



Received: 06 May 2016
Accepted: 27 July 2016
Published: 12 August 2016

*Corresponding author: Samta P. Pandya, School of Social Work, Tata Institute of Social Sciences, Mumbai, India
E-mail: pandya.samta@gmail.com

Reviewing editor:
Jamie Halsall, University of Huddersfield, UK

Additional information is available at the end of the article

SOCIOLOGY | RESEARCH ARTICLE

Aging spiritually: *Pitamaha Sadans* in India

Samta P. Pandya^{1*}

Abstract: Based on a study of 544 older adults living in *Pitamaha Sadans* (old age homes) under the aegis of Chinmaya Mission, a spiritual organization in India, this article attempts to understand how religiosity and spirituality contribute to their aging process, life satisfaction and happiness. Five scales have been used to study aspects of spirituality and spiritual experiences, religiosity, life satisfaction and happiness. Findings have been compared to a control group of 493 respondents from other paid old age institutions of secular nature. For majority of the *Pitamaha Sadan* residents, aging was a state of mind, something that could be modified with, and was contingent on, the quality of one's thought processes and thinking, and death was a process that led to God proximity. Results of the analysis of variance and *t*-tests showed that older adults from the *Pitamaha Sadans* scored better on spirituality and religiosity parameters, vis-à-vis the control group. These were in turn linked to their better scores on the life satisfaction and happiness scale scores. The case for spirituality and religiosity as protector variables as well as aspects promoting wellness and transcendence for older adults is thus substantiated.

Subjects: Development Studies; Environment; Social Work; Urban Studies; Social Sciences; Sociology & Social Policy

Keywords: aging; spirituality; old age homes

ABOUT THE AUTHOR

Samta P. Pandya is a faculty member at the School of Social Work, Tata Institute of Social Sciences, Mumbai, India. Her areas of research include faith, spirituality and social work with vulnerable groups.

PUBLIC INTEREST STATEMENT

Based on a study of 544 older adults living in *Pitamaha Sadans* (old age homes) under the aegis of Chinmaya Mission, a spiritual organization in India, this article attempts to understand how religiosity and spirituality contribute to their aging process, life satisfaction and happiness vis-à-vis a control group of 493 respondents from other paid old age institutions of secular nature. For majority of the *Pitamaha Sadan* residents, aging was a state of mind, something that could be modified with, and was contingent on, the quality of one's thought processes and thinking, and death was a process that led to God proximity. Vis-à-vis the control group, *Pitamaha Sadan* residents scored better on spirituality and religiosity parameters, which were in turn linked to better scores on the life satisfaction and happiness scales. The case for spirituality and religiosity as protector variables promoting wellness and transcendence for older adults is thus substantiated.

1. Introduction

Several studies have emphasized on the importance of religiosity and spirituality in successful aging or well-being and wellness in later life (e.g. Eggers, 2003; Mehta, 1997; Vahia et al., 2011; Yorgason, 2015). This has been in the context of several life cycle changes which occur during the aging years that manifest as stressors which include disengagement, diminished activity, deteriorating social support and networks and adjusting to the ideas and issues relating to death, dying and bereavement (Flannelly, Weaver, & Costa, 2004; Patrick & Henrie, 2015). The governing premise is the importance of transcendence in late life (Kalavar, Buzinde, Manuel-Navarrete, & Kohli, 2015) and the proposition that religiosity and spirituality can serve to be protector variables in the aging process (Miller & Worthington, 2011; Pargament, 2007). The way religion and spirituality serve to be protector variables is through enabling psychosocial coping (Newton & McIntosh, 2010), coping with disability (Swinton, 2011), promoting life satisfaction and a sense of gratitude (Krause, 2006). This, of course, is for those for whom religion and spirituality comprise an important aspect of understanding of the self and the world (Wink & Dillon, 2008). The further substantiation is that spiritual practices over time strengthen a person's spiritual relationship with God, resulting in greater self-esteem and less shame (Reinert, 2005). Further, older persons with chronic illness who have positive God images and pray frequently, experience fewer symptoms, deal better with psychopathologies, have better problem solving abilities and are able to see better meaning in the world (Harvey & Cook, 2010).

Essentially there is enough argument to propose the therapeutic, buffering, positive effect promoting and worldview enhancing potential of spirituality (e.g. Bradshaw, Ellison, & Flannelly, 2008; McFadden, Kimble, Ellor, Seeber, & Rost, 2011; Peloso, 2008; Sorajjakool, Aja, Chilson, Ramírez-Johnson, & Earll, 2008). Specifically this line of empirical argument has also been extended to older adults in institutional settings—including hospitals, hospices and old age homes. The focus here is coping, and sometimes reconciling, with the idea of institutionalization, long term illness and, in many cases, a sense of time remaining (e.g. Ardel & Koenig, 2006; Benjamins, 2005; Black & Hannum, 2015; Daaleman, Pereira, & Studenski, 2004). Further, discussions on religiosity, spirituality and aging have now begun to flourish across several faith traditions and cultural contexts (e.g. Baumsteiger, Chenneville, & McGuire, 2013; Ellor & Nakasone, 2012; Krause, 2006; Mullet & Azar, 2009; Nakasone, 2013).

The Indian context is specifically important here as there has been a rich spiritual heritage which has promoted the idea of gerotranscendence¹ (see Tornstam, 2005) and the importance of a spiritual worldview in old age (e.g. Chattopadhyay, 2008; Tilak, 1989). Lars Tornstam's concept of gerotranscendence, share core components with the last two stages of the four-stage Hindu model of the life span (Ramamurti & Jamuna, 2010). There have been few studies which have actually looked at the connection between religiosity, spirituality and aging in the Indian context (e.g. Bhatnagar, 2008; Biswas, 2008; Jain & Sharma, 2004a, 2004b; Kalavar et al., 2015; Singh, 2003; Ushashree, 1992a, 1992b; Ushashree & Basha, 2003). The focus of this literature has been the connection of Indic spirituality tenets with quality of life in old age, coping and positive psychosocial behavior, coping with the idea of death and dying, among others. Contrary to the traditional belief of withdrawal and disengagement, the focus is on how religiosity and spirituality promotes a natural progression towards maturation and wisdom in old age, redefinition of the self and of relationships to others and a new understanding of fundamental existential questions.²

Picking on this thread of understanding that aging years are associated with increased spiritual inclinations or that religiosity and spirituality have a lot to contribute to successful aging (Jeste, Depp, & Vahia, 2010; Martin et al., 2015), there have been some Indian faith-based and spiritual organizations and guru-led movements who have, within their mandates of sociality and social service (see Copeman & Ikegame, 2012), undertaken work with the older adults. The idea has been to combine their faith leaning and spiritual worldviews (drawing from traditional tenets and modifying them to suit modern temperaments) in working with older adults—to demonstrate social outreach and also simultaneously garner public support and followers.

This paper attempts to study one such model of service for the elderly done by a Hindu-based spiritual organization in India called the Chinmaya Mission. The main argument is to see how religiosity and spirituality contributes to the life satisfaction and happiness of the residents of their *Pitamaha Sadan* (old age home) project. This has been compared to those older adults who reside in other paid old age institutions of secular nature.

1.1. On Chinmaya mission

Chinmaya Mission, a Hindu spiritual organization, was started by a group of followers of a religious teacher Balakrishnan Menon aka Swami Chinmayananda (1916–1993) in Chennai, South India in 1953. Chinmayananda was influenced by the Advaita Vedanta or non-dualistic philosophy, which he read extensively on, as a resident of the Divine Life Society in Rishikesh, North India in the 1940s and later got initiated into ascetism in 1949 and subsequently started his own preaching and practice³. Swami Tejomayananda, who joined the Mission in 1970 as a student of the Vedanta philosophy training courses, currently heads the organization.⁴ The Mission essentially uses the non-dualist Vedanta philosophy as propagated by an 8th century saint called Adi Sankaracharya to validate its stance as a modern Hindu spiritual organization (see Locklin & Lauwers, 2009), which now has branches across the globe. Followers of the Mission see it as giving them a sense of connection with tradition and endowing them with the life skills to deal with the perils of modern life (see Emir, 2011; Thapan, 2005).

Like several contemporary new religious movements and spiritual organizations, one prominent legitimizing strategy that Chinmaya Mission uses is social work and welfare. Out of the donations received through philanthropic followers, it runs several social welfare projects such as residential schools, hospitals and rural development projects among others. Some scholars of religious studies say that it is a means of divesting their tax liabilities (Warrier, 2003) and yet others say that this gives them publicity and more followers (Lucia, 2014; Tøllefsen, 2014).

