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Preference for Religious Coping Strategies and Passive versus Active Coping Styles among Seniors Exhibiting Aggressive Behaviors

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Abstract: This article is theoretical and empirical. The theoretical part presents issues related to experiencing stress (including ways of coping with experienced problems) and the relationships between preference for various coping strategies and human behavior. The empirical part presents the results of research on the relationship between the frequency of seniors (n = 329) using 13 different ways to deal with experienced difficulties (including the strategy of turning to religion/religious coping) and 11 categories of aggressive behavior (retaliation tendencies, self-destructive tendencies, aggression control disorders, displaced aggression, unconscious aggressive tendencies, indirect aggression, instrumental aggression, self-hostility, physical aggression towards the environment, hostility towards the environment, and reactive aggression). The last part is devoted to a discussion on the obtained research results and the practical implications of using the strategy of turning to religion/religious coping in difficult situations as a factor protecting the elderly from aggressive behavior.

Keywords: elderly people; stress; religious coping strategies; active coping strategies; passive coping strategies; aggression

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1. Introduction

Issues concerning the ways in which seniors who exhibit aggressive behaviors cope with stress (including the use of positive religious coping strategies) will be presented in the following aspects:

1. The presence of stress-generating factors specific to seniors,
2. Characteristics of the process of coping with stress, and
3. A discussion of positive religious coping strategies.

1.1. The Presence of Stress-Generating Factors Specific to Seniors

The rationale for research on the relationship between seniors preference for coping strategies and manifesting aggressive behavior is the current population of approximately 600 million people aged 60 or older worldwide. Demographers predict that by 2025, this number will double for this age group, which will then constitute 30% of the total population (de Michelis 2017). Studies on how seniors function in difficult situations are part of *life-span* research—exploring behavioral changes in different periods of a person's life, paying particular attention to critical events that affect an individual's activity during each of these periods (Baltes et al. 1980).

Various factors may lead to significant changes in the way 60+ aged people function, including their mental attitude toward old age, their entire life achievements, level of vitality, psychophysical condition, external appearance, the severity of health problems (including experiencing chronic diseases), coping with everyday activities, marital status, professional activity, family involvement, social, informal and formal activities support (e.g., the quality

of medical care), level of education, financial and housing status (including material self-sufficiency) (Kalfoss and Halvorsrud 2009; Daly et al. 2010; Fidecki et al. 2011; Poulin et al. 2012; Ryff et al. 2012; Enkvist et al. 2013; Stewart et al. 2013; Stenhagen et al. 2014).

Changes in the lives of seniors often lead to psychological stress. Its intensity is a function of the discrepancy between the needs and/or tasks a person faces and the ability to meet these expectations and/or perform these tasks. Psychological stress is characteristic of a person experiencing difficult situations, and it mainly includes experiences such as deprivation of important biological and/or mental needs, overload (the need to perform tasks that exceed one's physical and/or mental abilities), painful situations (the need to endure physical and/or mental suffering, for example, insult, humiliation, and harm), motivational conflicts (long and tiring decision-making processes with a negative emotional overtone), threats (physical, those related to life, health or social, e.g., the possibility of losing one's social position), difficulties and frustration (limitations in intentional activity due to the lack of elements necessary for its implementation or the presence of an obstacle in the implementation of goal-oriented activities), and other new situations (the circumstances in which proven methods of action now fail). At the same time, the above-mentioned categories of difficulties are not mutually exclusive. They may coexist, leading to a greater intensity of stress in a shorter period, or they may overlap in the long term, generating chronic stress (Terelak 2001; Niewiadomska 2007).

Characteristics of the process of coping with stress. Coping with stress is an important human skill. The remedial process is triggered if the person classifies the situation as problematic or stressful. Their coping abilities are assessed in terms of two basic functions: (a) changing the situation into a better one (active strategies aimed at solving the problem), and (b) emotional self-regulation so that mental resilience or social functioning do not breakdown (passive strategies aimed at maintaining emotional and social balance). There are four types of stress coping strategies that simultaneously fulfill the functions listed above: (1) searching for information (active strategies consisting of reviewing a stressful situation to gain the knowledge needed to make a rational remedial decision or to reevaluate the existing problem), (2) undertaking direct action (active strategies aimed at changes in the environment or the causative entity), (3) restraining from performing a problem-solving activity (passive strategies consisting of initiating avoidance actions), and (4) launching intrapsychic processes aimed at emotional regulation, mainly defense mechanisms (passive strategies aimed at emotions). The coping process can be considered effective if it leads to a constructive solution to the problem and, at the same time, to positive emotions. Empirical research does not clearly indicate which coping strategies are most effective in overcoming stress. Some analyses lead to the conclusion that the effectiveness of remedial strategies depends on the situational context. On the other hand, others show that even when taking into account the situational context, active strategies have a greater adaptive value concerning passive actions, both avoidance and emotional (Lazarus and Folkman 1984; Lazarus 1986; Heszen-Niejodek 1997; Terelak 2001; Pervin and John 2002; Niewiadomska 2007; Niewiadomska and Chwaszcz 2010; Lemée et al. 2019; Yu et al. 2020).

Experiencing difficult situations can lead to all sorts of outcomes. As a rule, stressful reactions disrupt human functioning, but do not lead to disturbances in the adaptation process. However, after exceeding an individual's "tolerance threshold," the overload is so strong that it causes adaptation problems. Negative consequences are caused by a particularly high intensification of mental tension in traumatic situations or by chronic stress, which consists of experiencing negative emotional tension for a long time. At the level of mental functions, the destructive effects of severe or long-term stress may include states of anxiety, apathy, isolation from the environment, symptoms of post-traumatic stress, depression or neurosis; physiologically, they can lead to psychosomatic diseases or other health problems; in the behavioral dimension, they increase the risk of using psychoactive substances (e.g., alcohol and sedatives) and displaying various types of aggressive activities.

An aggressive act can be defined as any form of behavior aimed at causing harm or injury to another living being motivated to avoid such treatment. Adopting such a broad definition makes it possible to find a common basis for various typologies of aggressive behavior, including those due to the modality of the reaction (verbal aggression or physical aggression), the quality of the reaction (action or no action), directness (indirect aggression or direct aggression), visibility (overt aggression or hidden aggression), arousal (unprovoked action or retaliatory action), directed towards a target (enemy aggression or instrumental aggression), type of damage (physical or mental), and the persistence of consequences (temporary effects of aggression or long-term consequences of aggression). The common effects of experienced stress include, inter alia, aggressive behavior such as acts of self-destruction (including self-harm and/or suicide attempts), uncontrolled outbursts of rage and/or anger, hostility towards people, and using acts of aggression as a kind of response to the slightest provocation and the desire to dominate others (Baron and Richardson 1994; Poprawa 1998; Terelak 2001; Strelau et al. 2004; Krahe 2005; Niewiadomska 2007; Niewiadomska and Chwaszcz 2010; Siemieniecki et al. 2020).

