

Religiosity, Social Support, Perceived Stress, and Quality of Life Among Elderly Residing in Old Age Homes in Northern-Central India: A Cross-Sectional Study

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ABSTRACT

Background: Mental health and overall wellbeing are essential components of healthy ageing. Older adults often experience social, emotional, and physical challenges that may increase perceived stress and negatively affect their quality of life. Religiosity and social support are known to provide emotional resilience and coping strength, yet their influence on mental health among elderly individuals, especially those residing in old age homes, remains underexplored in the Indian context. With changing family structures, increasing longevity, and rising dependence on institutional care, it becomes important to understand the factors that shape wellbeing in later life. This study investigates the relationship between religiosity, social support, perceived stress, and quality of life among elderly residents of old age homes from northern central India. **Aim:** To explore the relationship between religiosity, social support, perceived stress, and quality of life among elderly individuals living in old age homes. **Methodology:** A cross-sectional study was conducted among 150 elderly participants aged 60 years and above, selected through simple random sampling from old age homes. Data were collected using structured face-to-face interviews. Tools included demographic and sociocultural questionnaires, a self-rating religiosity scale, the Modified Social Support Scale (MSSS), the Perceived Stress Scale (PSS-14), and the WHO Quality of Life (WHOQOL) questionnaire. Participants with psychiatric disorders or major cognitive impairments were excluded. Descriptive and inferential statistics were applied to analyze associations between psychosocial factors and quality of life. **Results:** The mean age of participants was 75.79 ± 8.84 years; 62% were males and 38% females. Most were married (73.34%), and 38% were illiterate. Urban and rural backgrounds were almost equally represented. Religiosity levels showed 46% with low, 37.3% with moderate, and 16.7% with high religiosity. Quality of life analysis revealed that 40% had good, 44.67% average, and 6.67% very good QOL, while 8.66% reported poor or very poor QOL. Perceived stress levels showed that 56.6% had low stress, 38% moderate, and 5.4% high stress. A significant association was found between perceived stress and QOL ($Z = 12.387$, $p = 0.00001$), with low-stress individuals reporting better wellbeing. Social support also showed a strong positive relationship with QOL ($p = 0.00001$); good QOL was highest among those with high social support (22%) and lowest among those with low support (10%). Demographic characteristics showed minor variations but were less strongly associated with QOL. **Conclusion:** The study highlights that perceived stress and social support are key determinants of quality of life among the elderly living in old age homes. Higher stress levels were linked to poorer wellbeing, while stronger social support significantly improved quality of life outcomes. These findings emphasize the need for stress-reduction programs, strengthening community and family support systems, and integrating spiritual or religious engagement to promote healthier ageing.

Keywords: Elderly, Perceived Stress, Religiosity, Social Support, Quality of Life, Mental Health, Old Age Homes

INTRODUCTION

Mental health is a fundamental aspect of overall health and plays a vital role in shaping an individual's emotional, psychological, and social wellbeing ⁽¹⁾. It influences how people understand themselves, respond to situations, form relationships, and cope with stressful or unexpected life events ⁽¹⁻²⁾. When mental health declines, individuals may experience persistent negative thoughts, emotions, and beliefs that interfere with their ability to function and significantly reduce their overall quality of life ⁽³⁾. These challenges can gradually affect day-to-day activities, decision-making, and interactions with others, making mental health an important area of focus for healthcare systems worldwide.

Older adults are especially vulnerable to mental health problems because aging often brings biological, psychological, and social changes that may increase stress and reduce coping abilities ⁽⁴⁾. Studies indicate that one in every five older adults is likely to experience some form of mental illness during late life ⁽¹⁾. Depression, anxiety, and substance abuse are some of the most common mental health conditions found in this age group ⁽⁵⁻⁸⁾. Alongside these, older adults also frequently experience other mental health-related concerns such as sleep disturbances, apathy, agitation, and aggressive behaviors ⁽⁹⁾. These conditions can be highly disabling and, in severe cases, may lead to suicidal tendencies or actions ⁽¹⁰⁻¹²⁾. Moreover, mental disorders create a significant financial burden on families, healthcare services, and society as a whole ⁽¹²⁾. Recognizing these concerns, the World Health Organization (WHO) has identified mental health care for older adults as a global priority and encourages countries to improve support systems and access to care ⁽²⁻³⁾. However, despite growing awareness, research on mental health among older adults remains limited, as the topic is relatively new within medical and biological sciences ⁽¹³⁾. This lack of research restricts the development of effective, evidence-based treatments that can address the complex needs of aging populations.