1.2. On Pitamaha Sadans

One project is the Central Chinmaya Vanaprastha Sansthan or CCVS (vanaprastha refers to the third stage in the Hindu view of human life denoting a sense of withdrawal, which comes after celibacy which is the first stage and householder duties which is the second and most active stage of a person's life). CCVS is the wing for older adults over sixty years of age, which is geared towards organizing programs at various centers for older adults to prepare them for a spiritual life in old age. CCVS motto is: "graceful aging through spiritual living". An important project of the CCVS is *Pitamaha Sadans* or old age institutions which provides residential facilities and amenities to older adults.

Pitamaha Sadans project was started in December 1995 by followers of the Mission in Allahabad, North India. The residential facilities are paid and spiritual training and programs form an essential part of life in the *Pitamaha Sadans*. Other aspects that are geared towards improving the lives of older adults are: training in prevention and cure of geriatric ailments through a holistic approach and financial security planning. The ethos is to prevent diseases, keep the body, mind and intellect healthy, have meaningful and healthy relationships, reduce fear and anxiety of death and dying and essentially achieve a spiritual goal. At present there are eight *Pitamaha Sadans* which are located in Allahabad, Kanpur, Rewa in North India, Tamaraiakkam, Coimbatore, Ellayapalle, Kothapatnam in South India and Kolhapur in North India.

The accommodation is affordable, spartan and comfortable, the food is vegetarian and the other facilities are library and reading room and medical services. Regular spiritual activities are held which include: group study of Vedanta, collective singing of devotional songs, listening to spiritual talks, and organizing periodic camps on yoga. Further older adults are also encouraged to do voluntary work in the social service projects of the Mission wherein they get an opportunity to use their experience and expertise and also be meaningfully engaged. *Pitamaha Sadans* attempt to link religiosity and spirituality to life satisfaction and happiness of older adults in their aging years.

2. Data and methods

The main objective of the study is to understand religiosity, spirituality, life satisfaction and happiness of the older adults residing in the Chinmaya Mission's *Pitamaha Sadans* and compare the same to older adults living in other paid old age institutions of secular nature, which comprised the control group.

Specifically the objectives are: (1) to understand the socio-demographic profile, health status and daily routine activities of the older adults residing in the *Pitamaha Sadans* and older adults living in other paid old age institutions of secular nature (2) to understand and compare their ideas on aging, death and dying (3) to study and compare their scores on the Daily Spiritual Experience Scale, Spiritual Experience Index (revised) and the Centrality of Religiosity Scale and (4) to study and compare their scores on the Satisfaction with Life Scale and the Oxford Happiness Questionnaire (5) to study the socio-demographic and health predictors of the scale scores of older adults living in the *Pitamaha Sadans*. The study is quantitative in nature and uses survey method of investigation.

2.1. Sampling

Data was collected from the older adults residing in the eight *Pitamaha Sadans* located in Allahabad, Kanpur, Rewa, Tamaraipakkam, Coimbatore, Ellayapalle, Kothapatnam, and Kolhapur in India. Lists of residents of the *Pitamaha Sadans* were obtained from the functionaries. Using systematic sampling ($k = 4$), from a total of 2,596 older adults across the eight homes, a sample of 544 respondents were obtained. The response rate was 77.20%.

Data for the control group respondents was collected from four paid old age institutions in four cities: Allahabad, Kanpur, Delhi and Mumbai. The choice of these institutions was governed by the permissions obtained. From the lists obtained from these institutions, a sample of 493 respondents were obtained using systematic sampling ($k = 5$), from a total of 2,678 older adults residing in the four homes. The response rate for the control group was 72.04%.

2.2. Methods

The interview schedule was used for interviewing the older adults comprising of questions on their: Socio-demographic profile, ailments and self rated health, healthcare seeking behavior, daily routine activities; open ended questions on their ideas on aging, death and dying; and five scales: Daily Spiritual Experience Scale, Spiritual Experience Index (revised); Centrality of Religiosity Scale; Satisfaction with Life Scale and Oxford Happiness Questionnaire. The same schedule was used for the control group.

2.3. Scales

2.3.1. Daily Spiritual Experience Scale (DSES)

The Daily Spiritual Experience Scale (DSES) developed by Underwood (2006, 2011) is a 16-item self-report measure designed to assess ordinary experiences of connection with the transcendent in daily life. For this six-point Likert scale (many times a day = 1 to never = 0), the lowest score is 16 and the highest is 94. Some examples of the statements on the daily spiritual experience scale include: I feel God's presence; I experience a connection all my life; I feel a deep inner peace or harmony; I feel a selfless caring for others, and similar statements. The first 15 items are scores on a six-point rating. The last statement i.e. in general how close do you feel to God is rated on a four-point rating: as close as possible, very close, somewhat close, not close at all. The cronbach α for the scale, calculated for this study is 0.86.

2.3.2. Spiritual Experience Index (revised) (SEI-R)

The Spiritual Experience Index (revised) developed by Genia (1997) is a 23-item scale that measures faith and spiritual journey and contains two subscales: Spiritual support (13 items) and spiritual openness (10 items). Four items on the spiritual openness subscale are reverse coded. Some examples of the statements on the spiritual support subscale include: I feel strongly related to a power greater than myself; my faith helps me confront tragedy and suffering; my faith is often a deeply

emotional experience; my faith guides my whole approach to life, and similar other statements. Some examples of statements on the spiritual openness subscale include: ideas from faiths different from my own may increase my understanding of spiritual truth; I feel a spiritual connection with all of humankind, and similar other statements. The four reverse coded items include: I believe that there is only one true faith; one should not marry someone from a different faith; I never challenge the teachings of my faith; and, I believe that the world is basically evil. For this six-point Likert-type scale (strongly disagree = 1 to strongly agree = 6), the lowest score is 43 and the highest is 118. The cronbach α for the scale, calculated for this study is 0.89.

2.3.3. Centrality of Religiosity scale (CRS)

The Centrality of Religiosity scale (CRS) developed by Huber and Huber (2012) is a measure of the centrality of religious meanings in individuals, containing five core dimensions: public practice, private practice, religious experience, ideology and intellect. I used the 15-item basic version, containing 15 questions with three questions on each of the dimension. Some examples of the statements on centrality of religiosity scale (basic version) include: How often do you think about religious issues? To what extent do you believe that God or something divine exists? How often do you take part in religious services? How often do you pray? How often do you experience situations in which you have the feeling that God or something divine intervenes in your life? and similar other statements covering aspects of intellect, ideology, public practice, private practice and experience. For this four-point Likert scale (never = 1 to very often = 4), the highest score is 60 and the lowest is 15. The cronbach α for the scale, calculated for this study is 0.78.

2.3.4. Satisfaction with Life scale (SWL)

The Satisfaction with Life scale (SWL) developed by Diener, Emmons, Larsen, and Griffin (1985) contains a list of five statements (agree/disagree) to understand satisfaction with life: in most ways my life is close to my ideal; the conditions of my life are excellent; I am satisfied with life; so far I have gotten the important things I want in life; and, if I could live my life over, I would change almost nothing. For this seven-point Likert scale (1 = strongly disagree to 7 = strongly agree), the score range is 0–35, the higher end score indicating higher levels of satisfaction with life. The cronbach α for the scale, calculated for this study is 0.76.

2.3.5. Oxford Happiness Questionnaire (OHQ)

The Oxford Happiness Questionnaire developed by Hills and Argyle (2002) comprises 29 statements which can be endorsed on a uniform six-point Likert scale of which 12 items are reverse coded. Some examples of the statements on the Oxford Happiness Questionnaire are: I am intensely interested in other people; I feel that life is very rewarding, and similar other statements. Some examples of the reverse coded statements are: I don't feel particularly pleased with the way I am; I rarely wake up feeling rested; I do not think that the world is a good place, and similar other statements. For this six-point Likert type scale (1 = strongly disagree to 6 = strongly agree), the lowest score is 89 and the highest is 114. The cronbach α for the scale, calculated for this study is 0.79.

For the respondents, the English versions of the scales were used and wherever required the Hindi translation was used. Scales were cross-checked for cross-cultural reliability and validity. The reasons for deploying scales developed in the western context in the Indian setting were theoretical and practical. The theoretical reason was that cross-cultural data would further strengthen the scale parameters. The practical reason was the unavailability of such similar scales in the Indian context.

2.4. Analysis

Data has been analysed through univariate and bivariate analysis. The STATA 13 computer package has been used. For the open ended questions on the ideas of older adults residing in the *Pitamaha Sadans* on aging, death and dying, the responses were manually coded and categories were then developed for further statistical procedures. In the analysis, the socio-demographic profile data has been presented for both the groups of respondents followed by the respondents' details on ailments, self-rated health, healthcare seeking behavior and daily routine activities. Further, for both the

groups, their ideas on aging, death and dying have been presented, cross-tabulated with socio-demographic profile data. The scale scores of both the respondent and the control groups have been presented and compared. Two logistic regression analyses have been presented to understand the *Pitamaha Sadan* residents' socio-demographic profile, health and other predictors of: Satisfaction with Life scale scores—high (1) or low (0); and the Oxford Happiness Questionnaire scale scores—high (1) or low (0). The findings generally attempt to show how the *Pitamaha Sadans* project of the Chinmaya Mission strives to connect life satisfaction and happiness in later years with religiosity and spirituality. For the logistic regression analysis, the nominal/categorical variables were suitably recoded into binary/dummy variables.