1.2. A Discussion of Positive Religious Coping Strategies

In the context of experiencing stress, it is important to note the differences that occur between religiosity and religious coping with stress. The expression of inner religiosity (e.g., building personal relationships of a transcendent nature, showing trust in God, experiencing help from a Higher Power, and taking care of development in the spiritual sphere) on the one hand is linked to human well-being (high sense of quality of life and health), while on the other hand it is a protective factor against the preference of destructive behaviors (Hackney and Sanders 2003; McCullough and Willoughby 2009; García-Alandete and Valero 2013; Dowson and Miner 2015; Aghababaei et al. 2018; Zarzycka and Puchalska-Wasyl 2020).

The experience of stress promotes actions in the form of religious coping strategies, which may be positive (serve to reduce stress), negative (reinforce negative experiences) or neutral, as they do not affect the level of stress experienced (Pargament et al. 2000; Tran et al. 2012). Positive religious coping strategies in stressful situations may include taking actions such as positive religious reevaluation, seeking spiritual support, attending religious meetings, undertaking religious practices, and initiating prayer. The effect of these actions is a greater sense of security, gaining peace of mind and finding meaning in experienced difficulties (Stein et al. 2009; Park 2013; Krok 2014; Thomas and Barbato 2020).

An important rationale for raising questions about religious coping is provided by the findings of a meta-analysis conducted on 49 independent reports from the literature, which concluded that there are moderate positive relationships between the preference for positive religious coping strategies and the constructive functioning of the person experiencing stress (experiencing a greater intensity of symptoms of positive adjustment, e.g., positive self-esteem, increased social relationships, and experiencing fewer negative symptoms such as lower levels of anxiety). Additionally, no clear causal links have been found between the preference for positive religious coping strategies and the effects of stress (Ano and Vasconcelles 2005).

The literature also indicates that religious positive coping strategies are often not an independent factor that leads to changes in the functioning of the person experiencing stress. This is because their effect depends on their association with subjective, situational, social, and cultural variables (Tran et al. 2012; Ellison et al. 2013; Park 2013; Ahles et al. 2016; Santos et al. 2017; Areba et al. 2018; Bradshaw and Kent 2018).

Presented below are examples of research findings that indicate discrepancies or ambiguities regarding the importance of positive religious coping strategies in stressful situations. Among others, it was found that effective coping with stress does not only depend on the preference for positive religious coping strategies, but also on the co-occurrence of three variables of a religious nature: positive religious coping, inner religiosity, and trust in God (Pirutinsky et al. 2020). The existence of mediators in the form of secondary cognitive appraisal and self-efficacy for the relationship between positive religious coping

strategies and the experience of negative psychological states (anxiety and depression) was also demonstrated. Namely, secondary cognitive appraisal and self-efficacy mediate the protective role of positive religious coping strategies against the occurrence of anxiety and depression symptoms and adjustment difficulties (Nairn and Merluzzi 2003; Dolcos et al. 2021). Other studies have shown that the occurrence of a positive religious coping strategy is an important mediator between a sense of meaning in life and the experience of loneliness, which is a risk factor for depression, suicidal behavior, and self-injury. Namely, loneliness is further alleviated when the experienced sense of meaning in life leads to an increase in positive religious coping (Yıldırım et al. 2021). However, research can be cited that is not entirely consistent with the regularities outlined above, as the use of positive religious coping strategies was found to be significantly associated with manifestations of positive affect (e.g., increased quality of life), whereas it did not reduce destructive symptoms of experienced stress, e.g., adjustment difficulties (Lee et al. 2014).

The results concerning factors differentiating the preference for positive religious coping strategies are also inspiring. Previous research has observed, among others, that in trauma situations, women are more likely than men to use positive religious strategies, which consequently leads to greater post-traumatic growth (Gerber et al. 2011). Differences in the preference for positive religious coping strategies by different professional groups have also been noted. For example, nurses in comparison to physicians significantly more often prefer this way of coping with stress, which may consequently translate into a lower intensity of negative psychological states (e.g., anxiety and/or depression) (Chow et al. 2021). National differences were also found in the use of positive religious coping strategies. Hispanics are significantly more likely than other nationalities to use this type of strategy (Gerber et al. 2011).

Important questions concerning the preference for positive religious coping strategies have been raised in the context of the high intensity of the crisis of religious institutions, which consequently leads to the fact that religiosity becomes more subjective, differentiated and detached from church institutions. It has been found, among other factors, that one effect of the crisis of church institutions is a lower preference for positive religious coping strategies over other ways of dealing with the experienced trauma (Zwingmann 2005; Zwingmann et al. 2006).

The relationship between religious and non-religious ways of coping with stress is also ambiguous. First, positive religious coping strategies have been shown to interact with active non-religious ways of coping with experienced problems and consequently jointly protect against the negative consequences of stress, e.g., development of PTSD, resignation, and job burnout (Heidari et al. 2016; Chow et al. 2021). Second, there are studies that have shown that religious and non-religious coping strategies independently influence psychosocial functioning for individuals experiencing traumatic events (Burker et al. 2005). Third, there are studies in which non-religious coping strategies have been shown to have a significant effect on psychosocial functioning (e.g., severity of anxiety and depression), whereas religious strategies are not significant (Koenig 2001; Zwingmann et al. 2006; Lupo and Strous 2011; Taheri-Kharameh et al. 2016; Francis et al. 2019).

The psychological mechanisms presented above justify the search for relationships occurring between the preference of coping strategies and the intensity of aggressive behavior in the population of seniors (60+ people). In particular, it is worthwhile to analyze the relationships between positive religious coping strategies and manifestations of aggressive behavior among elders. Such research is consistent with calls in the literature that studies should be developed to answer questions about what functions positive coping strategies serve (e.g., Nairn and Merluzzi 2003; Taheri-Kharameh et al. 2016; Francis et al. 2019).

Based on the literature review presented, four hypotheses were posed:

Hypothesis 1. *Among seniors, passive stress coping strategies are risk factors for aggressive behavior (increasing the intensity of passive coping strategies is significantly associated with an increase in the frequency of aggressive behavior).*

Hypothesis 2. *Among seniors, active stress coping strategies are factors that protect against aggressive behavior (an increase in the intensity of active coping strategies is significantly associated with a decrease in aggressive behavior).*

Hypothesis 3. *Among seniors, religious coping is a factor protecting against various types of aggressive behavior (the increase in the intensity of religious coping is significantly associated with a decrease in aggressive behavior).*

Hypothesis 4. *Among seniors, a religious coping strategy is one of the predictors of overall aggressiveness severity.*

2. Materials and Methods

2.1. Participants and Procedure

This study was conducted in 2019 in Poland. The selection of people for the research sample was random. Multistage sampling was used:

- The first stage of the selection consisted in using the criterion of the administrative division of Poland into provinces. Out of the 16 existing provinces 2 were drawn. In the second stage, 18 communities were randomly selected from the administrative division of the 2 provinces (6 out of 65 urban communities, 6 out of 47 urban-rural communities and 6 out of 174 rural communities).
- In the third stage, telephone directories that contained telephone numbers of people residing in the selected municipalities were used. Every fifth telephone number was dialed. In this way, more than 3000 people aged 60 or older were contacted and invited to participate in the survey.
- Interviewers met directly with 700 randomly selected seniors who were informed of the purpose of the survey. Interviewers accompanied the respondents while filling in the questionnaires. A total of 350 people were surveyed. The results of 11 respondents were rejected by the statistical program. The socio-demographic characteristics of the study participants are presented in Table 1.