Religious and spiritual (RS) beliefs extend beyond cultural traditions and represent a wide range of personal, community, and organizational practices that can shape an individual's worldview and behavior ⁽¹⁴⁾. Over recent years, many studies have found that involvement in RS activities is associated with better mental health outcomes, including lower levels of depression, reduced stress, improved coping ability, and overall emotional wellbeing ⁽¹⁵⁾. Nevertheless, there is still a need for a more focused and comprehensive pooled analysis that specifically examines older adults and incorporates a diverse range of RS practices ⁽¹⁶⁾. Such research is important because older adults tend to be more actively engaged in RS activities compared to younger populations ⁽¹⁷⁾, and many express the desire for

healthcare providers to acknowledge and understand their religious or spiritual beliefs during treatment ⁽¹⁸⁻¹⁹⁾.

Both religiosity and social support are essential elements of human wellbeing, playing a crucial role in strengthening physical, psychological, and social health. Globally, research has shown that religiosity can contribute to improved resilience, better stress management, and enhanced physical health outcomes such as lower blood pressure, reduced inflammation, and a reduced burden of chronic diseases. Social support, whether from family, friends, or the community, helps improve life satisfaction, promotes emotional stability, lowers the risk of depression, and fosters a sense of belonging an especially important factor for older adults who may face loneliness or social isolation.

In India, a major demographic shift is underway, with a rapid increase in the elderly population. As people age, they often face multiple challenges, including chronic illnesses, financial constraints, reduced mobility, loneliness, and psychological stress. In this context, understanding the factors that contribute to healthy and successful aging has become increasingly important. Despite the central role of religiosity and social support in Indian culture, research examining their influence on the health and wellbeing of older adults remains limited. Moreover, modernization, urbanization, and changing family structures such as the decline of joint family systems are reshaping traditional support networks. These societal changes may reduce the availability of emotional and practical support for the elderly, making it even more important to investigate how religiosity and social support affect their mental and overall health.

NEED OF THE STUDY

The rising number of elderly people, especially those living in old age homes, highlights the need to understand factors that affect their wellbeing. Older adults often face emotional, social, and physical challenges that increase their stress levels. However, limited research has examined how religiosity and social support influence perceived stress in this group. Since residents of old age homes commonly experience loneliness, reduced independence, and loss of social connections, studying these factors is important. This study aims to fill this gap by exploring the relationship between religiosity, social support, and health among elderly Indians, and by comparing the quality of life of those with strong support and religious values to those with less support. The findings may help guide culturally relevant strategies to improve the wellbeing of this vulnerable population.

AIM AND OBJECTIVES

AIM: To explore the relationship between religiosity, social support, and perceived stress and quality of life

among the elderly residing at old age homes in the Indian population.

OBJECTIVES:

- To assess the level of religiosity among the elderly in diverse Indian cultural and religious contexts
- To determine the impact of religiosity and social support on perceived stress and quality of life of elderly individuals

METHODOLOGY

Study Design: Cross-sectional study.
Study Setting: Will be conducted in elderly population living in old age homes of northern central Indian region.
Study Population: Elderly individuals aged 60 years and above from different religious and socioeconomic backgrounds.
Sample Size: Approximately 150 participants selected using simple random sampling to ensure representation across demographics.
Data Collection: Structured face-to-face interviews. Assistance from caregivers or family members where needed.

Inclusion Criteria

- Population age more than 60 years residing at old age homes.
- Those who were able to give informed written consent.

Exclusion Criteria

- Population having any psychiatric comorbidity including dementia or alzhiemers or any other organic psychiatric or chronic debilitating medical condition.