2.5. Limitations of the study

The main limitation of the study is that it lacks in-depth qualitative data on the religious and spiritual experiences of older adults in the *Pitamaha Sadans* as well as the control group. The number of respondents in the experiment group and the control group vary slightly due to unavoidable practical reasons of permissions and access to respondents. In the absence of any robust contextual literature, it has not been possible to arrive at any hypothesis, but the comparison between the experiment and control group, substantiate the main argument of the study.

2.6. Respondent profile

Of the sample of 544 older adults residing in the *Pitamaha Sadans*, 40.62% were in the age group 60–69 years, 32.72% were in the age group 70–79 years and 26.65% were in the age group 80 years and above. Approximately 51.29% were men and 48.71% were women. Around 18.75% had less than high school level educational qualifications, 57.90% had a bachelor's degree and 23.34% had professional qualifications. Occupational history data showed that 37.68% were into salaried employment, 22.97% were self-employed and 39.34% were homemakers. In terms of marital status, 19.30% were currently married, 74.44% were widowed and 6.25% were never married. All the respondents in the *Pitamaha Sadans* belonged to the Hindu religion. Further all the *Pitamaha Sadan* residents said that they had chosen (of their volition) to come and live in the institution (Table 1).

2.7. Control group profile

Of the sample of 493 older adults residing in other paid old age institutions, 31.64% were in the age group 60–69 years, 45.84% were in the age group 70–79 years and 22.52% belonged to the age group 80 years and above. Approximately 59.63% were men and 40.36% were women. Around 20.89% had less than high school level education, 42.60% had a bachelor's degree and 36.51% had professional qualifications. Occupational history data showed that 33.06% were into salaried employment, 37.11% were self-employed and 29.82% were homemakers. Approximately 20.68% were currently married, 71.39% were widowed and 7.91% were never married. Around 73.43% were Hindus, 11.35% were Catholics and 17.24% were Zoroastrians. Around 89.23% of the control group respondents said that they had come to the institution as a matter of choice. Around 10.77% of them said that they were here due to a combination of circumstances and choice or that this was the best possible practical option (Table 1).

3. Results

3.1. Health and daily routine of older adults residing in Pitamaha Sadans and other paid old age institutions

3.1.1. Health and daily routine of older adults residing in Pitamaha Sadans

Approximately 56.62% older adults residing in the *Pitamaha Sadans* said that they suffered from lifestyle ailments such as diabetes mellitus and cardiac problems. Approximately 21.39% of the older adults residing in the *Pitamaha Sadans* suffered from orthopedic problems such as osteoarthritis and osteoporosis. Around 21.99% of the respondents said that they had recurring eye and ear-nose-throat (ENT related) ailments. On the Pearson's chi-square test, age of the *Pitamaha Sadan* residents had a significant association with ailments ($\chi^2(8) = 76.89, p = 0.01$). A higher proportion of

Table 1. Respondent and control group profile

	Pitamaha Sadan residents (%)	Control group (%)
Age (in years)		
60–69	40.62	31.64
70–79	32.72	45.84
80 and above	26.65	22.52
Sex		
Male	51.29	59.63
Female	48.71	40.36
Education		
Up to high school	18.75	20.89
Bachelor's degree	57.90	42.60
Professional qualifications	23.34	36.51
Occupational history		
Salaried	37.68	33.06
Self-employed	22.97	37.11
Home-makers	39.34	29.82
Marital status		
Currently married	19.30	20.68
Widowed	74.44	71.39
Never married	6.25	7.91
Religion		
Hindu	100.00	73.43
Others (Catholics and Zoroastrians)	0.00	26.57
Institutional residence		
Choice	100.00	89.23
Circumstances and practical option	0.00	10.77
Total number	544	493

women suffered from osteoarthritis and osteoporosis (87.21%) vis-à-vis men (67.29%). A higher proportion of men suffered from lifestyle ailments such as diabetes mellitus and cardiac problems (81.27%) vis-à-vis women (69.82%). On the Pearson's chi-square test, sex of the respondents had a significant association with ailments ($\chi^2(4) = 81.29, p = 0.03$). A higher proportion of those who were widowed suffered from various ailments (91.26%) compared to their currently married and never married counterparts (71.29%). On the Pearson's chi-square test, marital status of the *Pitamaha Sadan* residents had a significant association with ailments ($\chi^2(8) = 102.12, p = 0.00$).

Around 36.12% rated their own health as very good, 42.18% said that it was good with occasional troubles and 21.70% said that their health was generally fair. A higher proportion of young old respondents rated their own health as very good (81.29%) vis-à-vis old-old and oldest old respondents (69.23%). On the Pearson's chi-square test, age of the *Pitamaha Sadan* residents had a significant association with their own perception of health ($\chi^2(4) = 56.71, p = 0.00$). A higher proportion of currently married respondents rated their own health as very good (78.12%). A higher proportion of single i.e. widowed and never married respondents rated their health as good with occasional troubles or generally fair (79.23%). On the Pearson's chi-square test, marital status of *Pitamaha Sadan* residents had a significant association with their own perception of health ($\chi^2(4) = 89.12, p = 0.00$).

In terms of healthcare, around 67.13% of the *Pitamaha Sadan* residents said that they used a combination of allopathy and alternative medicines (such as ayurveda, homeopathy and naturopathy). Approximately 32.87% of them said that they used only allopathic treatments for their ailments. A higher proportion of men used a hybrid healthcare plan i.e. a combination of allopathy and alternative medicines (78.23%) vis-à-vis women (67.81%). On the Pearson's test, sex of the respondents had a significant association with the preferred healthcare mechanisms ($\chi^2(2) = 91.28, p = 0.00$). A higher proportion of the respondents with bachelor's degree and professional qualifications used a hybrid healthcare plan (78.92%) vis-à-vis their less educated counterparts (56.72%). On the Pearson's chi-square test, education of the respondents had a significant association with the preferred healthcare plan ($\chi^2(2) = 106.72, p = 0.00$).

Pitamaha Sadan residents generally followed a daily routine comprising spiritual activities and religious readings (67.12%), personal hobby pursuits (15.13) and institutional admin work (17.75%). A higher proportion of young old *Pitamaha Sadan* residents pursued hobbies and contributed to institutional admin work (81.32%), than their older counterparts (65.24%). On the Pearson's chi-square test, age of the respondents had a significant association with daily routine ($\chi^2(4) = 97.45, p = 0.03$). A higher proportion of never married and widowed respondents spent more time in spiritual activities and religious reading (91.26%) than their currently married counterparts (56.23%). On the Pearson's chi-square test, marital status of the respondents had a significant association with their daily routine in the *Pitamaha Sadans* ($\chi^2(4) = 106.78, p = 0.00$).

3.1.2. Health and daily routine of older adults residing in other old age institutions

Around 56.13% of the older adults residing in other old age institutions i.e. the control group, had lifestyle ailments such as diabetes mellitus and cardiac ailments. Approximately 28.67% had orthopedic ailments such as osteoarthritis and osteoporosis. Around 15.12% said that they had eye ailments and ENT ailments which were of chronic and recurring nature. A higher proportion of the women respondents in the control group had orthopedic ailments (82.36%) vis-à-vis men (66.28%). A higher proportion of men had diabetes mellitus and cardiac ailments (81.28%) vis-à-vis women (76.89%). On the Pearson's chi-square test, sex of the respondents had a significant association with ailments ($\chi^2(4) = 96.29, p = 0.00$). A higher proportion of widowed respondents suffered from various ailments (91.28%) vis-à-vis their currently married and ever single counterparts (78.64%). On the Pearson's chi-square test, marital status of the control group respondents had a significant association with ailments.

Approximately 16.12% of the control group respondents rated their own health as very good. Around 25.89% of them said that their health was generally good with occasional troubles. Around 57.99% of the control group respondents rated their own health as fair. A higher proportion of the respondents with bachelor's degree and professional qualifications rated their own health as generally good (87.34%) vis-à-vis their less educated counterparts (67.54%). On the Pearson's chi-square test, education of the respondents had a significant association with their own perception of health ($\chi^2(4) = 92.31, p = 0.00$). A higher proportion of the currently married respondents rated their own health as good (76.83%) vis-à-vis widowed respondents (56.74%). On the Pearson's chi-square test, marital status of the respondents had a significant association with own perception of health ($\chi^2(4) = 117.12, p = 0.00$). A higher proportion of Hindu respondents rated their own health as good (81.67%) vis-à-vis Catholic and Zoroastrian respondents. On the Pearson's chi-square test, religion of the respondents had a significant association with their own perception of health ($\chi^2(4) = 89.72, p = 0.03$).