Table 1. Socio-demographic characteristics of the study participants (n = 329).

Descriptive Criterion						
Gender	**Women: *n* = 211; 64.1%**				**Men: *n* = 118**	
Age	**M = 67.31; ME(s) = 7.24 (Min. 60; Max. 90 Years Old)**					
Marital status	Formal relationship: n = 201; 61.1%	Informal relationship: n = 8; 2.4%	Widowhood: n = 74; 22.5%	Separation: n = 4; 1.2%	Divorce: n = 21; 6.4%	Unmarried: n = 21; 6.4%
Education	Higher education: n = 102; 31.0%		Secondary education: n = 123; 37.4%		Primary/vocational education: n = 104; 31.6%	
Place of residence	Big cities (over 100 thousand): n = 122; 37.2%		Average cities (20–100 thousand): n = 43; 13.1%	Small cities (less than 20 thousand): n = 31; 9.4%	Village: n = 132; 40.2%	
Religiosity level	High: n = 205; 62.5%		Medium: n = 57; 17.5%		Low: n = 66; 20%	

The table above shows the characteristics of the respondents in terms of their gender, age, marital status, education, place of residence, and level of religiosity.

2.2. Measurements

Coping Inventory (MINI-COPE)

The Polish version of the Mini-COPE (Juczyński and Ogińska-Bulik 2009) inventory was used to measure coping strategies. It is a shortened version of the Multimodal Inventory for the Measurement of Coping with Stress (COPE) (by Carver, Scheier, and Weintraub) which measures coping in terms of disposition. It consists of 28 statements that are part of 14 strategies for coping with stress, including active coping, planning, positive revalidation, acceptance, sense of humor, turn to religion, seeking emotional support, seeking instrumental support, taking care of someone else, denial, discharge, use of psychoactive substances, cessation of activities, and self-blaming. There are two theorems for each strategy. The tested respondent refers to each statement by marking one possible answer on a four-point scale, where 0 means "I rarely do so" and 3 means "I almost always do so." The obtained psychometric properties are satisfactory. The half-reliability for the 14 scales is 0.86 (Guttman's index 0.87) (Niewiadomska et al. 2021). Descriptive statistics for the participants' (n = 329) scores on the 28 statements/items in the Coping Inventory (MINI-COPE) are presented in Table 2.

Table 2. Descriptive statistics for the Coping Inventory (MINI-COPE) scores of the participants (n = 329).

Items	Mean (M)	Mediana (Me)	Standard Deviation (SD)	Minimum (Min.)	Maximum (Max.)
mini1	1.81	2.00	0.850	0	3
mini2	2.13	2.00	0.682	0	3
mini3	0.91	1.00	0.808	0	3
mini4	0.45	0.00	0.804	0	3
mini5	1.64	2.00	0.842	0	3
mini6	1.07	1.00	0.802	0	3
mini7	2.09	2.00	0.674	0	3
mini8	1.25	1.00	0.867	0	
mini9	1.37	1.00	0.878	0	3
mini10	1.74	2.00	0.866	0	3
mini11	0.41	0.00	0.769	0	3
mini12	1.70	2.00	0.745	0	3
mini13	1.43	1.00	0.878	0	3
mini14	1.84	2.00	0.785	0	3
mini15	1.74	2.00	0.769	0	3
mini16	0.98	1.00	0.838	0	3
mini17	1.77	2.00	0.790	0	3
mini18	1.24	1.00	0.870	0	3
mini19	1.52	2.00	0.849	0	3
mini20	1.70	2.00	0.803	0	3
mini21	1.22	1.00	0.878	0	3
mini22	1.71	2.00	1.023	0	3
mini23	1.77	2.00	0.775	0	3
mini24	1.98	2.00	0.719	0	3
mini25	2.05	2.00	0.728	0	3
mini26	1.34	1.00	0.864	0	3
mini27	1.70	2.00	0.990	0	3
mini28	0.49	0.00	0.654	0	3

Table 3 shows the internal correlations and Cronbach's α for each scale in the Coping Inventory (MINI-COPE).

Table 3. Intercorrelations and Cronbach's α for the scales in the Coping Inventory (MINI-COPE) calculated for a group of seniors (n = 329).

Scales	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Active coping	1													
2. Planning	0.617 **	1												
3. Positive revalidation	0.396 **	0.472 **	1											
4. Acceptance	0.270 **	0.372 **	0.362 **	1										
5. Sense of humor	0.062	0.149 **	0.367 **	0.176 **	1									
6. Turn to religion/religious coping	0.106 *	0.127 **	0.066	0.149 **	−0.008	1								
7. Seeking emotional support	0.359 **	0.451 **	0.400 **	0.287 **	0.137 **	0.271 **	1							
8. Seeking instrumental support	0.308 **	0.353 **	0.357 **	0.250 **	0.147 **	0.299 **	0.717 **	1						
9. Taking care of someone else	0.101 *	0.084	0.231 **	0.228 **	0.229 **	0.092	0.169 **	0.159 **	1					
10. Denial	−0.124 *	−0.203 **	0.025	0.013	0.171 **	0.047	−0.070	0.028	0.240 **	1				
11. Discharge	0.062	0.075	0.212 **	0.236 **	0.245 **	0.070	0.206 **	0.296 **	0.227 **	0.369 **	1			
12. Use of psychoactive substances	−0.121 *	−0.123 *	−0.126 **	−0.175 **	0.101 *	−0.218 **	−0.100 *	−0.106 *	−0.072	0.189 **	0.221 **	1		
13. Cessation of activities	−0.227 **	−0.119 *	0.061	0.158 **	0.173 **	0.030	−0.066	−0.036	0.165 **	0.350 **	0.307 **	0.146 **	1	
14. Self-blaming	−0.016	0.112 *	0.141 **	0.141 **	0.145 **	0.165 **	0.017	0.104 *	0.190 **	0.294 **	0.363 **	0.185 **	0.356 **	1
Cronbach's α	0.69	0.71	0.63	0.71	0.48	0.85	0.65	0.70	0.47	0.61	0.33	0.94	0.52	0.68

** $p < 0.01$; * $p < 0.05$.

Based on the results, coping strategies were divided into passive (2 avoidance strategies: using psychoactive substances and stopping activities; 3 emotional strategies: denial, discharging, and self-blame) and active (8 remedial methods: active coping, planning, positive reevaluation, acceptance, sense of humor, turning to religion/religious coping, seeking emotional support, and seeking instrumental support). One scale (taking care of someone else) was excluded from further analyses due to the lack of unambiguous classification into active or passive strategies. The reliability of the scales as measured by Cronbach's α ranges from 0.48 (for the planning scale) to 0.94 (for the scale of use of psychoactive substances). A scale found in the Coping Inventory method, turning to religion, was used to measure positive religious coping strategies. The scale consists of two statements: (1) When I am in a very difficult situation, I usually try to find solace in religion or my faith; (2) When I am in a very difficult situation, I usually pray or meditate. The reliability of the scale as measured by Cronbach's α is 0.85. The strongest negative correlation is between religious coping and psychoactive substance use in stressful situations (r = −0.22), while a positive correlation is between religious coping and the seeking instrumental support scale (r = 0.30).

