome loneliness and grief. It also helps the aged to fulfil the need for integration and the affirmation of oneself.

Hope was however, unrelated with social support in case of institutionalized and non-institutionalized elderly (with the exception of the relation between agency and social support which was found to be positive for institutionalized elderly). This might be due to fact that institutionalized and non-institutionalized elderly had higher levels of other resources which might be contributing to their levels of hope other than social support. Institutionalized elderly had relatively lower levels of social support and agency beliefs (an aspect of hope) as compared with non-institutionalized elderly. However, it is possible that due to higher levels of challenges that institutionalized elderly typically face, their self-efficacy and ,beliefs were adequate in dealing with situations. This also led them to there actually getting support from their co-inhabitants of the old age home and vice versa, functional social support received from co-inhabitants could have made them feel "competent" and "worthwhile". This possibly explains the positive relations obtained between agency beliefs and social support in case institutionalized elderly.

Two subscales of spiritual well-being, viz., religious well-being and existential well-being were negatively related with resilience and positively related with social support in the total sample only. This could be explained by the fact that elderly, regardless of institutionalization/or staying with their families, faced great stress which tended to get them involved in more spiritual/religious practices which provides them with needed emotional support and perceived base to handle adverse situations in life. Thus, though these elderly showed adequate levels of religious well-being and existential well being and were getting support of their near and dear, ones they might be facing too many problems in the sensitive stage. Moreover, it is possible that they were taking recourse to religious/spiritual practices in order to overcome their obstacles and challenges. Thus, spiritual well-being was found to be negatively related with resilience, and positively related with social support in case of the total sample.

On the other hand, spiritual well being was unrelated with resilience and social support for institutionalized as well as non-institutionalized elderly taken separately. This indicates that taking recourse to religious/spiritual practices may just be a way of handling conflicts, stresses, and pressures, but it may not lead to being resilient.

Moreover, having adequate spiritual well-being may not guarantee the support of near and dear ones. In fact, an elderly may seek solace in spirituality when he/she stopes receiving "functional support" from others. This possible explains the lack of relation found between spiritual well-being and social support.

As far as, the relations of resilience and social support are concerned, these relations were missing for the institutionalized elderly as well as the total sample (whereas, for non-institutionalized elderly, this relation was positive). This can be explained by the fact that elderly may face lots of hurdles and constraints in the old stage. They may take recourse to this by becoming resilient/hardy, but this resilience may not guarantee the support of other members of the society. In case of non-institutionalized elderly, living in families provided a support system to the senile, which in turn, made them resilient.

To conclude, it can be said that the findings of this research provide support to a number of

hypotheses framed in this research. This research also provides logical explanations for the results obtained in a study. Those explanations are often reached by comparing and contrasting the results to prior studies' findings. Also, the findings are interpreted in accordance with the theoretical underpinnings of the concerned variables.

Thus, there is a need to look into the psychological resources that might be promoted in the institutionalized and non-instutionalized elderly which may help them have a better quality of life.

CONCLUSION

To conclude, it can be said that QoL seems to be one of the facets of successful aging. In the present research, positive affect emerged as positive predictor of quality of life in institutionalized elderly. The key characteristics of highly resilient and happy individuals have been demonstrated in various studies, and include mental, social, and physical factors that lead to optimal outcomes of improved quality of life, happiness, and well-being as well as depression and despair.

Resilience has emerged as positive predictor of quality of life in the non-institutionalized elderly. The key characteristics of highly resilient and happy individuals have been demonstrated in various studies, and include mental, social, and physical factors that lead to optimal outcomes of improved quality of life, happiness, and well-being as well as depression and despair.

On the other hand, existential well-being emerged as a negative predictor of quality of life in case of non-institutionalized elderly. Non-institutionalized elderly have high mean scores on existential well-being but it is not leading to QoL. The reason being they have high existential well-being which makes them aware of more existential issues, and this awareness, in turn, could be demoralizing especially in the Indian socio-cultural context which is collectivistic in nature, and which often makes it challenging for elderly to adjust in their homes at an age when they themselves are dependent on others, and can hardly contribute effectively in running the household.

Thus, enhanced existential awareness could have possibly led to diminished quality of life in non-institutionalized elderly.

Positive affect and agency (a subscale of hope) emerged as positive predictors of quality of life

in total sample. It appears that individuals, who have the strength to cope with stressful life situations and have positive emotional states, may be more able to cope with challenging life events. Their experience of fear or worries can be dealt with adaptively at a practical and functional level and consequently, they are able to have a better QoL.