Tools

- **Demographic and Sociocultural Variables:** Age, gender, marital status, education, and Residency.
- **Self-Rating Scale of Religiosity:** Single-item scale with scores ranging from 0 (not religious) to 10 (very religious). Measures the participant's perceived level of religiosity.
- **Modified Social Support Scale (Zimet et al., 1988):** 12-item scale assessing emotional and instrumental support. Six-point Likert scale (1 = strongly disagree to 6 = strongly agree).
- **Perceived stress scale:** 14 item self-reported stress scale
- **WHO 5 well-being Index (WHO-5).**
- **WHO: Quality of life questionnaires**

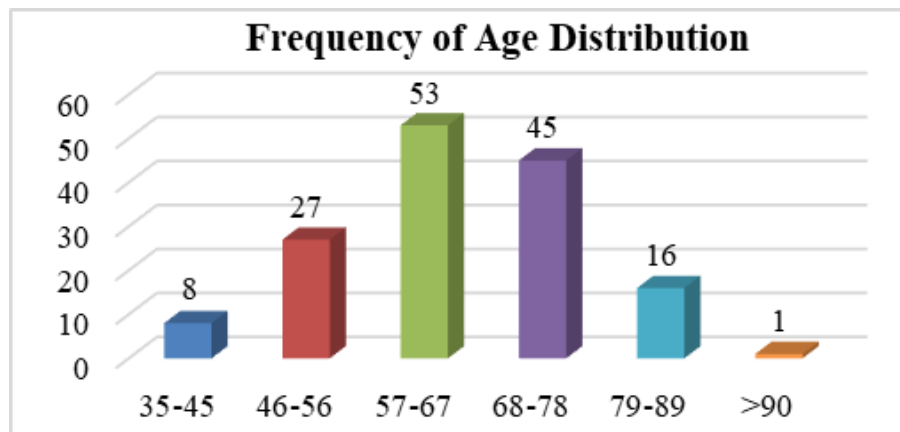
RESULT

A total of 150 elderly participants were included in the study. Most participants were in the 60–70 years age group (34.67%), followed by 71–81 years (33.33%) and 82–92 years (32%), with a mean age of 75.79 ± 8.84 years. The sample consisted of 62% males and 38% females. Majority were married (73.34%), and 38% were illiterate. Urban (50.67%) and rural (49.33%) residents were almost equally represented. Regarding religiosity, 46% had low, 37.3% moderate, and 16.7% high religiosity scores. [Tables 1]

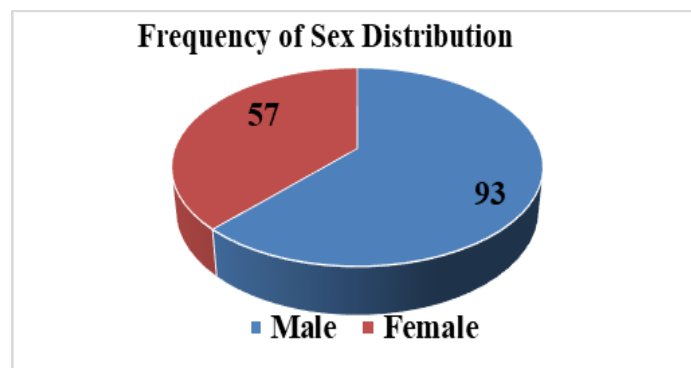
Table 1: Sociodemographic Characteristics of the Study Participants (Variables included: Age Distribution, Sex Distribution, Marital Status, Educational Status, Domicile, and Religiosity Scale)

Variable	Category	No.	%
Age (years)	60–70	52	34.67%
	71–81	50	33.33%
	82–92	48	32%
	Mean±S.D.	75.79±8.84	
Sex	Male	93	62%
	Female	57	38%
Marital Status	Married	110	73.34%
	Unmarried	9	6%
	Widow	17	11.33%
	Divorced/Separated	14	9.33%
Domicile	Urban	76	50.67%
	Rural	74	49.33%

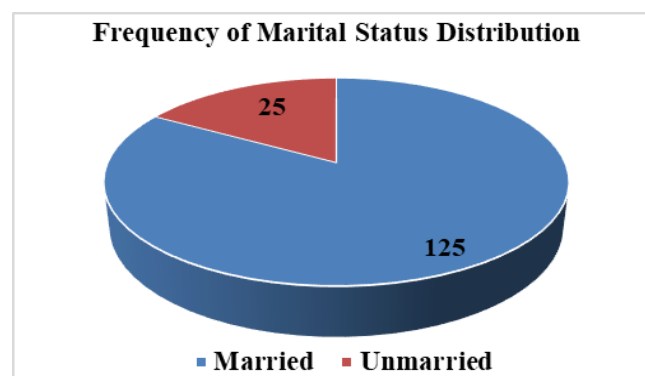
Education	Illiterate	57	38%
	Primary	20	13.33%
	Middle	18	12%
	High	27	18%
	Intermediate	14	9.33%
	Graduate	10	6.67%
	Post Graduate	4	2.67%
Religiosity Scale	Low religiosity (15–30)	69	46%
	Moderate religiosity (31–50)	56	37.3%
	High religiosity (51–75)	25	16.7%



