IMPACT OF SOCIO-DEMOGRAPHIC VARIABLES ON PSYCHOLOGICAL WELL-BEING AND SPIRITUAL EXPERIENCE: A STUDY AMONG MIZO ADULTS

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CERTIFICATE

This is to certify that the present work titled, "**Impact of Socio-demographic Variables on Psychological Well-Being and Spiritual Experience: A Study Among Mizo Adults**", is the original research work carried out by H. Lalnunmawii under my supervision. The work done is being submitted for the award of the degree of Master of Philosophy in Psychology of the Mizoram University.

This is to further certify that the research conducted by H. Lalnunmawii has not been submitted in support of an application to this or any other University or an Institute of Learning.

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DECLARATION

I, H. Lalnunmawii, hereby declared that the dissertation entitled, "Impact of Socio-demographic Variables on Psychological Well-Being and Spiritual Experience: A Study Among Mizo Adults" was carried out by me for the degree of Master of Philosophy and has not been submitted before to any institution for assessment purposes.

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CHAPTER-I

INTRODUCTION

Aging population is the most challenging demographic phenomenon worldwide. It begins with conception and terminates with death. According to Bernard Strehler (1977), aging is considered to be: (i) universal: occurring at differing degrees in all individuals of a species (ii) intrinsic: ageing must be endogenous and must not depend on extrinsic factors(iii) progressive: changes that lead to ageing must occur progressively throughout the life span (also in young individuals, albeit in a small proportion) (iv) deleterious: a phenomenon associated with ageing will only be considered as part of the ageing process if it is 'bad' for the individual.

Aging involves the following five dimensions: chronological, biological, cultural, psychological and spiritual. Given the same level of chronological and biological aging, individuals may differ widely in terms of psychological aging. Rybash, Roodin, and Santrock (1991) define psychological age in terms of both adaptability and attitude. Psychological age refers to the capability of an individual to adapt to the changing environmental demands as compared to the adaptability of other individuals identical chronological age. Individuals become suitable to their environments by studying on various psychological characteristics: learning, memory, intelligence, emotional control, motivational strengths, coping styles, and many more. As a result, individuals who show more of such psychological characteristics than their chronological age mates are considered "psychologically young" while those who possess such traits to a lesser degree are "psychologically old".

Physiologically aging is characterized by lessening of bodily functions (Arshad & Bhat, 2013). Some researchers divided old age into three categories: Early old age or young old age (age 60 to age 69), old age or advanced old age, (age 70 to age 79) and older old age

from age 80 and above (Zizza et al. 2009). According to Anjaneyulu (2002), the final stage of the normal life span is Elderly. Orimo et al. (2006) defined “elderly” as a chronological age of 65 years old or older, while those from 65 through 74 years old are referred to as “early elderly” and those over 75 years old as “late elderly”. Terms for old people include seniors, senior citizens, older adults and the elderly.

According to the World Health Organization (2007), most of the countries have selected an arbitrary chronological age of 60 or 65 as a definition of ‘older person’. Relating to the whole world the percentage of older persons is growing faster than the general population. In 1950 there were 205 million persons aged 60 years or over in the world. According to United Nations (2012), the number of older persons increased to almost 810 million. The elderly add up to nearly 8.25 per cent of India's population. In terms of numbers, according to Census of India (2011) this comes to an estimated 99.87 million. It is roughly calculated that by 2050 almost 50 per cent of the Indian population will consist of elderly people (Help Age India, 2012).

Aging was defined by Barren and Renner (1977) as the regular changes that occur in mature, genetically representative organisms living under representative environmental conditions as they advance in chronological age. This definition refers to noticeable figure of change particular of aging and indicates that one can search for causal agents in aging processes. Remembering both figures of change and causal agents is fundamental to supporting the scientific understanding of aging.

Aging was defined by most evolutionary biologists as an age-dependent or age-progressive decline in intrinsic physiological function that leads to an increase in age specified to mortality rate (i.e., a decrease in survival rate) and a decrease in age-specified to reproductive rate (e.g., Medawar, 1955; Williams, 1957; Rose, 1991; Partridge and Barton,

1996; Tatar, 2001; Promislow & Bronikowski, 2006; Flatt & Schmidt, 2009; Bronikowski & Flatt, 2010; Fabian & Flatt, 2011).

Many theories of aging have been propounded. Medvedev (1990) stated that there were more than 300 theories of aging and the number is increasing. This is a natural outcome of the fact that we are quickly improving by understanding the natural occurence that are associated with aging using new experimental methods and ideas. In reality, almost any important discovery in cellular and molecular biology has given rise to a new family of theories of aging or to improved versions of old ones. As a result, the job of reviewing these theories is becoming more difficult than before because they are either very selective or they are now old fashioned. However, Vijg and Muller (2000) pointed out that some of the old hypotheses of aging laid the ground for the big scientific revolution in our understanding of ageing, which occurs in our days. All the figure associated with the aging is unrealistic and is included in a unified theory. Besides, it is usually accepted that we do not have all the pieces to the puzzle of aging.

In 1956, Harman originally put forwarded one of the most important theories to explain aging is the free radical theory of aging. Harman stated that the free radical theory of aging as suggests that free radicals derived from oxygen are responsible for destruction related with aging. The antioxidant systems are not able to counterbalance all the free radicals continuously generated during the life of the cell and results in oxidative damage in the cell and also in tissues. There is a great deal of experimental proof in support of this theory. As old animals are showing a higher index of oxidation than young ones as expected they collect oxidized proteins, oxidized DNA forms, and oxidized lipids. The damage can be assigned to an increased rate of free radical production in older organisms. This theory as a cause of aging is supported by other experimental evidence. For example, increasing antioxidant protection was the result of an increase in the average life span. The reactive oxygen species

are involved in degenerative diseases associated with age. Likewise, in Drosophila, the antioxidant administration increases average life extent. Besides, hard experimental evidence that supports the free radical theory of aging was founded by Orr and Sohal (1992). Drosophila over-expressing both Cu/Zn-superoxide dismutase and catalase, show an increase in both average and maximal life span. Later, the same authors published that Drosophila over-expressing both Mn-superoxide dismutase and catalase, do not show an increased life span, despite the fact that the transgenic flies displayed an enhanced resistance to experimental oxidative stress. This observation suggests that modification of life span not only depends on resistance against oxidative stress, but also on the specific manipulation of antioxidant pool which is modified.

Classification of age varied between countries and over time, reflecting in many instances the social class differences or functional ability related to the workforce, but more often than not was a reflection of the current political and economic situation. Many times the definition is linked to the retirement age, which in some instances, was lower for women than men. This transition in livelihood became the basis for the definition of old age which occurred between the ages of 55 and 75 years for men (Thane, 1978).

The term demographics refers to particular characteristics of a population. It is derived from the Greek words for people (demos) and picture (graphy). Demographic information provides data regarding research participants and is necessary for the confirmation of whether the individuals in a specific study are a representative sample of the target population for generalization purposes. Usually demographics or research participant characteristics are reported in the methods section of the research report and serve as independent variables in the research design. Demographic variables are independent variables by definition because they cannot be manipulated.

Characteristics of socio-demographic include - age, gender, socio-economic status, locality, family type, number of children, bread earner, other support, house type, house ownership, caretaker, assets, social and religious involvement. Socio-demographic characteristics are often used to describe realised samples and to find out sampling error.

According to Berkman and Harootyan (2003), there are a number of vulnerabilities related to aging such as an increase in physical, mental, and emotional health issues and significant changes in social and economic status are experienced by many older adults. Choi and Jun (2009) stated that older adults frequently review their lives with contentment or discontentment, and if burdened with unsettled regrets they are likely to experience depressive symptoms which can lead to clinical depression. Similarly, Blazer (2003) uses Erikson's life stage theory to suggest that depression may occur when the developmental tasks of accepting certain unavoidable losses associated with late life (e.g., death of a loved one) are not fulfilled successfully by the individual.

Ryan and Deci (2001) states that well-being refers to finest functioning and experience. The exact nature of finest functioning is still not necessarily clear and many philosophers and psychologists provide differing conceptions of well-being. Although it is numerous and sometimes complex, these conceptions tend to revolve around two distinct, but related philosophies: (1) hedonism: A hedonic view of well-being equates wellbeing with pleasure and happiness (Kahneman et al. 1999; Ryan & Deci 2001) and (2) eudaimonism: A eudaimonic view of well-being evoke well-being in terms of the cultivation of personal strengths and contribution to the greater good (Aristotle, trans. 2000), acting in accordance with one's inner nature and deeply held values (Waterman, 1993), the realization of one's true potential (Ryff & Keyes, 1995), and the experience of purpose or meaning in life (Ryff, 1989). Hedonic and eudaimonic approaches to well-being can be further differentiated by the degree to which they rely on subjective versus objective criteria for determining wellness. To

illustrate, determinations of wellness from the hedonic approach focus around the experience of pleasure, a subjectively-determined positive affective state. From a eudaimonic perspective, well-being is achieved by meeting objectively-valid needs which are suggested to be rooted in human nature and whose realization is useful to human growth (Fromm, 1947). In short, the hedonic approach focuses on subjectively-determined positive mental states, whereas the eudaimonic approach focuses on experiences that are objectively good for the person (Kagan, 1992). Huppert (2009) summarised psychological well-being is about lives going well and the combination of feeling good and functioning effectively.

Ryan and Deci (2001) also states that the extent to which individuals define well-being in hedonic and eudaimonic terms has a great extent on practical conclusion and thus affects the behaviour in several area of functioning especially those which are connected to the experience of well-being. Without any doubt in the theorizing on hedonic against eudaimonic makes a proposal to well-being that it is accepted to be true that these proposals are separately connected with positive psychological functioning. Precisely, eudaimonic theories assert that many desired outcomes which are enjoyable may not essentially be good for the individual and would not promote wellness in this way. To make it clear, eating at a fine restaurant and participating in a marathon may produce experiences of a similar hedonic quality, such as the experiences of happiness. But, participating in a marathon likely provides more opportunity for personal growth, self-development, and feelings of competency than eating at a fine restaurant and would likely give increased well-being. Moreover, eudaimonic makes a proposal to well-being, because they involve activities that are essentially good for the individual and are likely related with long-term and enduring well-being, whereas the sense of well-being derived from the experience of simple happiness likely disappeares in the short-term (Steger et al. 2008). In support, research specifies that physical pleasure is connected with life satisfaction within a day but not over several weeks (Oishi et al. 2001).

Further, according to Stegar et al. (2008), the positive effects of eudaimonic activity during a single day are associated with subsequent reports of well-being over several days.

Additional theoretical and empirical research from diverse areas of inquiry, including research on self-determination theory (SDT; Ryan & Deci, 2001), intrinsic versus extrinsic goals (Kasser & Ryan 1993, 1996), the self-concordance of goals (Sheldon & Elliot 1999), personally-expressive activities (Waterman, 2005; Waterman et al. 2008), and psychological well-being (Ryff, 1989; Ryff & Singer, 1998), have found that behaviors and learning characteristics of a eudaimonic approach are generally associated with positive psychological functioning. In some occasions, researches point out that behaviors and cognition indicative of a hedonic approach may actually be harmful to well-being. For example, sensation-seeking has been associated with a number of negative outcomes, including substance use (Carrol & Zuckerman, 1977; Zuckerman, 1994) and risky behaviours (Zuckerman, 2009).

Psychological well-being is the based on feeling of happiness with life and work, sense of achievement, utility, belongingness, no distress, dissatisfaction or worry, etc. It may be continued in unfavourable fact and oppositely may be lost in favourable one. Psychological well-being gets more than not being ill but positive self-esteem, environmental understanding, autonomy, positive relationships with other people, a sense of purposefulness and meaning in life and feelings of continued growth and development (Ryff, 1995). According to Girum (2012), psychological well-being performs as an umbrella term for many other constructs that use one's psychological functioning.

Carol Ryff and her colleagues (1995) proclaimed that to be well psychologically well is more than just to be free of distress and mental problems and suggested a complex 6-dimensional representation of psychological well-being. (i) The capability to withstand communal forces and to make and follow one’s own decisions is autonomy. (ii) Purpose in

life is the belief that one's life is firm and important. (iii) The third element of well-being is positive relationships and about the capability to have comfortable, pleasing and unsuspecting relationships with others. (iv)Personal growth refers to the individual's sense of sustained growth and development as a person as well as openness to new experiences. (v) The fifth component, environmental mastery, is related with the capacity to effectively manage one's life and the neighbouring world. (vi) Self-acceptance is about being able to have a positive judgement of oneself and one's past life. People with overall high scores on these 6 components are considered as having high psychological well-being. Besides, a person may possess higher scores on some dimensions of psychological well-being.

Psychological well-being is very applicable to older people for some reasons. According to Medical Research Council (2010), the fastest-growing part in society are the oldest old and it is roughly calculated that in 20 years' time, nearly a part of the population in the UK will be aged 65 and over. As life span increases and treatments for life-threatening disease become more successful, the matter of continuing psychological well-being and self-esteem at older ages is becoming more important. In addition, a high amount of the budget for health and social care is committed to the care of older people, making it crucial to understand the issue of psychological well-being and its relationship with health outcomes.

In old age, there is a growth in interiority (Jung, 1971) and center on achieving integrity (Erickson, 1963). Gutmann (1978) and Neugarten (1973) point out that increasing interiority reflects a age-related normative movement in personality. Successful aging depends on a person's ability to continue a meaningful life in spite of physical decline, personal losses, and ageism (Wong, 1989). This struggle includes the combination of past experiences with current circumstances into a meaningful life story. It also includes a transition from achievements and external orientation toward an inner orientation (i.e.,

Neugarten, 1973; Wong, 1997). This shift from doing to being and from outer attachments to inner life facilitates spiritual growth.

In psychology, spirituality is a meeting of an ingrained need of all human beings to act according to their basic values and beliefs, giving meaning to life (Frankl, 1988) and a sense of hope (Spilka et al. 2003). It also calls on the capacity for superiority through inner peace, harmony, or connectedness to others (Boswell et al. 2006). it is a dual concept consisting (a) a straight component that can be considered to enclose superiority, in other words the relationship of the individual with a higher power or a value system, and (b) a parallel component referring to the role of superiority in the person's way of life and how they relate to themselves, to others, and to the environment, and so corresponding to the meaning they give to life (Chhabra, 1995). The growth of spirituality is a complex and unarranged action that extents the whole lifetime (Rothberg, 1996). There are two main research trends: (a) Cartwright (2001), expresses a chronological and consecutive growth of spirituality; the final stage of spiritual maturity and wisdom is called "gerotranscendence" (Erikson & Erikson 1997); (b) the second is based on the possibility of a relatively autonomous development of spirituality, which is also considered as a distinct line of growth of the human spirit (Wilber, 1999). It corresponds to a process of conversion and protects against the constrictions and misfortune related with age.

Spiritual aging refers to developmental changes on the spiritual dimension. Fowler (1981) has proposed that faith is proceeding through different developmental stages from simple faith to spirituality. Similar to Flower, Tornstam (1999) provides a theory of “gerotranscendence” that declares for an age-related spirituality. Tornstam (1999) suggests that seniors are more likely to be focused in the spiritual dimension, which includes a concentration with inter-generational relationship, the meaning of life and death. From a life-

span perspective, the developmental duty and primary values change in different development stages.

According to Rivier et al. (2008), spirituality is a human cognitive approach that seeks to give meaning to life, to set values, and sometimes to seek transcendence, resulting in a spiritual identity. This is part of human growth, mostly in adults and the elderly. For Dalby (2006), spirituality corresponds to a search for meaning and purpose at a time of life when earlier sources of meaning and purpose may be decreasing. In this sense, it appears to be important to involve features of spirituality/religion in psychological care (Ortiz & Langer, 2002).

Spirituality was defined by Reed (1992) on the basis of theoretical, practical and clinical nursing literature as the tendency to make meaning through a sense of relatedness to dimensions that go beyond the self in such a way that authorizes and does not devalue the individual. This relatedness may be practiced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the natural environment) and transpersonally (referring to a sense of relatedness to the unseen, God, or power greater than the self and ordinary source).

The aim of spirituality is compassion, literally meaning 'to suffer with.' It shines with actions of love for others. Compassion has always been the official mark of true spirituality, and the highest teaching of religion. As expected, "Loveless spirituality is an oxymoron and an ontological impossibility" (Elkins, 1998). The use of supernatural concepts in the explanation of spirituality has been a point of great argument. Some authors argue that it is necessary to involve the idea of the sacred. Others disagree, continuing that the definition can be independent of any given religious affiliation or even atheistic (Johnson et al., 2004). McSherry, Cash, & Ross (2004) suggest that spirituality can be presented into two major

schools: those who believe in God and those who do not. Meraviglia (1999) describes two dimensions of spirituality considering one‘s ultimate values or beliefs: (1) The straight dimension in one‘s relationship with God or a highest being. (2) The parallel dimension in one‘s relationship with nature. Rayburn (2004) defines the spiritual person as “caring for others,” and “seeking goodness and truth, transcendence, and forgiveness/cooperation/ peacefulness.”

Moberg (2001) declares that all humans have a spiritual dimension by nature of being human, and therefore, each person has the capacity for spirituality. Spirituality in late life composed of finding core meaning in life, responding to meaning, and being in relationship with God/Other. Aging invites thoughtful activities. As many people are growing older, these observations are expressed into the search for life-meaning (MacKinlay, 2006). Studies advice that having a strong sense of meaning in life results in better physical and mental health outcomes, as well as improved quality of life and subjective well-being (Krause, 2004; MacKinlay, 2001; Nygren, Alex, Jonsen, Gustafson, Norberg, & Lundman, 2005). This search for life-meaning is powerful for spiritual experiences and expressions, especially as one ages and challenges various realities connected with end of life. This development changes the nature of meaning making from provisional, everyday meaning to larger life-meaning (MacKinlay, 2006). Understanding the spiritual experiences of the oldest-old is important to better ground what we know as gerontologists regarding aging over the life course. In turn, this will help us better understand the suggestions of everyday life-meaning for older adults.

The joining of spirituality, religion, and aging accepted an increase of interest in the 1990s, and continues in the early 21st century (Zinnbauer & Pargament, 2005). In specific, an interest in health appeared during this time, specifying application on the practical feature of spirituality and religion concerning to aging. Understanding the relationship between

"spirituality" and "religion," including the extent to which they can be extracted, has been a central part of this spiritual turn in gerontology. The continuing interest in this debate is evidenced by the diversity of definitions and conceptualizations of "spirituality" and "religion" (Atchley, 2009; Johnson, 2009; McFadden, 2005; Zinnbauer & Pargament, 2005; Wink, 2003). Wink (2003) examines "religious dwellers" and "spiritual seekers" over the lifecourse, arguing that spirituality and religion have enough intersecting qualities that they do not need to be split as constructs. This argument suggests that older adults can differentiate a difference is salient within scholarly debates, but to the extent these differences are relevant for the every day practice of spirituality is questionable. Zinnbauer and Pargament (2005) define spirituality as the search for the sacred that which is special, set apart from the ordinary, and deserving of veneration. Religion refers to the search for importance in ways related to the sacred. The process of the search, or seeking, is important for their conceptualization of both spirituality and religion. In spite of these theoretical debates and differences, most scholars agree that spirituality and religion are related constructs.

Spirituality is necessarily related to religion, but not limited to it. Merton (1958) stated that "spiritual life is not mental life. Everything must be elevated and transformed by the action of God, in love and faith". May (1982) also recognizes that "no spiritual quest can progress very far without becoming religious). Marcoen (1994) emphasizes the subjective nature and value orientation of spirituality, which "exists as a way of perceiving and conceiving reality as a whole, holding and realizing certain human values, aims and goals, experiencing deep, positive emotions accompanying behaviours and actions in daily life". This spiritual orientation is considered as an innate capacity or tendency to transcend self-interest (Chandler, Miner-Holden, & Kolander, 1992). Spirituality has also been equated with what individuals consider to be sacred and most important in their lives (Gilchrist, 1992).

As many older adults continue to age, it becomes more important to understand how older adults are acknowledging to late life challenges and opportunities, such as the death of a spouse, the loss of physical functioning or changes in role status with retirement. Emphasizing on older adults' spiritual experiences is part of this larger understanding. As McFadden (2005) points out, "for many, but certainly not all older people, faith communities, spiritual and religious experiences and beliefs concerning the sacred will contribute to life quality and meaning". Spirituality gives a framework that guides individuals through painful and joyful events, often facilitating positive discoveries amidst negative experiences (Ardelt, Ai, & Eichenberger, 2008). As a result, spirituality is a powerful assets in late life providing many older adults with the ability to modify to changing individual needs.

Connectedness encloses various features that can play a role in every human. Connectedness with oneself is showed by features such as authenticity, inner peace, consciousness, self-knowledge and experiencing and searching for meaning in life (Elkins et al. 1998; Young-Eisendrath & Miller, 2000; Hungelmann et al. 1985; Howden, 1992; Mahoney & Graci, 1999; Chiu et al. 2004). Connectedness with others and with nature is related to understanding, caring, thankfulness and wonder. Connectedness with the transcendent includes connectedness with something or someone beyond the human level, such as the universe, transcendent reality, a high power or God. Features related to this last theme are awe, hope, sacredness, adoration of the transcendent and transcendental experiences (Cook, 2004).

Spirituality necessitates believing and behaving as if non observable and nonmaterial life forces have governing powers in ones' everyday incidents. So, a continual sensitiveness to core spiritual qualities takes first concern in ones' life and indeed is essential to one's personal well-being. In God conceptions, this occuring spiritual sensitiveness is not necessarily tied to formal church doctrine or participation (Jagers & Mock, 1993).

Spirituality includes an individual's search for meaning. It is subjective and individualistic, and does not always have an organized form of practices or rituals. Spirituality is expressed as having components of transcendental experiences, a search for meaning and purpose in life, a worldview, meditation, rituals, an existential being and belief in non-physical interventions, like prayer (Miller & Thoresen, 2003).

Spirituality has appeared as an important portion of quality of life and well-being (Aranda, 2008; Carmody, Reed, Kristeller & Merriam, 2008; Fiorito & Ryan, 2007) and is regarded as a fundamental dimension of the inner lives of human beings throughout the world (Mack, 2006). Sustainable evidence relates spirituality with general (Haber, Jacob, & Spangler, 2007; Maselko & Kubzansky; 2006), physical (Carmody et al., 2008; Litwinczuk & Groh, 2007) and psychological (Davis, 2005; Fabricatore, Handel & Fenzel, 2000; Kim & Seidlitz, 2002; Levenson, Aldwin & Yancura, 2006; Snoep, 2008; Temane & Wissing, 2006; Young, Cashwell & Shcherbakova, 2000) well-being. It is important to understand spirituality also in wider socio-demographic conditions that includes gender as a variable that may play a role in the dynamics of people's psycho-social well-being. Moreover, Depken (1994) has pointed out the gap in theories of well-being not including gender as a variable in the dynamics of health and wellness. The present study was designed to determine the impact of socio-demographic variables on psychological well-being and spiritual experience among Mizo adults.

REVIEW OF LITERATURE

Aging is an inclusive process that brings unavoidable alterations through changes in the physical, mental, hormonal and the social status of a person. A significant rise in the number of absolute and relative numbers of older people is evident in the population of both developed and developing countries in the 20th century (Fahey et al. 2003).

In India, if a person is or above 60 years of age, he/she is considered elderly or senior citizen. The proportion of elderly persons in India has risen from 5.63% of the total population in 1961 to 7.44% in 2011 (Census of India 2011). As far as total numbers are concerned, the elderly population has climbed form 24.6 million in 1951 to 96 million in 2011 by 2001 census. There is an increase in life expectancy from 40 years to 64 years in 1951 and 2011 respectively. In term of growth rate, general population (1.9) appears to be lower than that of elderly population (3.09) which has contributed 7.5% of the country's total population (Group for Economic & Social Studies, 2009).

According to 2001 Census, the 30th most populous state/union territory of India, Mizoram, has 888,573 people residing within its 21081 sq. Km area. The state has 8 districts with 22 RD Blocks and 817 villages where 707 are inhabited and 110 are uninhabited. Out of the total population, 50.4 percent belongs to the rural areas leaving 49.6 percent within urban areas which comprises 22 statutory towns as per 2001 Census. The growth rate of the population in 1991-2001 is higher than the national growth of 21.5 per cent. Old age population has drastically increased, greater growth rate than the total population over the past thirty years, from 4.42 percent in 1981 to 5.52 percent in 2001. The total population, from 493,757 people in 1981 to 888,573 people in 2001, grew by 80 percent. Accordingly, there is an increase in number, from 21832 persons to 49023 persons, showing greater increase of 124 percent of elderly population. The 48 percent growth rate seen in elderly

population from 1991-2001 has resulted to a total of 49,023 elderly person in Mizoram by 2001 while there is only 29 percent growth rate in total population.

Subtle increase in rate of percentage in total population is evident both in male and female elderly population. In 1981, 4.38 percent i.e., 11,270, of the total male population has escalated to 5.40 percent i.e., 24,800, of the whole male population of 2001 Census. Whilst the elderly female grew from 4.47 percent to 5.64 percent from 10,562 to 24,223 approximately, of the whole female population during the same time period. The amount of aged population accumulated gradually both in urban and rural region. Specifically to 4.60 percent to 5.74 percent in rural regions. The Statistics from 1981 and 2001 Census evidently proves an escalation of elderly population from 3.89 percent to 5.29 percent respectively. In 2001 Census, there were 28932 persons (59 percent) aging between 60-69. The age group 70-79 amounted for 14783 persons (30 percent). Population 80 years or over numbered 5308 persons (11 percent).

Psychological or subjective well-being is simply described as the mental or conscious intellectual determination of a person's life (Diener, Oishi & Lucas, 2003). These evaluations encompasses an individual's conscious state of mind, response to a situation, comprehension of sublimity, and one's delight over mundane aspects of life. It also focuses on one's interpretation of happiness (Diener, Oishi & Lucas, 2003). Although one's response, comprehension, and emotions differ through time, the subjective well-being offers stability over time as it is believed to be moulded by the individual's growth, behavioral attributes (Diener, Oishi, & Lucas, 2003), ambitions and cultural worth (Diener, Suh, Lucas, & Smith, 1999).