Approximately 76.52% of the control group respondents said that they used a combination of allopathy and alternative medicines as healthcare options. Approximately 23.48% of them said that they used primarily allopathy only as the main healthcare option. Majority Hindus (78.93%) preferred the hybrid or combined healthcare option vis-à-vis Christians and Zoroastrians (41.28%). On the Pearson's chi-square test, religion ($\chi^2(2) = 89.12, p = 0.00$) of the control group respondents had a significant association with the preferred healthcare option.

Approximately 31.16% of the control group respondents undertook hobbies and other leisure pursuits as a part of their daily routine. Majority (68.84%) of them said that they did nothing specific or planned in terms of their daily routine. Women (67.23%) vis-à-vis men (56.78%), those with higher education (71.62%) vis-à-vis those less qualified (27.18%) and Hindus (65.13%) vis-à-vis Christians and Zoroastrians (36.19%) said that they undertook hobbies and other leisure pursuits as a part of their daily routine. Hence control group respondents' sex ($\chi^2(1) = 68.12, p = 0.02$), educational attainment ($\chi^2(2) = 89.13, p = 0.03$) and religion ($\chi^2(2) = 78.19, p = 0.00$) had a significant association with their daily routine.

3.2. Ideas on aging, death and Dying of older adults residing in Pitamaha Sadans and other old age institutions

3.2.1. Ideas on aging, death and dying of older adults residing in Pitamaha Sadans

Approximately 36.28% of the *Pitamaha Sadan* residents said that they saw aging as a natural and inevitable life process. Around 63.72% of them said that aging was a state of mind—something that could be modified with, and was contingent on, the quality of one's thought processes and thinking. A higher proportion of young old (78.23%) vis-à-vis the older respondents (56.21%) and those with higher education (81.62%) vis-à-vis lower educational attainment (56.29%), said that aging was a state of mind. On the Pearson's chi-square test of significance, age ($\chi^2(2) = 91.39, p = 0.00$) and education ($\chi^2(2) = 89.26, p = 0.02$) of the *Pitamaha Sadan* residents had a significant association with their ideas or views on aging.

Approximately 41.96% of the respondents said that death and dying was a biological inevitability. Around 58.04% of them said that death and dying was a process which led to God proximity. A higher proportion of women (71.69%) vis-à-vis men (65.29%) said that they saw death and dying as a process which led to God proximity. On the Pearson's chi-square test, gender of the respondents had a significant association with their ideas on death and dying ($\chi^2(1) = 112.28, p = 0.03$).

3.2.2. Ideas on aging, death and dying of older adults residing in other old age institutions

Approximately 71.29% of the residents of other old age institutions said that they saw aging as a natural and inevitable life process. Around 28.71% of them said that aging was a state of mind. A higher proportion of those who were erstwhile employed (87.21%) vis-à-vis homemakers (56.72%) and a higher proportion of those ever single and widowed (88.92%) vis-à-vis currently married (66.78%), saw aging as a natural and inevitable life process. A higher proportion of the Hindu respondents in the control group (56.12%) vis-à-vis the Christians and the Zoroastrians (41.39%) said that they saw the aging process as a state of mind. On the Pearson's chi-square test, occupational history ($\chi^2(2) = 91.76, p = 0.00$), marital status ($\chi^2(2) = 117.56, p = 0.04$) and religion ($\chi^2(2) = 119.39, p = 0.03$) of the control group respondents had a significant association with their ideas on the aging process.

Approximately 69.12% of the residents of other old age institutions said that they saw death and dying as a biological inevitability. Around 30.88% of them said that death and dying was a process that led to God proximity. A higher proportion of Hindu respondents (21.52%) vis-à-vis Christian and Zoroastrian respondents (13.89%) saw death and dying as a process that led to God proximity. On the Pearson's chi-square test, religion ($\chi^2(2) = 87.19, p = 0.00$) control group respondents had a significant association with their ideas on death and dying.

3.3. Comparison of scores on various scales of Pitamaha Sadan residents and control group

3.3.1. Comparison of scores on the Daily Spiritual Experience Scale (DSES) of older adults residing in Pitamaha Sadans and control group

The average DSES scores for the *Pitamaha Sadan* residents was 81.29 (SD = 2.39). The effect of sex was significant, i.e. the average score was significantly higher for women ($M = 84.29, SD = 2.31$) than men ($M = 78.29, SD = 3.09$), $t(543) = 126.79, p = 0.021$. One-way analysis of variance showed that the

effect of marital status was also significant. Post hoc analysis using the Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for widowed residents of the *Pitamaha Sadans* ($M = 82.39$, $SD = 2.21$) than currently married and never married respondents combined ($M = 79.02$, $SD = 2.28$), $F(2, 543) = 112.92$, $p = 0.03$. The DSES scores of *Pitamaha Sadan* residents were further subjected to a two-way analysis of variance having two levels of gender (male, female) and two levels of marital status (widowed, currently married and ever single). All effects were significant at 0.05 significance level. The mean score was significantly higher for women than men. The main effect of marital status yielded an F -ratio of $F(2, 543) = 118.67$, $p = 0.029$, indicating that the average DSES score was significantly higher for widowed residents of the *Pitamaha Sadan* than for the currently married and ever single residents. Interaction effects were non-significant $F(1, 543) = 34.98$, $p = 0.093$.

The average DSES scores for the control group i.e. residents of other paid old age institutions was 57.29 ($SD = 2.36$). The effect of sex was significant, i.e. the average score was significantly higher for women ($M = 67.83$, $SD = 1.29$) than men ($M = 49.29$, $SD = 3.47$), $t(492) = 178.91$, $p = 0.02$. One-way analyses of variance showed that the effects of marital status and religion were also significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for widowed control group respondents ($M = 68.23$, $SD = 3.39$) than for currently married and ever single respondents ($M = 51.29$, $SD = 2.18$), $F(2, 492) = 76.29$, $p = 0.01$. Further, *post hoc* analysis using the Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for Hindu respondents in the control group ($M = 69.32$, $SD = 3.19$) than Christian and Zoroastrian respondents ($M = 43.21$, $SD = 2.19$), $F(2, 492) = 78.92$, $p = 0.04$. The DSES scores of the control group respondents were further subjected to a three-way analysis of variance having two levels of gender (male, female), two levels of marital status (widowed, currently married and ever single) and two levels of religion (Hindu, others). All effects were significant at 0.05 significance level. The mean score was significantly higher for women than men. The main effect of marital status yielded an F -ratio of $F(2, 492) = 78.29$, $p = 0.03$, indicating that the mean score was significantly higher for widowed respondents than for the currently married and ever single combined. The main effect of religion yielded an F -ratio of $F(2, 492) = 91.26$, $p = 0.01$, indicating that the mean DSES score was significantly higher for Hindu respondents from the control group than for older adults belonging to Christian and Zoroastrian religions. Interaction effects were non-significant $F(1, 543) = 78.54$, $p = 0.087$.

In general, the average DSES scores were significantly higher for *Pitamaha Sadan* residents than for the residents of other old age institutions. Results indicate a significant difference in the DSES scores of *Pitamaha Sadan* residents ($M = 81.29$, $SD = 2.39$) vis-à-vis the control group ($M = 57.29$, $SD = 2.36$), $t(1,035) = 154.76$, $p = 0.0032$. Hence *Pitamaha Sadan* residents had better DSES scores than those residing in other paid old age institutions of a secular nature. The *Pitamaha Sadan* residents' DSES scores were significantly affected by gender and marital status. DSES scores of older adults residing in other old age institutions were significantly affected by gender, marital status and religion (Table 2).

3.3.2. Comparison of scores on the Spiritual Experience Index-Revised (SEI-R) of older adults residing in *Pitamaha Sadans* and control group

The average SEI-R score of *Pitamaha Sadan* residents was 86.53 ($SD = 1.78$). The effect of sex was significant, i.e. the average score was significantly higher for women ($M = 92.87$, $SD = 1.96$) than men ($M = 81.52$, $SD = 2.99$), $t(543) = 112.76$, $p = 0.037$. One-way analysis of variance showed that the effect of marital status was also significant. Post hoc analysis using the Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for widowed residents of the *Pitamaha Sadans* ($M = 96.21$, $SD = 1.87$) than currently married and never married respondents combined ($M = 71.27$, $SD = 2.08$), $F(2, 543) = 98.73$, $p = 0.02$. The SEI-R scores of *Pitamaha Sadan* residents were further subjected to a two-way analysis of variance having two levels of gender (male, female) and two levels of marital status (widowed, currently married and ever single). All effects were significant at 0.05 significance level. The mean score was significantly higher for women than men.