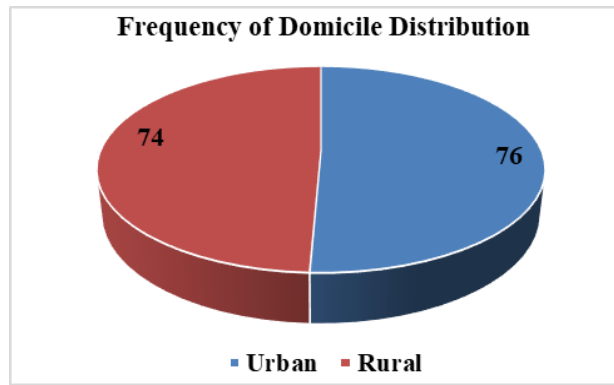
Graph 1: Frequency of Age Distribution



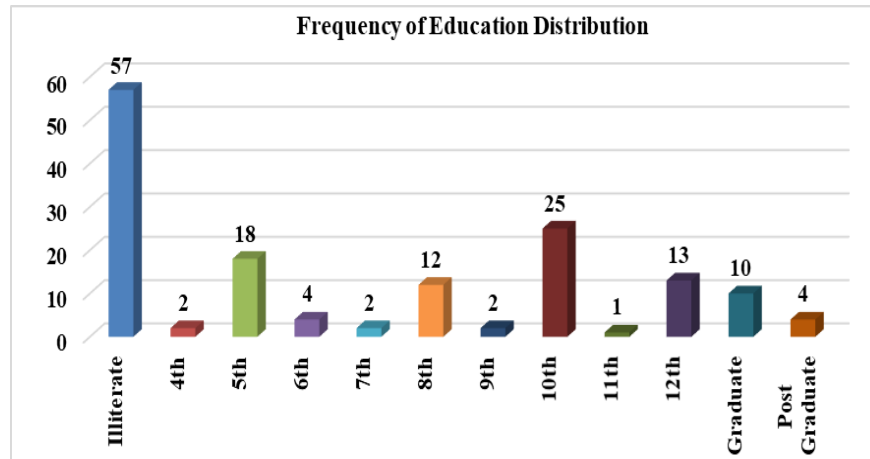
Graph 2: Frequency of Sex Distribution



Graph 3: Frequency of Marital Status Distribution



Graph 4: Frequency of Domicile Distribution



Graph 5: Frequency of Education Distribution

The mean domain-wise Quality of Life (QOL) scores showed no significant gender differences across physical, psychological, social, and environmental domains ($p > 0.05$). Overall QOL assessment revealed that 40% had good, 44.67% average, and 6.67% very good QOL, whereas 8.66% had poor or very poor QOL. QOL distribution varied slightly with age, sex, marital status, education, and domicile, but no strong demographic trends were observed. [Table 2-4]

Table 2: Domain-Wise Mean Quality of Life Scores Among Study Participants (N = 150)

QUALITY OF LIFE DOMAINS	MALE (n=93) Mean $\pm$ SD	FEMALE (n=57) Mean $\pm$ SD	TOTAL (n=150) Mean $\pm$ SD	Z-SCORE	P VALUE
Physical domain	54.72 $\pm$ 10.88	55.91 $\pm$ 11.34	55.17 $\pm$ 11.06	-0.52	0.603
Psychological domain	58.84 $\pm$ 10.41	57.32 $\pm$ 10.86	58.23 $\pm$ 10.58	0.78	0.437
Social relationship domain	64.11 $\pm$ 12.52	62.08 $\pm$ 13.44	63.33 $\pm$ 12.91	0.89	0.375
Environmental domain	65.02 $\pm$ 11.13	63.41 $\pm$ 11.52	64.36 $\pm$ 11.28	0.78	0.434

Table 3: Pattern of Quality of Life Among Study Participants (N = 150)