Studies have provided that psychological well-being is a phenomenon having different magnitude (MacLeod & Moore, 2000; Ryff, 1989; Wissing & Van Eeden, 2002),

resulting from the integation of mental bylaw, behavioral attributes, individuality and person's endurance in life (Helson & Srivastava, 2001). Age, eduction, gratification of things outside self and consciousness escalate psychological well-being while it decrease with emotional instability (Keyes et al. 2002).

Although physical well-being is but a vague definition which is loosely connected to the main branch of psychology, research on the particular area is popularized over the last two decades (Conway & Macleod, 2002). The major discovery of this endeavor is that bad physical well-being can cause mental sickness, for instance bad psychological well-being is closely connected to depression (Woods & Joseph, 2009), it precipitates anxiety (Ruini & Fava, 2009) and even causes stress (Malek, Mearns & Flin, 1994). Studies have also discovered that psychological well-being consists of several magnitudes and performs within the possibility of showing utmost potential to a complete emotional instability.

Contemporary literature attests that distinct parts of positive psychological well-being impact a person's condition in the following way: optimism lowers cardiovascular morality and decreases the chance of coronary heart disease (CHD) (Giltay, Kamphuis, Kalmijn, Zitman, & Kromhout, 2006; Tindle et al., (2009), as cited in Boehm, Peterson, Kivimaki & Kubzansky, (2011), others for example, Baruth et al., (2011) found out that an optimistic person is more likely to be physically active. In an experiment conducted by Fredrickson, Mancuso, Branigan, and Tugade (2000) volunteers were given a stressful tasks continued by a mood induction procedure. A fast rate of cardiovascular recovery from stress is shown by the volunteers having a good state of mind unlie the volunteers with bad mental state.

Psychological well-being attracts observational criticisms and academic judgments (Wissing & Van Eeden, 1998). A clear-cut definition of psychology well-being is, till now, absent, Bradburn’s (1969) thorough reasoning of psychological well-being gives a vivid

diversity of its effects. Researches done in the beginning were mostly about the experiences of positive and negative impacts, personal well-being and fulfilments, all of which originated from the greek word ‘eudaimonia’, meaning ‘happiness’ (Ryff, 1989). Happiness is regarded as the balance state between the good and bad effects. Scaoes where several research were invigilated such as Diener, Emmons, Larsen & Griffen’s (1985) Satisfaction with Life Scale, employed this individualized understanding of well-being (Conway & Macleod, 2002; Diener et al. 1985). The Satisfaction with Life Scale demands its subjects to have a conscious intellectual response instead of emotional response in relation to global satisfaction with their life's degree of excellence.

No meaningful diversity between male and female psychological well-being has been put to light by researchers (Roothman, Kirsten & Wissing, 2003). Furthermore, the understanding of bodily wellness and spirituality can link bridge between psychological well-being and emotional environment (Temane & Wissing, 2006a, 2006b).

Early researchers of well-being have attempted to decipher the demographic correlation to the entire theoretical entity. Wilson (1967) attempted to end the debate by saying that privileged individuals are often prone to happiness. To be more precise, Wilson argues that a happy person is a person who is “young, healthy, well-educated, well paid, extroverted, optimistic, worry-free, religious, married person with high self-esteem, high job morale, modest aspirations, of either sex or a wide range of intelligence”.

Contemporary studies on psychological well-being have shown the inapplicability of Wilson's argument in its entirety. His conclusions that have been proven true are those regarding marital status, religious approach, and individual qualities. According to research, a wedded person is more happy than a single, widowed or divorced person (Diener, Gohm, Suh & Oishi, 2000); a religious person has a more variable health (Ellison, 1991); and the more

socialized (Lucas, Diener, Grob, Suh & Shao, 1998) and positive mindset people (Taylor & Armor, 1996) are attributed with higher prosperity.

Jose and Sekher (2013), in their continuous research regarding the personal health of people aging 50 years or above in India, done so by their scaling their self-rated health, lack of functionality based on WHO Disability Assessment Schedule (WHODAS), and quality of life (WHOQoL) that better physical well-being, lower disability, and higher quality of life are enjoyed by people who are well educated and who has greater economic status of the households. In order to attain higher class of life and prosperity, having financial security and health insurance for older population is a must.

"The Effects of Gender, Family satisfaction and economic strain on Psychological Well-Being" by Mills, is a study conducted where only married respondents were considered for the survey. This elaborated survey show that husbands had higher Psychological Well-Being (Radloff's Psychological Well-being Scale was employed) than wives. The authors feel the need to conclude the article by suggesting that further research need to be done to validate why husbands score higher on the Psychological Well-Being Scale. (Mills, Grasmick, Morgan, & Wenk, 1992).

"Rural Poverty, Urban Poverty and Psychological Well-Being" is a study by Amato and Zuo which concerns about how the state of being poor can affect one's psychological well-being in urban and rural areas, shown in individuals' independent support of happiness, anxiety and physical well-being. Studies have shown a higher comprehensive health in urban than rural areas. The psychological well-being of poor is higher in rural than urban areas whereas it is the opposite for Caucasians (Amato & Zuo, 1992).

Natural, mental, social and cultural elements helped aged adults to have the acceptable requirements to counter the effects of habitual sickness (Wang et al. 2008). Distinguishing

systems that control the effect of medicinal conditions may add to an enhanced comprehension of the determinants of the whole well-being in more established grown-ups. Being keen to religion is often regarded as having great significance in emotional and physical state and also in practicality, hence proved to be crucial in frequent sickness recovery for grown-ups (Koenig et al. 2001; Krause, 2003; Pargament et al. 2004; Williams, 2006; Williams & Sternthal, 2007). Even without a clear-cut understanding of the whole connection, spiritual experiences are regarded as crucial in lowering the level of pain felt by an individual (Brennan et al. 2005). The ability of spiritual experiences to compromise bad emotional impacts of chronic sickness justify the recognition of spiritual experience as human's response to trauma and the fuss about the end of life. This may enlighten the person with illness with the inevitable demise and the body's fragility, but on the hand, may attain peace through spiritual development. A spiritually enlightened individual is often immune to anxiety and is satisfied with life (Aranda, 2008; Fallot, 2001; Krause, 1995; Wang et al. 2008).

Life's satisfaction and spirituality has good connection in grown-ups (Neill & Kahn, 1999; Katerndahl, 2008). Grown-ups burdened with frequent illness may experience decline in happiness and became spiritually unattached (Fernandez Ballesteros et al. 2001; Hamarat et al. 2002; Jafari et al., 2010; Manning-Walsh, 2005; Riley et al. 1998). While there are some beliefs saying that spirituality as an external activity like societal religion (i.e., church attendance or Sunday school), when forming a positive relationship with life satisfaction, is more likely than that of internal or personal experience (Neill & Kahn, 1999).

Validations have been made regarding approval of self and morality that brings slow increase in spiritual acceptance of older individuals (Atchley, 2000; Idler, Kasl, & Hays, 2001; Koenig, 2006; Moberg, 2001; Tornstam, 2005). Scholars propounded the possibility of attaining morality, inner peace, and an accepting state of mind as we grow older, the limited

nature of existence when fully comprehended could lead the person to be more open to his/her being (Atchley, 2000; McFadden, 2005). In the study of aging, studies have shown an increase in spiritual magnitude with the certainty of death (Johnson, 2009; Moberg, 2005; Tornstam, 2005). Having the chance to share the experience acquired through life by elders is crucial as the spiritual realization led to the development of self. Study of the spiritual condition is food for researchers (Atchley, 2000).

A proper nature of livelihood bears several proportions such as spiritual, physical and emotional well-being, and self-reliance (World Health Organization, 1997). Spirituality is a widely applicable word that has several definitions which is likely to change among different culture, nation and religion (Nakasone, 2005; Takahashi & Ide, 2003); accordingly, understanding the concept of aging can gain from the addition of awareness of spirituality being applicable in multiple approach (Cohen, Thomas, & Williamson, 2008).

The belief in the possibility of a greater well-being of spirit through a strong connection of physical state and spirituality was proposed by Gouveia, Marques and Pais-Ribeiro (2009), and Moberg (2002) says that blooming relationship with God, oneself and people around us and the fruits the relationship bears is the exact definition of spiritual well-being. Furthermore, Musick, Traplagan, Koenig, and Larson (2000) suggested that spirituality has been linked to both positive and negative physical state.

Spirituality includes our every being i.e., our actions, our possessions and ourself, everything that is related to our spirit (Moberg, 2002b). Spirituality is the center of human nature, applying science or studying it as a different entity is not possible as it is within us and is inseparable. Well renowned Psychologist Daniel Helminiak (1996), simply says “to be human is already to be spiritual. So underlying all expressions of spirituality is a core that is universal, a core that is simply human.”

The need for a good spirituality for elder population to acquire good health has come to the awareness of contemporary literature (Hybels, Blazer, George, & Koenig, 2012; Jewell, 2004). Spirituality could be regarded as the most important factor for older people to be in a healthy state as spiritual development goes hand in hand with aging (Cohen & Koenig, 2003; Coleman, 2005; Sadler & Biggs, 2006).

Literature that deals with spirituality and aging focuses primarily on escalation of a certain spirituality (MacKinlay, 2001). According to Musick et al., (2000), 88.7% of adults aged 55 and older identify themselves as reaching average to high levels of both religiousness and spirituality. The Berlin Aging Study that concerns spiritual beliefs of people aging 70 to 95 years shows that the awareness towards spirituality and serenity increases with the increase in the number of age (Baltes & Mayer, 1999). Serenity point towards the complete surrendering of self and the acceptance of faith and one's destiny governed by divine power.

As shown through years and years of research, spirituality is allegedly considered to be responsible for the protection of mental and emotional health (Ano &Vasconcelles, 2005; Bergin, 1983; Ellison & Levin, 1998; Hackney & Sanders, 2003; Hammermeister & Peterson, 2001; Koenig & Larson, 2001; McCullough, et al., 2000; Tix & Frazier, 1998). The importance of spiritual well-being in the nullification of depression and anxiety faced by people under stress and people under psychological recreation is reviewed while under religious coping (McCullough, et al., 2000; Pargament, 1997; Pargament et al., 2000). Ano and Vasconcelles (2005) in their quantitative statistical analysis of 49 studies, made a discovery about the positive relationship between positive religious coping strategies and positive outcomes when faced with stressful life events. Other breakthrough includes an inverse relationship between positive religious coping strategies and negative psychological adjustment, as well as a positive association between negative religious coping strategies and negative psychological adjustment (Ano &Vasconcelles, 2005).

It is no doubt exuberating to know the crucial role played by spirituality/religion to a person's well-being. However, literature on the other hand provides evidences that could turn the whole phenomenon around as the possibility for the negative effects on spirituality is backed by studies that supported the buffering effect of spirituality and religion on health (Richard & Bergin, 1997; Ellison & Levin, 1998; Feher & Maley, 1999; Gartner, 1996; Pardini, Plante, Sherman & Strap, 2000; Ritt-Olson, et al., 2004). The paradoxical assumption of the role played by spirituality in the physical and mental wellness of an individual and the increase in intensity with age is a matter both admired and faulted by a bunch of studies, by several researchers (Kirkpatrick & McCullough, 1999; Larson, Sawyers & McCullough, 1998; McCullough et al., 2000; Miller, 2003; Seybold & Hill, 2001; Shorkey et al., 2008).

CHAPTER-II
STATEMENT OF THE PROBLEM

The awareness of the growing disabilities faced by older people led to a greater examination of self. And with old age comes a number of burdens like decrease in wage, smaller social and familial circle, and decline in physical health. As people grow older they became less and less active and became less passionate about personal interest, they are more cautious and cynical about their future and start to lose normal sleep pattern. Social pressure and inability to acquire enough resources that alters the normal functioning of old people.

Characteristics such as health, social-economic status, number of age and many other characteristics differentiate the level of requirements among older people (Siva, 2002). A number of cases are associated with ageing such as decline in health, unstable emotional state, financial dominion and lost connection with younger generation (Ansari & Ahmed, 2002). Desire for isolation led by impaired memory, rigidity of outlook, adjustments, irritability, jealousy, inner withdrawal, depression, harassment, exploitation, mistreatment, neglect, abuse from loved ones are the challenges faced. Disrespecting older people and being abusive towards older people is common but unnoticed problem (Park, 2007). The lack of financial security, property and independence by old people or the family they live in led to a greater risk of disease infection, bad shelter, loss of respectability, and abuse by younger people (Gulzar et al., 2008).

The level of respect for older people is low due to the gradual change in our sense of value, new self-centering ideas, conventional social beliefs, and our respect for the flow of money and goods. Major influences also include the new found aspiration of liberal, capitalist economic of the globalised world which is deeply rooted to the minds of young generation who are enlightened about the rapid growth in modern industries, technology and education (Chowdhury et al., 2014). Older people cannot live with their children due to a severe

housing shortage, rent increases in urban areas. The participation of women in the labor market forces older people to live alone. Natural support and convenient places where the family lives together gradually destroy or threaten parents, neglect, abuse and destabilize them. Older people experience ignorance and indifference from more and more children. Being illiterate jobless, and less aware of the legal and economic rights of older women than her husband, older female people are more vulnerable than older men, to be ignored and violated by their own sons and daughters (Shah, 1995).

Older people felt that they can no longer attend important meetings as they perceive themselves as obsolete or useless. After surveys done in Haryana, Vermani and Darshan (2003), it was found out that most of them were related to less important and disadvantaged roles and felt forgotten when making important family decisions. Bato (2004) recognizes that older people who are still engaged in some kind of employment are economically stable and gain respect from their family and social life. A positive experience improves the quality of life. Conversely, unemployed parents are fully or partially dependent on the livelihood of their children, experience interpersonal relationships, emotional instability and loss of strength, and reduce the quality of life.

A number of psychological illness are brought upon by lost of family values and the framework of family support, economic insecurity, social isolation and elderly abuse, all of which are the results of rapid urbanization and societal modernization (Jamuna & Reddy, 1997). The financial issues of the older are bothered by components, for example, the absence of government managed savings and deficient offices for human services, restoration, and diversion. Likewise, in the majority of the creating nations, benefits and government managed savings is limited to the individuals who have worked in the general population division or the composed segment of industry. Many reviews have appeared

resigned older individuals are stood up to with the issues of money related instability and dejection (Kartikeyan et al., 1999).

The change in way of life after retirement can change a person's well-being. A jobless individual is bound to have more reliance on his close relatives (Lena et al., 2009). As we grow older we tend to be more and more vulnerable to diseases and the chance of getting severe illness is high when there are no medical facilities, poor diet, and less attention towards older patients (Rao, 2003).

Scientists presumed that older individuals require better physical medicinal services and mental consideration to sustain their prosperity. Because of fragile wellbeing condition, absence of satisfactory consideration and oak seed by the relatives, carelessness via parental figures, occupied life plan because of urbanization, older individuals are getting dismissed. Subsequently, they turn out to be increasingly helpless against physical and mental illnesses (Dhara & Jogsan, 2013). People that have come to their final years in life have evidently shown the increase in endeavour for truth and purpose in life and this often lead to spirituality i.e., love and relatedness, for forgiveness, and for spiritual integration (Reed, 1991; Staude, 2005; Steinhauser et al., 2008).

The general population possessing the province of Mizoram is known as Mizos to the outside world just as to the insiders. The word 'Mizo' is a nonexclusive term importance slope men or highlanders. It is fairly fascinating to take note of the permanent effect of Christianity on the state's way of life. The appearance of the nineteenth century Christian teachers extensively improved the state's way of life. Not exclusively was another and formal composition content was created, the solid effect of Christianity have brought about the Mizo occupants developing probably the best choir artists in the Indian subcontinent. Mizos are currently for all intents and purposes Christians and this being thus, the Mizo culture

additionally spins around Christianity and the Church assuming an indispensable job in the life of a Mizo which is in one way or the other associated with the Church and its complex exercises.

Thangchungnunga (2017) concerns about the job of older people in social and financial view points. He found an exceptional element of the matured people in Mizoram in that the life span of male and female are practically equivalent. He found that social movement among the matured is high among people with great wellbeing and higher financial foundation. Yet, he has not tested the explanations behind low movement among the matured people from the lower financial strata. He expresses that regularly more established people end up being better laborers. This announcement requires factual examination. As indicated by him, not at all like in the created countries where the low status of the more seasoned people is listed by their relatively low cooperation rates in the work constrain and by their low normal salary, the absence of such information makes it hard to examine the monetary status of the more established people in Mizoram. In Mizoram, the most urbanized province of India, the majority of the more youthful people move to urban areas and all things considered the town older will undoubtedly proceed with work. Not withstanding the family bolster component, the conventional routine with regards to family units among the Mizos has made most guardians live with just each other for organization and support in seniority.

Vanlalchhawna (2007) found an increasingly larger share of elderly population in the total population, a faster growth of elderly population compared to total population and an increasing dependency ratio in Mizoram during the period from 1981 to 2001. He found that the number of elderly woman per elderly man is also rising and so is the number of centenarians. His paper highlights some of the socio-economic characteristics of elderly persons in Mizoram like work status, literacy, education level, marital status etc. based on

1991 census. A significant finding of his paper is that elderly persons continued to remain economically active even after retiring from regular employment. He cites improvement of health conditions of the aged as the reason for the same. He found the elderly female work participation rate much lower than that of the male counterparts, the rural elderly work participation rate higher than the urban rate and about 75 per cent of the economically active elderly population to be cultivators.

Mizoram is a place where older people enjoy the luxury of being treated with respect and kindness. Religion, tradition, culture, social norms, along with good education, could be regarded as the main factors. People nowadays, compared to their same age group during the late 1960s to 1970s, aged a lot better due to better living conditions and health care, diet and nutrition owing to modernization, which were then lack of. Nonetheless, the living standards of rural and urban, educated and uneducated elderly do differ. (Thanseia, 2007).

The Mizoram Senior Citizens' Association (Mizoram Upa Pawl, MUP in short) was formed way back in 1961 in Mizoram, no serious academic discussion on the problem of aging was ever conducted in Mizoram. The Mizoram Upa Pawl has 511 units across the states, with more than 60,000 members. The association has been helping the poorer section of elders in the state since the past four decades. Under the aegis of the organisation, the International Old-Aged Day was observed across the state in different ways. Not only the NGOs, but also the Mizoram government had already taken various measures to help the senior citizens across the state. The various helping schemes include free medical treatment, taking group of elders from each village for a regular trip to various places and helping the elder self-help groups' for business.

Mizoram first experienced the start of Old Age Pension scheme during 1974-75. Old age people deficient of proper care were compensated with Rs. 32/month per individual, Old

Age Pension reached out to 150 old citizens. Indira Gandhi National Old Age Pension Scheme became the new name of NOAPS by 2006-2007. Today, the amount of approximately Rs. 500 is received every month by citizens who are 80 years of age and above, while Rs. 200 per month is received by people aging below 80 years through the Old Age Pension scheme. The Government of Mizoram contributed approximately Rs. 50 every month for the beneficiaries of Old Age Pension scheme.

The Indian Constitution has prioritized the need to provide healthy environment for older population. It has taken upon its duty to give right to work, the right to education, and the right to public assistance in the cases of unemployment, old age, sickness and disability, towards the aged population. Such policies are done through social security and socio-economic programmes.

The quality of life of an elderly is defined first and foremost, by the respect they have for themselves and secondly by the respect the outside world shown towards them. Seniors who have a healthy quality of life, continue to be active and are well groomed. This can be seen easily in the Mizo society as it is a close knit society when compared to other societies in the country. Active elderly in Mizo society may be studied based on level of (local) church participation. Mizoram being a hilly area and the location of local church is not always easily accessible especially for the elderly, however, elderly who are active are usually found to attend church services regularly. In addition, many of the elderly are found to be very active in the elderly organization (MUP), also some elderly especially 'church elders' are deeply valued in the society for their varied contributions. Church elders are appointed based on their significant contributions to the society and by virtue of being 'morally' of high standard.

Ralte, J. R. (2007) while featuring the well-being states of the older in Mizoram, found that the medicinal services conveyance structure needs to prepare for clear and

complete well-being needs of the old people, involving arrangements of "geriatric benevolent" emergency clinics and advances, expense decrease, medical coverage plans, dynamic contribution of private segment and NGOs. The main purpose of this study is to determine the impact of socio-demographic variables on psychological well-being and spiritual experience among Mizo adults.

Objectives of the study:

In view of the foregoing empirical findings and theoretical considerations, the study is designed with the following objectives:

1. To determine ‘gender’ differences on psychological well-being and daily spiritual experience.
2. To determine the impact of ‘age-group’ on psychological well-being and daily spiritual experience.
3. To determine the interaction effect of ‘gender X age-group’ on psychological well-being and daily spiritual experience.
4. To determine the relationship between psychological well-being and daily spiritual experience.
5. To determine the impact of other demographic variables on psychological well-being and daily spiritual experience.

Hypothesis:

To meet the target objectives the following hypotheses are set forth for the study:

1. It is expected that females as compared to males will show greater scores on daily spiritual experience and the reverse is expected on psychological well-being.

2. It is expected that middle adulthood as compared to late adulthood will show greater scores on psychological well-being and the reverse is expected on daily spiritual experience.

3. It is expected that decreasing scores on psychological well-being shall be observed from male in middle adulthood, female in middle adulthood, male in late adulthood and female in late adulthood and the reverse is expected on daily spiritual experience.

4. The coefficient of correlation for psychological well-being and daily spiritual experience is expected to be higher in the females as compared to males as well as late adulthood as compared to middle adulthood.

5. It is expected that other demographic variables will have impact on psychological well-being and daily spiritual experience.

CHAPTER-III

METHODS AND PROCEDURE

Sample:

The sample of the study is comprised of 309 Mizo adults (163 males & 146 females). The participants were identified following the multistage random sampling method from 3 constituencies of Aizawl city (Aizawl North II, Aizawl North III, & Aizawl East I). By following the works of Santrock (2013) the participants were further classified into two developmental stages: Middle Adulthood (40-60 years) and Late Adulthood (60 years & above). The selected 91 participants were from Aizawl North II, 103 participants were from Aizawl North III and 115 were from Aizawl East I.

The demographic information of the participants - age, gender, socio-economic status (derived from the background information of marital status, educational qualification, number of family members, occupational status and monthly income), locality, family type, number of children, bread earner, other support, house type, house ownership, caretaker, assets, social and religious involvement are carefully recorded to match or equate the participants in the study.

Design of the study:

The study employed 2 ‘gender’ (male & female) x 2 ‘age-group’ (middle adulthood & late adulthood) factorial design. The sample characteristic table (Table-1) portrays the 2X2 factorial design to be imposed on the psychological well-being and daily spiritual experience.

Table-1: The sample characteristic table of the 2 x 2 (2 gender x 2 age-group) factorial design of the study.

Gender	Middle Adulthood	Late Adulthood	Total
Male	94	69	163
Female	82	64	146
Total	176	133	309

Psychological tools:

Psychological General Well-Being Index (Dupuy, 1971): The Psychological General Well-Being Index (PGWBI) was developed for the evaluation of perceived well-being and distress. It assessed the area of Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health, and Vitality. In Anxiety and Depressed Mood higher score reflect lower anxiety and depressed mood whereas higher score in Positive Well-Being, Self-Control and Vitality reflect higher positive well-being, self-control and vitality. Each scale includes 3-5 items and questions allow multiple choice answers with scores ranging from 0 to 5 (best score value). In the present study, the Cronbach alphas of the dimensions emerged to be acceptable: Anxiety (0.72), Depressed Mood (0.56), Positive Well-Being (0.65), Self Control (0.54), General Health (0.56) and Vitality (0.58).

Daily Spiritual Experience Scale (Underwood & Teresi, 2002): The Daily Spiritual Experience Scale (DSES) is a 16-item self-report measure designed to assess ordinary experiences of connection with the transcendent in daily life. It specifically aims to measure ordinary, or daily, spiritual experiences-not mystical experiences (e.g., hearing voices) and how they are an everyday part of an individual's life. The first 15 items of the questionnaire

are measured on a 6-point Likert-type scale: many times a day, every day, most days, some days, once in a while, and never or almost never. Item 16 is measured on a 4-point scale: Not close at all, Somewhat close, Very close, As close as possible. The score of item 16 must be inverted to maintain the same direction as the other items. The total score is obtained by summing the scores of the 16 items, which can vary from 16 to 94. DSES higher scores reflect a lower frequency of daily spiritual experiences while lower scores reflect a higher frequency of daily spiritual experiences. Overall internal consistency as measured by Cronbach's alpha coefficient was 0.91.

Procedure:

Rapport was formed with each of the participants at the individual level and the consent for participation obtained with initial briefing and the explanation of requirements for the psychological task. The importance of the instructions relating to the psychological measures was clearly highlighted. The first phase of the interaction was followed by data collection and the participants were given forms containing the demographic information (age, gender, socio-economic status, locality, family type, number of children, bread earner, other support, house type, house ownership, caretaker, assets, social and religious involvement) along with Psychological General Well-Being Index and Daily Spiritual Experience Scale which were to be completed in the presence of the researcher.

The data collected were then carefully screened for missing responses, uncompleted scales and sub-scales for the participants. The data was then coded, cleaned and processed for the statistical analyses. The anonymity, confidentiality and ethics as cited/formulated by American Psychological Association (APA) were followed.

Operational definition:

The terminologies employed for the study are hereby explained as operationalized.

Age: The chronological age of the participants.

Gender: Though socially, male and female can each possess feminine and masculine tendency. Gender for the present study is employed as the biological male and female characteristics.