In sum, it may be said that the findings of study recommend designing interventions to enhance positive affect, hope, and resilience in the elderly which could eventually enhance their overall quality of life.

REFERENCES

1. Abbey, A., Abramis, D. J., & Caplan, R. D. (1985). Effects of different sources of social support and social conflict on emotional well-being. *Basic and Applied Social Psychology*, *6*(2), 111-129.
2. Adelmann, P. K. (1994). Multiple roles and psychological well-being in a national sample of older adults. *Journal of Gerontology*, *49*(6), 277-285.
3. Aggarwal, O. P., Bhasin, S. K., Sharma, A. K., Chhabra, P., Aggarwal, K., & Rajoura, O. P. (2005). A new instrument (scale) for measuring the socioeconomic status of a family: Preliminary study. *Indian Journal of Community and Medicine*, *30*(4), 111-114.
4. Ahern, N. R., Kiehl, E. M., Lou Sole, M., & Byers, J. (2006). A review of instruments measuring resilience. *Issues in Comprehensive Pediatric Nursing*, *29*(2), 103-125.
5. Ajitha, E.A. (2017). *The impact of hope resilience and positive affectivity on quality of work life and occupational stress of information technology professionals* (Unpublished doctoral dissertation, Karnatak University, Dharwad, Karnataka,India). Available at http://hdl.handle.net/10603/222640
6. Antonelli, E., Rubini, V., & Fassona, C. (2002). The self-concept in institutionalized and non-institutionalized elderly people. *Journal of Environmental Psychology*, *20*, 151-164.
7. Azeem, F., & Naz, M. A. (2015). Resilience, death anxiety, and depression among institutionalized and non-institutionalized elderly. *Pakistan Journal of Psychological Research*, *30*(1), 111-130.
8. Beck, A. T. (1976). *Cognitive therapy and emotional*

disorders. New York: International Universities Press.

9. Bergeron, L. R. (2001). An elderly abuse case study: Case gives stress or domestic violence. *Journal of Gerontogical Social Work*, *34*(3), 47-63.
10. Brinkman, D. D. (1990). An evaluation of the spiritual well-being scale: Reliability and measurement. *Western Conservative Baptist Seminary: Portland, OR, USA*.
11. Burckhardt, C. S., Woods, S. L., Schultz, A. A., & Ziebarth, D. M. (1989). Quality of life of adults with chronic illness: A psychometric study. *Research in Nursing and Health*, *12*, 347-354.
12. Chadha, N. K., Shah, S., & Mahajan, A. (1991). Leisure time activities among the aged: A comparative study. *Social Science International*, *7*(2), 12-24.
13. Chakrabarti, D. (2009). Well-being of the elderly residing in old age home vs. those in family setting in Tripura. *Nursing Journal of India*, *100*(10), 224.
14. Charles, S. T., & Almeida, D. M. (2007). Living with chronic health conditions: Age differences in affective well-being. *The Journals of Gerontology*, *62*(6), 313-321.
15. Chida, Y., & Steptoe, A. (2008). Positive psychological well-being and mortality: A quantitative review of prospective observational studies. *Psychosomatic Medicine*, *70*, 741–756.
16. Chubon, R. A. (1987). Development of a quality-of-life rating scale for use in health-care evaluation. *Evaluation & The Health Professions*, *10*(2), 186-200.
17. Diener, E. (1984). Subjective well-being and personality. In D. F. Barone, M. Hersen, and V. B. Van Hasselt (Eds.), *Advanced personality*. New York: Plenum Press.
18. Dudeja, P., Bahuguna, P., Singh, A., & Bhatnagar, N. (2015). Refining a socio-economic status scale for use in community-based health research in India. *Journal of Postgraduate Medicine*, *61*(2), 77-83.
19. Eggebeen, D. J., & Davey, A. (1998). Do safety nets work? The role of anticipated help in times of need. *Journal of Marriage and the Family*, *60*(4), 939-950.
20. Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology*, *11*(4), 330-338.