2.3. Aggression Syndrome Psychological Inventory (IPSA II)

This method measures the general level of aggression severity and the 11 factors of the psychological aggression syndrome: (1) retaliation tendency, (2) self-destructive tendencies, (3) aggression control disorders, (4) displaced aggression, (5) unconscious aggressive tendencies, (6) indirect aggression, (7) instrumental aggression, (8) self-hostility, (9) physical aggression towards the environment, (10) hostility towards the environment, and (11) reactive aggression (Gaś 1987).

Individuals were given the opportunity to respond to the 56 statements in three possible ways: true (2 points), hard to say (1 point), and false (0 points) (Gaś 1987). Descriptive statistics for the scores obtained by the participants (n = 329) on the 56 statements/items of the Aggression Syndrome Psychological Inventory (IPSA II) are presented in Table 4.

Table 4. Descriptive statistics for the Aggression Syndrome Psychological Inventory (IPSA II) scores of the participants (n = 329).

Items	Mean (M)	Mediana (Me)	Standard Deviation (SD)	Minimum (Min.)	Maximum (Max.)
IPSA_01	0.61	0.00	0.924	0	2
IPSA_02	0.41	0.00	0.807	0	2
IPSA_03	0.72	0.00	0.962	0	2
IPSA_04	0.86	0.00	0.992	0	2
IPSA_05	0.30	0.00	0.719	0	2
IPSA_06	0.77	0.00	0.974	0	2
IPSA_07	0.20	0.00	0.602	0	2
IPSA_08	0.29	0.00	0.701	0	2
IPSA_09	0.12	0.00	0.467	0	2
IPSA_10	0.44	0.00	0.828	0	2
IPSA_11	0.13	0.00	0.500	0	2
IPSA_12	0.31	0.00	0.725	0	2
IPSA_13	0.38	0.00	0.788	0	2
IPSA_14	0.51	0.00	0.873	0	2
IPSA_15	0.52	0.00	0.877	0	2
IPSA_16	0.30	0.00	0.719	0	2
IPSA_17	0.10	0.00	0.443	0	2
IPSA_18	0.53	0.00	0.883	0	2
IPSA_19	0.09	0.00	0.418	0	2
IPSA_20	0.19	0.00	0.594	0	2
IPSA_21	0.36	0.00	0.773	0	2
IPSA_22	0.09	0.00	0.418	0	2
IPSA_23	0.33	0.00	0.742	0	2
IPSA_24	0.38	0.00	0.783	0	2
IPSA_25	0.43	0.00	0.820	0	2
IPSA_26	0.30	0.00	0.719	0	2
IPSA_27	0.61	0.00	0.924	0	2
IPSA_28	0.35	0.00	0.758	0	2
IPSA_29	0.16	0.00	0.550	0	2
IPSA_30	0.38	0.00	0.783	0	2
IPSA_31	0.03	0.00	0.245	0	2
IPSA_32	0.29	0.00	0.707	0	2
IPSA_33	0.43	0.00	0.824	0	2
IPSA_34	0.41	0.00	0.811	0	2
IPSA_35	0.83	0.00	0.987	0	2
IPSA_36	0.57	0.00	0.905	0	2
IPSA_37	0.24	0.00	0.655	0	2
IPSA_38	0.12	0.00	0.479	0	2
IPSA_39	0.12	0.00	0.467	0	2
IPSA_40	0.10	0.00	0.431	0	2
IPSA_41	0.24	0.00	0.647	0	2
IPSA_42	1.94	2.00	0.344	0	2
IPSA_43	0.06	0.00	0.344	0	2
IPSA_44	0.15	0.00	0.531	0	2
IPSA_45	0.09	0.00	0.404	0	2
IPSA_46	0.50	0.00	0.870	0	2
IPSA_47	0.19	0.00	0.585	0	2
IPSA_48	0.55	0.00	0.896	0	2
IPSA_49	0.24	0.00	0.647	0	2
IPSA_50	0.12	0.00	0.479	0	2
IPSA_51	0.14	0.00	0.511	0	2
IPSA_52	0.09	0.00	0.418	0	2
IPSA_53	0.31	0.00	0.725	0	2
IPSA_54	0.08	0.00	0.390	0	2
IPSA_55	0.09	0.00	0.404	0	2
IPSA_56	0.22	0.00	0.625	0	2

Table 5 shows the internal correlations and Cronbach's α for each scale in the Aggression Syndrome Psychological Inventory (IPSA II).

Table 5. Intercorrelations and Cronbach's α for scales in the Aggression Syndrome Psychological Inventory (IPSA II) calculated for a group of seniors (n = 329).

Scales	1	2	3	4	5	6	7	8	9	10	11	12
1. Retaliation tendency	1											
2. Self-destructive tendencies	0.343 **	1										
3. Aggression control	0.495 **	0.410 **	1									
4. Disorders displaced aggression	0.671 **	0.376 **	0.580 **	1								
5. Unconscious aggressive tendencies	0.580 **	0.273 **	0.457 **	0.449 **	1							
6. Indirect aggression	0.803 **	0.402 **	0.467 **	0.631 **	0.550 **	1						
7. Instrumental aggression	0.591 **	0.614 **	0.413 **	0.591 **	0.474 **	0.623 **	1					
8. Self-hostility	0.414 **	0.370 **	0.385 **	0.423 **	0.339 **	0.492 **	0.444 **	1				
9. Physical aggression towards the environment	0.574 **	0.389 **	0.481 **	0.676 **	0.358 **	0.583 **	0.533 **	0.543 **	1			
10. Hostility towards the environment	0.689 **	0.325 **	0.404 **	0.546 **	0.418 **	0.546 **	0.462 **	0.629 **	0.497 **	1		
11. Reactive aggression	0.713 **	0.391 **	0.707 **	0.576 **	0.529 **	0.596 **	0.520 **	0.394 **	0.449 **	0.539 **	1	
General level of aggression	0.893 **	0.537 **	0.715 **	0.799 **	0.683 **	0.824 **	0.727 **	0.602 **	0.684 **	0.723 **	0.810 **	1
Cronbach's α	0.87	0.59	0.61	0.66	0.51	0.58	0.56	0.50	0.54	0.54	0.59	0.90

** $p < 0.01$; * $p < 0.05$.

The information presented in the table indicates that the method measures the psychological syndrome of aggression, as the results of correlations between the scales indicating specific symptoms of aggression correlate highly with the overall score: from r = 0.54 for the self-destructive tendencies scale to r = 0.89 for the retaliation tendency scale. There are also positive correlations between individual dimensions of the psychological syndrome of aggression, ranging from 0.27 (correlation between the scales of unconscious aggressive tendencies and self-destructive tendencies) to r = 0.80 (correlation between the scales of indirect aggression and retaliation tendency). The reliability of the scales as measured by Cronbach's α ranges from 0.50 (for the self-hostility scale) to 0.90 (for the general level of aggression scale).