Socio-economic status: Socioeconomic status refers to a person's position in the social hierarchy. Following the works of Kuppuswamy (1981) and Hollingshead (1975), socio-economic status is determined by the following:

(a) **Marital status:** Marital status was presented by four categories - married, widowed, divorced, single.

(b) **Education status:** Education status was measured by highest educational degree earned by respondents into six levels- primary level, middle level, high school level, higher secondary school level, graduate and post graduate level.

(c) **Number of family members:** Members of the immediate family.

(d) **Occupational status:** The occupation of an individual in determining the life style and also achieving the economic well beings. It is a key measure of socio-economic status (SES).

(e) **Monthly income:** The respondents have been asked to state their father's or head of the family's monthly income.

Locality: Information about the geographic location of the residence of the respondents and is treated into two levels:

(a) **Rural area:** A geographic area that is located outside towns and cities.

(b) **Urban area:** A location characterized by high human population density and many built environment features in comparison to the areas surrounding it. Urban areas may be cities, towns or conurbations.

Family type: The type of family in which the participant lives and is presented into three levels:

(a) **Single:** Having no spouse/life partner or children belonging to the same household.

(b) **Nuclear family:** Parents and their minor children who are living under one roof.

(c) **Joint family:** Where the grand-parents, father, mother, and children live unitedly under one roof.

Number of children: Number of children reported by the respondents.

Bread earner: The one who earns the livelihood for the family and is presented by four categories - self, mother, father and others.

Other support: The surplus money in the hands of any individual gives him/her a sense of satisfaction and sense of comforts.

Caretaker: Someone who is responsible for looking after the respondents. The possible responses are - spouse, grandchildren, nurse and maid.

House type: The types of house where the respondents are residing and is presented into three categories- Concrete type, Assam type and Others.

House ownership: The possession of a house is a status symbol in our society. The house ownership is likely to boost confidence of a person in understanding and handling of any situation or a problem. To identify the owner of the house two possible responses were given- (a) Owned (b) Rented.

Assets: Movable property such as two/four wheeler, washing machine, air conditioner, computer, television, fridge, mobile phones and immovable property such as insurance, stock/bond, savings, flat/LSC, commercial vehicle (bus, truck, taxi etc), heavy machinery (JCB, Road Roller etc).

Social involvement: Social participation of respondents based on societal position and societal status.

Religious involvement: Religious participation of respondents based on religious position and religious status.

Statistical Analyses:

To ascertain the applicability of the psychological tools and the descriptive nature of the demographic variables and the psychological tools, the following statistical treatments were employed:

Firstly, the descriptive statistics (mean, standard deviation, skewness and kurtosis) of the behavioural measures was computed. Secondly, bivariate correlation coefficient was computed for the behavioural measures of the study. Thirdly, the internal consistency of the psychological tools was ascertained.

Fourthly, analysis of covariance (ANCOVA) for the effect of 'gender' and 'age-group' on the behavioural measures with the demographic variables as the covariate was employed to show the patterns of variation. Scheffe Test, which is a parametric Post-hoc

multi-comparison was employed to elucidate the patterns of groups/means differences for significant independent and interaction effect of ‘gender’ and ‘age-group’ on the behavioural measures.

To sum up the overall findings of the study and to determine the impact of socio-demographic variables on psychological well-being and spiritual experience, stepwise hierarchical multiple regression was employed.

CHAPTER-IV

RESULTS AND DISCUSSION

In the present study, the analysis plan of the total variables is 309. Among the 309 participants, 62.1% are from Middle Adulthood and 37.9 from Late Adulthood. Gender which is coded as Male=1 is 163 which is 52.8% and Female=2 is 146 which is 47.2%. majority of the participants i.e, 78.6% are from urban and 21.4% are from rural and their socio-economic status include marital status, education, number of family member, occupation and income. A joint family is the type of the family which secure the highest (81.9%), nuclear type (9.7%) and single tye (8.4%). Number of children size ranges from 0 to 10 with the majority 80.9% reported less than five childrens. In terms of breadearner, majority of the participants reported that there is only one breadearner in the family (63.4%) whereas 33.7% reported there are two breadearners and 2.9% reported there are three breadearners in the family. There are 91.3% of the participants who did not received other support whereas 8.7% of the participants reported that they receieved support from others.

In terms of caretaking of the aged participants in the study, 67.6% of the participants are taken care by their spouse, 24.3% by their children/grandchildren, 0.6% by nurse and 7.4% by maid. Among the 309 participants, 53.7% of the participants are living in concrete house, 45.3% in assam type and 1.0% living in other house type. In terms of house ownership, majority of the participants 63.4% reported that they are living in their own house whereas 36.6% are living in rented house. Assets are things that can produce value which is classified as movable and immovable assets. Social and religious involvement which is classified as status and position they hold in the society and religion respectively.

The results (Table-2) describes the mean, standard deviation, skewness and kurtosis of the behavioral measures of Daily Spiritual Experience Scale (Underwood & Teresi, 2002)

and Psychological General Well-Being Index (Dupuy, 1971) with the subscales of Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health, and Vitality. The table also revealed the statistics of the transformed set of scores in view of moderate violation of parametric assumptions.

Table-2: Mean, Standard Deviation, Skewness and Kurtosis of the behavioural measures of the study (N=309).

	Mean	**SD**	**Skewness**		**Kurtosis**	
			Statistic	**Std. Error**	**Statistic**	**Std. Error**
Daily Spiritual Experience	42.91	1.39	.68	.14	.67	.28
Daily Spiritual Experience	***6.51***	***.79***	***.25***	***.14***	***.48***	***.28***
Anxiety	17.60	4.12	-.38	.14	-.23	.28
Depressed Mood	1.79	2.57	-.43	.14	-.12	.28
Depressed Mood	***2.41***	***.59***	***.21***	***.14***	***-.37***	***.28***
Positive Wellbeing	11.81	3.13	.32	.14	.35	.28
Self-Control	1.50	2.41	-.38	.14	-.18	.28
General Health	9.49	2.20	-.51	.14	.81	.28
General Health	***1.29***	***.40***	***.04***	***.14***	***.49***	***.28***
Vitality	13.11	2.94	-.22	.14	.35	.28

The Skewness and Kurtosis statistics (Table-2) were employed to discern the pattern of distribution of the measured variables for the scales and subscales of Psychological General Well-Being Index with subscales Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health, and Vitality. Square root transformation was done for daily spiritual experience, depressed mood and general health in order to secure the desirable range.

The bivariate correlation matrix of the demographic variables and the scales and subscales of the behavioural measures is presented in Table-3. The results (Table-3) revealed that 'Age' to be positively correlated with number of children and anxiety and negative correlation with locality, house ownership, religious involvement and daily spiritual experience; 'Gender' shows positive correlation with social involvement and negative correlation with daily spiritual experience; socio-economic status emerged to be positively correlated with locality, number of children, bread earner, caretaker, house type, assets and vitality and negatively correlated with other support, house ownership and social involvement; locality also emerged to be positively correlated with bread earner, house type, house ownership and assets and negative correlation with social involvement, religious involvement, anxiety, depressed mood and self control.

Family type shows positive correlation with number of children, house type, anxiety, self-control and vitality and negative correlation with other support and caretaker; number of children is also positively correlated with bread earner and assets and negatively correlated with caretaker and religious involvement; breadearner emerged to be positively correlated with assets, daily spiritual experience, depressed mood and general health and negatively correlated with other support, house ownership and religious involvement; other support shows positive correlation with caretaker and negative correlation with daily spiritual experience and general health; caretaker shows negative correlation with house type, anxiety and self-control.

House type emerged to be positively correlated with assets and positive well-being and negatively correlated with house ownership; house ownership also emerged to be negatively correlated with assets, anxiety, depressed mood, self-control, general health and vitality; assets shows positive correlation with daily spiritual experience and negative correlation with social and religious involvement; social involvement has positive correlation

with religious involvement and daily spiritual experience but negatively correlated with positive well-being, self-control and vitality; religious involvement emerged to be positively correlated with daily spiritual experience and negatively correlated with positive well-being, self-control, general health and vitality.

Finally, the bivariate relationships are also observed between the scales/subscales of the behavioural measures. The results (Table-3) revealed that daily spiritual experience to be negatively correlated with all the subscales of Psychological General Well-Being Index (PGWBI) and significant relationship was found for anxiety, positive well-being, self-control and vitality. All the subscales of PGWBI show highly significant positive relationship in all possible combinations.

Table-3: The bivariate correlation matrix of the demographic variables and the behavioural measures of the study (N=309).

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Age	-																				
Gender	.02	-																			
Socio-economic Status	-.06	-.03	-																		
Locality	-.12*	-.03	.21**	-																	
Family Type	-.07	.06	.04	-.11	-																
No. of Children	.28**	-.06	.13*	-.08	.24**	-															
Bread Earner	-.02	.04	.34**	.12*	-.02	.11*	-														
Other Support	.02	.01	-.13*	.09	-.24**	-.05	-.15**	-													
Caretaker	.10	.10	.13*	.06	-.58**	-.30**	.03	.13*	-												
House Type	.01	-.08	.12*	.17**	.12*	-.06	.11	-.07	-.14*	-											
House Ownership	-.17**	.05	-.22**	.25**	-.07	-.11	-.16**	.06	.04	-.15**	-										
Assets	-.09	-.08	.47**	.33**	.11	.13*	.32**	-.10	-.05	.39**	-.30**	-									
Social Involvement	.08	.25**	-.18**	-.24**	.01	-.04	-.02	-.02	.10	-.09	-.05	-.13*	-								
Religious Involvement	-.12*	-.04	-.09	-.13*	-.03	-.12*	-.16**	-.01	.05	-.10	.09	-.14*	.25**	-							
Daily Spiritual Experience	-.20**	-.12*	-.05	.02	-.01	-.06	.14*	-.14*	.09	-.01	.06	.15**	.13*	.22**	-						
Anxiety	.16**	-.05	.01	-.24**	.25**	.09	.02	-.08	-.16**	.04	-.20**	-.06	.04	-.08	-.25**	-					
Depressed Mood	.10	-.03	.07	-.21**	.09	.08	.14*	-.09	-.02	.01	-.27**	.06	.04	-.09	-.11	.63**	-				
Positive Well-Being	.01	.02	.10	.04	.08	.00	.09	.01	-.10	.18**	-.10	.04	-.24**	-.21**	-.38**	.53**	.45**	-			
Self-Control	.04	.04	.11	-.13*	.20**	.02	-.07	-.01	-.12*	.08	-.18**	-.05	-.15**	-.14*	-.52**	.63**	.48**	.61**	-		
General Health	-.03	-.04	.10	-.03	.06	.00	.20**	-.18**	-.02	.02	-.16**	.04	-.05	-.13*	-.03	.50**	.49**	.41**	.33**	-	
Vitality	.06	-.03	.12*	-.09	.13*	.04	.05	-.05	-.09	.05	-.19**	.05	-.25**	-.23**	-.32**	.53**	.48**	.58**	.54**	.53**	-

**** Significant at .01 level; * Significant at .05 level**

Table-4: The Cronbach alphas of the behavioral measures of internal consistency.

	1	2	3	4	5	6	7
1. Daily Spiritual Experience	***.91***						
2. Anxiety	-.25**	***.72***					
3. Depressed Mood	-.11	.63**	***.56***				
4. Positive Well-Being	-.38**	.53**	.45**	***.65***			
5. Self-Control	-.52**	.63**	.48**	.61**	***.54***		
6. General Health	-.03	.50**	.49**	.41**	.33**	***.56***	
7. Vitality	-.32**	.53**	.48**	.58**	.54**	.53**	***.58***

***. Correlation is significant at the 0.01 level (2-tailed).*

{Values in parentheses are cronbach alphas of the Scale/Sub-Scale}

The results (Table-4) highlighted the Cronbach Alphas of the behavioral measures of internal consistency. Cronbach's Alpha of Daily Spiritual Experience was found to be .91 which is excellent, Anxiety was found to be .72 which is considered acceptable, Depressed Mood was found to be .56, Positive Well-Being=.65, Self-Control=.54, General Health=.56, Vitality=.58 which is considered as low.

The results (Table-4) also revealed that daily spiritual experience to be negatively correlated with all the subscales of Psychological General Well-Being Index (PGWBI) and significant relationship was found for anxiety, positive well-being, self-control and vitality. All the subscales of PGWBI show highly significant positive correlation in all possible combinations.

Contrary to this finding, early researches have mentioned the relationship of religious beliefs (Kaliampos & Roussi, 2017) and spirituality (Visser, Garssen & Vingerhoets, 2010)

with psychological well-being. Soleimani et al. (2015) also stated that religious orientation especially intrinsic one can be a strong predictor of psychological well-being.

Following the objectives of the study, '2 gender' (male & female) x '2 age-group' (middle adulthood & late adulthood) factorial design was employed. To illustrate the effect of 'gender' and 'age-group' on the behavioural measures, series of analysis of covariance with the demographic variables as the covariate was separately run for the scales and sub-scales of the psychological tools.

Table-5a: Levene's test of equality of error variances in the analysis of covariance for 'gender' and 'age-group' on the behavioural measures with the demographic variables as the covariate.

Behavioral Measures	**F**	**df1**	**df2**	**Sig.**
Daily Spiritual Experience	1.69	3	305	0.17
Anxiety	0.89	3	305	0.45
Depressed Mood	1.49	3	305	0.22
Positive Well-Being	0.98	3	305	0.41
Self-Control	1.35	3	305	0.26
General Health	0.53	3	305	0.66
Vitality	0.98	3	305	0.40

The results (Table-5a) highlighted Levene's test of Equality of Error Variances in the analysis of covariance for the effect of 'gender' and 'age-group' on the behavioural measures with the demographic variables which revealed that there is statistically non-significant equality of variance for Daily spiritual Experience Scale and Psychological General Well-Being Index with the subscales of Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health and Vitality.

Table-5b: The effect of demographic variables on the dependent measures in the analysis of covariance with the demographic variables as the covariate.

Source	Dependent Variable	Sum of Squares	df	Mean Square	F	Sig.	η^2	Observed Power
Socio-economic Status	Daily Spiritual Experience	6.29	1	6.30	12.28	.001	.04	.94
	Anxiety	4.40	1	4.40	.29	.588	.00	.08
	Depressed Mood	.03	1	.03	.09	.768	.00	.06
	Positive Well-Being	13.83	1	13.83	1.58	.210	.01	.24
	Self-Control	36.84	1	36.85	7.25	.007	.02	.77
	General Health	.00	1	.00	.03	.874	.00	.05
	Vitality	11.24	1	11.24	1.48	.225	.01	.23
Locality	Daily Spiritual Experience	.02	1	.02	.04	.842	.00	.06
	Anxiety	132.92	1	132.92	8.89	.003	.03	.84
	Depressed Mood	2.47	1	2.47	7.76	.006	.03	.79
	Positive Well-Being	.44	1	.44	.05	.823	.00	.06
	Self-Control	12.66	1	12.66	2.49	.116	.01	.35
	General Health	.00	1	.00	.01	.908	.00	.05
	Vitality	25.11	1	25.11	3.31	.070	.01	.44
Family Type	Daily Spiritual Experience	.51	1	.51	.99	.321	.00	.17
	Anxiety	140.20	1	140.20	9.38	.002	.03	.86
	Depressed Mood	.31	1	.31	.98	.324	.00	.17
	Positive Well-Being	2.07	1	2.07	.24	.627	.00	.08
	Self-Control	33.21	1	33.21	6.54	.011	.02	.72
	General Health	.036	1	.04	.24	.622	.00	.08
	Vitality	16.40	1	16.40	2.16	.143	.01	.31
No. of Children	Daily Spiritual Experience	.03	1	.03	.06	.809	.00	.06
	Anxiety	8.63	1	8.63	.58	.448	.00	.12
	Depressed Mood	.02	1	.01	.06	.812	.00	.06
	Positive Well-Being	3.58	1	3.58	.41	.523	.00	.10
	Self-Control	5.51	1	5.51	1.08	.299	.00	.18
	General Health	.01	1	.01	.03	.856	.00	.05
	Vitality	6.11	1	6.11	.80	.371	.00	.15
Bread Earner	Daily Spiritual Experience	3.40	1	3.40	6.63	.011	.02	.73
	Anxiety	1.46	1	1.46	.10	.755	.00	.06
	Depressed Mood	1.00	1	1.00	3.13	.078	.01	.42
	Positive Well-Being	6.79	1	6.79	.78	.379	.00	.14
	Self-Control	14.72	1	14.72	2.90	.090	.01	.40
	General Health	1.11	1	1.11	7.55	.006	.03	.78
	Vitality	.00	1	.00	.00	.995	.00	.05
Other Support	Daily Spiritual Experience	2.62	1	2.62	5.11	.024	.02	.62
	Anxiety	.29	1	.29	.02	.890	.00	.05
	Depressed Mood	.12	1	.12	.38	.536	.00	.10
	Positive Well-Being	6.18	1	6.18	.71	.401	.00	.13
	Self-Control	3.87	1	3.87	.76	.384	.00	.14
	General Health	.88	1	.88	5.99	.015	.02	.68
	Vitality	.02	1	.02	.00	.962	.00	.05

Source	Dependent Variable	Sum of Squares	df	Mean Square	F	Sig.	η^2	Observed Power
Caretaker	Daily Spiritual Experience	4.19	1	4.19	8.18	.005	.03	.81
	Anxiety	8.92	1	8.92	.60	.440	.00	.12
	Depressed Mood	.00	1	.00	.01	.910	.00	.05
	Positive Well-Being	11.23	1	11.23	1.29	.258	.00	.20
	Self-Control	1.20	1	1.20	.24	.627	.00	.08
	General Health	.00	1	.00	.02	.883	.00	.05
	Vitality	1.00	1	1.00	.13	.717	.00	.07
House Type	Daily Spiritual Experience	.19	1	.19	.37	.546	.00	.09
	Anxiety	.08	1	.08	.01	.943	.00	.05
	Depressed Mood	.01	1	.01	.03	.863	.00	.05
	Positive Well-Being	60.40	1	60.40	6.91	.009	.02	.75
	Self-Control	9.33	1	9.33	1.84	.176	.01	.27
	General Health	.00	1	.00	.02	.883	.00	.05
	Vitality	.01	1	.01	.00	.978	.00	.05
House Ownership	Daily Spiritual Experience	.44	1	.44	.86	.354	.00	.15
	Anxiety	38.17	1	38.17	2.55	.111	.01	.36
	Depressed Mood	2.06	1	2.06	6.47	.011	.02	.72
	Positive Well-Being	17.13	1	17.13	1.96	.163	.01	.29
	Self-Control	35.54	1	35.54	6.99	.009	.02	.75
	General Health	1.06	1	1.06	7.19	.008	.02	.76
	Vitality	42.45	1	42.45	5.59	.019	.02	.65
Assets	Daily Spiritual Experience	5.56	1	5.56	10.85	.001	.04	.91
	Anxiety	.01	1	.01	.00	.983	.00	.05
	Depressed Mood	.04	1	.04	.12	.728	.00	.06
	Positive Well-Being	22.72	1	22.72	2.60	.108	.01	.36
	Self-Control	31.18	1	31.18	6.14	.014	.02	.70
	General Health	.14	1	.14	.97	.325	.00	.17
	Vitality	1.95	1	1.95	.26	.612	.00	.08
Social Involvement	Daily Spiritual Experience	1.58	1	1.58	3.08	.080	.01	.42
	Anxiety	.55	1	.55	.04	.848	.00	.05
	Depressed Mood	.00	1	.00	.01	.942	.00	.05
	Positive Well-Being	119.17	1	119.17	13.63	.000	.04	.96
	Self-Control	35.96	1	35.96	7.08	.008	.02	.76
	General Health	.06	1	.06	.42	.516	.00	.10
	Vitality	134.38	1	134.38	17.69	.000	.06	.99
Religious Involvement	Daily Spiritual Experience	6.50	1	6.50	12.69	.000	.04	.94
	Anxiety	25.30	1	25.30	1.69	.194	.01	.25
	Depressed Mood	.52	1	.52	1.63	.203	.01	.25
	Positive Well-Being	43.45	1	43.45	4.97	.027	.02	.60
	Self-Control	18.83	1	18.83	3.71	.055	.01	.48
	General Health	.29	1	.29	1.98	.161	.01	.29
	Vitality	56.61	1	56.61	7.45	.007	.03	.78

The results (Table-5b) revealed: significant independent effect of socio-economic status on daily spiritual experience and self-control; significant independent effect of locality on anxiety and depressed mood; significant independent effect of family type on anxiety and self-control; significant independent effect of bread earner on daily spiritual experience and general health; significant independent effect of other support on daily spiritual experience and general health; significant independent effect of caretaker on daily spiritual experience; significant independent effect of house type on positive well-being; significant independent effect of house ownership on depressed mood, self-control, general health and vitality; significant independent effect of assets on daily spiritual experience and self-control; significant independent effect of social involvement on positive well-being, self-control and vitality; and significant independent effect of religious involvement on daily spiritual experience, positive well-being and vitality.

The results (Table-5c) displayed the significant instances for the effect of the demographic variables in the analysis of covariance for the effect of 'gender' and 'age-group' on the behavioural measures with the demographic variables as the covariate.

Table-5c: The significant effect of the demographic variables in the analysis of covariance for 'gender' and 'age-group' on the behavioural measures with the demographic variables as the covariate.

Independent Variable	Dependent Variable	Sum of Squares	df	Mean Square	F	Sig.	η^2	Observed Power
Gender	Daily Spiritual Experience	4.24	1	4.24	8.27	0.004	0.03	0.82
Age-group	Daily Spiritual Experience	4.67	1	4.67	9.10	0.003	0.03	0.85
	Anxiety	93.84	1	93.84	6.28	0.013	0.02	0.71
Gender x age-group	Depressed Mood	1.95	1	1.95	6.12	0.014	0.02	0.69
	General Health	1.60	1	1.60	10.82	0.001	0.04	0.91

The results (Table-5c & Figure-1) highlighted significant independent effect of 'gender' on daily spiritual experience which revealed that females to show higher daily spiritual experience as compared to males. Recent population surveys reveal that, among both Christian and non-Christian populations, women are more likely than men to affiliate with religious institutions, to pray, to say religion is important in their lives, to read religious texts, and to believe in life after death (Stark, 2002). Strawbridge, Cohen, and Shema (2000) indicated that women report more frequent weekly religious attendance than men (30% versus 21%). Cloniger and colleagues (1994) evaluated transcendence and personality traits in 1,388 individuals and reported that women had 18% higher self-transcendence scores compared to men. With regards to the growing literature on health and religion/spirituality, research has suggested there may be gender-based differences. For example, studies have shown that women are more likely than men to seek religious consolation (Ferraro & Kelley-Moore, 2000) and to use social support from religious institutions to cope with illness (Strawbridge et al., 2000).

The results (Table-5c & Figure-2) also highlighted significant independent effect of 'ag-group' on daily spiritual experience which revealed that late adulthood showed higher daily spiritual experience than middle adulthood. Atchley (1997), for example, suggests that ageism and age discrimination push many older adults to spirituality, presumably by fostering disengagement and curtailing life choices. Further, physical aging, while restricting one's mobility, creates opportunities to experience meditation and contemplative silence, and thus facilitates spiritual development. McFadden (1996) proposes that spirituality may be especially meaningful in old age because of the many losses and difficulties encountered in late life. Obviously, the "growth" and "deficit or adversity" models of spiritual development are not mutually exclusive because a deficit may trigger growth.

The result (Table-5c & Figure-3) highlighted significant effect of 'age-group' on anxiety which revealed that middle adulthood showed higher level of anxiety than late adulthood. Consistent to this finding, most cross-sectional studies have found a decrease in anxiety symptoms and/or anxiety disorders in older age groups (Regier et al. 1988; Henderson et al. 1998; Jorm, 2000; Schaub & Linden, 2000; Sheikh et al. 2004; Kessler et al. 2005), although other studies have found no reduction or an increase in prevalence in older age groups (Eaton et al. 1989; Beekman et al. 1998).

The results (Table-5c & Figure-4) also highlighted significant interaction effect of 'gender X age-group' on depressed mood. The results revealed that female in middle adulthood showed higher depressed mood than female in late adulthood. Consistent to this finding, major depression appears to be less frequent among older adults than at earlier ages (Hasin, Goodwin, Stinson, & Grant, 2005). This may be due to that leisure time is constricted in middle adulthood due to family and work obligations whereas leisure time increases in late adulthood (Hansen, Dik & Zhou, 2008). Middle age adults see physical, competitive, and outdoor activities as separate interests whereas older adults do not make such a distinction.

Finally, the results (Table-5c & Figure-5) highlighted significant interaction effect of 'gender X age-group' on general health which revealed that male in middle adulthood showed higher general health than male in late adulthood.This may be due to that during late adulthood the immune system is no longer as capable as it once was in guarding against disease. Body systems and organs, such as the heart and lungs, become less efficient. Most older men cannot eat the way they did in their middle aged and maintain a healthy weight. As men age, they typically become less active, lose muscle and gain fat. Some of which may be due to lifestyle, such as poor diet and lack of exercise, rather than illness or the aging process.

Figure-1: The plot of observed weighted means for the significant independent effect of 'gender' on Daily Spiritual Experience.

