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A Study on Quality of Life, Satisfaction with Life and Guilt Proneness

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A B S T R A C T

Life changes after 60 years of age in many different ways. Retirement is a major change-provoking life situation. The aim of the study is to understand the correlation between Quality of Life, Satisfaction with Life and Guilt Proneness among working and non-working geriatric (people aged above 60) population. To test the hypothesis which was that there is no significant relationship between Quality of Life, Satisfaction with Life and Guilt Proneness among working and non-working geriatrics, 66 respondents: 33 working and 33 non-working individuals voluntarily participated in a semi-interview and gave their valuable responses over 3 sub-scales: Older People's Quality of Life Questionnaire (OPQOL-35), Satisfaction with Life Questionnaire (SWLS) and Five-Item Guilt Proneness Scale (GP-5). The result showed a positive correlation between quality of life and satisfaction with life among working geriatrics as compared to non-working geriatrics. No significant relationship was evident in the guilt proneness area of working and non-working geriatrics. Hence, rejecting the hypothesis for quality of life and satisfaction with life variables, while accepting the hypothesis for guilt proneness variable. Findings of this study suggest various implications to policymakers and health professionals towards designing interventions and well-being programs for geriatrics, especially in context of work and retirement. Further research can be done to better explore the same population with different variables, such as happiness and quality of life or gender. Overall, this study contributes to the literature on geriatric mental health and highlights the importance of considering working status as an important determinant of well-being in geriatrics.

Keywords: : geriatrics, quality of life, satisfaction with life, retirement, mental health, working status, guilt proneness, working geriatric population, non-working geriatric population, older adults, well-being.

1. Introduction

1.1 QUALITY OF LIFE

From a linguistic viewpoint, Quality is linked with the Latin word *Qualitas*, which connotes the intrinsic nature or the level of perfection in something. The concept of Quality of Life refers to an individual's perception about their way of living. Different elements that makeup Quality of Life are health, social relationships, home and neighborhood, freedom/control over life, psychological and emotional well-being as well as religious and cultural ideas. According to the definition provided by World Health Organization (W.H.O.) Quality of Life is shaped by an individual's subjective assessment of their own circumstances and position in life, taking into account their cultural context, values, goals, expectations, beliefs, and interests which can be influenced by their mental health, independence and personal and social relationships. It is important to note that an individual's quality of life is greatly influenced by their cognitive context vis-à-vis different aspects of life and how these aspects hang together with one another.

The most primitive data constructed on Quality-of-Life ages back to Aristotle's Ethics (384-322 B.C.). In this manuscript, Aristotle explained that happiness does not lie in being wealthy but is a state of mind or somewhat an activity. His idea was centered majorly on the upper-class. Thomas More democratized this idea and spread it among masses. In the Age of Enlightenment, major focus was on utilitarian approach, in which it was understood that material well-being is the most potent source of happiness. Arthur Pigou, an economist, stated that economic growth can facilitate total well-being. This theory was tested by Richard Easterlin by using psychological measures of well-being. This gave rise to happiness approach to quality of life.

Different psychologists have different viewpoints in regard to quality of life. Sigmund Freud (1856-1939) believed that Quality of Life is to seek pleasure, gratify instincts and abstain from pain. One can achieve independent life if their childhood has been free of pain. (Mahfouz, 2006, pp. 125-180). Abraham Maslow, founder of Humanistic school of thought, gave Hierarchy of Needs and postulated that as one keeps on climbing up the hierarchy to satisfy their needs, the quality of life keeps on improving. Starting from basic needs, that is, physiological needs to higher needs, that is, self-actualization. (Gepner, 2003)

1.2 SATISFACTION WITH LIFE

Satisfaction means to make or do enough. Satisfaction with life implies acceptance of one's life situations or ability to meet one's needs and wants. A person may have a good quality of life and still may not be satisfied. The difference in both terminologies lies in the fact that quality of life talks about living conditions or lifestyle while life satisfaction means finding contentment in those conditions. Empirical research suggests that disabled individuals

do not report lower levels of life satisfaction than non-disabled ones. (Sousa & Lyubomirsky, 2001) Neugarten was the first person to bring about the concept of life satisfaction in 1961 and this later led to many researches. He defined life satisfaction as the difference in the result obtained from what we need and what we get in life. (Onur, 1997). It includes not just a person's "individual" lives but also every aspect of their lives. This means that life satisfaction indicates a person's 'apparent' quality of life together with mental and physical health.