2.4. Statistical Methods

Pearson's *r* parametric correlation test was used to analyze the relationships between coping strategies (measured by the MINI-COPE) and aggressive behavior (measured by the IPSA II).

Linear regression analysis was used to identify predictors of psychological aggression syndrome. Enter method was used to select the predictors. Regression analysis allows us to test whether the obtained model of the explained variables (coping strategies: measurement in MINI-COPE) can significantly predict the value of the explained variable (psychological aggression syndrome: total score in IPSA II). Model fitting is performed using analysis of variance; adjusted R2 indicates the percentage of variance explained). Regression analysis also allows us to determine which predictors can significantly predict the explained variable (using Beta standardized coefficient values and their level of significance).

3. Results

3.1. Passive Coping Strategies as Risk Factors for Aggressive Seniors

To verify hypothesis 1, a correlation analysis was carried out between the results concerning the senior's preferred passive coping strategies (two avoidance strategies: using psychoactive substances and stopping activities; three emotional strategies: denial, discharging, and self-blame) and displaying aggressive behavior (a general intensity in the aggression syndrome and its 11 dimensions). The results of the analyses are presented in Table 6.

Table 6. Correlations (Pearson's *r*) between passive strategies of coping with stress (measurement: MINI-COPE—two avoidance strategies, three emotional strategies) and the manifestation of aggressive behavior (measurement: IPSA II—a general intensity in the aggression syndrome and its 11 dimensions) among seniors (*n* = 329).

	Denial	Discharge	Psychoactive Substance Use	Stopping Activities	Self-Blame
Manifestations of aggressive behavior:					
Retaliation tendencies	0.178 ***	0.239 ***	0.321 ***	0.154 **	0.011
Self-destructive tendencies	0.116 *	0.140 *	0.244 ***	0.213 ***	0.180 ***
Aggression control disorders	0.201 ***	0.213 ***	0.269 ***	0.173 **	0.079
Aggression displaced	0.114 *	0.147 **	0.366 ***	0.134 *	0.034
Unconscious aggressive tendencies	0.146 **	0.181 ***	0.248 ***	0.162 **	0.056
Indirect aggression	0.148 **	0.192 ***	0.277 ***	0.199 ***	0.022
Instrumental aggression	0.075	0.098	0.286 ***	0.209 ***	0.038
Self-hostility	0.155 **	0.169 **	0.182 ***	0.253 ***	0.199 ***
Physical aggression towards the environment	0.147 **	0.126 *	0.293 ***	0.160 **	0.051
Hostility towards the environment	0.213 ***	0.194 ***	0.247 ***	0.228 ***	0.020
Reactive aggression	0.162 **	0.254 ***	0.292 ***	0.152 **	0.124 *
Intensified aggression syndrome	0.227 ***	0.265 ***	0.387 ***	0.239 ***	0.100

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Based on the data presented in Table 6, it can be concluded that in the group of seniors, the following relationships exist between passive strategies for coping with stress and aggressive behavior:

- There are statistically significant positive correlations between the avoidance coping strategy of drug use and the 12 categories of aggressiveness: (1) intensified aggression syndrome (r = 0.387; $p < 0.000$), (2) displaced aggression (r = 0.366; $p < 0.000$), (3) retaliation tendencies (r = 0.321; $p < 0.000$), (4) physical aggression towards the environment (r = 0.293; $p < 0.000$), (5) reactive aggression (r = 0.292; $p < 0.000$), (6) instrumental aggression (r = 0.286; $p < 0.000$), (7) indirect aggression (r = 0.277; $p < 0.000$), (8) aggression control disorders (r = 0.269; $p < 0.000$), (9) unconscious aggressive tendencies (r = 0.248; $p < 0.006$), (10) hostility towards the environment (r = 0.247; $p < 0.000$), (11) self-destructive tendencies (r = 0.244; $p < 0.000$), and (12) self-hostility (r = 0.182; $p < 0.001$);
- There are statistically significant positive correlations between the avoidance coping strategy of stopping activities and the 12 categories of aggressiveness: (1) self-hostility (r = 0.253; $p < 0.000$), (2) intensified aggression syndrome (r = 0.239; $p < 0.000$), (3) hostility towards the environment (r = 0.228; $p < 0.000$), (4) self-destructive tendencies (r = 0.213; $p < 0.000$), (5) instrumental aggression (r = 0.209; $p < 0.000$), (6) indirect aggression (r = 0.199; $p < 0.000$), (7) aggression control disorders (r = 0.173; $p < 0.002$), (8) unconscious aggressive tendencies (r = 0.162; $p < 0.003$), (9) physical aggression towards the environment (r = 0.160; $p < 0.004$), (10) retaliation tendencies (r = 0.154; $p < 0.005$), (11) reactive aggression (r = 0.152; $p < 0.006$), and (12) displaced aggression (r = 0.134; $p < 0.015$);
- There are statistically significant positive correlations between the emotional coping strategy in the form of denial and 11 categories of aggressiveness: (1) intensified aggression syndrome (r = 0.227; $p < 0.000$), (2) hostility towards the environment (r = 0.213; $p < 0.000$), (3) aggression control disorders (r = 0.201; $p < 0.000$), (4) retaliation tendencies (r = 0.178; $p < 0.001$), (5) reactive aggression (r = 0.162; $p < 0.003$), (6) self-

hostility (r = 0.155; $p < 0.005$), (7) indirect aggression (r = 0.148; $p < 0.007$), (8) physical aggression towards the environment (r = 0.147; $p < 0.008$), (9) unconscious aggressive tendencies (r = 0.146; $p < 0.008$), (10) self-destructive tendencies (r = 0.116; $p < 0.035$), and (11) displaced aggression (r = 0.114; $p < 0.039$);

- There are statistically significant positive correlations between one's emotional coping strategy in the form of discharge and 11 categories of aggressiveness: (1) intensified aggression syndrome (r = 0.265; $p < 0.000$), (2) reactive aggression (r = 0.254; $p < 0.000$), (3) retaliation tendencies (r = 0.239; $p < 0.000$), (4) aggression control disorders (r = 0.213; $p < 0.000$), (5) hostility towards the environment (r = 0.194; $p < 0.000$), (6) indirect aggression (r = 0.192; $p < 0.000$), (7) unconscious aggressive tendencies (r = 0.181; $p < 0.001$), (8) self-hostility (r = 0.169; $p < 0.002$), (9) displaced aggression (r = 0.147; $p < 0.008$), (10) self-destructive tendencies (r = 0.140; $p < 0.011$), and (11) physical aggression towards the environment (r = 0.126; $p < 0.022$);
- There are statistically significant positive correlations between the emotional coping strategy in the form of self-blame and three categories of aggressiveness: (1) self-hostility (r = 0.199; $p < 0.000$), (2) self-destructive tendencies (r = 0.180; $p < 0.001$), and (3) reactive aggression (r = 0.124; $p < 0.025$).