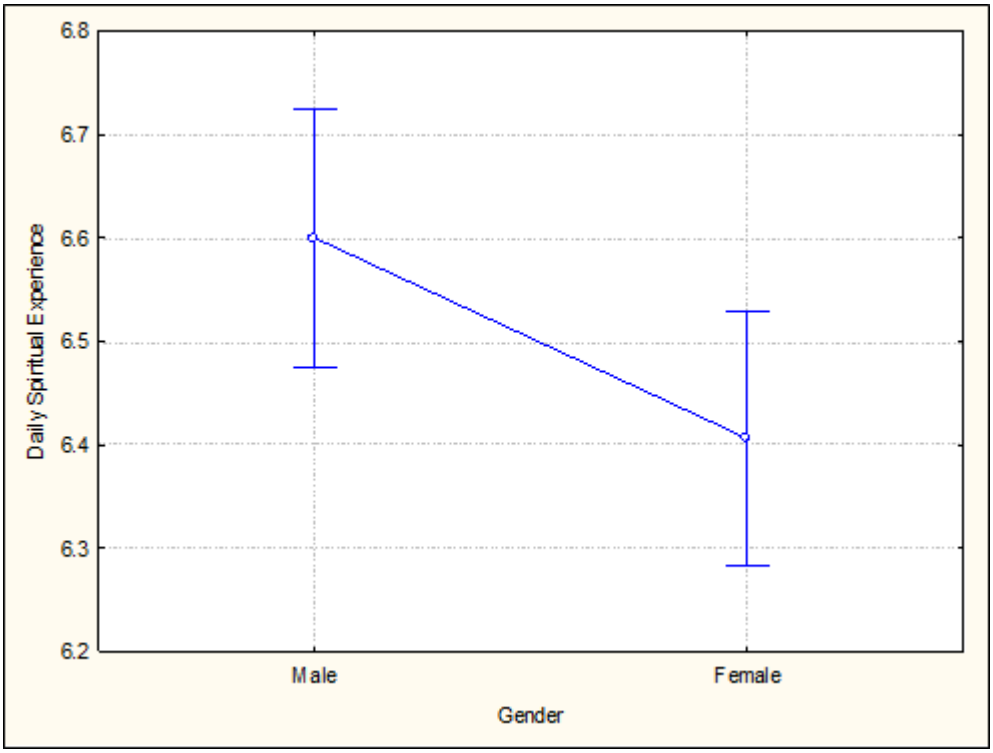


Figure-2: The plot of observed weighted means for the significant independent effect of 'age-group' on Daily Spiritual Experience.

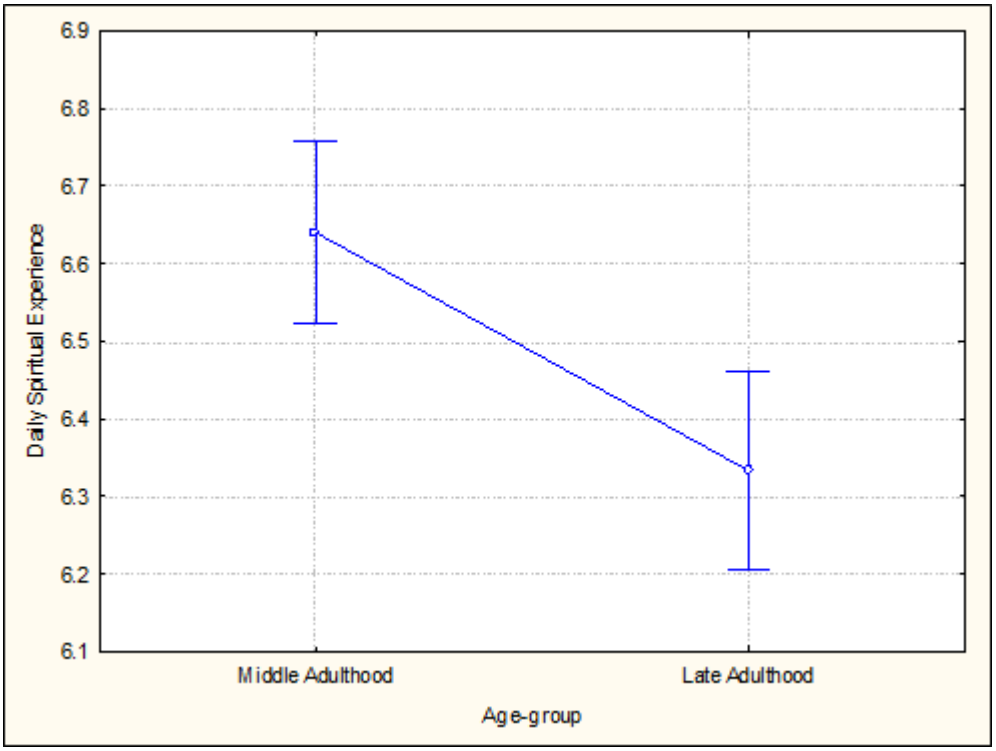


Figure-3: The plot of observed weighted means for the significant independent effect of 'age-group' on Anxiety.

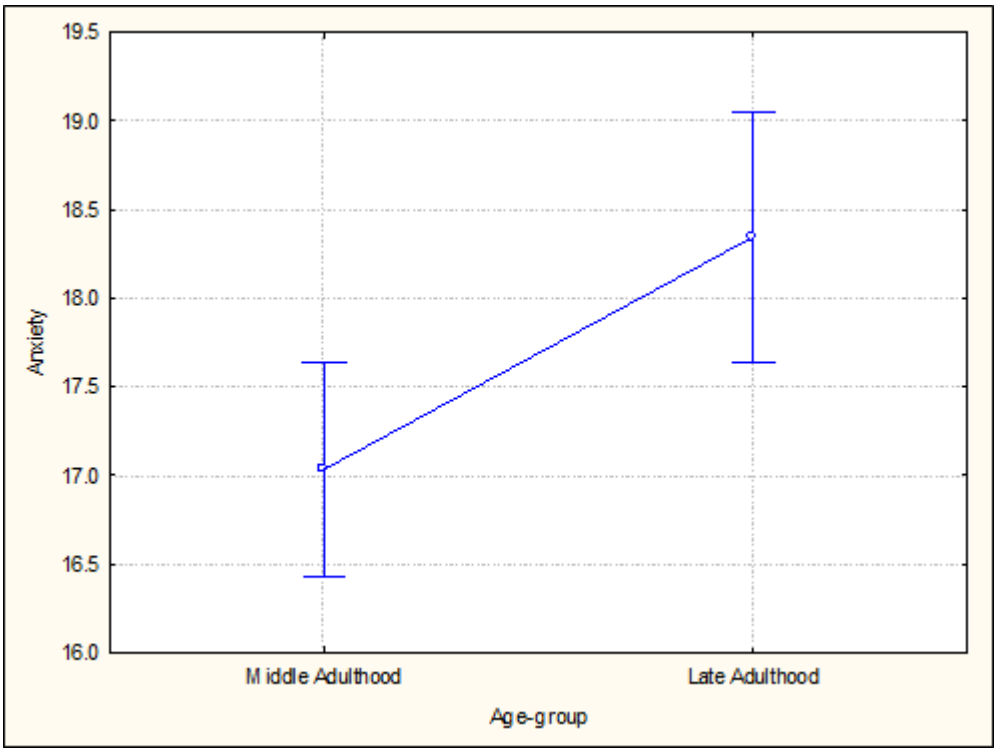


Table-5d: Probabilities for Post Hoc Tests for significant independent effect of 'gender X age-group' on Depressed Mood.

	1	**2**	**3**	**4**
Mean Ranks	**2.43**	**2.26**	**2.41**	**2.55**
1. Male Middle Adulthood	X			
2. Female Middle Adulthood	0.25	X		
3. Male Late Adulthood	1.00	0.44	X	
4. Female Late Adulthood	0.67	0.03*	0.59	X

**. Significant at the 0.05 level*

Figure-4: The plot of observed weighted means for the significant independent effect of 'gender X age-group' on Depressed Mood.

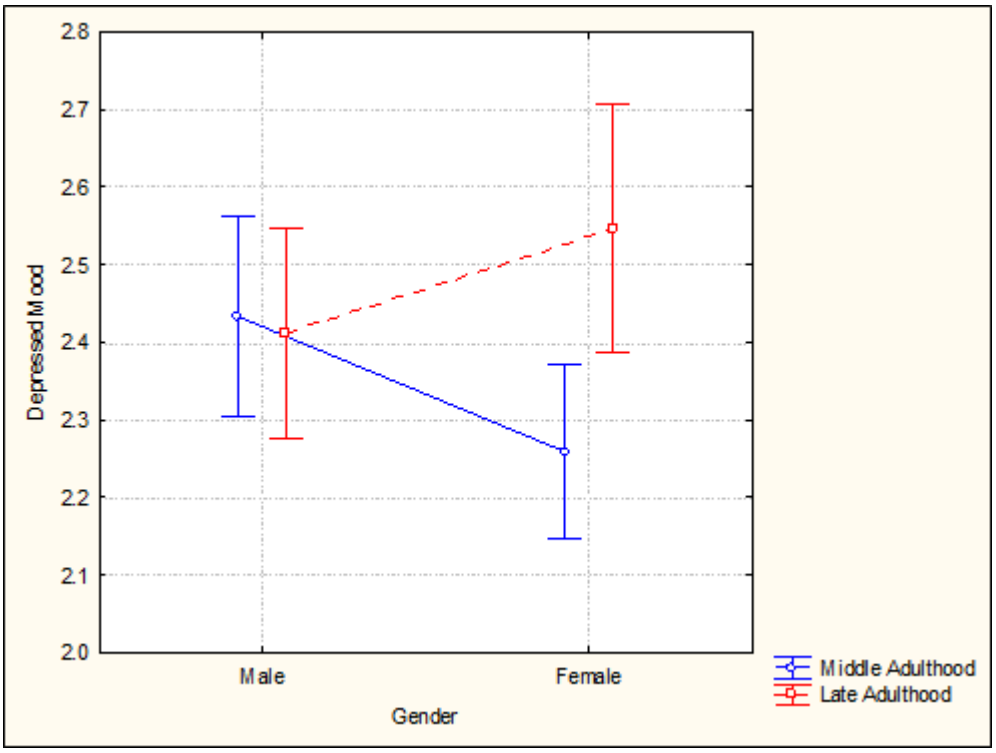
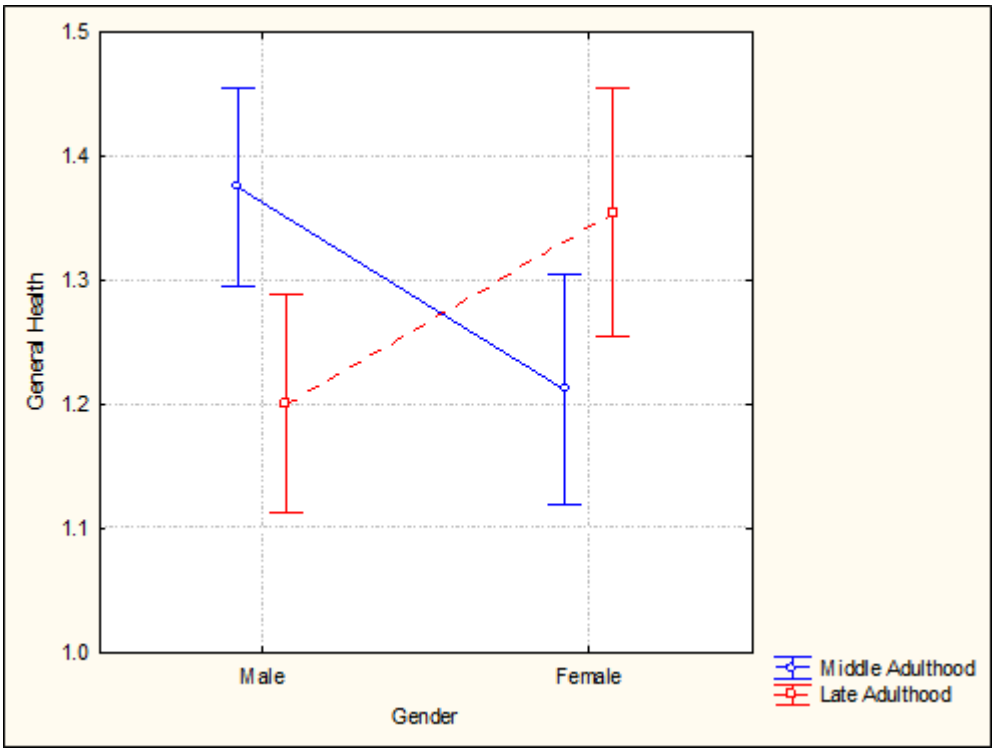


Table-5e: Probabilities for Post Hoc Tests for significant independent effect of 'gender X age-group' on General Health.

	1	**2**	**3**	**4**
Mean Ranks	**1.38**	**1.21**	**1.20**	**1.35**
1. Male Middle Adulthood	X			
2. Female Middle Adulthood	0.05	X		
3. Male Late Adulthood	0.04*	1.00	X	
4. Female Late Adulthood	0.99	0.18	0.15	X

**. Significant at the 0.05 level*

Figure-5: The plot of observed weighted means for the significant independent effect of 'gender X age-group' on General Health.



To determine the impact of socio-demographic variables on psychological well-being and spiritual experience among Mizo adults stepwise hierarchical multiple regression was employed. The observed beta values for the interpretability of Daily Spiritual Experience Scale and subscales of Psychological General Well-Being Index from socio-demographic variables are presented in Table-6. In model-1, age and gender are entered, in model-2, socio-economic status, locality, family type, number of children, bread earner, other support and caretaker are entered. In model-3, house type, house ownership and assets. In model-4, social involvement and religious involvement were all entered. Beta values of final model were all significant at the Adjusted R-square. The Durbin Watson statistics, Tolerance (minimum=.53) and range of Variance Inflation Factor (VIF=1.14-1.89) warranted the interpretability of the stepwise hierarchical multiple regression.

Table-6: Stepwise regression for the prediction of Daily Spiritual Experience Scale, Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health, and Vitality from the demographic variables of the study.

	DSES	*ANX*	*DEPM*	PWB	SCON	GENH	VIT
Age	-.20**	.16**	.06	.02	.07	-.06	.04
Gender	-.16**	-.07	-.04	.08	.08	-.05	.02
Socio-economic Status	-.20**	.02	.00	.08	.18**	.02	.07
Locality	-.02	-.19**	-.17*	-.01	-.10	.02	-.11
Family Type	.05	.22**	.08	.04	.18**	.05	.11
No. of Children	.05	-.08	-.02	-.06	-.09	-.03	-.06
Bread earner	.17**	.02	.12	.06	-.10	.17**	.00
Other Support	-.11*	-.01	-.04	.04	.04	-.15*	-.01
Caretaker	.19**	-.05	.04	-.08	-.04	.03	-.02
House Type	-.05	.00	-.02	.16*	.08	-.02	.00
House Ownership	.07	-.10	-.18**	-.09	-.16*	-.16*	-.15*
Assets	.24**	-.01	.02	-.14	-.17*	-.11	-.05
Social Involvement	.11	.01	.01	-.22**	-.16**	-.03	-.25**
Religious Involvement	.19**	-.08	-.07	-.13*	-.11	-.10	-.16**
Durbin-Watson	1.33	1.99	1.90	1.92	1.85	1.80	2.15
Adjusted R^2	.19**	.12**	.08**	.10**	.13**	.06**	.12**

**. *Significant at the .01 level*

*. *Significant at the .05 level*

{Italicized variables are reverse scored}

{DSES=Daily Spiritual Experience; ANX=Anxiety; DEPM=Depressed Mood; PWB=Positive Well-Being; SCON=Self-Control; GENH=General Health; VIT=Vitality}

The results (Table-6) revealed that increase in age predicted higher daily spiritual experience. Evidence indicates that for many aging individuals spiritual capacity gradually increases, especially with regards to self-acceptance and perceptions of one's life having integrity (Atchley, 2000; Idler, Kasl, & Hays, 2001; Koenig, 2006; Moberg, 2001; Tornstam, 2005).Scholars argue the natural process of aging, or the passage of chronological time with afinite and foreseeable end, creates a context where older adults can become more self reflexive and self-accepting, opening the mind/body/spirit to an expansion and deeper sense of knowing (Atchley, 2000; McFadden, 2005). Within the field of aging, there is evidence that as individuals grow closer to the natural end of their lives, the spiritual dimension gains in prominence (Johnson, 2009; Moberg, 2005; Tornstam, 2005). Recognizing that spirituality is an important aspect of the meaning-making and developmental process in later life, it is vital that elders are afforded the opportunity to share their spiritual experiences. Explorations of their spiritual lives provide researchers with insight (Atchley, 2000).

The study also revealed that females showed higher daily spiritual experience than males. In support to this finding, Vahia et al. (2011) found that spirituality was a key factor for women in promoting resilience to stress over the life course. Foley (2000) using the Spiritual Well-Being Index found that spirituality was of considerable importance to the women in her study and that high levels of spirituality was a predictor of higher levels of self-rated health and subjective well-being. Harvey (2006) also found that for African-American women in later life, spirituality was a key component in the management of chronic illness. These researchers, along with others, claim that more investigation is needed concerning the spiritual lives of older women.

Participants with better socio-economic status showed higher daily spiritual experience. Contrary to this finding, Albrecht and Heaton (1984) found that low socio-

economic individuals are more likely to seek God's will through prayer, and tend to report higher levels of divine interaction (Pollner, 1989), feeling connected with God (Krause, 2002), religious meaning and coping (Krause 2003, 1995), God-mediated control (Krause 2005, 2007), and the sense of divine control (Schieman et al. 2006). Moreover, low SES groups tend to derive greater psychological benefits from religiosity (Ellison, 1991; Krause, 1995; Pollner, 1989).

The results also revealed that when there are more number of bread earners in the family daily spiritual experience is lower, whereas, more number of received other support indicated higher daily spiritual experience. The findings also suggest that increase in distance of the degree of relationship with the caretaker indicated lower spiritual experience and more assets owned predicted lower spiritual experience.

From the study respondents with higher religious involvement shows lower daily spiritual experience. Thus, spirituality seems to be a broader term than religiosity. In fact, the two constructs are closely linked, few people engage in religious activity without having an associated sense of spirituality, while a small group of people experience spirituality that is not connected to any form of religious belief or activity (Underwood, 2006).

Hill et al. (2000) distinguished religion from spirituality with an important feature. Religion involves organised means and methods for the search for the sacred that are validated and supported by a community. As such, religion is composed of two elements: (1) the search for the sacred and (2) the group-validated means involved in the search. Spirituality only necessitates the first element. According to the authors, such a framework suggests that spirituality is an essential component of religion that can occur within the context of religion. If this is the case, one can argue that it is not possible to refer to religion without a spiritual element. Thus, for further clarity, religion must be said to be composed of

(1) a spiritual core and (2) participation in religious activities, or religious involvement. Having clarified this two-part conception of religion, it is clearer that one can refer to religion without a spiritual element. One could be religiously involved without actually experiencing spirituality. Similarly, spirituality can lead to people becoming part of a group with a prescribed doctrine, but it may also be experienced without any religious involvement. Therefore, an individual who is spiritual may not be religious at all in the organisational sense.

The finding of the present study revealed that older adults are less likely to experience anxiety than younger adults indicating that people who live into old age generally have developed strengths and coping skills that enable them to experience fewer negative emotional reactions, tolerate life's ups and downs, and deal effectively with crises.

Participants in joint family are less likely to experience anxiety than those in nuclear family. In contrast to this finding, Srivastava (1984) conducted a study to find out the relationship between family structure (nuclear or joint) manifest anxiety and self disclosure among urban boys. For this purpose Sinha anxiety scale and Sinha Self Disclosure inventory were administered 100 boys each, 16-18 years, from nuclear and joint families, residing in the city of Kanpur. Subjects were matched for age, education, birth order and socio-economic status. Results indicated that the boys of nuclear family had significantly lower manifest anxiety and they had significantly higher self disclosure than their counter parts from joint families. Result support the assumption that nuclear families are more congenial for healthy and integrated personality development of the Indian children in an urban setting in the context of rapid social change, urbanization and industrialization.

The results revealed that those who live in urban have higher level of anxiety than those living in rural locality. The risk for some major mental illnesses (e.g. anxiety,

psychotic, mood, or addictive disorders) is generally higher in cities. Studies on anxiety disorders (including posttraumatic stress disorder, distress, anger, and paranoia) found higher rates in urban versus rural areas in several Latin American and Asian countries (Prina AM, Ferri CP, Guerra M, Brayne C, Prince M, 2011; Sharifi V, Amin-Esmaeili M, Hajebi A, et al.,2015). Overcrowding and increase in population with an under-standard life, Unemployment, poverty, Crime, Pollution, Cultural change, conflict, estrangement, isolation, Child employment, Disintegration of families, Rapid increase in shanty houses, living in poor home environment, decay in aesthetic structure, Traffic problems, Uncertainty of future, and anxiety. Thus, negatively affected mental health of individuals.

The results also revealed that respondents living in rented homes have more symptoms of depression than those who owned a house. Emerging evidence suggests that housing tenure is an important determinant of health (Szabo et al., 2017). Studies from the UK have shown that housing tenure (owner occupied, rented from the public sector or rented privately) is associated with illness and mortality (Filakti and Fox, 1995; Fogelman et al., 1987). Compared with those who rent, owning your own home appears to be associated with fewer chronic illnesses (Smith et al., 2001; Hiscock et al., 2003; Macintyre et al., 2001), and lower mortality rates (Filakti and Fox, 1995; Fogelman et al., 1987; McMunn et al., 2009). Furthermore, those who rent are more likely to experience mental health problems and symptoms of depression and anxiety (Macintyre et al., 2001; Ellaway and Macintyre, 1998; Kind et al., 1998).

From the present study poorer housing conditions indicated higher positive well-being. In contrast to this finding, poor quality housing can be a source of stress for individuals (Rogers, Pilgrim 2010, Osypuk 2015), and predispose individuals to mental disorders by lowering their baseline mental health. Low energy efficiency in housing is one

aspect that impacts on mental health through fuel poverty, chronic thermal discomfort, and concerns that drought is damaging to physical health and possessions (Liddell, Guiney 2015). Some research indicates that many consider housing to be a major problem during later years of life. Suitable housing condition is important for any one regardless of age. Few factors have as much potential for promoting the well-being of the elderly as housing of appropriate size, which offers safety, comfort, and opportunity of choice between privacy and contact with the community.

Respondents who reported attending or participating in social and religious activities were less likely to report low levels of positive well-being compared to those who reported not participating in such activities. In contrast, Clark and Lelkes (2003) reported that the positive influence of religion on subjective well-being could be attributed to capacity of religion as a potential resource to neutralize daily stressors like low income, sad events, or unemployment. Also, it is believed that religious practices give some sort of social support, feeling of inclusion, increases social contact, and promotes peoples' healthy life style.

Participants with better socio-economic status showed higher level of self-control than those with lower socio-economic status. Moffitt et al. (2011) use the term self-control synonymously with conscientiousness, a large class of personality traits that includes responsibility, industriousness, and orderliness. The common thread running through diverse conceptualizations of self-control is the idea of effortful regulation of the self by the self. Self-controlled individuals are more adept than their impulsive counterparts at regulating their behavioral, emotional, and attentional impulses to achieve long-term goals.

The study also revealed that those who live in joint family showed higher level of self-control than living in nuclear family. Moffitt et al. (2011) presented the analyses for the potential confounds of intelligence and family background, two variables that in prior studies

have been associated with self-control. Moreover, to account for the possibility of unmeasured aspects of the family environment driving the predictive correlations between self-control and later outcomes, Moffitt et al. (2011) compare in a separate sample self-controlled children with their less self-controlled siblings. Consistent with their main analyses, childhood self-control continues to predict later outcomes, even when controlling for family effects in this quasi-experimental design.

The results also revealed that living in rented house as compared to owned house indicated lower self-control. In support to this finding, Kathrin Schlafmann (2015) found that people with stronger problems of self-control are less likely to become home owners, even though houses serve as commitment for saving. The paper then investigates the welfare effects of regulating mortgage products if people differ in their degree of self-control. Higher down payment requirements and restrictions on prepayment turn out to be beneficial to people with sufficiently strong problems of self control, even though these policies further restrict access to the commitment device.

More assets possessed predicted lower self-control in the present study. Lunt (1996) suggested that, in the economic environment with higher materialism and more opportunities that are accompanied by risks, more importance should be placed on self-control.

In the present study more social involvement indicated lower self-control. Contrary to this finding, Gottfredson and Hirschi (1990) also take a similar position that with regard to the relationship between self-control and social bonds even though they favor self-control over social bonds. However, Gottfredson and Hirschi (1990), indeed, open up a possibility of combining self-control and social bonds into a single theoretical model as they postulate that deviance and weak social bonds are the products of low self-control.

The finding that more number of bread earner in the family indicated better general health because if there are more earners and more earning in the family maintenance of health is easy. Money can provide physical health and the sense of well-being necessary to be of service to others. With high-income, individuals tending to be in better health than low-income persons. This relationship has been observed for a wide range of health measures, including mortality (Backlund, Sorlie, and Johnson 1996; McDonough et al., 1997), chronic conditions (Case, Lubotsky & Paxson. 2002), obesity (Schmeiser, 2009), functional limitations (Zimmer & House, 2003), and self-reported health status (Deaton & Paxson, 1998). Case, Lubotsky, and Paxson (2002) and Lindahl (2005) suggest that a higher income causes improvements in health outcomes, and Arno and colleagues (2009) present preliminary evidence that income-support programs increase access to health insurance and improve certain health outcomes. Bound (1989), Haveman and colleagues (1995), and Smith (1999, 2004), however, maintain that lower incomes are due to the decline in productivity that results from poor health and disabilities rather than the reverse.

Financial supports have played an important role in the health and status of elderly for physical, social and psychological wellbeing. More financial support indicated the increased in health care concepts (MacLeod et al., 2017) whereas among the Mizo community, being increased in receiving other support lowers their general health.

Living in rented house emerged to show lower general health than living in owned house. Health may be adversely affected by substandard physical conditions of the home, such as poor ventilation, mold, or pest infestation, which may lead to infectious disease, injuries, and chronic conditions. Although poor physical and psychosocial conditions can exist in both rental and owner-occupied homes, these conditions may be more difficult to resolve in rental homes because unresponsive property owners may not correct hazardous

conditions and there may be fewer pecuniary resources to make repairs.

Living in rented house is more preferable with low income and moderate living conditions and some rented for the period of accumulating their savings for future ownerships. Lower vitality is predicted by living in rented house which is mostly seen to those individual with low income and moderate lifestyle. In the contrary, Crull & Cook (2015) results showed higher vitality with individual rented-occupied house.