Table 2. Comparison of scores on the DSES of Pitamaha Sadan residents and control group

	Pitamaha Sadan residents				Control group				t	P > t
	M	SD	95% confidence interval		M	SD	95% confidence interval			
DSES scores	81.29	2.39	78.1271	89.6652	57.29	2.36	48.1972	61.2612	154.76	0.0032

The main effect of marital status yielded an F -ratio of $F(2, 543) = 143.78, p = 0.03$, indicating that the average SEI-R score was significantly higher for widowed residents of the *Pitamaha Sadan* than for the currently married and ever single residents. Interaction effects were non-significant $F(1, 543) = 56.29, p = 0.085$.

The average SEI-R scores for the control group i.e. residents of other paid old age institutions was 43.29 (SD = 2.19). The effect of sex was significant, i.e. the average score was significantly higher for women ($M = 58.67, SD = 2.13$) than men ($M = 41.23, SD = 1.43$), $t(492) = 156.25, p = 0.03$. The effects of marital status and religion were also significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for widowed control group respondents ($M = 52.78, SD = 2.76$) than for currently married and ever single respondents ($M = 39.76, SD = 3.98$), $F(2, 492) = 97.23, p = 0.02$. Further, *post hoc* analysis using the Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for Hindu respondents in the control group ($M = 59.78, SD = 1.29$) than Christian and Zoroastrian respondents ($M = 33.21, SD = 1.98$), $F(2, 492) = 109.72, p = 0.03$. The SEI-R scores of the control group respondents were further subjected to a three-way analysis of variance having two levels of gender (male, female), two levels of marital status (widowed, currently married and ever single) and two levels of religion (Hindu, others). All effects were significant at 0.05 significance level. The mean score was significantly higher for women than men. The main effect of marital status yielded an F -ratio of $F(2, 492) = 108.23, p = 0.02$, indicating that the mean score was significantly higher for widowed respondents than for the currently married and ever single combined. The main effect of religion yielded an F -ratio of $F(2, 492) = 102.69, p = 0.02$, indicating that the mean SEI-R score was significantly higher for Hindu respondents from the control group than for older adults belonging to Christian and Zoroastrian religions. Interaction effects were non-significant $F(1, 492) = 76.88, p = 0.09$.

In general, the average SEI-R scores were significantly higher for *Pitamaha Sadan* residents than for the residents of other old age institutions. Results indicate a significant difference in the SEI-R scores of *Pitamaha Sadan* residents ($M = 86.53, SD = 1.78$) vis-à-vis the control group ($M = 43.29, SD = 2.19$), $t(1,035) = 203.87, p = 0.00$. Hence *Pitamaha Sadan* residents had better SEI-R scores than those residing in other paid old age institutions of a secular nature. The *Pitamaha Sadan* residents' SEI-R scores were significantly affected by gender and marital status. SEI-R scores of older adults residing in other old age institutions were significantly affected by gender, marital status and religion (Table 3).

3.3.3. Comparison of scores on the Centrality of Religiosity Index (CRI) of older adults residing in Pitamaha Sadans and control group

The average CRI scores of older adults residing in the *Pitamaha Sadans* was 48.92 (SD = 2.38). A one-way analysis of variance showed that the effect of marital status was significant. Post hoc analysis using the Scheffe *post hoc* criterion for significance showed that the average CRI scores were higher for widowed residents of the *Pitamaha Sadans* ($M = 51.29, SD = 1.38$) than for those who were currently married and ever single ($M = 43.29, SD = 1.67$), $F(1, 543) = 114.38, p = 0.02$. The average CRI scores of older adults residing in other old age institutions was 23.56 (SD = 3.29). The effect of sex was significant, i.e. the average CRI scores were significantly higher for women residents of other old age institutions ($M = 39.86, SD = 4.19$), than men ($M = 19.08, SD = 3.87$), $t(492) = 116.89, p = 0.03$.

Table 3. Comparison of scores on the SEI-R of Pitamaha Sadan residents and control group

	Pitamaha Sadan residents				Control group				t	P > t
	M	SD	95% confidence interval		M	SD	95% confidence interval			
SEI-R scores	86.53	1.78	78.1251	92.1162	43.29	2.19	41.8176	56.1127	203.87	0.00

Table 4. Comparison of scores on the CRI of Pitamaha Sadan residents and control group

	Pitamaha Sadan residents				Control group				t	P > t
	M	SD	95% confidence interval		M	SD	95% confidence interval			
CRI scores	48.92	2.38	41.2716	54.3339	23.56	3.29	21.7762	28.9121	196.32	0.00

In general the average CRI scores were significantly higher for older adults residing in the *Pitamaha Sadans* ($M = 48.92$, $SD = 2.38$) than for those in other old age institutions ($M = 23.56$, $SD = 3.29$), $t(1035) = 196.32$, $p = 0.00$. The CRI scores of *Pitamaha Sadan* residents were significantly affected by their marital status. The scores of older adults residing in other old age institutions were significantly affected by their gender (Table 4).

3.3.4. Comparison of scores on the Satisfaction with Life scale (SWL) of older adults residing in Pitamaha Sadans and control group

The average SWL scale score for *Pitamaha Sadan* residents was 27.43 ($SD = 3.21$). A one-way analysis of variance showed that the effect of education was significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average SWL scale score was significantly higher for those having graduate and above level education ($M = 31.49$, $SD = 1.39$) than those with lower education ($M = 26.31$, $SD = 2.19$), $F(2, 543) = 45.78$, $p = 0.003$. The effects of DSES and SEI-R scores were also significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average SWL scale scores were significantly higher for those with high DSES scores ($M = 29.34$, $SD = 1.76$) than for those with lower DSES scores ($M = 26.14$, $SD = 1.98$), $F(3, 543) = 97.63$, $p = 0.004$. Similarly *post hoc* analysis using Scheffe *post hoc* criterion for significance indicated that the average SWL scores were significantly higher for *Pitamaha Sadan* residents with high SEI-R scores ($M = 31.67$, $SD = 2.16$) than for those with low SEI-R scores ($M = 28.16$, $SD = 1.79$), $F(3, 543) = 107.82$, $p = 0.003$. SWL scores for *Pitamaha Sadan* residents were further subjected to a three-way analysis of variance having two levels of education (bachelor’s degree and above, below bachelor’s degree), DSES scores (high, low) and SEI-R scores (high, low). All effects were statistically significant at 0.05 level. Interaction effects were non-significant $F(1, 543) = 189.64$, $p = 0.286$.

The average SWL scale score for the control group was 25.32 ($SD = 2.46$). A one-way analysis of variance showed that the effect of education was significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for those with higher education ($M = 29.38$, $SD = 2.19$) than for those with lower education ($M = 26.17$, $SD = 2.09$), $F(2, 492) = 89.63$, $p = 0.003$. The effect of occupation history was also significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for the control group respondents who were salaried or self-employed earlier ($M = 31.28$, $SD = 4.39$) than for those who were homemakers ($M = 26.89$, $SD = 3.86$), $F(2, 492) = 97.21$, $p = 0.003$. SWL scale scores of the control group, were further subjected to a two-way analysis of variance having two levels of education (bachelor’s degree and above, below graduate) and occupational history (salaried and self employed, homemakers). All effects were statistically significant at 0.05 significance level. The interaction effects were non-significant $F(1, 492) = 187.34$, $p = 0.763$.

Table 5. Comparison of scores on the SWL scale of Pitamaha Sadan residents and control group

	Pitamaha Sadan residents				Control group				t	P > t
	M	SD	95% confidence interval		M	SD	95% confidence interval			
SWL scale scores	27.43	3.21	23.1526	30.1167	25.32	2.46	21.3627	29.0876	78.16	0.0037

The average SWL score was significantly higher for *Pitamaha Sadan* residents than for the control group respondents. Results indicated a significant difference in the SWL scale scores of *Pitamaha Sadan* residents ($M = 27.43, SD = 3.21$) vis-à-vis the control group ($M = 25.32, SD = 2.46$), $t(1,035) = 78.16$, $p = 0.0037$. Hence *Pitamaha Sadan* residents were more satisfied with their lives as per SWL scores than the control group. *Pitamaha Sadan* residents' SWL scores were significantly influenced by their education, DSES and SEI-R scores. SWL scores of the residents of other secular paid old age institutions were significantly influenced by their education and occupational history (Table 5).

3.3.5. Comparison of scores on the Oxford Happiness Questionnaire (OHQ) of older adults residing in Pitamaha Sadans and control group

The average OHQ scores for *Pitamaha Sadan* residents was 111.14 ($SD = 4.87$). A one-way analysis of variance showed that the effect of DSES scores was significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average OHQ score was significantly higher for *Pitamaha Sadan* residents ($M = 129.35, SD = 4.78$) than for the control group ($97.49, SD = 5.03$), $F(3, 543) = 98.32$, $p = 0.00$. The effects of SEI-R scores were also significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average OHQ scores were significantly higher for those with higher SEI-R scores ($M = 119.21, SD = 3.89$) than for those with lower scores ($M = 104.56, SD = 3.98$), $F(3, 543) = 90.32$, $p = 0.00$. OHQ scores of *Pitamaha Sadan* residents were further subject to a two-way analysis of variance with two levels DSES scores (high, low) and SEI-R scores (high, low). All effects were statistically significant at 0.05 significance level. Interaction effects were non-significant $F(1, 543) = 312.63$, $p = 0.785$.