Based on the presented dependencies, it can be concluded that the first hypothesis has been confirmed. In the group of seniors, passive stress coping strategies are risk factors for aggressive behavior. The relationships presented below constitute the basis for a positive verification of the hypothesis. First, the avoidance coping strategies of substance use and stopping activities are risk factors for 12 tested aggressive behaviors in the senior community. The presented conclusion results from the fact that the remedial strategy, both in the form of taking psychoactive substances and stopping activities, is significantly associated with both the general severity of the aggression syndrome and the 11 dimensions of this syndrome: (1) a retaliation tendency, (2) physical aggression towards the environment, (3) hostility towards the environment, (4) reactive aggression, (5) displaced aggression, (6) indirect aggression, (7) instrumental aggression, (8) self-hostility, (9) self-destructive tendencies, (10) aggression control disorders, and (11) unconscious aggressive tendencies.

Second, emotional strategies in the form of denial and discharge are risk factors for 11 tested aggressive behaviors in seniors. The obtained results justify the conclusion that both an increase in the intensity of the strategy of denial of the occurring events as well as emotional discharge in a problematic situation are significantly associated with an increase in aggressive behavior (a general intensity of the aggression syndrome) and its 10 dimensions: (1) a retaliation tendency, (2) physical aggression towards the environment, (3) hostility towards the environment, (4) reactive aggression, (5) displaced aggression, (6) indirect aggression, (7) self-hostility, (8) self-destructive tendencies, (9) aggression control disorders, and (10) unconscious aggressive tendencies. Emotional countermeasures in the form of denial and discharge are not risk factors only in the appearance of instrumental aggression.

Third, the emotional coping strategy of self-blame is a risk factor for three tested types of aggressiveness in the senior population. This means that an increase in self-blame in a problematic situation increases the risk of symptoms of aggressiveness, such as (1) self-hostility, (2) self-destructive tendencies, and (3) reactive aggression.

3.2. Active Coping Strategies as Factors Protecting against Aggressive Behavior in Seniors

The basis for verifying hypothesis 2 is the results of the correlation analysis between the active strategies of coping with stress preferred by seniors (8 remedial methods: active coping, planning, positive reevaluation, acceptance, sense of humor, turning to religion/religious coping, seeking emotional support, seeking instrumental support) and the presence of aggressive behavior (a general intensity of the aggression syndrome and its 11 dimensions). The results of the analyses are presented in Table 7.

Table 7. Correlations (Pearson's *r)* between active stress coping strategies (measurement: MINI-COPE—8 strategies) and the manifestation of aggressive behavior (measurement: IPSA II—a general intensity of the aggression syndrome and its 11 dimensions in the group of seniors (*n* = 329).

	Active Coping	Planning	Positive Reevaluation	Acceptance	Sense of Humor	Turning to Religion/Religious Coping	Seeking Emotional Support	Seeking Instrumental Support
Manifestations of aggressive behavior:								
Retaliation tendencies	0.017	0.005	0.032	0.064	0.064	−0.191 ***	−0.153 **	−0.056
Self-destructive tendencies	−0.095	−0.128 *	−0.158 **	−0.040	−0.081	−0.077	−0.118	−0.146 **
Aggression control disorders	−0.093	−0.153 **	−0.174 **	−0.079	0.018	−0.112 *	−0.132 *	−0.020
Aggression displaced	−0.043	−0.077	−0.051	0.029	0.059	−0.083	−0.096	−0.010
Unconscious aggressive tendencies	−0.075	−0.047	−0.005	0.038	0.054	−0.151 **	−0.021	−0.028
Indirect aggression	−0.015	−0.035	−0.004	0.041	0.054	−0.122 *	−0.147 **	−0.041
Instrumental aggression	−0.073	−0.029	0.003	−0.005	−0.001	−0.083	−0.150 **	−0.142 **
Self-hostility	−0.185 ***	−0.150 **	−0.045	0.028	0.062	0.033	−0.098	−0.051
Physical aggression towards the environment	−0.142 **	−0.174 **	−0.127 *	−0.065	−0.025	−0.099	−0.141 **	−0.089
Hostility towards the environment	−0.063	−0.057	−0.019	0.050	0.084	−0.079	−0.104	−0.053
Reactive aggression	0.010	−0.001	−0.038	0.012	0.060	−0.139 *	−0.142 **	−0.041
Intensified aggression syndrome	−0.065	−0.077	−0.046	0.026	0.065	−0.159 **	−0.148 **	−0.063

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Based on the data presented in Table 7, it can be concluded that, in the group of seniors, the following relationships exist between the intensity of active coping strategies and the occurrence of aggressive behavior:

- Statistically significant negative correlations exist between an active coping strategy in the form of seeking emotional support and seven manifestations of aggressiveness: (1) retaliation tendencies (r = −0.153; $p < 0.005$), (2) instrumental aggression (r = −0.150; $p < 0.006$), (3) intensified aggression syndrome (r = −0.148; $p < 0.007$), (4) indirect aggression (r = −0.147; $p < 0.008$), (5) reactive aggression (r = −0.142; $p < 0.010$), (6) physical aggression towards the environment (r = −0.141; $p < 0.011$), and (7) aggression control disorders (r = −0.132; $p < 0.017$);
- Statistically significant negative correlations exist between an active coping strategy in the form of turning to religion/religious coping and six manifestations of aggressiveness: (1) retaliation tendencies (r = −0.191; $p < 0.000$), (2) intensified aggression syndrome (r = −0.159; $p < 0.004$), (3) unconscious aggressive tendencies (r = −0.151; $p < 0.006$), (4) reactive aggression (r = −0.139; $p < 0.012$), (5) indirect aggression (r = −0.122; $p < 0.027$), and (6) aggression control disorders (r = −0.112; $p < 0.044$);
- Statistically significant negative correlations exist between an active coping strategy in the form of planning and four manifestations of aggressiveness: (1) physical aggression towards the environment (r = −0.174; $p < 0.002$), (2) aggression control disorders (r = 0.153; $p < 0.006$), (3) self-hostility (r = −0.150; $p < 0.007$), and (4) self-destructive tendencies (r = −0.128; $p < 0.021$);
- Statistically significant negative correlations exist between an active coping strategy in the form of positive reevaluation and three types of aggressiveness: (1) aggression control disorders (r = −0.174; $p < 0.002$), (2) self-destructive tendencies (r = −0.158; $p < 0.004$), and (3) physical aggression towards the environment (r = −0.127; $p < 0.021$);
- Statistically significant negative correlations exist between the task coping strategy in the form of active coping and two types of aggressiveness: (1) self-hostility (r = −0.185; $p < 0.001$), and (2) physical aggression towards the environment (r = −0.142; $p < 0.010$);
- Statistically significant negative correlations exist between an active remedial strategy in the form of seeking instrumental support and two types of aggressiveness: (1) self-destructive tendencies (r = −0.146; $p < 0.008$), and (2) self-hostility (r = −0.142; $p < 0.010$).