QUALITY OF LIFE GRADES (SCORES)	MALE (n=93) N & %	FEMALE (n=57) N & %	TOTAL (n=150) N & %
Very Good (80-100)	5 (5.38%)	5 (8.77%)	10 (6.67%)
Good (60-80)	35 (37.63%)	25 (43.86%)	60 (40.00%)
Average (Neither poor nor good) (40-60)	45 (48.38%)	22 (5.26%)	67 (44.67%)
Poor (20-40)	5 (5.38%)	3 (5.26%)	8 (5.33%)
Very Poor (0-20)	3 (3.23%)	2 (3.51%)	5 (3.33%)

Table 4: Quality of Life with Respect to Demographic Variables Among Study Participants (N = 150)

Variables	Very Poor	Poor	Average	Good	Very Good	Total (N)
Age (years)						
60–70 (n = 52)	2	3	25	18	4	52
71–81 (n = 50)	1	2	22	20	5	50
82–92 (n = 48)	3	4	20	17	4	48
Total	6	9	67	55	13	150
Sex						
Male (n = 93)	3	5	45	35	5	93
Female (n = 57)	2	3	22	25	5	57
Total	5	8	67	60	10	150
Marital Status						
Married (n = 110)	4	6	55	38	7	110
Unmarried (n = 9)	0	1	4	3	1	9
Widow (n = 17)	1	2	8	5	1	17
Divorced/Separated (n = 14)	1	1	6	5	1	14
Total	6	10	73	51	10	150
Education						
Illiterate (n = 57)	3	4	25	20	5	57
Primary (n = 20)	1	1	9	7	2	20
Middle (n = 18)	1	1	8	6	2	18
High School (n = 27)	1	2	12	10	2	27
Intermediate (n = 14)	1	1	6	5	1	14
Graduate (n = 10)	0	1	4	4	1	10
Post-Graduate (n = 4)	0	0	1	2	1	4
Total	7	10	65	54	14	150
Domicile						
Urban (n = 76)	3	4	35	28	6	76
Rural (n = 74)	2	4	30	32	6	74
Total	5	8	65	60	12	150

Perceived stress assessment showed that 56.6% had low stress, 38% moderate, and 5.4% high stress. A significant association was noted between perceived stress and QOL ($Z = 12.387$, $p = 0.00001$), where low-stress individuals had better QOL (46.67%), whereas high-stress individuals showed poorer QOL (4.00%). [Table 5 and 6]

Table 5: Distribution of Study Participants According to Severity of Perceived Stress

Category of Perceived Stress	PSS-10 Score Range	Number and Percentage of Elderly
Low Stress	0–13	85 (56.6%)
Moderate Stress	14–26	57 (38%)
High Perceived Stress	27–40	8 (5.4%)

Table 6: Quality of Life with Respect to Perceived Stress Among Study Participants

Perceived Stress	Good Quality of life		Poor Quality of life		Total	
	No.	%	No.	%	No.	%
Low Perceived Stress	70	46.67%	15	10.00%	85	56.67%
Moderate Perceived Stress	31	20.67%	26	17.33%	57	38.00%
High Perceived Stress	2	1.33%	6	4.00%	8	5.33%
Total	103	68.67%	47	31.33%	150	100%
Z Score	12.387					
P value	0.00001					

Modified Social Support Scale analysis showed 52% had moderate, 26.67% high, and 21.33% low social support. Social support was strongly associated with QOL ($p = 0.00001$): good QOL was highest among participants with high social support (22%) and lowest among those with low support (10%). [Table 7-10]

Table 7: Distribution of Modified Social Support Scale Scores Among Study Participants

MSSS Score Category	Score Range	Frequency (N)	Percentage (%)
Low Social Support	0 – 12	32	21.33%
Moderate Social Support	13 – 24	78	52.00%
High Social Support	25 – 36	40	26.67%

Table 8: Comparison of Modified Social Support Scale with Quality of Life (N = 150)

Modified Social Support Scale	Good Quality of Life		Poor Quality of Life		Total	
	No.	%	No.	%	No.	%
Low Social Support	15	10.00%	17	11.33%	32	21.33%
Moderate Social Support	55	36.67%	23	15.33%	78	52.00%
High Social Support	33	22.00%	7	4.67%	40	26.67%
Total	103	68.67%	47	31.33%	150	100%
P-value	0.00001					