The average OHQ score of control group respondents was 109.16 ($SD = 5.68$). A one-way analysis of variance showed that the effect of education was significant. Post hoc analysis using Scheffe *post hoc* criterion for significance indicated that the average score was significantly higher for those with higher education i.e. bachelor's degree and above ($M = 112.13, SD = 4.39$) than for those with less than bachelor's degree ($M = 108.19, SD = 5.12$), $F(2, 492) = 69.13$, $p = 0.002$.

Thus the average OHQ scores were significantly higher for *Pitamaha Sadan* residents than for the control group. Results indicate a significant difference in the OHQ scores of the control group ($M = 109.16, SD = 5.68$) vis-à-vis *Pitamaha Sadan* residents ($M = 111.14, SD = 4.87$), $t(1,035) = 67.14$, $p = 0.002$. Hence *Pitamaha Sadan* residents had higher OHQ scores and a higher propensity to be happy than the control group. Their OHQ scores were influenced by their DSES scores and SEI-R scores. The OHQ scores of the control group respondents were significantly influenced by their education (Table 6).

3.4. Logistic regression analysis

Two log regression models have been developed. The first model (Table 7) determines predictors of SWL scale scores of residents of *Pitamaha Sadans* (high = 1, low = 0). Nominal/categorical variables were suitably recoded into binary/dummy variables for the analysis. A test of full model against a constant only model was statistically significant indicating that the predictors as a set reliably distinguished between those *Pitamaha Sadan* residents who had high scores vis-à-vis those who had low scores [$LR \chi^2(7) = 178.87$, Prob. $> \chi^2 = 0.0001$]. Prediction success was 45.23% (pseudo $R^2 = 0.4523$). To look at the effect size of the said predictors, the odds ratio of the predictors education, DSES scores and SEI-R scores are greater than one. This means that those *Pitamaha Sadan* residents with

Table 6. Comparison of scores on the OHQ of Pitamaha Sadan residents and control group

	Pitamaha Sadan residents				Control group				t	P > t
	M	SD	95% confidence interval		M	SD	95% confidence interval			
OHQ scores	111.14	4.87	98.1218	117.8912	109.16	5.68	97.1652	116.2615	67.14	0.002

Table 7. Logistic regression—predictors of satisfaction with life scale (SWL) scores of Pitamaha Sadan residents (high = 1, low = 0)

SWL scores (high = 1, low = 0)	Odds ratio	Std. error	z	P > z	95% confidence interval	
Constant	3.21	0.9812	2.13	0.03	2.1378	5.6787
Age	0.92	0.4534	1.28	0.67	0.6821	5.7782
Sex	0.95	0.8752	1.87	0.08	0.1872	4.5672
Education	1.12	0.6753	2.03	0.02	0.8872	8.7925
Occupation history	0.88	0.6653	3.15	0.09	0.1357	2.8996
Marital status	0.92	0.7629	2.87	0.12	0.7635	3.1287
DSES scores	1.12	0.7627	2.89	0.02	-1.1376	3.1287
SEI-R scores	1.19	0.6523	3.18	0.04	0.1137	3.9872
CRI scores	0.89	0.8752	3.98	0.78	-1.3782	1.9783

higher education i.e. bachelor’s degree and above, those with higher DSES scores and those with higher SEI-R scores were more likely to have higher life satisfaction as per SWL scores.

The second model (Table 8) determines predictors of OHQ scores of *Pitamaha Sadan* residents (high = 1, low = 0). Nominal/categorical variables were suitably recoded into binary/dummy variables for the analysis. A test of full model against a constant only model was statistically significant indicating that the predictors as a set reliably distinguished between those *Pitamaha Sadan* residents who had high OHQ scores vis-à-vis those who had low scores [$LR\chi^2(7) = 156.37$, Prob. $> \chi^2 = 0.0001$]. Prediction success was 51.34% (pseudo $R^2 = 0.5134$). To look at the effect size of the said predictors, the odds ratio of the predictors DSES scores and SEI-R scores are greater than one. This means that those *Pitamaha Sadan* residents with higher DSES scores and those with higher SEI-R scores were more likely to have higher levels of happiness as per the OHQ scores.

4. Discussion and conclusion

The findings in general have shown that the older adults residing in *Pitamaha Sadans* scored better on religiosity and spirituality scales and were more satisfied with their lives and were more happy vis-à-vis the control group respondents. Their life satisfaction and happiness was in turn influenced by their scores on the DSES, SEI-R and CRI.

The profile of the *Pitamaha Sadan* and control group respondents in general showed that a large number of them were widowed, corroborating thereby the empirical literature on institutionalized elderly in India which poses that more widowed elderly tend to live in institutions (e.g. See Kalavar, Jamuna, & Ejaz, 2013; Sreerupa & Rajan, 2010). As both types of institutions were paid, both groups of respondents were class comfortable. Predictably, a large part of the daily routine of *Pitamaha Sadan* residents comprised religious and spiritual activities. Majority of the control group respondents said that they did nothing specific during their leisure time.

In line with the last two stages of the four stage model of Hindu thought on life (Ramamurti & Jamuna, 2010), *Pitamaha Sadan* residents proposed that aging was a state of mind, contingent on

Table 8. Logistic regression—predictors of oxford happiness questionnaire (OHQ) scores of Pitamaha Sadan residents (high = 1, low = 0)

OHQ scores (high = 1, low = 0)	Odds ratio	Std. error	z	P > z	95% confidence interval	
Constant	2.98	0.9721	3.34	0.03	2.1379	4.5672
Age	0.92	0.8723	2.18	0.09	0.3892	3.4519
Sex	0.95	0.4372	2.89	0.18	0.7862	4.5628
Education	0.93	0.3289	3.19	0.13	0.1138	8.9056
Occupation history	0.88	0.2367	2.89	0.23	0.1452	6.7802
Marital status	0.91	0.3572	1.38	0.24	-1.1378	4.1156
DSES scores	1.18	0.4178	1.98	0.03	0.3829	3.9896
SEI-R scores	1.09	0.3287	1.29	0.02	-2.1376	3.1198
CRI scores	0.95	0.6723	2.13	0.17	-1.2867	3.4892

one’s thought processes and thinking; and, death and dying were processes that led to God proximity, thereby implying a gerotranscendence of sorts. Education and gender however significantly influenced these views, with more women demonstrating the transcendental inclinations. This corroborates feminist theological understandings and feminist studies in religion, which imply greater propensity of women to get clued into spiritual quests (e.g. See Keller, 2008; King, 2009).

Pitamaha Sadan residents scored better on the DSES, SEI-R and CRI than the control group. Their DSES and SEI-R scores were affected by gender and marital status. More women and those widowed had spiritual experiences, and more so, on a daily basis. The analysis of CRI scores also revealed that more widowed residents of the *Pitamaha Sadans* were more religious. From the control group too Hindus, women and widowed respondents scored better on religiosity and spirituality scales. *Pitamaha Sadan* residents also scored better on life satisfaction and happiness scales, both of which were influenced by their DSES and SEI-R scores.

Hence in general the findings promote religiosity and spirituality as protective and wellness promoting variables for older adults. Life satisfaction and happiness were contingent on levels of religiosity-spirituality of *Pitamaha Sadan* residents who also showed a propensity towards transcendence as reflected in their views on aging and dying. In contrast, control group respondents fared less well on all parameters and variations were due to religion, gender, marital status education and occupational history. Even among the control group respondents, Hindus, women, those who were widowed, were better qualified and having a history of employment (paid and self employed) had better scores.

For the field of social gerontology, findings provide an impetus to developing religious and spiritual programs for older adults. Further, in terms of praxis, this implies working in and with faith-based and spiritual organizations having programs for the elderly so as to build into an understanding of spiritual aging and gerotranscendence as the way forward.

Funding

The authors received no direct funding for this research.

Author details

Samta P. Pandya¹
 E-mail: pandya.samta@gmail.com
¹ School of Social Work, Tata Institute of Social Sciences, Mumbai, India.

Citation information

Cite this article as: Aging spiritually: Pitamaha Sadans in India, Samta P. Pandya, *Cogent Social Sciences* (2016), 2: 1219212.

Notes

1. Gerotranscendence is Lars Tornstam understanding of aging as a process involving a development in which individuals gradually change their basic conceptions, from a materialistic and rational view of the world to a more cosmic and transcendental one, normally accompanied by an increase in life satisfaction.
2. Existing studies in the Indian context have linked spirituality and aging in a manner where they propose that spiritually inclined aging persons become more selective in their choices of social and other activities. There is an increased feeling of affinity with past generations and a decreased interest in superfluous social interaction.