The presented regularities constitute the basis for concluding that hypothesis 2 was confirmed. In the group of seniors, active stress coping strategies are factors that protect against the occurrence of aggressive behavior. The performed statistical analysis allowed identifying various combinations of factors protecting seniors against aggressiveness in the form of preference for active coping strategies. The detailed dependencies are as follows:

- Decreasing physical aggression towards the environment significantly coexists with an increase in four protective factors: seeking emotional support, planning, positive reevaluation, and active coping;
- Lowering aggression control disorders is significantly associated with an increase in four protective factors: seeking emotional support, turning to religion/religious coping, planning, and positive reevaluation;
- Reducing self-destructive tendencies significantly correlates with an increase in the intensity of three protective factors: planning, positive reevaluation, and seeking instrumental support;
- A decrease in self-hostility is significantly accompanied by an increase in three protective factors: planning, active coping and seeking instrumental support;
- Decreasing retaliation tendencies is significantly associated with an increase in two protective factors: seeking emotional support and turning to religion/religious coping;
- A lowered general intensity of the aggressiveness syndrome is significantly related to an increase in the levels of two protective factors: seeking emotional support and turning to religion/religious coping;
- Reduced indirect aggression significantly coexists with an increase in the intensity of two protective factors: seeking emotional support and turning to religion/religious coping;
- Decreased reactive aggression is significantly accompanied by an increase in the level of two protective factors: seeking emotional support and turning to religion/religious coping;
- Decreasing the intensity of unconscious aggressive tendencies is significantly accompanied by an increase in the level of one protective factor: turning to religion/religious coping;
- Reduced instrumental aggression is significantly associated with an increase in the intensity of one protective factor: seeking emotional support.

3.3. Characteristics of the Religious Strategy/Religious Coping as a Factor Protecting against Aggressive Behavior in Seniors

The information in Table 7 justifies the conclusion that hypothesis 3 has been confirmed. In the group of seniors, the remedial strategy in the form of turning to religion/religious coping is a protective factor concerning six manifestations of aggression: (1) the general intensity of the aggression syndrome, (2) a retaliation tendency, (3) unconscious aggressive tendencies, (4) aggression control disorders, (5) reactive aggression, and (6) indirect aggression. Therefore, it can be concluded that an increase in the frequency of coping with problems by seeking security and/or solace in religion or faith through religious practice, prayer and/or meditation (a counter-strategy in the form of turning to religion/religious coping) coexists significantly with:

- A lower intensity of various manifestations of aggression (the general intensity of the aggression syndrome);
- Reduced aggressive behavior as performing intended revenge, seeking opportunities to retaliate for experienced failures and/or interpreting aggressive actions as necessary reactions in interpersonal contacts (retaliation tendencies);
- A lower intensity of the tendency to manifest seemingly non-aggressive behavior, a form of conflict-free and unpunished aggressiveness (unconscious aggressive tendencies);
- A decrease in difficulties in controlling manifestations of self-aggressiveness, controlling impulsiveness, explosiveness, choosing less harmful and socially accepted forms of aggression (aggression control disorders);
- A lower level of impulsiveness, which is reflected in less frequent behaviors characterized by a strong emotional hue with the simultaneous lack of a rational attitude towards the situation (reactive aggression);

- A reduced tendency to change various types of direct attacks to indirect attacks, meaning to attack other people by ridiculing, gossiping, and complaining about them, ridiculing other people's views, unfair treatment, excessive criticism, and using threats (indirect aggression).

3.4. Predictors of Overall Aggression Severity among Seniors

A regression analysis was conducted to verify hypothesis 4, which was that in a group of seniors, a religious coping strategy is among the predictors of overall aggression severity. The results of the statistical calculations are presented in Table 8.

Table 8. Results of regression analysis to explain the general intensity of the aggression syndrome by passive and active stress coping strategies in a group of seniors (n = 329).

	B	SE	Beta	t	*p*
(Stable)	21.557	3.988		5.406	0.000
Denial	−0.221	0.640	−0.021	−0.346	-
Discharge	1.469	0.676	0.127	2.174	0.030
Psychoactive substance use	3.038	0.545	0.303	5.571	0.000
Withdrawal	1.565	0.661	0.138	2.369	0.018
Self-blame	−0.551	0.563	−0.055	−0.977	-
Active coping strategy	−2.650	0.854	−0.207	−3.103	0.002
Planning	0.977	0.781	0.085	1.252	-
Positive reevaluation	0.037	0.700	0.003	0.053	-
Acceptance	0.143	0.705	0.011	0.203	-
Sense of humor	−0.180	0.674	−0.015	−0.267	-
Turning to religion/positive religious coping strategy	−0.891	0.435	−0.109	−2.047	0.041
Seeking emotional support	−1.704	0.782	−0.154	−2.179	0.030
Seeking instrumental support	0.740	0.742	0.070	0.996	-

Dependent variable: intensified aggression syndrome (IPSA II: global score); B—unstandardized coefficient; beta—standardized coefficient; skorygowane R^2: 0.232.

The search for predictors of overall aggression severity included five passive coping strategies (denial, discharge, psychoactive substance use, withdrawal, and self-blame) and eight active coping strategies (active coping, planning, positive reevaluation, acceptance, humor, turning to religion/positive religious coping, seeking emotional support, and seeking instrumental support).

Results of regression analysis (explaining 23% of the variance) showed that six coping strategies were predictors of seniors' overall aggression severity.

- Three passive strategies—psychoactive substance use (Beta = 0.303; $p < 0.000$), discharge (Beta = 0.127; $p < 0.03$), and withdrawal (Beta = 0.138; $p < 0.018$);
- Three active strategies—active coping (Beta = −0.207; $p < 0.002$), seeking emotional support (Beta = −0.154; $p < 0.03$), and turning to religion/positive religious coping strategy (Beta = −0.109; $p < 0.041$).

Therefore, it can be concluded that the general intensity of aggression in seniors increases when, in problematic situations, a person: drinks alcohol/uses other psychoactive substances in order to feel better or to survive the existing difficulties (use of psychoactive substances), displays negative emotions (discharge), gives up intended goals and/or does not try to solve the situation.

On the other hand, the decrease in the general intensity of aggressiveness is associated with the introduction of ways of coping with stress by seniors such as making efforts aimed

at solving/improving the existing situation (active coping), receiving encouragement and understanding from other people (seeking emotional support), and prayer and finding solace in faith (turning to religion/positive religious coping strategy).

Based on the results presented, it can be concluded that hypothesis 4 was confirmed, as a positive religious coping strategy is one of the 6 predictors of overall aggression severity.

4. Discussion

The results of our study in the form of isolating a positive religious coping strategy as one of the six predictors of overall aggressiveness severity allow us to support the position found in the literature that positive religious coping strategies interact with active non-religious ways of coping with experienced problems and consequently jointly protect against the negative effects of stress (Heidari et al. 2016; Chow et al. 2021).

The results of our research show that passive stress coping strategies, including using psychoactive substances, stopping activities, and discharge, are risk factors in the aggressive behavior of seniors, consistent with reports in the literature on the subject. The results obtained both in different groups and under various stress-generating circumstances allow us to conclude that passive coping strategies increase the risk of the destructive effects of experienced stress.