Being higher in social involvement is considered to be more acceptable and more positive outcomes as aged which support the increase in social involvement with higher vitality. The more social involvement, the higher to live longer and better health with decrease mental illness (Antonucci, 2001; Berkman, 1985; Vaillant, Meyer, Mukamal & Soldz, 1998; Antonucci, Fuhrer & Dartiques, 1997). Religious is considered to give hope, blessed, meaningful life as age increased and voluntary social activity. With increased in age and religious involvement their life, health, behaviors to social is considered to be good with positive morality (Kaplan & Berkman, 2016). From our findings, higher social and religious involvement decreased with vitality which is not applicable among Mizo society.

CHAPTER-V

SUMMARY AND CONCLUSION

Life for middle-aged and older adults is naturally full of challenges. Those in middle adulthood struggle to balance career, parenthood, and perhaps care of elderly parents. Those in late adulthood face empty nests, impending retirement and are more likely to experience losses of loved ones and declines in physical health (Staudinger & Bluck, 2001). Despite facing a similar pattern of stresses over the course of adult development, some individuals are able to maintain high levels of well-being and spiritual experience throughout, whereas others experience hopelessness or depression.

The present study was designed to determine the impact of socio-demographic variables on Psychological Well-Being and Spiritual Experience among Mizo Adults. The participants comprised of 309 Mizo adults (163 males & 146 females) further classified into two developmental stages: Middle Adulthood (40-60 years) and Late Adulthood (60 years & above). The participants were selected based on multistage random sampling procedure from 3 constituencies of Aizawl city (Aizawl North II, Aizawl North III, & Aizawl East I). Informed consent was obtained and the demographic profiles of the participants – age, gender, socio-economic status (derived from the background information of marital status, educational qualification, number of family members, occupational status and monthly income based on the works of Hollingshead, 1975 and Kuppuswamy, 1981), locality, family type, number of children, bread earner, other support, house type, house ownership, caretaker, assets, social and religious involvement are carefully recorded to match or equate the participants in the study. The study employed 2 ‘gender’ (male & female) x 2 ‘age-group’ (middle adulthood & late adulthood) factorial design.

The study incorporated the behavioral measures of Psychological General Well Being Index (Dupuy, 1971) and Daily Spiritual Experience Scale (Underwood & Teresi, 2002). The responses of the participants after careful screening, cleaning and coding are processed with statistical packages. The responses of the participants obtained through the psychological measures of Psychological General Well-Being Index and Daily Spiritual Experience Scale as well as the demographic variables of the participants were screened, coded and analyzed by employing computer software programmes.

The statistical analysis of the study included the descriptive statistics (mean, SD, skewness, kurtosis and bivariate correlation matrix) for the behavioural measures as well as internal consistency (Cronbach alphas) of the behavioural measures. The descriptive statistics and the Cronbach Alphas revealed all the scales/subscales of the behavioural measures to be applicable for the measurement in the target population. The outcomes revealed that daily spiritual experience to be negatively correlated with all the subscales of Psychological General Well-Being Index (PGWBI) and significant relationship was found for anxiety, positive well-being, self-control and vitality. All the subscales of Psychological General Well-Being Index show highly significant positive correlation in all possible combinations.

Secondly, analysis of covariance (ANCOVA) for the effect of 'gender' and 'age-group' on scales/subscales of the behavioural measures with the demographic variables as the covariate was employed to show the patterns of variation. Scheffe Test, which is a parametric Post-hoc multi-comparison was employed to elucidate the patterns of groups/means differences for significant independent and interaction effect of 'gender' and 'age-group' on the behavioural measures.

The results revealed that females to show higher daily spiritual experience as compared to males. This may be due to the fact that women are more likely than men to seek

religious consolation (Ferraro & Kelley-Moore, 2000). The finding also revealed that late adulthood showed higher daily spiritual experience than middle adulthood. In support to this finding, Beit-Hallahmi and Argyle (1998) found that older adults rate religion as more important in their lives than do younger adults. Scholars have posited that aspects of both religiosity and spirituality are important resources in helping individuals productively cope with age-related losses (Krause & Tran, 1989). Spirituality might be increasingly beneficial with advancing age as many older adults face the developmental challenges of transcending their physical self (Peck, 1968) and coming to better terms with their mortality (Havighurst, 1972). Engagement with religious communities might also benefit older adults in particular by providing social relationships and support in later life (Neill & Kahn, 1999).

The results also revealed that middle adulthood showed higher level of anxiety as compared to late adulthood. Early researches supported the present findings that in cross-sectional studies, older age is related to lower level of negative affect (Carstensen, Pasupathi, Mayr, & Nesselroade, 2000; Diener & Suh, 1997; Mroczek & Kolarz, 1998). Blazer (2003), Piazza & Charles (2006) also highlighted that older age is related to lower rates of anxiety and major depressive disorder. In longitudinal studies, Charles, Reynolds, & Gatz (2001) also reported that older age is related to lower levels of negative affect, increases in life satisfaction (Mroczek & Spiro, 2003), and stable levels of positive affect (Charles et al. 2001).

The findings also revealed that females in middle adulthood showed higher depressed mood than females in late adulthood (Hasin, Goodwin, Stinson, & Grant, 2005) and males in middle adulthood showed higher general health than males in late adulthood. This may be due to the fact that during late adulthood the skin continues to lose elasticity, reaction time slows further, and muscle strength diminishes. The immune system is weakened, and many older people are more susceptible to illness, cancer, diabetes, and other ailments.

Cardiovascular and respiratory problems become more common in old age. Seniors also experience a decrease in physical mobility and a loss of balance, which can result in falls and injuries.

Finally, stepwise hierarchical multiple regression was employed for the prediction of Psychological Well-being and Spiritual Experience from the socio-demographic variables. All the findings are also supported by analysis of covariance (ANCOVA).

The results revealed that increase in age (Atchley, 2000; Idler, Kasl, & Hays, 2001; Koenig, 2006; Moberg, 2001; Tornstam, 2015), being female (Vahia et al, 2011; Foley, 2000; Harvey, 2006), better socio-economic status, and more number of received other support indicated higher spiritual experience whereas more number of bread earners in the family, increase in distance of the degree of relationship with the caretaker, assets owned and higher religious involvement (Underwood, 2006) predicted lower daily spiritual experience. Increase in age and joint as compared to nuclear family type predicted lower anxiety.

The results also highlighted that urban participants showed higher level of anxiety and depressed mood than the rural participants (Prina AM, Ferri CP, Guerra M, Brayne C, Prince M, 2011; Sharifi V, Amin-Esmaeili M, Hajebi A, et al., 2015). Better socio-economic status and joint as compared to nuclear family type predicted higher self-control (Moffitt et al., 2011). Poorer housing conditions indicated higher positive well-being.

More number of bread earners in the family also indicated higher general health. Consistent to this finding, Case, Lubotsky, and Paxson (2002) and Lindahl (2005) suggest that a higher income causes improvements in health outcomes, and Arno and colleagues (2009) present preliminary evidence that income-support programs increase access to health insurance and improve certain health outcomes. Bound (1989), Haveman and colleagues (1995), and Smith (1999, 2004), however, maintain that lower incomes are due to the decline

in productivity that results from poor health and disabilities rather than the reverse. Living in rented house showed higher depression and lower self-control, general health, and vitality. More number of received other support also indicated lower general health. More assets possessed predicted lower self-control. Higher social and religious involvement predicts lower positive well-being and vitality and higher social involvement predicted lower self-control.

In sum, the outcomes of the present study revealed that socio-demographic variables such as age, gender, socio-economic status, locality, family type, bread earner, other support, caretaker, house type, house ownership, assets, social and religious involvement successfully predicted Psychological Well-Being and Daily Spiritual Experience.

Limitations of the study:

The limitation of the study is that the sample comprised of 309 Mizo adults out of which 163 are male and 146 female which is far less than half of the population. The other limitation of the study is that during the course of data collection some participants reported auditory and visual problems especially those in late adulthood and participants with a low level of education also struggle with tasks which needs verbal communication to respond the tasks. The other limitation is that some participants were uncooperative about answering the questionnaires even though they were given proper informed consent and confidentiality, many returned incomplete questionnaires, left a few items unanswered where some participants stated that it was a form of invasion of privacy or gave two answers to the same question which was generally the demographic profile sheet.

REFERENCES

Albrecht, S.L., & Tim, B.H. (1984). "Secularization, Higher Education, and Religiosity." *Review of Religious Research*, 26:43 – 58.

Amato, P.R. (1992). Rural Poverty, Urban Poverty and Psychological Well-Being. *The Sociological Quarterly*, Vol 33 (2), 229-240.

Anjaneyulu, G. (2002). Challenges before public health organizations, National Health Programmes. *Indian Journal of Public Health*, 46 (4) : 131-34.

Ano, G., & Vasconcelles, E. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology*, 61(4) 461-480.

Ansari, N.A., & Ahmad, N. (2002.) Recent advances in geriatric medicine. Pravara Med Rev 4: 7-11.

Antonucci, T.C. (2001). Social relations. In: Birren JE, Schaie KW, editors. *Handbook of the psychology of aging*. San Diego: Academic Press. pp. 427–453.

Antonucci, T.C., Fuhrer, R., & Dartigues, J.F. (1997). Social relations and mental health in a sample of community dwelling French elderly. *Psychology and Aging*, 12, 189–195.

Aranda, M.P. (2008). Relationship between religious involvement and psychological well-being: A social justice perspective. *Health & Social Work*, 33(1), 9-21.

Ardelt, M., Ai, A.L., & Eichenberger, S.E. (2008). In search for meaning: The differential role of religion for the middle-aged and older persons diagnosed with a life threatening illness. *Journal of Religion, Spirituality & Aging*; 20(4):288–312.

Aristotle. (2000). Nicomachean ethics. R. Crisp (Trans.). Cambridge: Cambridge University Press.

Arno, P.S., Sohler, N., Viola, D., & Schechter, C. (2009). Bringing Health and Social Policy Together: The Case of the Earned Income Tax Credit. *Journal of Public Health Policy*; 30(2):198–207.

Arshad, M., & Bhat, S.A. (2013). Global ageing trends: A sociological perspective. *Int J Curr Res Acad Rev* 1: 55-64.

Atchley, R. (1997). Everyday mysticism: Spiritual development in later adulthood. *Journal of Adult Development*, 4, 123–134.

Atchley, R. (2009). Spirituality and aging. Baltimore, MD: The Johns Hopkins University Press.

Atchley, R. (2000). Social forces and aging: *An introduction to social gerontology*. Belmont, CA: Wadsworth.

Backlund, E., Sorlie, P.D., & Johnson, N. J. (1996). The shape of the relationship between income and mortality in the United States: Evidence from the National Longitudinal Mortality Study. *Annals of Epidemiology*, 6, 12–20.

Baltes, P. B., & Mayer, K. U. (1999). The Berlin Aging Study: Aging from 70 to 100. New York: Cambridge University Press.

Barren, J.E., & Renner, V.J. (1977). Research on the Psychology of Aging: Principles and Experimentation, In Birren, J.E., & Schaic, K.W. (Eds.), *Handbook of the Psychology on Aging*, New York: Van Nostand Reinhold Company.

Baruth, M., Lee, D.C., Sui, X., Church, T., Marcus, B., Wilcox, S., & Blair, S. (2011). Emotional Outlook on Life Predicts Increases in Physical Activity Among Initially Inactive Men. *Health education and Behaviour*, 38(2), 150-158.

Batra, S. (2004). Social components of active aging: A comparative study of engaged and disengaged women after retirement. *J Res Dev* 10: 23-29.

Beekman, A.T.F., Bremmer, M.A., Deeg, D.J.H., van Balkom, A.J.L.M., Smit, J.H., de Beurs, E., van Dyck, R., & van Tilburg, W. (1998). Anxiety disorders in later life : a report from the longitudinal aging study Amsterdam. *International Journal of Geriatric Psychiatry*. 13:717–726.

Beit-Hallahmi, B., & Argyle, M. (1998). Religious Behavior, Belief, and Experience. New York: Routledge.

Bergin, A.E. (1983). Religiosity and psychological well-being: A critical re-evaluation and meta-analysis. *Professional Psychology: Research and Practice*, 14, 170–184.

Berkman, L.F. (1985). The relationship of social network and social support to morbidity and mortality. In: Cohen S, Syme LS, editors. *Social support and health*. New York: Academic Press. pp. 241–262.

Berkman, B., & Harootyan, L. (Eds.). (2003). Social work and health care in an aging society: education, policy, practice, and research. New York, N.Y.: Springer Publishing Company, Inc.

Birkenmaier, J.M., Behrman, G., & Berg-Weger, M. (2005). Integrating curriculum and practice with students and their field supervisors: Reflections on spirituality and the aging (rosa) model. *Educational Gerontology*, 31(10), 745.

Blazer, D.G. (2003). Depression in late life: review and commentary. *Journal of Gerontology*, 58A, (3), 249-265.

Boehm, J., Peterson, C., Kivimaki, M., & Kubzansky, L.D. (2011). Heart health when life is satisfying: evidence from the Whitehall II cohort study. *European Heart Journal*, 32(21), 2672-2677.

Boswell, G.H., Kahana, E., & Dilworth-Anderson, P. (2006). Spirituality and healthy lifestyle behaviors: stress counter-balancing effects on the well-being of older Adults. *Journal of Religion and Health*, 45(4), 587-602.

Bound, J. (1989). The Health and Earnings of Rejected Disability Insurance Applicants. *American Economic Review*, 79(3):482–503.

Bradburn, N.M. (1969). The structure of psychological well-being. Chicago: Aldine.

Brennan, M., Laditka, S.B., & Cohen, A. (2005). Postcards to god: Exploring spiritual expression among disabled older adults. *Journal of Gerontological Social Work*, 45(1/2), 203-222.

Bronikowski, A.M., & Flatt, T. (2010).Aging and its demographic measurement. Nat. Educ. Knowl.1, 3.

Canda, E.R., & Furman, L.D. (1999). Spiritual diversity in social work practice: The heart of helping. New York: The Free Press.

Carmody, J., Reed, G., Kristeller, J., & Merriam, P. (2008). Mindfulness, spirituality and health-related symptoms. *Journal of Psychosomatic Research*, 64,393-403.

Carroll, M.M. (2001). Conceptual models of spirituality. In E. R. Canda, & E. D. Smith (Eds.). Transpersonal perspectives on spirituality in social work (pp. 5-21). Binghamton, NY: Haworth Press, Inc.

Carrol, E.N & Zuckerman, M. (1977). Psychopathology and sensation seeking in 'downers', 'speeders', and 'trippers': A study of the relationship between personality and drug choice. *International Journal of the Addictions*, 12, 591-601.

Carstensen, L.L., Pasupathi, M., Mayr, U., & Nesselroade, J.R. (2000). Emotional experience in everyday life across the adult life span. *Journal of Personality & Social Psychology*. 79:644–655.

Cartwright, K. (2001). Cognitive developmental theory and spiritual development. *Journal of Adult Development*, 8(4), 213-220.

Case, A., Lubotsky, D., & Paxson, C. (2002). Economic Status and Health in Childhood: *The Origins of the Gradient. American Economic Review*; 92(5):1308–44.

Census of India. (1991). Ageing Population of India-An Analysis of the 1991 Census Data, Registrar General, India, New Delhi.

Census of India. (2001). Mizoram Primary Census Abstract Directorate of Census Operation, Mizoram.

Census of India. (2011). Census organisation of India.www.censusindia.net.

Chandler, C.K., Miner-holden, J., & Kolander, C.A. (1992). Counseling for spiritual wellness: Theory and practice. *Journal of Counseling and development*, 71, 168-174.

Charles, S.T., Carstensen, L.L., & McFall, R.M. (2001). Problem-solving in the nursing home environment: Age and experience differences in emotional reactions and responses. *Journal of Clinical Geropsychology Special Issue: Management of Behavioral Problems in Late Life Therapeutic Approaches and Related Issues.* 7:319–330.

Charles, S.T., Reynolds, C.A., & Gatz, M. (2001). Age-related differences and change in positive and negative affect over 23 years. *Journal of Personality and Social Psychology*; 80:136–151.

Chhabra, R.P., Kim, J.D., Lee, E.S., Lee, C.Y., & Ross, L. (1995). The spiritual dimension: Its importance to patients' health, well-being and quality of life and its implications for nursing practice. *International Journal of Nursing Studies*, 32(5), 457-468.

Chiu, L., Emblen, J.D., Hofwegen, L., Sawatzky, R., & Meyerhoff, H. (2004). An integrative review of the concept of spirituality in the health sciences. *Western journal of Nursing Research*. 26:405-428.

Choi, N.G. & Jun, J. (2009). Life regrets and pride among low-income older adults: relationships with depressive symptoms, current life stressors and coping resources. *Aging & Mental Health*, 13 (2), 213-225.

Chowdhury, A., Patnaik, M.M., Choudhury, R., & Raut, G. (2014). Family victimisation and plight of elderly women: A representative study in Odisha state of India. *Int Res J Soc Sci* 3: 44-53.

Clark, A.E., & Lelkes, O. (2003). Keep the faith: Is social capital just an instrument? Unpublished manuscript, Department et Laboratoire d'Economic Theoretique et Appliquee, Paris, France.

Cloninger, C., Pryzbeck, R., Svrakic, T. R., Dragan, M. & Wetzel, R. D. (1994). The temperament and character inventory, St. Louis, WA: Washington University.

Cohen, A.B., & Koenig, H.G. (2003). Religion, religiosity and spirituality in the biopsychosocial model of health and ageing. *Ageing International*, 28, 215-241.

Cohen, H.L., Thomas, C.L., & Williamson, C. (2008). Religion and spirituality as defined by older adults. Journal of Gerontological Social Work, 51(3-4), 284-99.

Coleman, P.G. (2005). Spirituality and ageing: The health implications of religious belief and practice. *Age & Ageing*, 34, 318-319.

Conway, C., & MacLeod, A. (2002). Well-being: Its importance in clinical practice and research. *Clinical Psychology*, 16, 26-29.

Cook, C.C.H. (2004). Addiction and spirituality. Addiction;99:539-551.

Crull, S.R., & Cook, C.C. (2015). Housing and Economic Vitality in Rural Midwestern Counties. Pages 16-32 Published online: 09 Jun 2015.

Dalby, P. (2006). Is there a process of spiritual change or development associated with ageing? A critical review of research. *Aging & Mental Health*, 10, 4 12.

Davis, B. (2005). Mediators of the relationship between hope and well-being in older adults. *Clinical Nursing Research*, 14(3), 253-272.

Depken, D. (1994). Wellness through the lens of gender: A paradigm shift. *Wellness Perspectives*, 10(2), 52-63.

Dhara, R.D., & Jogsan, Y.A. (2013). Depression and psychological well-being in old age. *Journal of psychology and psychotherapy*, 3, 117.

Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, 49, 71–75.

Diener, E., Gohm, C., Suh, E., & Oishi, S. (2000). Similarity of the relations between marital status and subjective well-being across cultures. *Journal of Cross Cultural Psychology*, 31(4), 419-436.

Diener, E., Oishi, S., & Lucas, R.E. (2003). Personality, Culture, and Subjective Well-Being: Emotional and Cognitive Evaluations of Life. *Annual Review of Psychology*, 54, 403-425.

Diener, E., Suh, M.E. (1997). Subjective well-being and age: An international analysis. In: Schaie KW, Lawton MP, editors. *Annual review of gerontology and geriatrics.* Vol. 17. New York: Springer; pp. 304–324.

Diener, E., Suh, E., Lucas, R., Smith, H. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125(2), 276-302.

Dupuy, H.J. (1971). The Psychological General Well-Being (PGWB) Index. In: Assessment of Quality of Life in clinical trials of cardiovascular therapies. Edited by Wenger NK, Mattson ME, Furberg CD, Elinson J.Le Jacq Publishing; Chap 9:170-183.

Eaton, W.W., Kramer, M., Anthony, J.C., Dryman, A., Shapiro, S., Locke, B.Z. (1989). The Incidence of specific DIS/DSM-III mental disorders : data from the NIMH Epidemiologic Catchment Area Program. *Acta Psychiatrica Scandinavica*. 79:163–178.

Edwards, P. (2002). Spiritual themes in social work counseling: facilitating the search for meaning. *Australian Social Work*, 55 (1), 78-87.

Eisenhandler, S.A. (2005). Religion is the finding thing: an evolving spirituality in late life. *Journal of Gerontological Social Work*, 45(1/2), 85-103.

Elkins, D.N. (1998). Beyond religion: A personal program for building a spiritual life outside the walls of traditional religion. Wheaton, Il.: Quest Books.

Elkins, D.N., Hedstrom, L.J., Hughes, L.L., Leaf, J.A., & Saunders, C. (1998). Toward a humanistic phenomenological spirituality. Definition, description, and measurement. *Journal of Humanistic Psychology*. 28:5-18.

Ellaway, A., Macintyre, S. (1998). Does housing tenure predict health in the UK because it exposes people to different levels of housing related hazards in the home or its surroundings? *Health Place* 4 (2), 141-150.

Ellens, J. H. (2007). Radical grace: How belief in a benevolent god benefits our health. Westport, CT: Praeger Publishers.

Ellison, C.G. (1991). Religious involvement and subjective well-being. *Journal of Health and Social Behavior*, 32, 80-99.

Ellison, C., & Levin, J. (1998). The religion health connection: Evidence theory and future directions. *Health Education and Behavior*, 25(6), 700-720.

Erickson, E.H. (1963). Childhood and society. New York: Norton.

Erikson, E.H., & Erikson, J. (1997). The Life Cycle Completed: Extended Version. New-York: W.W. Norton.

Fabian, D., & Flatt, T. (2011).The evolution of aging. Nat. Educ. Knowl.2, 9.

Fabricatore, A.N., Handel, 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.

Fahey, T., Montgomery, A.A., Barnes, J., & Protheroe. J. (2003). Quality of care among elderly residents in nursing homes and elderly people living at home: *Controlled observational study*. Brit Med J 32: 580-84.

Fallot, R.D. (2001). Spirituality and religion in recovery: Some current issues. *Psychiatric Rehabilitation Journal*, 30(4), 261-270.

Feher, & Maley (1999). Coping with breast cancer in later life: The role of religious faith. *Psycho-Oncology*, 8, 408-416.

Fernandez-Ballesteros, R., Zamarron, M.D,, & Ruiz, M.A. (2001). The contribution of socio-demographic and psychosocial factors to life satisfaction. *Ageing and Society*, 21, 25-43.

Ferraro, K.F., & Kelley-Moore, J.A. (2000). Religious consolation among men and women: Do health problems spur seeking?. *Journal for the Scientific Study of Religion*, 39: 220–234.

Filakti, H., Fox, J. (1995). Differences in mortality by housing tenure and by car access from the OPCS. Longitudinal Study. Popul. Trends.:27–0.

Fiorito, B., & Ryan, K. (2007). Spirituality and psychological well-being: A mediator-moderator study. *Review of Religious Research*, 48(4), 341-368.

Flatt, T., & Schmidt, P.S. (2009).Integrating evolutionary and molecular genetics of aging. Biochim.Biophys. Acta 1790, 951–962.

Fogelman, K., Fox, A., Power, C. (1987). Social Statistics Research Unit, City University; UK. Class and Tenure Mobility: Do they Explain Social Inequalities in Health Among Young Adults in Britain?

Foley, L. (2000). Exploring the experience of spirituality in older women finding meaning in life. *Journal of Religious Gerontology*. 12(1):5–15.

Fowler, J.W. (1981). Stages of faith: The psychology of human development and the quest for meaning. San Francisco: Harper & Row.

Frankl, V.F. (1969/1988). The will to meaning. Foundations and applications of logotherapy. New York: Penguin, Expanded edition.

Fredrickson, B.L., Mancuso, R.A., Branigan, C., & Tugade, M. (2000). The undoing effect of positive emotions. *Motivation and Emotion*, 24, 237–258.

Fromm, E. (1947). Man for himself: An inquiry into the psychology of ethics. New York: Fawcett.

Gartner, J. (1996). Religious commitments, mental health, and prosocial behavior: A review of the empirical literature. In E. P. Shafranske (Ed). *Religion in the clinical practice of psychology*. (pp. 187-214). Washington, DC: American Psychological Association.

Gilchrist, R. (1992). The need of holistic counseling. American Counselor, 1, 10-13.

Giltay, E.J., Kamphuis, M., Kalmijn, S., Zitman, F.G., & Kromhout, D. (2006). Dispositional optimism and the risk of cardiovascular death: the Zutphen Elderly Study. *Archives of Internal Medicine*, 166(4), 431-436.

Girum, T. (2012). Psychological wellbeing as a function of religious involvement, spirituality and personal meaning in life among community - residing elders in Dessie Town. M. A. thesis.

Gottfredson, M.R., & Hirschi, T. (1990). A general theory of crime. Stanford, CA: Stanford University Press.

Gouveia, M.J., Marques, M., & Pais-Ribeiro, J.L. (2009).Versãoportuguesa do questionário de bem-estarespiritual (SWBQ): Análiseconfirmatória da suaestrutura factorial [Portuguese version of the spiritual well-being questionnaire (SWBQ): Confirmatory analysis of its factorial structure]. *PsicologiaSaúdeDoenças*, 10, 285-293.

Group for Economic & Social Studies. (2009). Rising crime against elderly people and responsibility of police in metros. Project Report. Bureau of police research and development. Ministry of Home Affairs, Government of India New Delhi.

Gulzar, F., Zafar, M.F., Ahmad, A., & Ali, T. (2008). Socio-economic problems of senior citizens and their adjustment in Punjab, Pakistan. Pak J Agri Sci 45: 56-62.

Gutmann, D. (1978). Personal transformation in the post-parental period: A crosscultural view. Washington, DC: American Association for the Advancement of Science.