- Experiences of decreased interest in material things and a greater need for solitary “meditation” are also specified. Positive solitude becomes more important. There is also often a feeling of cosmic communion with the spirit of the universe, and a redefinition of time, space, life and death (Czerenda, 2006, 2010; Gupta, 2011; Lamb, 2000; Menon, 2012, 2013; Ramamurti & Jamuna, 2010; Reddy & Hanna, 1998).
3. Swami Chinmayananda was born on 8th May 1916 as Balakrishnan Menon in Ernakulam, Kerala. At the age of 13, he began studying at the Maharaja college in Ernakulam. In 1940 Balakrishnan joined the Lucknow University for an MA in English Literature and a secondary course in Law. During this time he participated in the Quit India Movement following which an arrest warrant was issued against him. Hence he spent one year in Kashmir out of the range of British officials. However he was arrested in Punjab during this movement and spent time in the Delhi prison in difficult conditions. Later he went to Baroda where writing articles for newspapers under the pen name Mochi wherein he highlighted the importance of socialism. In 1947, with an idea of writing an article on Swamis and Sadhus of the Himalayas he arrived to Rishikesh and visited the Divine Life Society of Swami Sivananda. This was the beginning of his spiritual leanings. Thereafter he undertook pilgrimage in the Himalayas and visited several ashrams including that of Tapovan Maharaj. On 25th February 1949 he was initiated into ascetism by Sivananda Swami and given the new name Swami Chinmayananda. During this time, Swami Chinmayananda also sought lessons from Tapovan Maharaj of the popular Divine Life Society. Later in 1951 he began his mission of spreading teachings of Vedanta, the first one of which was held in Pune. From the year 1952 he set out as a full-fledged wandering mendicant—the object being that of “harnessing the spiritual wealth and introducing Hinduism to Hindus”. The ashram buildings and venues, Vedanta course creation, social service activities development and developing a cadre of personnel qualified to propagate the Sankara Bhasya of Vedanta as a tool for change led to centers in Indian and abroad. On 3rd August 1993, he attained Mahasamadhi (passing away) in San Diego, US.
4. The current spiritual head Swami Tejomayananda was born to a Maharashtrian family on 30th June 1950 in Madhya Pradesh, India as Sudhakar Kaitwade. While doing his masters in physics, he met Swami Chinmayananda during the course of his public lectures in 1970 and subsequently joined the Chinmaya Mission Vedanta course in Mumbai. In 1975, he completed the course and was posted to the Chinmaya Mission centers in Bhopal. Kanpur and Sidhbari. He was the first acharya (teacher) at the Sidhbari’s Sandeepany Ashram and in charge of the Vedanta course in Hindi there. On 21st October 1983 he was initiated into sannyas (ascetism) and was re-christened Swami Tejomayananda. In 1989, he was sent to San Jose (US) and became an acharya of Chinmaya Mission West. After the passing away of Swami Chinmayananda in 1993, he became the head of the Mission. Several projects have been executed under his direction including the Chinmaya International Residential School, Coimbatore; Chinmaya Centre of World Understanding, New Delhi; Chinmaya Heritage Centre, Chennai; and, Chinmaya Mission Hospital, Bangalore.
- References**
- Ardelt, M., & Koenig, C. S. (2006). The role of religion for hospice patients and relatively healthy older adults. *Research on Aging*, 28, 184–215. <http://dx.doi.org/10.1177/0164027505284165>
- Baumsteiger, R., Chenneville, T., & McGuire, J. (2013). The roles of religiosity and spirituality in moral reasoning. *Ethics & Behavior*, 23, 266–277.
- Benjamins, M. R. (2005). Social determinants of preventive service utilization: How religion influences the use of cholesterol screening in older adults. *Research on Aging*, 27, 475–497. <http://dx.doi.org/10.1177/0164027505276048>
- Bhatnagar, C. P. (2008). Death as divine wedding: The Sant Mat perspective. In S. C. Chatterjee, P. Patnaik, & V. Charian (Eds.), *Discourses on aging and dying* (pp. 149–167). Delhi: Sage.
- Biswas, A. (2008). A Buddhist way to overcome Jara-Maranam. In S. C. Chatterjee, P. Patnaik, & V. Charian (Eds.), *Discourses on aging and dying* (pp. 134–146). Delhi: Sage. <http://dx.doi.org/10.4135/9788132111894>
- Black, H., & Hannum, S. (2015). Aging, spirituality and time: A qualitative study. *Journal of Religion, Spirituality & Aging*, 27, 145–165.
- Bradshaw, M., Ellison, C. G., & Flannelly, K. J. (2008). Prayer, God imagery, and symptoms of psychopathology. *Journal for the Scientific Study of Religion*, 47, 644–659. <http://dx.doi.org/10.1111/jssr.2008.47.issue-4>
- Chattopadhyay, M. (2008). Death and dying: A Buddhist analysis. In S. C. Chatterjee, P. Patnaik, & V. Charian (Eds.), *Discourses on aging and dying* (pp. 115–133). Delhi: Sage. <http://dx.doi.org/10.4135/9788132111894>
- Copeman, J., & Ikegame, A. (2012). Guru logics. *HAU: Journal of Ethnographic Theory*, 2, 289–336. <http://dx.doi.org/10.14318/hau2.1>
- Czerenda, A. J. (2006). *A caring inquiry into the meaning of widowhood and health for older Indian widows* (Doctoral dissertation, UMI No. 1176546131). Retrieved from Proquest Dissertations and Theses database.
- Czerenda, A. J. (2010). The meaning of widowhood and health to older middle-class Hindu widows living in a south Indian community. *Journal of Transcultural Nursing*, 21, 351–360. <http://dx.doi.org/10.1177/1043659609360715>
- Daaleman, T. P., Pereira, S., & Studenski, S. A. (2004). Religion, spirituality, and health status in geriatric outpatients. *The Annals of Family Medicine*, 2, 49–53. <http://dx.doi.org/10.1370/afm.20>
- Diener, E., Emmons, R., Larsen, Randy J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49, 71–75. http://dx.doi.org/10.1207/s15327752jpa4901_13
- Eggers, S. J. (2003). Older adult spirituality: What is it? A factor analysis of three related instruments. *Journal of Religious Gerontology*, 14, 3–33. http://dx.doi.org/10.1300/J078v14n04_02
- Ellor, J. W., & Nakasone, R. Y. (2012). Religion and old age: Christianity and East Asian Buddhist reflections. In P. McNamara & W. J. Windman (Eds.), *Science and the world religions: Enriching understanding by merging scientific and spiritual insights. Volume 2: Persons and groups* (pp. 185–202). Haverhill, MA: Praeger Press.
- Emir, R. (2011). *At every breath, A teaching*. Mumbai: Central Chinmaya Mission Trust.
- Flannelly, K. J., Weaver, A. J., & Costa, K. G. (2004). A systematic review of religion and spirituality in three palliative care journals, 1990–1999. *Journal of Palliative Care*, 20, 50–56.
- Genia, V. (1997). The spiritual experience index: Revision and reformulation. *Review of Religious Research*, 38, 344–361. <http://dx.doi.org/10.2307/3512195>
- Gupta, R. (2011). Death beliefs and practices from an Asian Indian American Hindu perspective. *Death Studies*, 35, 244–266. <http://dx.doi.org/10.1080/07481187.2010.518420>
- Harvey, I. S., & Cook, L. (2010). Exploring the role of spirituality in self-management practices among older African-American and non-Hispanic White women with chronic conditions. *Chronic Illness*, 6, 111–124. <http://dx.doi.org/10.1177/1742395309350228>