Table 9: Comparison of Religiosity Scale with Gender Distribution (N = 150)

	Good Quality of Life		Poor Quality of Life		Total	
	No.	%	No.	%	No.	%
Low religiosity (15–30)	47	68.1	22	31.9	69	100
Moderate religiosity (31–50)	39	69.6	17	30.4	56	100
High religiosity (51–75)	17	68.0	8	32.0	25	100
Total	103	68.7	47	31.3	150	100

Table 10: Distribution of Study Participants According to Religiosity Scale and Gender (N = 150)

Religiosity Scale	Male (n = 93)		Female (n = 57)		Total (n = 150)	
	N	%	N	%	N	%
Low religiosity (15–30)	43	46.2	26	45.6	69	46.0
Moderate religiosity (31–50)	35	37.6	21	36.8	56	37.3
High religiosity (51–75)	15	16.1	10	17.5	25	16.7
Total	93	100	57	100	150	100

DISCUSSION

In the present study involving 150 elderly participants, the majority belonged to the 60–70-year age group, with a mean age of 75.79 ± 8.84 years. A similar age distribution was reported by **Tripathy et al. (2020)**⁽²⁰⁾, who found that most elderly respondents belonged to the 60–69 years category, indicating that younger-old individuals are more likely to participate in community-based surveys. The present study also had a higher proportion of males (62%), which is consistent with the findings of **Rao et al. (2015)**⁽²¹⁾, who noted a male predominance in geriatric health studies due to better mobility and participation among males.

Most participants were married (73.34%), which aligns with the findings of **Kumar et al. (2012)**⁽²²⁾, who reported that marital status is an important determinant of emotional stability and social functioning among older adults. Educational status revealed that 38% were illiterate, comparable to the **George et al. (2017)**⁽²³⁾,

which also reported high illiteracy rates among Indian elderly, especially in rural settings.

Regarding quality of life (QOL), the present study observed that 40% of participants had good QOL, whereas 44.67% had an average QOL. Similar observations were made by **George et al. (2017)**⁽²³⁾, who found that around 45% of elderly participants experienced moderate QOL levels, with only a small proportion reporting very good QOL. In the current study, gender differences across physical, psychological, social, and environmental domains were not statistically significant, which corresponds with findings by **Banik et al. (2018)**⁽²⁴⁾ who also noted no major gender differences in overall QOL scores among the elderly.

A notable finding was that perceived stress had a strong and statistically significant association with QOL ($p = 0.00001$). Individuals with low stress demonstrated better QOL, while those with high stress had poor QOL. This result is consistent with a study by **Akhter et al.**

(2019)⁽²⁵⁾, which reported that high perceived stress scores were significantly associated with poor psychological and physical health outcomes among elderly individuals. Similarly, **Wong et al. (2011)**⁽²⁶⁾ emphasized that chronic stress adversely affects cognitive functioning, social adjustment, and general well-being in older adults.

The study also observed that social support played a crucial role in determining QOL. Participants with high social support reported better QOL compared to those with low support, and the association was statistically significant ($p = 0.00001$). This finding aligns with the work of **Taylor (2011)**⁽²⁷⁾ who concluded that social support acts as a protective factor against stress-related health deterioration, particularly in older populations.

Religiosity in the present study showed that nearly half of the participants had low religiosity scores. Although religiosity was not directly analyzed with QOL, existing literature suggests that spiritual engagement positively correlates with psychological well-being and life satisfaction. For example, **Koenig (2012)**⁽²⁸⁾ found that religious involvement promotes emotional resilience, provides social support, and enhances perceived meaning of life.

Overall, the present study reinforces that elderly QOL is influenced by stress levels, social support, and sociodemographic patterns. The results are in close agreement with previous Indian and international studies, emphasizing the need for strengthening social support systems, stress-reduction programs, and community-based mental health interventions for the ageing population.

STRENGTHS OF THE STUDY

The present study has several strengths. First, it specifically focused on elderly individuals residing in old age homes, a population that may be particularly vulnerable to loneliness, psychosocial stress, and reduced social support. Second, the study assessed multiple psychosocial dimensions, including religiosity, social support, perceived stress, and quality of life, thereby providing a broader understanding of factors associated with wellbeing in later life. Third, standardized assessment tools were used to evaluate perceived stress, social support, religiosity, and quality of life. Fourth, the study included 150 elderly participants from different sociodemographic backgrounds, including variations in age, sex, education, marital status, and rural or urban background. Finally, the study identified statistically significant associations between perceived stress, social support, and quality of life, providing clinically relevant findings for the development of psychosocial and supportive interventions for elderly residents of old age homes.