Haber, J.R., Jacob, T., & Spangler, D.J.C. (2007). Dimensions of religion/spirituality and relevance to health research. The International *Journal for the Psychology of Religion*, 17(4), 265-288.

Hackney, C. H., & Sander, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, 42 (1), 43-55.

Hamarat, E., Thompson, D., Steele, D., Matheny, K,, & Simons, C. (2002). Age differences in coping resources and satisfaction with life among middle-aged, young-old, and oldest-old adults. *Journal of Gerontological Psychology*, 163(3), 360-367.

Hammermeister, J. & Peterson, M. (2001). Does spirituality make a difference? Psychological and health-related characteristics of spiritual well-being. *American Journal of Health Education*, 32(5), 293-297.

Hansen, J.C., Dik, B.J., Zhou, S. (2008). An examination of the structure of leisure interests of college students, working-age adults, and retirees. *J. Counsel. Psychol*. 55(2), 133-145.

Harman, D. (1956). Aging: a theory based on free radical and radiation chemistry.*J. Gerontol*.11, 298 – 300.

Harvey, I. (2006). Self-management of a chronic illness: An exploratory study on the role of spirituality among older African American women. *Journal of Women & Aging*. 18(3):75–88.

Hashemi, L., & Jokar, B. (2011). The Relationship between Spiritual Elevation and Resilience among Students. *Educational Psychology*. 8(13): 123-142.

Hasin, D.S., Goodwin, R.D., Stinson, F.S., Grant, B.F. (2005). Epidemiology of major depressive disorder: Results from the National Epidemiologic Survey on Alcoholism and Related Conditions. *Arch. Gen.Psychiatr*. 62:1097–106.

Haveman, R., Wolfe, B., Buron, L., Hill, S.C. (1995). The Loss of Earnings Capability from Disability/Health Limitations: Toward a New Social Indicator. *Review of Income and Wealth*, 41(3):289–304.

Havighurst, R.J. (1972). Developmental Tasks and Education. New York: David McKay Company.

Helminiak, D.A. (1996). The human core of spirituality: Mind as psyche and spirit. Albany: State University of New York Press.

Help Age India. (2012). India's elderly suffer abuse silently: Help Age report, Hindustan Times, India. June 15, 2011.

Helson, S. & Srivastava, S. (2001) Three paths of adult development: conservers, seekers, and achievers. *Journal of Personality and Social Psychology*, 80, 995, 1010.

Henderson, A.S., Jorm, A.F., Korten, A.E., Jacomb, P., Christensen, H., Rodgers, B. (1998). Symptoms of depression and anxiety during adult life : evidence for a decline in prevalence with age. *Psychological Medicine*. 28:1321–1328.

Hill, P.C., Pargament, K., Hood, R.W., McCullough, M.E., Swyers, J.P., Larson, D.B., et al. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, 30, 51–77.

Hiscock, R., et al. (2003). Residents and residence: factors predicting the health disadvantage of social renters compared to owner-occupiers. *J. soc. Issues,* 59 (3), 527-546.

Hollingshead, A.B. (1975). Four factor index of social status. Unpublished manuscript, Yale University, New Haven, CT.

Howden, J.W. (1992). Development and psychometric characteristics of the spirituality assessment scale. Ann Arbor: Texas Woman's University, UMI Dissertation Services.

Hybels, C., Blazer, D., George, L., & Koenig, H. (2012).The complex association between religious activities and functional limitations in older adults. *The Gerontologist*, 52, 5, 676-685.

Hungelmann, J.A., Kenkel-Rossi, E., Klassen, L., & Stollenwerk, R.M. (1985). Spiritual well being in older adults: Harmonious interconnectedness. *Journal of Religion and Health*. 24:147-153.

Huppert, F.A. (2009). Psychological well-being: Evidence regarding its causes and consequences. *Applied Psychology: Health and Well-Being*, 1, 137–164.

Idler, E.L., Kasl, S.V., & Hays, J.C. (2001). Patterns of religious practice and belief in the last year of life. *Journals of Gerontology: Social Sciences*; 56B (6):S326–S34.

Jafari, E., Najafi, M., Sohrabi, F., Dehshiri, G.R., Soleymani, E., & Heshmati, R. (2010). Life satisfaction, spirituality well-being and hope in cancer patients. Procedía - *Social and Behavioral Sciences*, 5, 1362-1366.

Jagers, R., & Mock, I. (1993). Culture and social outcomes among inner-city African American children: An Afrographic exploration. *Journal of Black Psychology*, 19, 391-405.

Jamuna, D., & Reddy, L.K. (1997). The impact of age and length of widowhood on the self concept of elderly widows. *Indian J Gerontol* 7:91-95.

Jewell, A. (2004). Nourishing the inner being — a spirituality model. In: A. Jewel (Eds.) *Ageing, spirituality and well-being* (pp 11-26). London: Jessica Kingsley.

Johnson, M. (2009). Spirituality, finitude and theories of the lifespan. In: Bengston, V.; Gans, D.; Putney, N.; Silverstein, M., editors. *Handbook of theories of aging*. 2nd ed. New York: Springer. p. 659-674.

Johnson, T.J., Kristeller, J., & Sheets, V.L. (2004). Religiousness and spirituality in college students: Separate dimensions with a unique and common correlates. *Journal of College Students Values*, 5(8), 1-36.

Jorm, A.F. (2000). Does old age reduce the risk of anxiety and depression ? A review of epidemiological studies across the adult life span. *Psychological Medicine*. 30:11–22.

Jose, J., & Sekher, T.V. (2013). Health status, functional disability and quality of life: An assessment of wellbeing of India's older population. XXVII IUSSP International Population Conference Paper, International Union for the Scientific Study of Population.

Jung, C.G. (1971). The stages of life.In R. F. C. Hill, The portable Jung. New York: Viking.

Kagan, S. (1992). The limits of well-being. In E. F. Paul, F. D. Miller, Jr., & J. Paul (Eds.), The good life and the human good (pp. 169-189). Cambridge: Cambridge University Press.

Kahneman, D., Diener, E., & Schwarz, N. (1999). Well-being: The foundations of hedonic psychology. New York: Russell Sage Foundation.

Kaliampos, A., & Roussi, P. (2017). Religious beliefs, coping, and psychological well-being among Greek cancer patients. *J Health Psychol*. 22(6): 754-64

Kaplan, D.B., & Berkman, B. (2016). Social Work in Health and Aging. New Work: Oxford University Press.

Kartikeyan, S., Pedhambkar, B.S., & Jape, M.R. (1999). Social security and the global scenario. *Indian Journal of Occupational Health.* 42:91–8.

Kasser, T., & Ryan, R.M. (1993). A dark side of the American dream: Correlates of financial success as a central life aspiration. *Journal of Personality and Social Psychology*, 65, 410-422.

Kasser, T., & Ryan, R.M. (1996). Further examining the American dream: Differential correlates of intrinsic and extrinsic goals. *Personality and Social Psychology Bulletin*, 22, 280-287.

Katerndahl, D.A. (2008). Impact of spiritual symptoms and interactions on health services and life satis faction. *Annals of Family Medicine*, 6(5), 412-420.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions' of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 62:593–602.

Keyes, C.L.M., Schmotkin, D. & Ryff, C.D. (2002). Optimizing well-being: the empirical encounter of two traditions. *Journal of Personality & Social Psychology*, 87, 1007 – 1022.

Kim, Y., & Seidlitz, L. (2002). Spirituality moderates the effect of stress on emotional and physical adjustment. *Personality and Individual Differences*, 32, 1377-1390.

Kind, P., et al. (1998). Variations in population health status: results from a United Kingdom national questioonaire survey. Br. Med. J. 316 (7133), 736-741.

Kirkpatrick, S. & McCullough, M. (1999). Religion and spirituality in rehabilitation psychology. *Rehabilitation Psychology*, 44, 388. 402.

Koenig, H. (2006). Religion, spirituality and aging. *Aging & Mental Health*; 10(1):1–3.

Koenig, H.G. & Larson, D.B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry*, 13, 67-78.

Koenig, H.G., McCullough, M.E., & Larson, D.B. (2001). *Handbook of religion and health*. New York: Oxford University Press.

Krause, N. (1995). Religiosity and self-esteem among older adults. *Journals of Gerontology B Psycho logical Science and Social Science*, 5011(5), 236-246.

Krause, N. (2002). Church-based Social Support and Health in Old Age: Exploring Variations by Race, *Journal of Gerontology: Social Sciences*, vol. 57B (pg. S332-47).

Krause, N. (2003). Religious meaning and subjective well-being in late life. *Journals of Gerontology B Psychological Science and Social Science*, 58B(3). S 160-S 170.

Krause, N. (2004). Stressors arising in highly valued roles, meaning in life, and the physical health status of older adults. *Journals of Gerontology: Social Sciences*. 59B(5):S287–S297.

Krause, N. (2005). God-Mediated Control and Psychological Well-Being in Late Life, *Research on Aging*, vol. 27 (pg. 136-64).

Krause, N. (2007). Social Involvement in Religious Institutions and God-mediated Control Beliefs: A Longitudinal Investigation, *Journal for the Scientific Study of Religion*, vol. 46 (pg. 519-37).

Krause, N., & Van, T.T. (1989). Stress and religious involvement among older blacks. *Journal of Gerontology:* Social Sciences;44:S4–S13.

Kuppuswamy, B. (1981). Manual of socioeconomic status scale (urban). Delhi: Manasayan.

Larson, M., Sawyers, & McCullough, M. (Eds.) (1998). Scientific Research on Spirituality and Health: A consensus report. Rockville, MD: National Institute.

Lena, A., Ashok, K., Padma, M., Kamath, V., & Kamath, A. (2009). Health and social problems of the elderly: A Cross-sectional study in Udupi taluk, Karnataka. *Indian J Community* Med 34: 131-34.

Levenson, M.R., Aldwin, M.C., & Yancura, L. (2006). Positive emotional change: Mediating effects of forgiveness and spirituality. Explore, November/December, 2(6), 498- 508.

Liddell, C., Guiney, C. (2015). Living in a cold and damp home: frameworks for understanding impacts on mental well-being. *Public health*, 129(3), pp. 191-199.

Lindahl, M. (2005). Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income. *Journal of Human Resources*; 40(1):144–68.

Litwinczuk, K.M., & Groh, C.J. (2007).The relationship between spirituality, purpose in life and well-being in HIV-Positive persons. *Journal of the Association of Nurses in AIDS care*, 18(3), 13-22.

Lucas, R.E., Diener, E., Grob, A., Suh, E., & Shao, L. (1998). Cross-cultural evidence for the fundamental features of extraversion: The case against sociability. *Journal of Personality & Social Psychology*, 79(3), 452-468.

Lunt, P. (1996). Discourses of savings. *Journal of Economic Psychology*, 17, 677-690.

Macintyre, S., et al. (2001). Housing tenure and car access: further exploration of the nature of their relations with health in a UK setting. *J. Epidemoil. Community Health*, 55 (5), 330-331.

Mack, J.E. (2006). Psychoanalysis and the self: Toward a spiritual point of view. Explore, January, 2(1), 30-36.

MacKinlay, E. (2001). The spiritual dimension of caring: applying a model for spiritual tasks of ageing. *Journal of Religious Gerontology*, 12(3/4), 151-166.

MacKinlay, E. (2006). Spiritual care in the fourth age of life. London, England: Anthecum Press.

MacLeod, A.K., & Moore, R. (2000). Positive thinking revisited: positive cognitions, well-being and mental health. *Clinical Psychology and Psychotherapy*, 7, 1-10.

MacLeod, S., Musich, S., Hawkins, K., and Armstrong, Douglas G .(2017). "The growing need for resources to help older adults manage their financial and healthcare choices" BMC Geriatr. 2017; 17: 84.

Mahoney, M.J., & Graci, G.M. (1999). The meanings and correlates of spirituality: Suggestions from an exploratory survey of experts. Death studies. 23:521-528.

Malek, M.D.A., Mearns, K. & Flin, R. (1994). Stress and psychological well-being in UK and Malaysian fire fighters. Cross Cultural Management: *An International Journal*, 17(1), 50 – 61.

Manning-Walsh, J. (2005). Spiritual struggle: Effect on quality of life and life satisfaction in women with breast cancer. *Journal of Holistic Nursing*, 23(2), 120-140.

Marcoen, A. (1994). Spirituality and personal well-being in old age. *Aging and Society*, 14, 521-536.

Maselko, J., & Kubzansky, L.D. (2006). Gender differences in religious practices, spiritual experiences and health: Results from the US General Social Survey. Social Sciences & Medicine, 62, 2848-2860.

May, G. (1982). Will and spirit: A contemplative psychology. San Francisco: Harper & Row.

McCullough, M.E., Hoyt, W.T., Larson, D.B., Koenig, H.G., & Thoresen, C. (2000). Religious involvement and mortality: A meta -analytic review. *Health Psychology*, 9(3), 211-2.

McDonough, P., Duncan, G.J., Williams, D., & House, J. (1997). Income dynamics and adult mortality in the United States, 1972 through 1989. *American Journal of Public Health*, 87, 1476–1483.

McFadden, S. (1996a). Religion and spirituality. *In Encyclopedia of Gerontology* (Vol. 2, pp. 387–397). San Diego, CA: Academic Press.

McFadden, S, H. (2005). Points of connection: Gerontology and the psychology of religion. In: Paloutzian, R.; Park, C., editors. *Handbook of the psychology of religion and spirituality*. New York: Guilford. p. 162-176.

McMunn, A., Nazroo, J., Breeze, E. (2009). Inequalities in health at older ages: a longitudinal investigation of the onset of illness and survival effects in England. *Age Ageing*; 38(2):181–187.

McSherry, W., Cash, K., & Ross, L. (2004). Meaning of spirituality: Implications for nursing practice. *Journal of Clinical Nursing*, 13(8), 934-941.

Medawar, P.B. (1955). "The definition and measurement of senescence," in Ciba Foundation Colloquia on Ageins, General Aspects, Vol. 1, eds G. E. W. Wolstenholme, M. P. Cameron, and J. Etherington (London: J&A Churchill).

Medical Research Council. (2010). Lifelong Health and Well-Being Programme, A Strategy for Collaborative Ageing Research in the UK, London: Medical Research Council.

Medvedev, Z.A. (1990). An attempt at a rational classification of theories of aging. Biol. Rev.65, 375 – 398.

Meraviglia, M.G. (1999). Critical analysis of spirituality and its empirical indicators. *Journal of Holistic Nursing*, 17(1), 18-33.

Merton, T. (1958). Thoughts in solitude. New York: Farrar, Straus, & Giroux.

Miller, W., & Thoresen, C. (2003). Spirituality, religion, and health. *American Psychologist,* 58(1), 24-35.

Mills, R.J., Grasmick, H.G., Morgan, C.S., & Wenk, D. (1992). The effects of gender, family satisfaction and economic strain on Psychological Well-Being. *Family Relations*, Vol 41, 440-445.

Moberg, D. (2001). Aging and spirituality: Spiritual dimensions of aging theory, research, practice, and Policy. Binghamton, NY: Haworth Press.

Moberg, D.O. (2002a). Assessing and measuring spirituality: confronting dilemmas of universal and particular evaluative criteria. *Journal of Adult Development*, 9(1), 47-60.

Moberg, D.O. (2002b). Religion and spirituality. *Social Compass*, 49 (1), 133-138.

Moberg, D. (2005). Research in spirituality, religion, and aging. *Journal of Gerontological Social Work,* 45(1/2):11–40.

Moffitt, T.E, et al. (2011). A gradient of childhood self-control predicts health, wealth, and public safety. Proc Natl Acad Sci USA. 108:2693–2698.

Mohanty, S.P., (1989). 'Demographic and socio-cultural aspects of ageing in India: some emerging issues', in R.N. Pati and B. Jena (eds.), Elderly in India: socio-demographic dimension. Ashish, New Delhi, pp. 37-45.

Mroczek, D.K., & Kolarz, C.M. (1998). The effect of age on positive and negative affect: A developmental perspective on happiness. *Journal of Personality & Social Psychology*. 75:1333–1349.

Mroczek, D.K., & Spiro, A. (2003). Modeling intraindividual change in personality traits: Findings from the Normative Aging Study. *Journals of Gerontology: Psychological Sciences.* 58B:153–165.

Musick, M., Traplagan, J., Koenig, H., & Larson, D. (2000). Spirituality in physical health and aging. *Journal of Adult Development*, 7, 73-86.

Nakasone, R.Y. (2005). Spirituality and ageing in the San Francisco Japanese community. In Barnes, L. & Starr S. S. (Eds.) *Religion and Healing in America. New York, Oxford University Press.*

Neill, C.M., & Kahn, A.S. (1999). The role of personal spirituality and religious social activity on the life satisfaction of older widowed women. *Sex Roles*. 40(3), 319-329.

Neugarten, B.L. (1973). Personality change in late life: A developmental perspective. In C. Eisdorfer and M. P. Lawton (Eds.), *The psychology of adult development and aging* (pp. 311-335). Washington, DC: American Psychological Association.

Nygren, B.B., Aléx, L.L., Jonsén, E.E., Gustafson, Y.Y., Norberg, A.A., & Lundman, B.B. (2005). Resilience, sense of coherence, purpose in life and self-transcendence in relation to perceived physical and mental health among the oldest old. *Aging & Mental Health*; 9(4):354–362.

Oishi, S., Schimmack, U., & Diener, E. (2001). Pleasures and subjective well-being. European *Journal of Personality*, 15, 153-167.

Orimo H., Ito, H., Suzuki T., Araki A., Hosoi T., & Sawabe M. (2006). Reviewing the definition of elderly. *Geriatr and GerontolInt* 6: 149-58.

Orr, W.C., & Sohal, R.S. (1992). The effects of catalase gene over expression on life span and resistance to oxidative stress in transgenic Drosophila melanogaster. Arch. Biochem. Biophys.297, 35 – 41.

Ortiz, L.P.A. & Langer, N. (2002). Assessment of spirituality and religion in later life. *Journal of Gerontological Social Work*, 37, 5–21.

Osypuk, T.L. (2015). Shifting from policy relevance to policy translation: do housing and neighbourhoods affect children's mental health?. *Social Psychiatry & Psychiatric Epidemiology*, 50(2), pp. 215-217.

Pardini, D.A., Plante, T.G., Sherman, A., & Stump, J.E. (2000). Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. *Journal of Substance Abuse Treatment*, 19, 347-354.

Pargament, K.I. (1997). The psychology of religion and coping. New York, NY: Guilford Press.

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

Pargament, K.I,, Koenig, H.G., Tarakehwar, N,, & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology*, 9(6), 713-730.

Park, K. (2007.) Parks text book of Preventive and Social Medicine. pp 475-76. Banarsidas Bhanot publishers, Jabalpur.

Partridge, L., & Barton, N.H. (1996). On measuring the rate of ageing. Proc. R. Soc. Lond. B. 263, 1365–1371.

Peck, R. (1968). Psychological Developments in the Second Half of Life. In: Neugarten BL, editor. *Middle Age and Aging*. Chicago: University of Chicago Press; pp. 88–92.

Piazza, J., & Charles, S.T. (2006). Mental health and the baby boomers. In: Whitbourne SK, Willis SL, editors. The Baby Boomers at Midlife: Contemporary Perspectives on Middle Age. New Jersey: Lawrence Erlbaum Associates.

Pollner, M. (1989). Divne Relations, Social Relations, and Well-Being, *Journal of Health and Social Behavior*. Vol. 22 (pg. 92-104).

Prina, A.M., Ferri, C.P., Guerra, M., Brayne, C., Prince, M. (2011). Prevalence of anxiety and its correlates among older adults in Latin America, India and China: cross-cultural study. *Br J Psychiatry*. 199:485–491.

Promislow, D.E.L., & Bronikowski, A.M. (2006). "The evolutionary genetics of senescence," in: Evolutionary Genetics: Concepts and Case Studies, eds J. B. Wolf and C. Fox (New York: Oxford University Press), 464–481.

Ralte, J.R. (2007). Health conditions and access to health care services by elderly in Mizoram, in Lianzela and Vanlalchhawna (Eds.), *Ageing in North East India* Vol.1, New Delhi: Akansha Publishing House, 60-73.

Rao, M. (2003). Health status of the rural aged in Andhra Pradesh; A sociological perspective in Help Age India. Res & Dev J 9: 71-85.

Rayburn, C.A. (2004). Religion, spirituality, and health. American Psychologist, 59(1), 52-53.

Reed, P.G. (1991). Spirituality and mental health in older adults: extant knowledge for nursing. *Family and Community Health*, 14(2), 14-25.

Reed, P.G. (1992). An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing and Health*. 15:349-347.

Regier, D.A., Boyd, J.H., Burke, J.D., Rae, D.S., Myers, J.K., Kramer, M., Robins, L.N., George, L.K., Karno, M., & Locke, B.Z. (1988). One-month prevalence of mental disorders in the United States. Based on five Epidemiologic Catchment Area sites. *Archives of General Psychiatry*. 45:977–986.

Richard, P.S., & Bergin, A. (1997).A spiritual strategy for counseling and psychotherapy. Washington, DC: American Psychological Association.

Riley, B.B., Perna, R., Tate, D.G., Forchheimer, M., Anderson, C,, & Luera, G. (1998). Types of spiritual well-being among persons with chronic illness: Their relation to various forms of quality of life. *Archives of Physical Medicine and Rehabilitation*, 79(3), 258-264.

Ritt-Olson, A., Milam, J., Unger, J., Trinidad, D., Teran, L., Dent, C., et al. (2004).The protective influence of spirituality and "health-as-a-value" against monthly substance abuse use among adolescents varying risk. *Journal of Adolescent Health*, 34, 192-199.

Rivier, E., Hongler, T. & Suter, C. (2008). La spiritualitéensoinspalliatifs, guide des soinspalliatifs. Lausanne: SociétéVaudoise de Médecine.

Rogers, A., Pilgrim, D. (2010). A sociology of mental health and illness. Maidenhead: McGraw-Hill Open University Press.

Roothman, B., Kirsten, D., Wissing, M. (2003). Gender differences in aspects of psychological well-being. *South African Journal of Psychology*, 33(4), 212-218.

Rose, M.R. (1991). Evolutionary Biology of Aging. New York: Oxford University Press.

Rothberg, D. (1996). How Straight is the spiritual path? Revision, 19, 25-41.

Ruini, C., & Fava, G.A. (2009). Well-being therapy for generalized anxiety disorder. *Journal of Clinical Psychology: In Session*, 65(5), 510-519.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52, 141-166.

Rybash, J.W., Roodin, P.A., & Santrock, J.W. (1991). Adult development and aging (2nd ed.). Dubuque, IA: Wm C. Brown Publishers.

Ryff, C.D. (1989a). Beyond Ponce de Leon and life satisfaction: new directions in quest of successful aging. *International Journal of Behavioral Development*, 12, 35–55.

Ryff, C.D. (1989b). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57,1069–1081.

Ryff, C.D. (1995). Well-Being in Adult Life. *Current Directions in Psychological Science*, Vol. 4, No. 4, pp 99-104.

Ryff, C.D., & Keyes, C.L.M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69, 719-727.

Ryff, C.D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry*, 9, 1-28.

Sadler, E., & Biggs S. (2006). Exploring the links between spirituality and successful ageing. *Journal Social Work Practice*, 20, 267-280.

Santrock, J.W. (2013). Life-span development. 14th Ed. New York: McGraw-Hill.

Schaub, R.T., & Linden, M. (2000). Anxiety and anxiety disorders in the old and very old – results from the Berlin Aging Study (BASE) *Comprehensive Psychiatry*. 41:48–54.

Schieman, S., Pudrovska, T., Pearlin, Leonard I., Ellison, C. (2006). The Sense of Divine Control and Psychological Distress: Variations by Race and Socioeconomic Status, *Journal for the Scientific Study of Religion* , vol. 45 (pg. 529-50).

Schlafmann, Kathrin. (2015). "Housing, Mortgages, and Self-Control." mimeo .

Seybold, K., & Hill, P. (2001). The role of religion and spirituality in mental health and physical health. *Current Directions in Psychological Science*, 10 (1), 21-24.

Shah, G. (1995). Elder abuse in India. J Elder Abuse Negl 6: 101-18.

Sharifi, V., Amin-Esmaeili, M., Hajebi, A., Motevalian, A., Radgoodarzi, R., Hefazi, M., Rahimi-Movaghar, A. (2015). Twelve-month prevalence and correlates of psychiatric disorders in Iran: the Iranian mental health survey, 2011. Arch Iran Med. 18(2):76–84.

Sheikh, J.I., Swales, P.J., Carlson, E.B., Lindley, S.E. (2004). Aging and panic disorder : phenomenology, comorbidity, and risk factors. *American Journal of Geriatric Psychiatry*. 12:102–109.

Sheldon, K.M., & Elliot, A.J. (1999). Goal striving, need satisfaction, and longitudinal wellbeing: The self-concordance model. *Journal of Personality and Social Psychology*, 76, 482-497.

Shorkey, C., Uebel, M., & Windsor, L. (2008). Measuring dimensions of spirituality in chemical dependence treatment and recovery: Research and practice. *International Journal of Mental Health*, 6, 286-305.

Siva, R. S. (2002). Health Status of the Urban Elderly: A medico-social study, B. R. Publishing Co, Delhi.

Smith, B.H., et al. (2001). The impact of chronic pain in the community. Fam. Prac. 18 (3), 292-299.

Smith, J.P. (1999). Healthy Bodies and Thick Wallets: The Dual Relation between Health and Economic Status. *Journal of Economic Perspectives*, 13(2):145–66.

Smith, J.P. (2004). Unraveling the SES-Health Connection. *Population and Development Review*, 30:108–32. (suppl.: Aging Health and Public Policy).

Snoep, L. (2008). Religiousness and happiness in three nations: A research note. *Journal of Happiness Studies*, 9, 207-211.