21. Ellison, C. W., & Smith, J. (1991). Toward an integrative measure of health and well-being. *Journal of Psychology and Theology*, *19*(1), 35-45.
22. Fabricatore, A. N., Handal, P. J., & Fenzel, L. M. (2000). Personal spirituality as a moderator of the relationship between stressors and subjective well-being. *Journal of Psychology and Theology*, *28*(3), 221-228.
23. Fan, T. H. D. (2007). *Beliefs about aging and later life health and well-being among the elderly in Taiwan.* Doctoral dissertation, The University of Texas, Austin. Texas Scholar Works.
24. Felton, B. J., Revenson, T. A., & Hinrichsen, G. A. (1984). Stress and coping in the explanation of psychological adjustment among chronically ill adults. *Social Science & Medicine*, *18*(10), 889-898.
25. Ferrans, C. E. (1990). Development of a quality of life index for patients with cancer. *Oncology Nursing Forum, 17*, 15–21.
26. Flach, F. (1988). *Resilience: Discovering a new strength at times of stress.* New York: Fawcett Columbine.
27. Flanagan, J. C. (1978). A research approach to improving our quality of life. *American Psychologist*, *33*, 238-147.
28. Joseph, S., & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology*, *9*(3), 262-280.
29. Joseph, M. I., & George, T. (2011). Alienation in old age: A comparative study. *The Psychespace*, *5*(2), 20-25.
30. Kaplan, B. H. (2002). Social support and health. *Journal of Medical Care*, *15*, 47-57.
31. Khosla, M., & Hangal, E. (2004). Role of optimism and pessimism in coping with stress. *Journal of Personality and Clinical Studies, 20*, 71-78.
32. Killien, M., & Jarrett, M. E. (1993). *Return to work: Impact on postpartum mother's health*. Unpublished data as cited in Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the Resilience Scale. *Journal of Nursing Measurement*, *1*, 165-178.
33. Kirschling, J. M., & Pittman, J. F. (1989). Measurement of spiritual well-being: A hospice caregiver sample. *The Hospice Journal*, *5*(2), 1-11.
34. Levin, J. (2001). A prolegomenon to an

epidemiology of love: Theory, measurement, and health outcomes. *Journal of Social and Clinical Psychology*, *19*, 117–136.

35. Lopes, H., Mateus, C., & Rosati, N. (2020). Identifying the long-term care beneficiaries: Differences between risk factors of nursing homes and community-based services admissions. *Aging Clinical and Experimental Research*, *32*(10), 2099-2110.

36. Luppa, M., Luck, T., Weyerer, S., König, H. H., Brähler, E., & Riedel-Heller, S. G. (2010). Prediction of institutionalization in the elderly. A systematic review. *Age and Ageing*, *39*(1), 31-38.

37. Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favourable and unfavourable environments. Lessons from research on successful children. *American Psychologist*, *53*(2), 205-220.

38. Moreira-Almeida, A., & Koening, H. G. (2006). Retaining the meaning of the words religiousness and spirituality. *Journal of Social Science and Medicine*, *63*(4), 840-845.

39. Nandhini, S., & Parvathi, S. (1996). Sense of well-being and depression among the institutionalized and non-institutionalized senior citizens. *Indian Journal of Applied Psychology*, *33*, 7-10.

40. Nehra, R., Kulhara, P., & Verma, S. K. (1996). Adaptation of social support questionnaire in Hindi. *Indian Journal of Clinical Psychology*, *23*, 33-39.

41. Neil, J. T., & Dais, K. L. (2001). Adventure education and resilience: The double aged sword. *Journal of Adventure Education and Outdoor Learning*, *1*(2), 35-42.

42. Paloutzian, R. F., & Ellison, C. W. (2009). Loneliness, spiritual well-being and the quality of life. In L. A. Peplau, and D. Perlman (Eds.), *Loneliness: A sourcebook of current theory, research and therapy* (pp. 224-236). New York: John Wiley & Sons.

43. Panzini, R. G., & Bandeira, D. R. (2007). Spiritual/religious coping. *Revista de Psiquiatra Clínica*, *34*, 126-35.

44. Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, *56*(4), 519-543.

45. Peterson, C. (2000). The future of optimism. *American Psychologist, 55*, 44-55.

46. Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin, 131*, 925-971.

47. Rathee, N. (2004). *Role of positive emotions in optimising health and well being*. Paper presented at the 8th International Conference of the Indian Academy of Applied Psychology. M.D. University, Rohtak, India.

48. Reivich, K., & Shatte, A. (2002). *The resilience factor: Seven essential skills for overcoming life's inevitable obstacles*. New York: Broadway Book.

49. Roh, S., Lee, K. H., & Yoon, D. P. (2013). General well-being of Korean immigrant elders: The significance of religiousness/spirituality and social support. *Journal of Social Service Research*, *39*(4), 483-497.