- Hills, P., & Argyle, M. (2002). The Oxford happiness questionnaire: A compact scale for the measurement of psychological well-being. *Personality and Individual Differences*, 33, 1073–1082.
[http://dx.doi.org/10.1016/S0191-8869\(01\)00213-6](http://dx.doi.org/10.1016/S0191-8869(01)00213-6)
- Huber, S., & Huber, O. (2012). The centrality of religiosity scale. *Religions*, 3, 710–724.
- Jain, M., & Sharma, A. (2004a). Quality of life of religious older people: Effect of productive engagement in activities and gender. *Indian Journal of Gerontology*, 18, 103–114.
- Jain, M., & Sharma, A. (2004b). Significance of productive engagement in work on perceived death anxiety: A study of religious elderly. *Help Age India, R & D Journal*, 10, 22–37.
- Jeste, D. V., Depp, C. A., & Vahia, I. V. (2010). Successful cognitive and emotional aging. *World Psychiatry*, 9, 78–84.
<http://dx.doi.org/10.1002/wps.2010.9.issue-2>
- Kalavar, J. M., Jamuna, D., & Ejaz, F. (2013). Elder abuse in India: Extrapolating from the experiences of seniors in India's "pay and stay" homes. *Journal of Elder Abuse and Neglect*, 25, 3–18.
<http://dx.doi.org/10.1080/08946566.2012.661686>
- Kalavar, J., Buzinde, C., Manuel-Navarrete, C., & Kohli, N. (2015). Gerotranscendence and life satisfaction: Examining age differences at the Maha Kumbha Mela. *Journal of Religion, Spirituality & Aging*, 27, 2–15.
- Keller, C. (2008). The apophysis of gender: A fourfold unlaying of feminist theology. *Journal of the American Academy of Religion*, 76, 905–933.
<http://dx.doi.org/10.1093/jaarel/lfm090>
- King, U. (2009). Religion and gender: Embedded patterns, interwoven frameworks. In U. King (Ed.), *Religion and gender* (pp. 70–86). Oxford: Basil Blackwell.
- Krause, N. (2006). Gratitude toward God, stress, and health in late life. *Research on Aging*, 28, 163–183.
<http://dx.doi.org/10.1177/0164027505284048>
- Lamb, S. (2000). *White saris and sweet mangoes*. Berkeley, CA: University of California Press.
- Locklin, R., & Lauwers, J. (2009). Rewriting the sacred geography of advaita: Swami Chinmayananda and the Sankara-Dig-Vijaya. *The Journal of Hindu Studies*, 2, 179–208.
<http://dx.doi.org/10.1093/jhs/hip017>
- Lucia, A. J. (2014). "Give Me Sevā Overtime": Selfless service and humanitarianism in Mata Amritanandamayi's transnational Guru movement. *History of Religions*, 54, 188–207.
<http://dx.doi.org/10.1086/677812>
- Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist*, 55, 14–25.
<http://dx.doi.org/10.1093/geront/gnu044>
- McFadden, S. H., Kimble, M. A., Ellor, J. W., Seeber, J. E., & Rost, R. (2011). The center on aging, religion, and spirituality: Lessons learned. *Journal of Religion, Spirituality & Aging*, 23, 62–76.
- Mehta, K. (1997). The impact of religious beliefs and practices on aging: A cross-cultural comparison. *Journal of Aging Studies*, 11, 101–114.
[http://dx.doi.org/10.1016/S0890-4065\(97\)90015-3](http://dx.doi.org/10.1016/S0890-4065(97)90015-3)
- Menon, U. (2012). Withdrawal or second childhood: The challenge of old age in the temple town of Bhubaneswar. *Journal of Cross-Cultural Gerontology*, 27, 29–49.
<http://dx.doi.org/10.1007/s10823-012-9162-5>
- Menon, U. (2013). The Hindu concept of self-refinement: Implicit yet meaningful. *Psychology and Developing Societies*, 25, 195–222.
<http://dx.doi.org/10.1177/0971333613477320>
- Miller, A. J., & Worthington, E. (2011). Connection between personality and religion and spirituality. In J. D. Aten, K. A. O'Grady, & E. R. Worthington Jr. (Eds.), *The psychology of religion and spirituality for clinicians: Using research in your practice* (pp. 101–129). New York, NY: Routledge.
- Mullet, E., & Azar, F. (2009). Apologies, repentance, and forgiveness: A Muslim–Christian comparison. *International Journal for the Psychology of Religion*, 19, 275–285.
<http://dx.doi.org/10.1080/10508610903146274>
- Nakasone, R. (2013). Spiritual genealogy: Interfaith and multicultural reflections on spirituality and aging with an introduction to the articles. *Journal of Religion, Spirituality & Aging*, 25, 2–11.
- Newton, A., & McIntosh, D. N. (2010). Specific religious beliefs in a cognitive appraisal model of stress and coping. *International Journal for the Psychology of Religion*, 20, 39–58.
<http://dx.doi.org/10.1080/10508610903418129>
- Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.
- Patrick, J. H., & Henrie, J. A. (2015). Religious doubt and spiritual growth among adults bereaved of a grandparent. *Journal of Religion, Spirituality & Aging*, 27, 93–107.
- Peloso, J. M. (2008). Adult images of God: Implications for pastoral counselling. *Journal of Pastoral Counseling*, 43, 15–31.
- Ramamurti, P. V., & Jamuna, D. (2010). Geropsychology in India. In G. Misra (Ed.), *Psychology in India: Clinical and health psychology* (Vol. 3, pp. 185–252). Noida: Dorling Kindersley.
- Reddy, I., & Hanna, F. J. (1998). The lifestyle of the Hindu women: Conceptualizing female clients from Indian origin. *Journal of Individual Psychology*, 54, 384–398.
- Reinert, D. F. (2005). Spirituality, self-representations, and attachment to parents: A longitudinal study of roman catholic college seminarians. *Counseling and Values*, 49, 226–238. <http://dx.doi.org/10.1002/cvj.2005.49.issue-3>
- Singh, S. (2003). Issues of emotional integration, peace and happiness—The Vedantic view. *Indian Journal of Gerontology*, 17, 31–40.
- Sorajjakool, S., Aja, V., Chilson, B., Ramirez-Johnson, J., & Earll, A. (2008). Disconnection, depression, and spirituality: A study of the role of spirituality and meaning in the lives of individuals with severe depression. *Pastoral Psychology*, 56, 521–532.
<http://dx.doi.org/10.1007/s11089-008-0125-2>
- Sreerupa, & Rajan, S. I. (2010). Gender and widowhood: Disparity in health status and health care utilization among the aged in India. *Journal of Ethnic And Cultural Diversity in Social Work*, 19, 287–304.
<http://dx.doi.org/10.1080/15313204.2010.523650>
- Swinton, J. (2011). Who is the God we worship? theologies of disability: Challenges and new possibilities. *International Journal of Practical Theology*, 14, 273–307.
- Thapan, A. (2005). *The Penguin Swami Chinmayananda reader*. New Delhi: Penguin Books India Pvt.
- Tilak, S. (1989). *Religion and aging in the Indian tradition*. Delhi: Satguru Publications.
- Tøllefsen, I. (2014). *Transcendental meditation, the art of living foundation, and public relations: From psychedelic romanticism to science and schism*. London: Oxford University Press.
- Tornstam, L. (2005). *Gerotranscendence: A developmental theory of positive aging*. New York, NY: Springer Publishing Company.
- 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 / Archiv für Religionspsychologie*, 28, 181–218.
<http://dx.doi.org/10.1163/00846720677832562>

- Underwood, L. G. (2011). The daily spiritual experience scale: Overview and results. *Religions*, 2, 29–50. <http://dx.doi.org/10.3390/rel2010029>
- Ushashree, S. (1992a). *A study of sources of and reactions to frustrations among the elderly*. New Delhi: Project Report submitted to the ICSSR.
- Ushashree, S. (1992b). *A study of sources and reactions to frustrations among British elderly*. London: Project Report submitted to the Association of Commonwealth Universities.
- Ushashree, S., & Basha, S. A. (2003). Religiosity as a contributor to meaning in life. *Indian Journal of Gerontology*, 17, 85–98.
- Vahia, I., Depp, C., Palmer, B., Fellows, I., Golshan, S., Thompson, W., ... Jeste, D. (2011). Correlates of spirituality in older women. *Aging and Mental Health*, 15, 97–102. <http://dx.doi.org/10.1080/13607863.2010.501069>
- Warrier, M. (2003). Guru choice and spiritual seeking in contemporary India. *International Journal of Hindu Studies*, 7, 31–54. <http://dx.doi.org/10.1007/s11407-003-0002-7>
- Wink, P., & Dillon, M. (2008). Religiousness, spirituality, and psychosocial functioning in late adulthood: Findings from a longitudinal study. *Psychology of Religion and Spirituality*, 1, 102–115. <http://dx.doi.org/10.1037/1941-1022.S.1.102>
- Yorgason, J. B. (2015). Exploring daily religious/spiritual activities among older couples: Religious/spiritual influence moderating the effects of health symptoms on marital interactions. *Journal of Religion, Spirituality & Aging*, 27, 201–221.



© 2016 The Author(s). This open access article is distributed under a Creative Commons Attribution (CC-BY) 4.0 license.

You are free to:

Share — copy and redistribute the material in any medium or format
Adapt — remix, transform, and build upon the material for any purpose, even commercially.
The licensor cannot revoke these freedoms as long as you follow the license terms.

Under the following terms:

Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made.
You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.
No additional restrictions

You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.



Cogent Social Sciences (ISSN: 2331-1886) is published by Cogent OA, part of Taylor & Francis Group.

Publishing with Cogent OA ensures:

- Immediate, universal access to your article on publication
- High visibility and discoverability via the Cogent OA website as well as Taylor & Francis Online
- Download and citation statistics for your article
- Rapid online publication
- Input from, and dialog with, expert editors and editorial boards
- Retention of full copyright of your article
- Guaranteed legacy preservation of your article
- Discounts and waivers for authors in developing regions

Submit your manuscript to a Cogent OA journal at www.CogentOA.com