Soleimani, K.A., Mansouri, K.A., Mohammadi, M.R., Zarabipour, H., Malekpou,r V. (2015). Predicting dimensions of psychological well-being based on religious orientations and spirituality: an investigation into a causal model. *Iran J Psychiatry*. 10(1): 50-5.

Spilka, B., Hood, R.W., Jr, Hunsberger, B., & Gorsuch, R. (2003). The psychology of religion. New York: The Guilford Press.

Srivastava, R.K. (1984). Family structure, manifest anxiety and disclosure of self among urban boys. *Psychological Studies*, 29 (2) : 169-121.

Stark, R. (2002). Physiology and faith: addressing the "universal" gender difference in religious commitment. *Journal for the Scientific Study of Religion*, 41(3): 495–507.

Staude, J.R. (2005). Autobiography as a spiritual practice. *Journal of Gerontological Social Work*, 45(3), 249-269.

Staudinger, U.M., & Bluck, S. (2001). A view on midlife development from life-span theory. In: Lachman ME, editor. *Handbook of midlife development*. Wiley; Hoboken, NJ. pp. 3–39.

Steger, M.F., Kashdan, T.B., & Oishi, S. (2008). Being good by doing good: Daily eudaimonic activity and well-being. *Journal of Research in Personality*, 42, 22-42.

Steinhauser, K.E., Alexander, S.C., Byock, I.R., George, L.K., Olsen, M.K., & Tulsky, J.A. (2008). Do preparation and life completion discussions improve functioning and quality of life in seriously ill patients? Pilot randomized control trial. *Journal of Palliative Medicine*, 11(9), 1234-1240.

Strawbridge, W.J., Cohen, R.D. & Shema, S.J. (2000). Comparative strength of association between religious attendance and survival. *International Journal of Psychiatry in Medicine*, 30(4): 200–308.

Strehler, B.L. (1977). Time, Cells and Aging, 2nd ed., Academic Press, New York.

Szabo, A. (2017). Longitudinal trajectories of quality of life and depression by housing tenure status. *J. Gerontol. B Psychol. Sci. Soc. Sci.*

Takahashi, M., & Ide, S. (2003). Implicit theories of spirituality across three generations: A cross-cultural comparison in the U.S. and Japan. *Journal of Religious Gerontology*, 15, 15-38.

Tatar, M. (2001). “Senescence,” in: Evolutionary Ecology – Concepts and Case Studies, eds C. W. Fox, D. A. Roff, and D. J. Fairbairn (New York: Oxford University Press), 128–141.

Taylor, S.E., & Armor, D.A. (1996). ‘Positive Illusions and Coping with Adversity’, *Journal of Personality*, 64,4, 873-898.

Temane, Q.M., & Wissing, M.P. (2006). The role of subjective perception of health in the dynamics of context and psychological well-being. *South African Journal of Psychology*, 36(3), 564-581.

Temane, Q.M., & Wissing, M.P. (2006b). The role of spirituality as a mediator for psychological well-being across different contexts. *South African Journal of Psychology*, 36(3),582–597.

Thane, P. (1978). The muddled history of retiring at 60 and 65.New Society. 45(826):234-236.

Thangchungnunga. (2017). Social and economic status of elderly persons in Mizo society, in Lianzela Vanlalchhawna (Eds.), *Ageing in North East India* Vol.1, New Delhi: Akansha Publishing House, 39-47.

Thanseia. (2007). Ageing gracefully: Role and activities of Mizoram Upa Pawl, in Lianzela Vanlalchhawna (Eds.), *Ageing in North East India* Vol.1, New Delhi: Akansha Publishing House, 48-59.

Tix, A.P., & Frazier, P.A. (1998). The use of religious coping during stressful life events: main effects, moderation and mediation. *Journal of Consulting and clinical Psychology*, 66(2), 411-422.

Tornstam, L. (2015). Gerotranscendence: A developmental theory of positive aging. New York: Springer.

Tornstam, L. (1999). Late-life transcendence: A new developmental perspective on aging. In L. E. Thomas & S. A. Eisenhandler (Eds.), *Religion, belief, and spirituality in late life*. New York: Springer.

Underwood, L.G., & Teresi, J.A. (2002). The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health related data. *Annals of behavioural medicine*, 24, 22-33.

Underwood, L.G. (2006). Ordinary spiritual experience: qualitative research, interpretive guidelines, and population distribution for the daily spiritual experience scale. *Archive for the Psychology of Religion*, 28, 181–218.

United Nations. (2012). World population ageing. Population division, Department of economic and social affairs, New York.

Vahia, I.V., Depp, C.A., Palmer, B.W., Fellows, I., Golshan, S., Thompson, W., et al. (2011). Correlates of spirituality in older women. *Aging & Mental Health*. 15(1):97–102.

Vaillant, G.E., Meyer, S.E., Mukamal, K., Soldz, S.(1998). Are social supports in late midlife a cause or a result of successful ageing? *Psychological Medicine*. 28:1159–1168.

Vanlalchhawna. (2007). Magnitude and growth of elderly population in Mizoram, n Lianzela Vanlalchhawna (Eds.), *Ageing in North East India* Vol.1, New Delhi: Akansha Publishing House, 19-38.

Vermani, M., & Darshan, S. (2003.) Changing social status of elders in rural Haryana. *Aging and Society* 13: 1-2.

Vijg, J., & Muller, W.E.G. (2000). The science of aging and the need for a mechanistic approach. *Mech. Ageing Dev*. 114, 1-3.

Visser, A., Garssen, B., Vingerhoets, A. (2010). Spirituality and well-being in cancer patients: a review. Psychooncology. 19(6): 565-72

Wang, C.W., Chan, C.L., W,, Ng, S.M., & Ho, A. H. Y. (2008). The impact of spirituality on health-related quality of life among Chinese older adults with vision impairment. *Aging and Mental Health*, 12(2), 267-275.

Waterman, A.S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of Personality and Social Psychology*, 64, 678-691.

Waterman, A.S. (2005). When effort is enjoyed: Two studies of intrinsic motivation for personally salient activities. *Motivation and Emotion*, 29, 165-188.

Waterman, A.S., Schwartz, S.S., & Conti, R. (2008). The implications of two conceptions of happiness (hedonic enjoyment and eudaimonia) for the understanding of intrinsic motivation. *Journal of Happiness Studies*, 9, 41-79.

Wilber, K. (1999). Spirituality and developmental lines: Are there stages? *Journal of Transpersonal Psychology*, 3/(1), 1-10.

Williams, G.C. (1957). Pleiotropy, natural selection, and the evolution of senescence. *Evolution*, 11, 398–411.

Williams, A. (2006). Perspectives on spirituality at the end of life: A meta-summary. *Palliative and Supportive Care*, 4, 407-417.

Williams, D.R., & Sternthal, M.J. (2007). Spirituality, religion, and health: Evidence and research directions. *The Medical Journal of Australia*, I86 (10), S47-S50.

Wilson, W.R. (1967). Correlates of avowed happiness. *Psychological Bulletin*, 67, 294-306.

Wink, P. (2003). Dwelling and seeking in late adulthood: The psychosocial implications of two types of religious orientation. In: McFadden S, Brennan M, Patrick J, editors. New directions in the study of late life religiousness and spirituality. Binghamton, NY: Hawthorne Pastoral Press. pp. 101–118.

Wissing, M.P., & Van Eeden, C. (1998). Psychological well-being: a fortigenic conceptualization and empirical clarification. In L. Schlebusch (Ed.), South Africa beyond transition: psychological well-being (379-393). Pretoria: Psychological Society of South Africa.

Wissing, M.P., & Van Eeden, C.(2002) Empirical clarification of the nature of psychological well-being. *South African Journal of Psychology*, 32, 32 – 44.

Wong, P.T.P. (1989). Personal meaning and successful aging. *Canadian Psychology*, 30,516-525.

Wong, P.T.P. (1997). Meaning-centered counseling: A cognitive- behavioral approach to logo therapy. *The International Forum for Logo therapy*, 20, 85-94.

Wood, A.M. & Joseph, S. (2009). The absence of positive psychological (eudemonic) well-being as a risk factor for depression: A ten year cohort study. *Journal of Affective Disorders*, 122(3), 213-217.

World Health Organization. (2007). Ageing and life course programme. *J Psychiatric Res* 17:37-49.

World Health Organization. (1997). Quality of Life Assessment Group. Measuring quality of life. Geneve, Switzerland: Author.

Young, J.S., Cashwell, C.S., & Shcherbakova, J. (2000).The moderating relationship of spirituality on negative life events and psychological adjustment. *Counseling and Values*, 45(1), 49-57.

Young-Eisendrath, P., & Miller, M.E. (2000). Beyond enlightened self-interest: the psychology of mature spirituality in the twenty-first century. In: Young-Eisendrath, P., Miller, M.E., editors. *The psychology of mature spirituality. Integrity, wisdom, transcendence*. London: Routledge; 2000. pp. 1-7.

Zinnbauer, B.J., & Pargament, K.I. (2005). Religiousness and spirituality. In: Paloutzian R, Park C, editors. *Handbook of psychology of religion, and spirituality*. New York: Guilford. pp. 21–42.

Zizza, C.A., Ellison, K.J., & Wernette, C.M. (2009). Total water intakes of community living middle-old and oldest-old adults. *J Gerontol Series*: BiolSci Med Sci 64: 481-92.

Zuckerman, M. (1994). Behavioral expressions and biosocial bases of sensation seeking. New York, NY: Cambridge University Press.

Zuckerman, M. (2009). Sensation seeking. In M. R. Leary, & R. H. Hoyle (Eds.), *Handbook of individual differences and social behavior* (pp. 455-465). New York, NY: Guilford Press.

Appendix-I

Code: ……

DEMOGRAPHIC PROFILE:

Please fill up the following as applicable:

1. Age: _____

2. Sex: (a) Male (b) Female

3. Marital status: (a) Married (b) Single (c) Divorced (d) Widowed

4. Locality: (a) Rural (b) Urban

5. Education status: (a) Primary (b) Middle (c) High School
(d) Higher Secondary (e) Graduate (f) Post Graduate

6. Family type: (a) Single
(b) Nuclear family
(c) Joint family

7. Number of children: _____

8. Family size: _____

9. Occupation: _____

10. Monthly income: _____

11. Bread earner: (a) Self (b) Mother (c) Father (d) Others

12. Other support: _____

13. House type: (a) Concrete (b) Assam type (c) Others

14. House ownership: (a) Owned (b) Rent

15. Caretaker: (a) Spouse (b) Children/grandchildren (c) Nurse (d) Maid

16. Moveable assets (Tick the following as applicable):

(a) Two/Four wheeler (b) Washing Machine (c) Air conditioner

(d) Computer (e) TV (f) Fridge

(g) Mobile phone

17. Immoveable assets (Tick the following as applicable):

(a) Insurance (b) Stock/Bond (c) Savings (d) Flat/LSC _____

(e) Commercial Vehicle (bus, truck, taxi etc.)

(f) Heavy Machinery (JCB, Road Roller etc.)

18. Societal status: (a) Highly involved

(b) Moderately involved

(c) Not involved

29. Societal position (Tick the following which you involved):

(a) YMA (b) Local Council/Village Council (c) MUP

(d) MHIP (e) Not involved

20. Religious status: (a) Highly involved

(b) Moderately involved

(c) Not involved

21. Religious position (Tick the following which you involved):

(a) Upa/Kohhran Committee

(b) Committee/Sub-Committee Office Bearers (OB)

(c) Committee/Sub-Committee member

(d) Member only

(e) Others

Appendix-IIa

PSYCHOLOGICAL GENERAL WELL-BEING INDEX

This section of the examination contains questions about how you feel and how things have been going with you. For each question check the answer which best applies to you.

1. **How have you been feeling in general? (DURING THE PAST MONTH)**

   5 ( ) In excellent spirits
   4 ( ) In very good spirits
   3 ( ) In good spirits mostly
   2 ( ) I have been up and down in spirits a lot
   1 ( ) In low spirits mostly
   0 ( ) In very low spirits

2. **How often were you bothered by any illness, bodily disorder, aches or pains? (DURING THE PAST MONTH)**

   0 ( ) Every day
   1 ( ) Almost every day
   2 ( ) About half of the time
   3 ( ) Now and then, but less than half the time
   4 ( ) Rarely
   5 ( ) None of the time

3. **Did you feel depressed? (DURING THE PAST MONTH)**

   0 ( ) Yes-to the point that I felt like taking my life
   1 ( ) Yes-to the point that I did not care about anything
   2 ( ) Yes-very depressed almost every day
   3 ( ) Yes-quite depressed several times
   4 ( ) Yes-a little depressed now and then
   5 ( ) No-never felt depressed at all

4. **Have you been in firm control of your behavior, thoughts, emotions, or feelings? (DURING THE PAST MONTH)**

   5 ( ) Yes, definitely so
   4 ( ) Yes, for the most part
   3 ( ) Generally so
   2 ( ) Not too well
   1 ( ) No, and I am somewhat disturbed
   0 ( ) No, and I am very disturbed

5. **Have you been bothered by nervousness or your nerves? (DURING THE PAST MONTH)**
   0 ( ) Extremely so-to the point where I could not work or take care of things
   1 ( ) Very much so
   2 ( ) Quite a bit
   3 ( ) Some-enough to bother me
   4 ( ) A little
   5 ( ) Not at all

6. **How much energy, pop, or vitality did you have or feel? (DURING THE PAST MONTH)**
   5 ( ) Very full of energy-lots of pep
   4 ( ) Fairly energetic most of the time
   3 ( ) My energy level varied quite a bit
   2 ( ) Generally low in energy or pep
   1 ( ) Very low in energy or pep most of the time
   0 ( ) No energy or pep at all-I felt drained, sapped

7. **I felt downhearted and blue DURING THE PAST MONTH.**
   5 ( ) None of the time
   4 ( ) A little of the time
   3 ( ) Some of the time
   2 ( ) A good bit of the time
   1 ( ) Most of the time
   0 ( ) All of the time

8. **Were you generally tense-or did you feel any tension? (DURING THE PAST MONTH)**
   0 ( ) Yes-extremely tense, most or all of the time
   1 ( ) Yes-very tense most of the time
   2 ( ) Not generally tense, but did feel fairly tense several times
   3 ( ) I felt a little tense a few times
   4 ( ) My general tension level was quite low
   5 ( ) I never felt tense or any tension at all
9. **How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAST MONTH)**
   5 ( ) Extremely happy-could not have been more satisfied or pleased
   4 ( ) Very happy most of the time
   3 ( ) Generally satisfied-pleased
   2 ( ) Sometimes fairly happy, sometimes fairly unhappy
   1 ( ) Generally dissatisfied, unhappy
   0 ( ) Very dissatisfied or unhappy most or all the time

10. **Did you feel healthy enough to carry out the things you like to do or had to do? (DURING THE PAST MONTH)**
    5 ( ) Yes-definitely so
    4 ( ) For the most part
    3 ( ) Health problems limited me in some important ways
    2 ( ) I was only healthy enough to take care of myself
    1 ( ) I needed some help in taking care of myself
    0 ( ) I needed someone to help me with most or all of the things I had to do

11. **Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)**
    0 ( ) Extremely so-to the point that I have just about given up
    1 ( ) Very much so
    2 ( ) Quite a bit
    3 ( ) Some-enough to bother me
    4 ( ) A little bit
    5 ( ) Not at all

12. **I woke up feeling fresh and rested DURING THE PAST MONTH.**
    0 ( ) None of the time
    1 ( ) A little of the time
    2 ( ) Some of the time
    3 ( ) A good bit of the time
    4 ( ) Most of the time
    5 ( ) All of the time

13. **Have you been concerned, worried, or had any fears about your health? (DURING THE PAST MONTH)**
    0 ( ) Extremely so
    1 ( ) Very much so
    2 ( ) Quite a bit
    3 ( ) Some, but not a lot
    4 ( ) Practically never
    5 ( ) Not at all
14. **Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel or of your memory? (DURING THE PAST MONTH)**
    5 ( ) Not at all
    4 ( ) Only a little
    3 ( ) Some-but not enough to be concerned or worried about
    2 ( ) Some and I have been a little concerned
    1 ( ) Some and I am quite concerned
    0 ( ) Yes, very much so and I am very concerned

15. **My daily life was full of things that were interesting to me DURING THE PAST MONTH.**
    0 ( ) None of the time
    1 ( ) A little of the time
    2 ( ) Some of the time
    3 ( ) A good bit of the time
    4 ( ) Most of the time
    5 ( ) All of the time

16. **Did you feel active, vigorous, or dull, sluggish? (DURING THE PAST MONTH)**
    5 ( ) Very active, vigorous every day
    4 ( ) Mostly active, vigorous-never really dull, sluggish
    3 ( ) Fairly active, vigorous-seldom dull, sluggish
    2 ( ) Fairly dull, sluggish-seldom active, vigorous
    1 ( ) Mostly dull, sluggish-never really active, vigorous
    0 ( ) Very dull, sluggish every day

17. **Have you been anxious, worried, or upset? (DURING THE PAST MONTH)**
    0 ( ) Extremely so-to the point of being sick or almost sick
    1 ( ) Very much so
    2 ( ) Quite a bit
    3 ( ) Some-enough to bother me
    4 ( ) A little bit
    5 ( ) Not at all

18. **I was emotionally stable and sure of myself DURING THE PAST MONTH.**
    0 ( ) None of the time
    1 ( ) A little of the time
    2 ( ) Some of the time
    3 ( ) A good bit of the time
    4 ( ) Most of the time
    5 ( ) All of the time

19. **Did you feel relaxed, at ease or high strung, tight, or keyed-up? (DURING THE PAST MONTH)**
    5 ( ) Felt relaxed and at ease the whole month
    4 ( ) Felt relaxed and at ease most of the time
    3 ( ) Generally felt relaxed but at times felt fairly high strung
    2 ( ) Generally felt high strung but at times felt fairly relaxed
    1 ( ) Felt high strung, tight, or keyed up most of the time
    0 ( ) Felt high strung, tight, or keyed up the whole month

20. I felt cheerful, lighthearted DURING THE PAST MONTH.

0 ( ) None of the time
1 ( ) A little of the time
2 ( ) Some of the time
3 ( ) A good bit of the time
4 ( ) Most of the time
5 ( ) All of the time

21. I felt tired, worn out, used up, or exhausted DURING THE PAST MONTH.

5 ( ) None of the time
4 ( ) A little of the time
3 ( ) Some of the time
2 ( ) A good bit of the time
1 ( ) Most of the time
0 ( ) All of the time

22. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)

0 ( ) Yes, almost more than I could bear or stand
1 ( ) Yes, quite a bit of pressure
2 ( ) Yes, some-more than usual
3 ( ) Yes, some-but about usual
4 ( ) Yes, a little
5 ( ) Not at all

Appendix-IIb

PSYCHOLOGICAL GENERAL WELL-BEING INDEX

(Mizo Translation)

Kaihhruaina: A hnuaia zawhna hi ngun takin chhiar la, a dik ber a i hriat thlan tur ani. He zawhna chhang tur hian hun tiam chin a awm lova, hmanhmawh miah lo a uluk taka **THLA KHAT KAL TA CHHUNG A I DINHMUN** ngaihtuah in min chhan sak turin ka ngen a che.

1. **Enge I an? I tha maw?**

   5 ( ) Hlim tak leh hrisel tak niin ka inhria

   4 ( ) Hlim leh hrisel niin ka inhria

   3 ( ) Hlim lohna leh hrisel lohna ka neih em em ka hre lo

   2 ( ) A changin hlim leh hrisel takin ka awm

   1 ( ) Hlimlo leh hrisello niin ka inhria

   0 ( ) Hlimlo leh hrisello tak niin ka inhria

2. **Rilrunuam lo, taksa nuam lo, na them thum I nei em?**

   0 ( ) Ni tinin

   1 ( ) Nitin deuh thaw

   2 ( ) A chang changin

   3 ( ) Nei ve fo

   4 ( ) Nei meuh lo

   5 ( ) Nei ngai lo/Nei miah lo

3. **Rilru lamah harsatna I nei em?**

   0 ( ) Aw, ka nunna hial pawh lak ka duh

   1 ( ) Aw, thil dang engmah ka ngaihtuah thei lo

   2 ( ) Aw, nitin deuh thaw rilru hnual tak in ka awm thin

   3 ( ) Aw, vawi tam tak rilru hnualin ka awm thin

   4 ( ) Aw, tlema rilru hnualin ka awm thin

   5 ( ) Aih, rilru lamah harsatna ka nei lo

4. **I nungchang, ngaihtuahna leh rilru chhungril I thunun thei em?**

   5 ( ) Aw, teh reng mai

   4 ( ) Aw, a then a zar

   3 ( ) A tlangpuiin

   2 ( ) Thei mumal lo

   1 ( ) Aih, tlemin ka buai

   0 ( ) Aih, nasa takin ka buai

5. **Zamna leh hlauhna te hian a tibuai thin che em?**

   0 ( ) Hna thawk thei lo leh thil dang ti thei lo khawpin min tibuai

   1 ( ) Tibuai nasa

   2 ( ) Tibuai ve viau

   3 ( ) Tlemin tibuai

   4 ( ) Tlem tein

   5 ( ) Tibuai lem lo

6. **Chakna, phurna, thathona neiin I inhria em?**

   5 ( ) Chak leh thatho viauin ka inhre reng thin

   4 ( ) Chak leh thatho tak niin ka inhre tlangpui

   3 ( ) A chang changin

   2 ( ) Chak leh thatho tak ka ni lemlo

   1 ( ) Chakna leh thathona ka nei lo

   0 ( ) Chau leh hah tak ka ni

7. **Rilru leh taksaah chau leh nguiin ka inhria.**

   5 ( ) Engtik lai mahin

   4 ( ) Tlem tein

   3 ( ) Eng emaw changin

   2 ( ) Hre zeuh zeuh

   1 ( ) Hre deuh reng

   0 ( ) Engtik lai pawhin

8. **Rilru leh taksa ah tangtunin I inhria em?**

   0 ( ) Aw-Engtik lai pawhin

   1 ( ) Aw- A tlangpuiin

   2 ( ) Nasa lutuk loin ka inhria

   3 ( ) Tlem tein ka inhria

   4 ( ) Hre mang lo

   5 ( ) Hre ngailo

9. **I mimal nunah, hlimna, lungawina leh lawmna neiin I inhria em?**

   5 ( ) Hlim tak ka ni, hei baka hlimna, lungawina leh lawmna hi a awm leh tawh chuang lo vang

   4 ( ) Ka hun tam zawkah chuan hlim tak ka ni

   3 ( ) A tlangpuiin hlim thei tak ka ni

   2 ( ) A chang chuan ka hlim a, amaherawhchu hlim loh chang pawh ka nei thin tho

   1 ( ) A tlangpuiin, hlimna leh lungawina hi ka nei lo

   0 ( ) Engtik lai mai pawh hian lungawina leh hlimna ka nei lo

10. **I tihtur tul leh I chak zawngte ti turin rilru leh taksaah hriselin I inhria em?**

    5 ( ) Aw, hre teh reng mai

    4 ( ) Aw, hria e

    3 ( ) A changchuan hrisellohna hian min tibuai ve thin

    2 ( ) Keimah pawh ka inbuaipu ithei tawk a ni

    1 ( ) Keimah inbuaipui tur pawh hian midangte tanpuina ka mamawh fo

    0 ( ) Eng pawh ti dawn ila, midangte tanpuina ka mamawh thin

11. **Harsatna avangin lungngai, beidawng leh beisei bo in I inhria em?**

    0 ( ) Hre teh reng mai

    1 ( ) Hria e

    2 ( ) Tlem tein

    3 ( ) A changin

    4 ( ) Hre zeuh zeuh

    5 ( ) Hre ngai lo

12. **Mutkham, harhvang leh thatho takin zingah ka tho thin.**

    0 ( ) Engtik lai mahin ka tho ngai lo

    1 ( ) Tho zeuh zeuh

    2 ( ) Eng emaw changin

    3 ( ) Tho ve fo

    4 ( ) Tho ve thin

    5 ( ) Tuktin ka tho thin

13. **I taksa leh rilru hriselna te ngaihsak ngai leh hlauhthawnawm a awmin I hria em?**

    0 ( ) Hre teh reng mai

    1 ( ) Hre fo

    2 ( ) Hre ve tho

    3 ( ) Hre ve zeuh zeuh

    4 ( ) Hre ngai lo

    5 ( ) Hre lo hulhual

14. **Chhia leh tha hriatna mumal loh vanga chetzia, tawngkam, rilru leh thinlunga ngaihtuahna leh hriatrengna thunun thei lo khawpa inhriat chang I nei em?**

    5 ( ) Nei lo

    4 ( ) Nei lem lo

    3 ( ) Eng emaw changin, mahse min tibuai lem lo

    2 ( ) Eng emaw changin ka thunun thei lo thin a, chuchuan ka nun a tibuai zeuh zeuh thin

    1 ( ) A changin ka ngaih a titha lo hial thin

    0 ( ) Aw, ka inthunun thei lo thin a, ka buai phah fo thin

15. **Ka nitin nun hi a phurawmin a nuam em em a ni.**

    0 ( ) Engtik lai mahin

    1 ( ) Tlem tein

    2 ( ) Eng emaw changin

    3 ( ) Nuam ve tho

    4 ( ) Nuam lutuk

    5 ( ) Engtik lai pawhin

16. **Thatho leh phur emaw ngui leh chaua inhriatna I nei em?**

5 ( ) Aw, ni tin mai hian ka phur/thatho reng thin

4 ( ) Ka phur/thatho tlangpui

3 ( ) Ka phur/thatho ve viau

2 ( ) Ka phur/thatho lem lo

1 ( ) Ka phur/thatho ngai lo

0 ( ) Phurna/thathona ka nei lo

17. **Hlauthawng, vei nei leh mangangin I inhria em?**

0 ( ) Hria e, rilru emaw taksa a harsatna nei hial khawpin

1 ( ) Hre deuh reng

2 ( ) Hre ve zeuh zeuh

3 ( ) A chang changin

4 ( ) Hre ngai meuh lo

5 ( ) Hre ngai lo

18. **Mahni inhriatchianna leh thinlung taka thlamuanna ka nei.**

0 ( ) Engtik lai mahin

1 ( ) Tlem tein

2 ( ) Eng emaw changin

3 ( ) A chang changin

4 ( ) Nei deuh reng

5 ( ) Engtik lai pawhin

19. **Hahdam leh thlamuang emaw tawt leh tang teuha inhriat chang I nei em?**

5 ( ) Aw, hahdam leh thlamuang tak niin ka inhria

4 ( ) Hahdam leh thlamuangin ka inhre tlangpui

3 ( ) A tlangpuiin ka hahdam a, chutih rualin tawt leh tang teuha awm chang pawh ka nei tho