According to Diener (1984) life satisfaction includes, satisfaction from life, desire to change life, satisfaction from the past, satisfaction from the future, and the views of the person's relatives about the person. Different areas of one's life satisfaction can include: family, work, neighborhood, health, finances, leisure and social relationships. Life satisfaction deeply impacts an individual's mental health. (Aydmer, 2011) It indicates how well people thrive in their lives.

There are two levels of life satisfaction; external conditions and inner psychological processes. If we can understand what external situations create life satisfaction, government schemes can be made/implemented to bring about such conditions for all. On the other hand, if we can understand what mental processes lead a person towards a satisfactory life, then, it would be theoretically possible to assist others to acquire them.

Theories related to life satisfaction are: top-down theories and bottom-up theories. Bottom-up theories of life satisfaction state that life satisfaction is a sum of different life domains, such as, health, work, family, money, social relations, neighborhood, safety, and so on. Assumption being that overall life satisfaction comes from concrete areas of life. (Heller et al., 2004) Various theories in conjunction to bottom-up theories are: multiple discrepancy theory (Michalos, 1985), Hierarchy of Needs theory by Abraham Maslow (Maslow, 1970) and the self-concordance model (Sheldon and Elliot, 1999) which state that the more needs are satisfied, the greater the satisfaction of life as a whole is. Top-down theories rest on the premise that life satisfaction depends on an individual's personality traits and genetic effects. (Headey, 2014). It is a dispositional explanation of life satisfaction. (Steel et al.,2008) The distinction between both these theoretical approaches were explained by Ed Diener in 1984.

1.3 GUILT PRONENESS

Life is not always what we expect it to be. It does not come with a manual. Many a times, life experiences surprise us with the worst of times. Bad feelings emerge out of nowhere. Guilt is a common feeling among individuals of all ages. But it is not always a negative emotion. It influences our actions/overt behaviors and may motivate people to do good deeds. (Estrada-Hollenbeck & Heatherton, 1998) A feeling of guilt occurs when an individual feels responsible for someone feeling negative. Individuals experiencing guilt focus on how their behavior affects others.

Historically, Freud in his earlier works focused on guilt. Freud defined guilt as an emotion resulting from a conflict between the morally superior superego and the hedonistic Id. Within Anthropology, guilt was conceptualized as an emotion resulting from private act of committing a moral violation of law.

Guilt and guilt proneness are interrelated but are different terms. Guilt proneness is a personality characteristic related to "a predisposition to experience negative feelings about personal wrongdoing, even when the wrongdoing is private" (Cohen et al., 2012, p.2) while guilt is an uncomfortable emotion that occurs when a person has committed a felony/crime or transgressed a social rule. Guilt proneness depicts the level of a person's unethical behavior. Higher guilt proneness shows lower levels of unethical behavior. (Cohen et al.,2012) Tangney (1991) described guilt proneness as healthy and adaptive. Feelings of guilt can bring about behaviors by motivating a person to repair the outcomes of one's mistakes and to ensure that steps are taken to avoid similar outcomes in the future.

Erik Erikson was influenced by Freud's work and gave the Psychosocial theory where he described how social environment can influence our personality. It is divided into eight stages where each stage has a conflict that needs to be resolved. The last stage of this theory is called "Integrity Vs Despair" which occurs during old age. At this stage, the person looks back at their life and determine whether what they did was right or wrong. If the person feels that they have lived a good life, a sense of fulfilment arises from it, hence, resolving the conflict associated to this stage. Studying the variable guilt proneness lets us know how a person looks back at situations where they had to choose between right or wrong.