The most frequently mentioned consequences of passively coping with the experienced mental tension in a problem situation include that it remains for a long time after the end of stressful circumstances, a negative mood, a low level of self-esteem, a high level of anxiety, depression symptoms, post-traumatic stress disorder (PTSD), frequent use of psychoactive substances, preference for various forms of aggressive behavior, and the increased risk of criminal behavior (e.g., Niewiadomska 2002; Cofini et al. 2015; Liu et al. 2016; Baral 2019; Lemée et al. 2019).

Also confirmed in the literature on the subject is the positive verification of the hypothesis that in the group of seniors, active stress coping strategies (e.g., seeking emotional support and active coping) constitute factors that protect a senior against the occurrence of aggressive behavior. The analysis of dependencies concerning the preference for active coping strategies to deal with the experienced trauma, e.g., by actively engaging in changing the environment, solving existing problems, helping others, or increasing social contacts, reduces the risk of destructive adaptation methods, e.g., the occurrence of mental problems in the form of post-traumatic stress, depression, anxiety (Tang 2006; Cofini et al. 2015; Baral 2019; Yu et al. 2020).

A positive verification of the hypothesis that a positive religious strategy protects seniors against the destructive effects of stress in the form of aggressive behavior is also consistent with the results of analyses conducted by other researchers. So far, two important regularities have been established in terms of the relationship between preference for positive religious coping strategies in problem situations and the effects of experienced stress. First, the use of such activities inhibits the occurrence of the negative consequences of stress, including symptoms of depression, anxiety, post-traumatic stress, and the frequent use of alcohol and/or other psychoactive substances (Smith et al. 2003; Ghandour et al. 2009; Tran et al. 2012; Feder et al. 2013; Areba et al. 2018; Pirutinsky et al. 2020).

Second, significant relationships were found between positive religious coping strategies in difficult circumstances (e.g., through a positive religious reevaluation, relying on a safe relationship with a merciful God, seeking spiritual support, religious practices, and prayer) and the constructive effects of stressful events. These include forms of post-traumatic growth, discovering a better life orientation, finding answers to important existential questions, strengthening beliefs about the meaning of life, increasing the quality of one's existence (life satisfaction), and increasing self-esteem and/or self-efficacy (Pargament 1997; Pargament et al. 2000; Harrison et al. 2001; Pargament et al. 2001; Ano and Vasconcelles 2005; Haslam et al. 2009; García-Alandete and Valero 2013; Park 2013; Büssing et al. 2015; Dowson and Miner 2015; Aghababaei et al. 2018; Bradshaw and Kent 2018; Fatima et al. 2018; Baral 2019; Zarzycka and Zietek 2019; Zarzycka and Puchalska-Wasyl 2020).

5. Conclusions

This study supports the following conclusions:

1. Passive stress coping strategies, such as using psychoactive substances, stopping activities, denial, discharge, and self-blame, are risk factors for aggressive behavior in the senior population. Due to the correlational nature of the associations obtained, one cannot conclude the existence of causal relationships, but only the co-occurrence of the risk factors tested with the preference for manifestations of aggressiveness.
2. Active stress coping strategies (seeking emotional support, seeking instrumental support, planning, positive reevaluation, and active coping) constitute factors protecting against the occurrence of aggressive behavior in the group of seniors. The correlation analysis between the preference for active coping strategies and the intensity of aggressive behavior justifies the conclusions about the co-occurrence of the tested variables. However, it does not provide a basis for treating the results obtained in terms of causal relationships.
3. A positive religious stress coping strategy in the senior group is a factor that protects against the following forms of aggression: (1) the general intensity of the aggression syndrome, (2) a retaliation tendency, (3) unconscious aggressive tendencies, (4) aggression control disorders, (5) reactive aggression, and (6) indirect aggression. The presented relationships were obtained by conducting a correlation analysis. Therefore, the existence of causal relationships cannot be inferred, but only the co-occurrence of a positive religious strategy of coping with stress with the intensity of the mentioned manifestations of aggressiveness.
4. A positive religious coping strategy is one of six significant predictors of overall aggression severity among seniors. The preference for three passive coping strategies (substance use, discharge, and/or withdrawal) contributes to the increase in aggressive behavior, while the prevalence of three active coping strategies (active coping, seeking emotional support, and turning to religion/positive religious coping strategy) contributes to the decrease.
5. The obtained research results justify two practical implications in terms of searching to provide adequate support for a group of seniors in stressful situations, e.g., during the COVID-19 pandemic (Yu et al. 2020). The first step is for specialists to stimulate the elderly to abandon passive coping strategies in favor of active ways of coping with stress in difficult life situations. The second implication relates to strengthening positive religious stress coping strategies among the senior population, because this way of coping with perceived mental tension: (a) inhibits the onset of adaptation disorders; (b) generates positive effects of the perceived stress; and (c) in situations of traumatic events (e.g., catastrophes), is more often used by the elderly as compared to younger age groups (Cofini et al. 2015; Baral 2019).

Research limitations. The results presented here are mainly exploratory in nature. Therefore, this study on the relationship between the 13 coping strategies and the overall aggressiveness severity and its 11 dimensions was mainly conducted in a correlational model. Regression analysis was conducted only when explaining the overall aggression severity (total score in IPSA II). The obtained results are in line with previous conclusions formulated in the literature on the subject. The first conclusion is that there is a moderate relationship between the preference for a positive religious coping strategy and the intensity of aggressiveness. The second conclusion is that the analyses conducted mainly allow for correlational rather than causal conclusions. Only when explaining the overall severity of aggression (constituted by different manifestations of aggressive behavior) can predictive conclusions be made (Ano and Vasconcelles 2005). In subsequent analyses on the presented issue, longitudinal studies should be carried out, which can capture changes in the dynamics and stability of active and passive stress coping strategies in different periods of life according to the *life-span* research methodology (Baltes et al. 1980; Fraley and Roberts 2005). Future studies should also use more advanced statistical analyses that will further clarify the nature of the relationships obtained. In further exploration of the results,

age should be considered as a moderating factor in the relationship between preferred coping strategies (including positive and negative religious strategies) and behaviors in difficult situations. It is also worthwhile to include a path analysis in the proposed research in order to search for associations of religious coping strategies not only with the intensity of aggressive behavior, but also with other variables of a subjective, situational, social, and cultural nature. This type of research is specifically supported in the literature (Tran et al. 2012; Ellison et al. 2013; Park 2013; Ahles et al. 2016; Santos et al. 2017; Areba et al. 2018; Bradshaw and Kent 2018; Pirutinsky et al. 2020).

On the other hand, further exploration of the relationship between coping strategies and the effects of stress in the senior population should take into account the following issues: (1) relationships between positive and negative religious strategies and the destructive consequences of experiencing problem situations, (2) the coexistence of positive and negative religious strategies along with the positive consequences of traumatic events, and (3) the relationship between positive and negative religious strategies and short-term and long-term consequences of stress (Yu et al. 2020).

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