2 ( ) A tlangpuiin tawt leh tang teuhin ka awm a, chutih rualin hahdam taka wm chang pawh ka nei tho

1 ( ) Engtik lai mai pawh hian tawt leh tang teuhin ka inhria

0 ( ) Hahdam leh thlamuanga awm ka nei lo

20. **Hlim leh lawmin ka inhria.**

0 ( ) Hre ngai lo

1 ( ) Hre ve thin

2 ( ) Hre ve zeuh zeuh

3 ( ) Hre ve fo mai

4 ( ) Hre deuh reng

5 ( ) Hre reng

21. **Chau, ngui, hah leh zawi em emin ka inhria.**

5 ( ) Hre ngai lo

4 ( ) Hre ve thin

3 ( ) Hre ve zeuh zeuh

2 ( ) Hre ve fo

1 ( ) Hre deuh reng

0 ( ) Hre reng

22. **Chau, rim leh tawt up upa inhriatna I nei em?**

0 ( ) Aw, a chang chuan ka tawrh zawh loh tur hialin

1 ( ) Aw, nei deuh reng

2 ( ) Aw, ka nei fo

3 ( ) Aw, a changin ka nei thin

4 ( ) Aw, tlem tein

5 ( ) Nei ngai lo

Appendix-IIIa

DAILY SPIRITUAL EXPERIENCE SCALE

The list that follows includes items which you may or may not experience, please consider how often you directly have this experience, and try to disregard whether you feel you should or should not have these experiences. A number of items use the word God. If this word is not a comfortable one for you, please substitute another idea which calls to mind the divine or holy for you.		**Many Times a Day**	**Everyday**	**Most Days**	**Some Days**	**Once in a While**	**Never or Almost Never**
1.	I feel God's presence.	1	2	3	4	5	6
2.	I experience a connection all of life.	1	2	3	4	5	6
3.	During worship, or at other times when connecting with God, I feel joy, which lifts me out of my daily concerns.	1	2	3	4	5	6
4.	I find strength in my religion or spirituality.	1	2	3	4	5	6
5.	I find comfort in my religion or spirituality.	1	2	3	4	5	6
6.	I feel deep inner peace or harmony.	1	2	3	4	5	6
7.	I ask for God's help in the midst of daily activities.	1	2	3	4	5	6
8.	I feel guided by God in the midst of daily activities.	1	2	3	4	5	6
9.	I feel God's love for me directly.	1	2	3	4	5	6
10.	I feel God's love for me through others.	1	2	3	4	5	6
11.	I am spiritually touched by the beauty of creation.	1	2	3	4	5	6
12.	I feel thankful for my blessings.	1	2	3	4	5	6
13.	I feel a selfless caring for others.	1	2	3	4	5	6
14.	I accept others even when they do things I think are wrong.	1	2	3	4	5	6
15.	I desire to be closer to God or in union with the divine.	1	2	3	4	5	6
		Not Close at All		Somewhat Close		Very Close	As Close as Possible
16.	In general, how close to you feel to God?	1		2		3	4

Appendix-IIIb

DAILY SPIRITUAL EXPERIENCE SCALE

(Mizo Translation)

Kaihhruaina: A hnuaia zawhna hrang hrangte hi ngun takin chhiar la, I thil lo tawn tawh leh la tawn ngai miahloh pawh a ni thei a, felfai takin a dik ber a I hriat zawnah tick mark pek mai tur a ni. He zawhna chhang tur hian hun tiam china awm lova, hmanhmawh miah lo a uluk taka min chhan sak turin ka ngen a che.		**Ni khatahvawi tam tak**	**Ni tinin**	**Ni tin deuhthaw**	**A chang chang in**	**Eng emaw changin vawi khat**	**Ngailo/Englai mahin**
1.	Pathian hi a awm tih hriatna ka nei.	1	2	3	4	5	6
2.	Nunna min pe tu nen kan inzawm tih ka hria.	1	2	3	4	5	6
3.	Inkhawm laiin emaw Pathian nena kan inpawl laiin, hlimna nasa tak ka chang thin a, chu chuan ka nitin nun min chhawk zang khai thin.	1	2	3	4	5	6
4.	Pathian ka biakna leh thlarau pawlna ka dawn te hian chakna min pe a ni.	1	2	3	4	5	6
5.	Pathian ka biakna leh thlarau pawlna ka dawn te hian min chhawk zangkhai thin.	1	2	3	4	5	6
6.	Thinlung chhungrilah lungawina leh thlamuanna ka nei thin.	1	2	3	4	5	6
7.	Pathian venna leh tanpuina ka dil thin.	1	2	3	4	5	6
8.	Pathian venna leh tanpuina ka dawng thin.	1	2	3	4	5	6
9.	Pathian min hmangaihna hi a takin ka dawng thin.	1	2	3	4	5	6
10.	Pathian min hmangaihna hi midangte kaltlangin ka hre thin.	1	2	3	4	5	6

Kaihhruaina: A hnuaia zawhna hrang hrangte hi ngun takin chhiar la, I thil lo tawn tawh leh la tawn ngai miahloh pawh a ni thei a, felfai takin a dik ber a I hriat zawnah tick mark pek mai tur a ni. He zawhna chhang tur hian hun tiam chin a awm lova, hmanhmawh miah lo a uluk taka min chhan sak turin ka ngen a che.		**Ni khatahvawi tam tak**	**Ni tinin**	**Ni tin deuhthaw**	**A chang chang in**	**Eng emaw changin vawi khat**	**Ngailo/ Englai mahin**
11.	Pathian thilsiam mawi tak takte hian ka rilru leh thlarau a hneh em em thin.	1	2	3	4	5	6
12.	Malsawmna ka dawnah te hian ka lawm em em thin.	1	2	3	4	5	6
13.	Midangte hma ngai thei tak niin ka inhria.	1	2	3	4	5	6
14.	Midangte hian thil dik lo nia ka hriat pawh lo ti mah se, ka pawm thiam mai thin.	1	2	3	4	5	6
15.	Pathian hnaiha awm leh thianghlim taka awm ka tum thin.	1	2	3	4	5	6
16.	A tlangpuiin, Pathian hnaihin I inhria em?	Hnaih em em		Hnaih viau		Hnaih ve tho	Hnaih lo

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DEGREE	:	Master of Philosophy
DEPARTMENT	:	PSYCHOLOGY
TITLE OF DISSERTATION	:	"Impact of Socio-demographic Variables on Psychological Well-Being and Spiritual Experience: A Study Among Mizo Adults"
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(ABSTRACT)

IMPACT OF SOCIO-DEMOGRAPHIC VARIABLES ON PSYCHOLOGICAL WELL-BEING AND SPIRITUAL EXPERIENCE: A STUDY AMONG MIZO ADULTS

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Aging population is the most challenging demographic phenomenon worldwide. It involves the following five dimensions: chronological, biological, cultural, psychological and spiritual. Given the same level of chronological and biological aging, individuals may differ widely in terms of psychological aging. Rybash, Roodin, and Santrock (1991) define psychological age in terms of both adaptability and attitude. Psychological age refers to the capability of an individual to adapt to the changing environmental demands as compared to the adaptability of other individuals identical chronological age. Individuals become suitable to their environments by studying on various psychological characteristics: learning, memory, intelligence, emotional control, motivational strengths, coping styles, and many more. As a result, individuals who show more of such psychological characteristics than their chronological age mates are considered "psychologically young" while those who possess such traits to a lesser degree are "psychologically old".

According to Berkman and Harootyan (2003), there are a number of vulnerabilities related to aging such as an increase in physical, mental, and emotional health issues and significant changes in social and economic status are experienced by many older adults. Choi and Jun (2009) stated that older adults frequently review their lives with contentment or discontentment, and if burdened with unsettled regrets they are likely to experience depressive symptoms which can lead to clinical depression. Similarly, Blazer (2003) uses Erikson's life stage theory to suggest that depression may occur when the developmental tasks of accepting certain unavoidable losses associated with late life (e.g., death of a loved one) are not fulfilled successfully by the individual. Fowler (1981) has proposed that faith is proceeding through different developmental stages from simple faith to spirituality. Similar to Flower, Tornstam (1999) provides a theory of "gerotranscendence" that declares for an age-related spirituality. Tornstam (1999) suggests that seniors are more likely to be focused in the spiritual dimension, which includes a concentration with inter-generational relationship, the

meaning of life and death. From a life-span perspective, the developmental duty and primary values change in different development stages.

The awareness of the growing disabilities faced by older people led to a greater examination of self. And with old age comes a number of burdens like decrease in wage, smaller social and familial circle, and decline in physical health. As people grow older they became less and less active and became less passionate about personal interest, they are more cautious and cynical about their future and start to lose normal sleep pattern. Social pressure and inability to acquire enough resources that alters the normal functioning of old people.

Scientists presumed that older individuals require better physical medicinal services and mental consideration to sustain their prosperity. Because of fragile wellbeing condition, absence of satisfactory consideration and oak seed by the relatives, carelessness via parental figures, occupied life plan because of urbanization, older individuals are getting dismissed. Subsequently, they turn out to be increasingly helpless against physical and mental illnesses (Dhara & Jogsan, 2013). People that have come to their final years in life have evidently shown the increase in endeavour for truth and purpose in life and this often lead to spirituality i.e., love and relatedness, for forgiveness, and for spiritual integration (Reed, 1991; Staude, 2005; Steinhauser et al., 2008).

The study attempted to explore the impact of socio-demographic variables on psychological well-being and spiritual experience among 309 Mizo adults (163 males & 146 females). The participants were identified following the multistage random sampling method from 3 constituencies of Aizawl city (Aizawl North II, Aizawl North III, & Aizawl East I). Following the works of Santrock (2013) the participants were further classified into two developmental stages: Middle Adulthood (40-60 years) and Late Adulthood (60 years &

above). The selected 91 participants were from Aizawl North II, 103 participants were from Aizawl North III and 115 were from Aizawl East I.

The study employed 2 ‘gender’ (male & female) x 2 ‘age-group’ (middle adulthood & late adulthood) factorial designs and incorporated the behavioral measures of Psychological General Well-Being Index (Dupuy, 1971) and Daily Spiritual Experience Scale (Underwood & Teresi, 2002). Rapport was formed with each of the participants at the individual level and the consent for participation was obtained. The importance of the instructions relating to the psychological measures was clearly highlighted. The first phase of the interaction was followed by data collection and the participants were given forms containing the demographic information - age, gender, socio-economic status (derived from the background information of marital status, educational qualification, number of family members, occupational status and monthly income based on the works of Hollingshead, 1975 and Kuppuswamy, 1981), locality, family type, number of children, bread earner, other support, house type, house ownership, caretaker, assets, social and religious involvement are carefully recorded to match or equate the participants in the study.

The data collected were then carefully screened for missing responses, uncompleted scales and sub-scales for the participants. The responses of the participants obtained through the psychological measures as well as the demographic variables of the participants were screened, coded and analyzed by employing computer software programmes.

The statistical analysis of the study included the descriptive statistics (mean, SD, skewness, kurtosis and bivariate correlation matrix) for the behavioral measures as well as internal consistency (Cronbach alphas) of the behavioral measures. The descriptive statistics and the Cronbach alphas revealed all the scales/subscales of the behavioral measures to be applicable for the measurement in the target population. The outcomes revealed that daily

spiritual experience to be negatively correlated with all the subscales of Psychological General Well-Being Index (PGWBI) and significant relationship was found for anxiety, positive well-being, self-control and vitality. All the subscales of Psychological General Well-Being Index show highly significant positive correlation in all possible combinations.

Secondly, analysis of covariance (ANCOVA) for the effect of 'gender' and 'age-group' on scales/subscales of the behavioral measures with the demographic variables as the covariate was employed to show the patterns of variation. Scheffe Test, which is a parametric Post-hoc multi-comparison was employed to elucidate the patterns of groups/means differences for significant independent and interaction effect of 'gender' and 'age-group' on the behavioral measures.

The results revealed that females to show higher daily spiritual experience as compared to males. This may be due to the fact that women are more likely than men to seek religious consolation (Ferraro & Kelley-Moore, 2000). The finding also revealed that late adulthood showed higher daily spiritual experience than middle adulthood. In support to this finding, Beit-Hallahmi and Argyle (1998) found that older adults rate religion as more important in their lives than do younger adults. Scholars have posited that aspects of both religiosity and spirituality are important resources in helping individuals productively cope with age-related losses (Krause & Tran, 1989). Spirituality might be increasingly beneficial with advancing age as many older adults face the developmental challenges of transcending their physical self (Peck, 1968) and coming to better terms with their mortality (Havighurst, 1972). Engagement with religious communities might also benefit older adults in particular by providing social relationships and support in later life (Neill & Kahn, 1999).

The results also revealed that middle adulthood showed higher level of anxiety as compared to late adulthood. Early researches supported the present findings that in cross-

sectional studies, older age is related to lower level of negative affect (Carstensen, Pasupathi, Mayr, & Nesselroade, 2000; Diener & Suh, 1997; Mroczek & Kolarz, 1998). Blazer (2003), Piazza & Charles (2006) also highlighted that older age is related to lower rates of anxiety and major depressive disorder. In longitudinal studies, Charles, Reynolds, & Gatz (2001) also reported that older age is related to lower levels of negative affect, increases in life satisfaction (Mroczek & Spiro, 2003), and stable levels of positive affect (Charles et al., 2001).

The findings also revealed that females in middle adulthood showed higher depressed mood than females in late adulthood (Hasin, Goodwin, Stinson, & Grant, 2005) and males in middle adulthood showed higher general health than males in late adulthood. This may be due to the fact that during late adulthood the skin continues to lose elasticity, reaction time slows further, and muscle strength diminishes. The immune system is weakened, and many older people are more susceptible to illness, cancer, diabetes, and other ailments. Cardiovascular and respiratory problems become more common in old age. Seniors also experience a decrease in physical mobility and a loss of balance, which can result in falls and injuries.

Finally, stepwise hierarchical multiple regression was employed for the prediction of Psychological Well-being and Spiritual Experience from the socio-demographic variables. All the findings are also supported by analysis of covariance (ANCOVA).

The results revealed that increase in age (Atchley, 2000; Idler, Kasl, & Hays, 2001; Koenig, 2006; Moberg, 2001; Tornstam, 2015), being female (Vahia et al, 2011; Foley, 2000; Harvey, 2006), better socio-economic status, and more number of received other support indicated higher spiritual experience whereas more number of bread earners in the family, increase in distance of the degree of relationship with the caretaker, assets owned and higher

religious involvement (Underwood, 2006) predicted lower daily spiritual experience. Increase in age and joint as compared to nuclear family type predicted lower anxiety.

The results also highlighted that urban participants showed higher level of anxiety and depressed mood than the rural participants (Prina A.M, Ferri C.P, Guerra M, Brayne C, Prince M, 2011; Sharifi V, Amin-Esmaeili M, Hajebi A, et al., 2015). Better socio-economic status and joint as compared to nuclear family type predicted higher self-control (Moffitt et al, 2011). Poorer housing conditions indicated higher positive well-being.

More number of bread earners in the family also indicated higher general health. Consistent to this finding, Case, Lubotsky, and Paxson (2002) and Lindahl (2005) suggest that a higher income causes improvements in health outcomes, and Arno and colleagues (2009) present preliminary evidence that income-support programs increase access to health insurance and improve certain health outcomes. Bound (1989), Haveman and colleagues (1995), and Smith (1999, 2004), however, maintain that lower incomes are due to the decline in productivity that results from poor health and disabilities rather than the reverse. Participants living in rented house showed higher depression and lower self-control (Kathrin Schlafmann, 2015), general health, and vitality. More number of received other support also predicted lower general health. More assets possessed predicted lower self-control. Higher social and religious involvement predicts lower positive well-being and vitality and higher social involvement predicted lower self-control.

In sum, the outcomes of the present study revealed that socio-demographic variables such as age, gender, socio-economic status, locality, family type, bread earner, other support, caretaker, house type, house ownership, assets, social and religious involvement successfully predicted Psychological Well-Being and Daily Spiritual Experience.

Limitations of the study:

The limitation of the study is that the sample comprised of 309 Mizo adults out of which 163 are male and 146 female which is far less than half of the population. The other limitation of the study is that during the course of data collection some participants reported auditory and visual problems especially those in late adulthood and participants with a low level of education also struggle with tasks which needs verbal communication to respond the tasks. The other limitation is that some participants were uncooperative about answering the questionnaires even though they were given proper informed consent and confidentiality, many returned incomplete questionnaires, left a few items unanswered where some participants stated that it was a form of invasion of privacy or gave two answers to the same question which was generally the demographic profile sheet.

REFERENCES

Arno, P.S., Sohler, N., Viola, D., Schechter, C. (2009). Bringing Health and Social Policy Together: The Case of the Earned Income Tax Credit. *Journal of Public Health Policy*; 30(2):198–207.

Atchley, R. (2000). Social forces and aging: *An introduction to social gerontology*. Belmont, CA: Wadsworth.

Beit-Hallahmi, B., & Argyle, M. (1998). Religious Behavior, Belief, and Experience. New York: Routledge.

Berkman, B., & Harootyan, L. (Eds.). (2003). Social work and health care in an aging society: education, policy, practice, and research. New York, N.Y.: Springer Publishing Company, Inc.

Blazer, D.G. (2003). Depression in late life: review and commentary. *Journal of Gerontology*, 58A, (3), 249-265.

Bound, J. (1989). The Health and Earnings of Rejected Disability Insurance Applicants. *American Economic Review*, 79(3):482–503.

Carstensen, L.L., Pasupathi, M., Mayr, U., Nesselroade, J.R. (2000). Emotional experience in everyday life across the adult life span. *Journal of Personality & Social Psychology*. 79:644–655.

Case, A., Lubotsky, D., Paxson, C. (2002). Economic Status and Health in Childhood: *The Origins of the Gradient. American Economic Review*; 92(5):1308–44.

Charles, S.T., Carstensen, L.L., McFall, R.M. (2001). Problem-solving in the nursing home environment: Age and experience differences in emotional reactions and responses. *Journal of Clinical Geropsychology Special Issue: Management of Behavioral Problems in Late Life Therapeutic Approaches and Related Issues.* 7:319–330.

Charles, S.T., Reynolds, C.A., Gatz, M. (2001). Age-related differences and change in positive and negative affect over 23 years. *Journal of Personality and Social Psychology*; 80:136–151.

Choi, N.G. & Jun, J. (2009). Life regrets and pride among low-income older adults: relationships with depressive symptoms, current life stressors and coping resources. *Aging & Mental Health*, 13 (2), 213-225.

Dhara, R.D., & Jogsan, Y.A. (2013). Depression and psychological well-being in old age. *Journal of psychology and psychotherapy*, 3, 117.

Diener, E., Suh, M.E. (1997). Subjective well-being and age: An international analysis. In: Schaie KW, Lawton MP, editors. *Annual review of gerontology and geriatrics.* Vol. 17. New York: Springer; pp. 304–324.

Dupuy, H.J. (1971). The Psychological General Well-Being (PGWB) Index. In: Assessment of Quality of Life in clinical trials of cardiovascular therapies. Edited by Wenger NK, Mattson ME, Furberg CD, Elinson J.Le Jacq Publishing; Chap 9:170-183.

Ferraro, K.F., & Kelley-Moore, J.A. (2000). Religious consolation among men and women: Do health problems spur seeking?. *Journal for the Scientific Study of Religion*, 39: 220–234.

Foley, L. (2000). Exploring the experience of spirituality in older women finding meaning in life. *Journal of Religious Gerontology*. 12(1):5–15.

Fowler, J.W. (1981). Stages of faith: The psychology of human development and the quest for meaning. San Francisco: Harper & Row.

Hasin, D.S., Goodwin, R.D., Stinson, F.S., Grant, B.F. (2005). Epidemiology of major depressive disorder: Results from the National Epidemiologic Survey on Alcoholism and Related Conditions. *Arch. Gen.Psychiatr*. 62:1097–106.

Harvey, I. (2006). Self-management of a chronic illness: An exploratory study on the role of spirituality among older African American women. *Journal of Women & Aging*. 18(3):75–88.

Haveman, R., Wolfe, B., Buron, L., Hill, S.C. (1995). The Loss of Earnings Capability from Disability/Health Limitations: Toward a New Social Indicator. *Review of Income and Wealth*, 41(3):289–304.

Havighurst, R.J. (1972). Developmental Tasks and Education. New York: David McKay Company.

Hollingshead, A.B. (1975). Four factor index of social status. Unpublished manuscript, Yale University, New Haven, CT.

Idler, E.L., Kasl, S.V., & Hays, J.C. (2001). Patterns of religious practice and belief in the last year of life. *Journals of Gerontology: Social Sciences*; 56B (6):S326–S34.

Koenig, H. (2006). Religion, spirituality and aging. *Aging & Mental Health*; 10(1):1–3.

Krause, N., & Van, T.T. (1989). Stress and religious involvement among older blacks. *Journal of Gerontology:* Social Sciences;44:S4–S13.

Kuppuswamy, B. (1981). Manual of socioeconomic status scale (urban). Delhi: Manasayan.

Lindahl, M. (2005). Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income. *Journal of Human Resources*; 40(1):144–68.

Moberg, D. (2001). Aging and spirituality: Spiritual dimensions of aging theory, research, practice, and Policy. Binghamton, NY: Haworth Press.

Moffitt, T.E, et al. (2011). A gradient of childhood self-control predicts health, wealth, and public safety. Proc Natl Acad Sci USA. 108:2693–2698.

Mroczek, D.K., & Kolarz, C.M. (1998). The effect of age on positive and negative affect: A developmental perspective on happiness. *Journal of Personality & Social Psychology*; 75:1333–1349.

Mroczek, D.K., & Spiro, A. (2003). Modeling intraindividual change in personality traits: Findings from the Normative Aging Study. *Journals of Gerontology: Psychological Sciences.* 58B:153–165.

Neill, C.M., & Kahn, A.S. (1999). The role of personal spirituality and religious social activity on the life satisfaction of older widowed women. *Sex Roles*. 40(3), 319-329.

Peck, R. (1968). Psychological Developments in the Second Half of Life. In: Neugarten BL, editor. *Middle Age and Aging*. Chicago: University of Chicago Press; pp. 88–92.

Piazza, J., & Charles, S.T. (2006). Mental health and the baby boomers. In: Whitbourne SK, Willis SL, editors. The Baby Boomers at Midlife: Contemporary Perspectives on Middle Age. New Jersey: Lawrence Erlbaum Associates.

Prina, A.M., Ferri, C.P., Guerra, M., Brayne, C., Prince, M. (2011). Prevalence of anxiety and its correlates among older adults in Latin America, India and China: cross-cultural study. *Br J Psychiatry*. 199:485–491.

Reed, P.G. (1991). Spirituality and mental health in older adults: extant knowledge for nursing. *Family and Community Health*, 14(2), 14-25.

Rybash, J.W., Roodin, P.A., & Santrock, J.W. (1991). Adult development and aging (2nd ed.). Dubuque, IA: Wm C. Brown Publishers.

Santrock, J.W. (2013). Life-span development. 14th Ed. New York: McGraw-Hill.

Schlafmann, Kathrin. (2015). "Housing, Mortgages, and Self-Control." mimeo .

Sharifi, V., Amin-Esmaeili, M., Hajebi, A., Motevalian, A., Radgoodarzi, R., Hefazi, M., Rahimi-Movaghar, A. (2015). Twelve-month prevalence and correlates of psychiatric disorders in Iran: the Iranian mental health survey, 2011. Arch Iran Med. 18(2):76–84.

Smith, J.P. (1999). Healthy Bodies and Thick Wallets: The Dual Relation between Health and Economic Status. *Journal of Economic Perspectives*, 13(2):145–66.

Smith, J.P. (2004). Unraveling the SES-Health Connection. *Population and Development Review*, 30:108–32. (suppl.: Aging Health and Public Policy).

Staude, J.R. (2005). Autobiography as a spiritual practice. *Journal of Gerontological Social Work*, 45(3), 249-269.

Steinhauser, K.E., Alexander, S.C., Byock, I.R., George, L.K., Olsen, M.K., & Tulsky, J.A. (2008). Do preparation and life completion discussions improve functioning and quality of life in seriously ill patients? Pilot randomized control trial. *Journal of Palliative Medicine*, 11(9), 1234-1240.

Tornstam, L. (1999). Late-life transcendence: A new developmental perspective on aging. In L. E. Thomas & S. A. Eisenhandler (Eds.), *Religion, belief, and spirituality in late life*. New York: Springer.

Tornstam, L. (2015). Gerotranscendence: A developmental theory of positive aging. New York: Springer.

Underwood, L.G., & Teresi, J.A. (2002). The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health related data. *Annals of behavioural medicine*, 24, 22-33.

Underwood, L.G. (2006). Ordinary spiritual experience: qualitative research, interpretive guidelines, and population distribution for the daily spiritual experience scale. *Archive for the Psychology of Religion*, 28, 181–218.

Vahia, I.V., Depp, C.A., Palmer, B.W., Fellows, I., Golshan, S., Thompson, W., et al. (2011). Correlates of spirituality in older women. *Aging & Mental Health*. 15(1):97–102.