LIMITATIONS OF THE STUDY

The study has several limitations that should be considered while interpreting the findings. First, the cross-sectional design does not allow determination of causal relationships between religiosity, social support, perceived stress, and quality of life. Second, the sample was restricted to elderly individuals residing in selected old age homes in the northern-central Indian region; therefore, the findings may not be generalizable to community-dwelling elderly individuals or to elderly populations from other geographical regions. Third, the sample size was relatively limited to 150 participants, which may have reduced the statistical power for detecting smaller associations and subgroup differences. Fourth, the study relied primarily on self-reported measures and face-to-face interviews, which may have introduced recall, response, or social desirability bias, particularly for sensitive variables such as religiosity and perceived stress. Fifth, although religiosity was assessed, its relationship with quality of life was not examined in depth using multivariable statistical analysis. Finally, potential confounding factors such as duration of stay in the old age home, socioeconomic status, physical comorbidities, medication use, family contact, frequency of religious participation, and previous psychosocial experiences were not comprehensively analyzed. Future longitudinal and multicenter studies with larger and more diverse samples are recommended to clarify these relationships and improve generalizability.

FUTURE DIRECTIONS

Future research should include larger, multicentric, and longitudinal studies involving elderly individuals from different geographical, cultural, religious, and socioeconomic backgrounds to improve the generalizability of findings. Further studies should examine the longitudinal effects of religiosity, social support, and perceived stress on quality of life and determine whether changes in these factors lead to meaningful improvements in psychological wellbeing.

Future investigations should also incorporate potentially important variables such as duration of residence in old age homes, frequency of family contact, physical comorbidities, socioeconomic status, functional independence, loneliness, participation in religious or spiritual activities, and access to social and community resources. Multivariable statistical models may help determine the independent contribution of religiosity, social support, and perceived stress to quality of life while accounting for potential confounding factors.

Interventional studies are also warranted to evaluate the effectiveness of structured stress-management programs, peer-support groups, family-engagement interventions, recreational activities, and culturally appropriate spiritual or religious support programs. Such interventions may help develop comprehensive and

culturally sensitive approaches to promoting healthy ageing and improving quality of life among elderly residents of old age homes.

CONCLUSION

The present study concludes that the quality of life among the elderly is significantly shaped by psychosocial factors, particularly perceived stress and social support. While most participants demonstrated average to good quality of life, those experiencing high perceived stress consistently reported poorer outcomes, whereas individuals with low stress levels had markedly better well-being, indicating a strong and statistically significant association. Similarly, higher social support was strongly linked with better quality of life, highlighting the protective role of supportive relationships in ageing. Although demographic factors such as age, sex, marital status, education, and domicile showed some variation in scores, they were less influential than stress and social support. Overall, the findings emphasize that reducing stress and strengthening social support networks are essential strategies for improving the quality of life of the elderly population.

DECLARATIONS

Conflict of Interest Statement

The authors declare that there is no conflict of interest related to this cross-sectional study on religiosity, social support, perceived stress, and quality of life among elderly residents of old age homes in the Northern Central Indian population.

Informed Consent and Human Rights Statement

Informed consent was obtained from all participants included in this study. For participants with impaired capacity, consent was obtained from legally authorized representatives. All interviews, psychological assessments, and data collection procedures were carried out in accordance with the ethical standards of the institutional and/or national research committee and complied with the 1964 Helsinki Declaration and its later amendments.

Authorization for the Use of Human Subjects / Ethical Approval

The study protocol involving human subjects was reviewed and approved by the Institutional Ethics Committee of the Department of Psychiatry, Mata Gujri Memorial Medical College, Kishanganj, Bihar. The research adhered strictly to national regulations and institutional policies governing human participant research, particularly those relevant to geriatric and mental health populations.

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Disclosures

The authors report no financial or non-financial conflicts of interest related to this study on religiosity, social support, perceived stress, and quality of life among the elderly population residing in old age homes.

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