50. Saroj, S., Punia, S., Singh, K. C., & Balda, S. (2007). Psycho-social status of senior citizens and related factors. *Human Ecology, 22*(3), 255-259.

51. Sawatzky, R., Gadermann, A., & Pesut, B. (2009). An investigation of the relationships between spirituality, health status and quality of life in adolescents. *Applied Research in Quality of Life, 4*, 5–22.

52. Schneider, B., & Stevenson, D. (1999). *The ambitious generation*. New Haven, CT: Yale University Press.

53. Sharma, D. (2016). *Hope humor happiness and positive affectivity as correlates of emotional creativity* (Unpublished doctoral dissertation, The IIS University, Jaipur, India). Available at http://hdl.handle.net/10603/123885

54. Smith, J. R., Brooks-Gunn, J., & Jackson, A. (1997). Parental employment and children. In R. M. Hauser, B. V. Brown, and W. R. Prosser (Eds.), *Indicators of children's well-being*. New York: Russell Sage Foundation.

55. Snyder, C. R. (2000). The past and possible futures of hope. *Journal of Social and Clinical Psychology*, *19*, 11-28.

56. Snyder, C. R., Irving, L., & Anderson, J. R. (1991). Hope and health: Measuring the wills and the ways. In C.R. Snyder and D.R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (p. 285-305). Elmsford, NY: Pergamon Press.

57. Staats, S. (1987). Hope: Expected positive affect in an

adult sample. *The Journal of Genetic Psychology: Research and Theory on Human Development*, *148*(3), 357-364.

58. Theophil, M. (2009). Holding on to hope against all odds. *The Therapy*, *12*, 218–222.
59. Thompson, E. R. (2007). Development and validation of an internationally reliable short-form of the positive and negative affect schedule (PANAS). *Journal of Cross-Cultural Psychology*, *38*(2), 227-242.
60. Tornstam, L. (1994). Gerotranscendence - A theoretical and empirical exploration. In L..E.Thomas and S.E. Eisenhandler (Eds.), *Aging and the religious dimension* (pp. 203-225). Westport, CT: Greenwood.
61. Trama, S., & Mehta, R. (2013). *A study of quality of life in institutionlized elderly: Role of perceived stress, coping, strength use, and resilience* M.Phil dissertation, Department of Psychology, Punjabi University, Patiala, India.
62. Trama, S., & Omna (2019). *Risk factors of alcoholism in young adult women* (Unpublished doctoral dissertation, Punjabi University, Patiala, Punjab, India). Available at http://hdl.handle.net/10603/325608
63. Trama, S., & Mehta, R. (2020a). Effect of gender on quality of life, perceived stress, coping, strength use, and resilience in institutionalized elderly. *The Journal of Oriental Research*. *10*, 49-60.
64. Trama, S., & Mehta, R. (2020b). A study of quality of life in institutionalized elderly: Role of perceived stress, coping, strength use and resilience. *Weseleyan Journal of Research*. *13*, 41-52.
65. Trama, S., & Mehta, R. (2021). Quality of life and its resources: A comparative study institutionalized versus non-institutionalized elderly. *Journal of Psychology and Education*, 58(5), 1991-2021.
66. Upshaw, F. G. (1988). The effects of of a communications skills training program on marital satisfaction, commitment, social desirability, and spiritual well-being (Doctoral dissertation, Western Conservative Baptist Seminary, 1985). *Dissertation Abstracts International*, *48*, 369.
67. Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the resilience scale. *Journal of Nursing Measurement*, *1*, 165-178.

68. Wahl, A., Burckhardt, C. S., Wiklund, I., & Hanestad, B. R. (1998). The Norwegian version of the Quality of Life Scale (QOLS-N). A validity and reliability study in patients suffering from psoriasis. *Scandanavian Journal of Caring Sciences*, *12***,** 215-222.

69. Warner, R. S. (1993). Work in progress toward a new paradigm for the sociological study of religion in the United States. *American Journal of Sociology*, *98*(5), 1044-1093.

70. Watson D., & Clark L. A. (1988). Positive and negative affectivity and their relation to anxiety and depressive disorders. *Journal of Abnormal Psychology*, *97*, 346–353.

71. Watson, D., Clark L. A., & Tellegen A. (1988). Development and validation of brief measures of Positive and Negative Affect: The PANAS Scales. *Journal of Personality and Social Psychology*, *54*, 1063–1070.

72. Wolf, K. (1959). Group psycho-therapy with geriatric patients in a state hospital setting: Results of a three year study. *Group Psychotherapy*, *12*, 218–222.