2. Rationale

India's demography consists of geriatric population that is increasing with each passing year. (Magnus G.,2012; Lodha P. & De Sousa A.,2018) According to population census carried out in 2011, there are nearly 104 million elderly persons. The proportion of senior citizens has increased to 10.1% in 2021 and is further likely to increase to 13.1% in 2031. The geriatric population has different needs and the solution to which must be tailored to them. This leads to many challenges. Major challenges include growing population of individuals aged 60 years and above, increase in neurodegenerative disorders like dementia, limited mobility, disability, losing a loved one, severe physical or mental pain, reluctance to seek help for mental health issues, untrained professionals, heterogeneity in clinical picture due to varying degrees of medical illnesses and multiple medications by multiple doctors. (Lodha P. & De Sousa A.,2018)

Retirement is a major challenge for the geriatrics. The retirement age for both men and women lie approximately between 56-65 years of age in the Indian sub-continent. Decrease in physical and mental levels occurs on the very next day of retirement because of changes in daily schedule. Self-esteem and self-confidence also hit rock bottom as retirement brings a bigger sense of dependency on their children which may cause unpleasant feeling in senior citizens. (Adams GA & Rau BL,2011; Bloom DE et al.,2010) Service deliveries are tougher as 80% of the population lives in rural India. (Chakrabarti S & Sarkar A,2011) Government pension schemes are inaccessible to 25.24 million senior citizens. (Pal S, Palacios R.,2011) Nuclear families are becoming

commoner in India and shifting from a locality after 60 years is difficult for elderly. (Liebig PS & Rajan SI,2003; Bartels SJ & Naslund JA, 2013; Lodha & De Sousa,2018) Quality of Life as a whole gets influenced as soon as a person gets retired.

3. Review of Literature

In the research conducted by VR Shah, DS Christian, AC Prajapati, MM Patel and KN Sonaliya (2017) on quality of life of elderly population residing in urban field practice area of tertiary care institute of Ahmedabad city, Gujarat. It was found that none of the geriatrics had poor quality of life, 56% fell into “good” category while 50.8% had “excellent” QOL. Physical, environmental and psychological domains were better in educated and married individuals who lived with their spouse. QOL as per four different domains was significantly better among males than females. Mean age of the population studied was 65.8 years with a standard deviation of 5 years. Researches need to be conducted on a comparison between quality of life and life satisfaction.

Saurav Chandra Acharya Samadarshi, Pimsurang Taechaboonsermsak, Mathuros Tipayamongkholgul and Korravaran Yodmai (2022) researched on quality of life and associated factors among older adults in a remote community of Nepal in which 671 older adults aged 60 years participated. It was found that most participants were female (53.0%), illiterate (70.6%), married (64.2%) and living with family (53.9%). Among participants, 82.4% had fair QOL, and the autonomy domain received the lowest score (average=10.98). After adjusting the model, the elderly aged <70 years had 11.07 times better QOL, elderly with high sufficient income had 2.73 times better QOL and elderly free from depression had 9.45 times better QOL compared to their counterparts. The elderly receiving social support had 9.97 times better QOL than those who did not and those able to afford healthcare services had 4.69 times better QOL than those who could not afford it.

Shilpa Devraj and MK D’mello did a cross-sectional study on the determinants of quality of life among elderly population in urban areas of Mangalore, Karnataka. The sample size contained 384 elderlies aged 60 years and above. QOL was found to be average among 74.3% of the elderly (mean score: 80.28–91.1). The factors such as age of the individual, gender, marital status, living status, education, occupation, socioeconomic status, interaction with people, use of mobile phones, and social media determined the QOL of the elderly ($P < 0.001$)

A cross-sectional study on quality of life among geriatric population was conducted by Nabarun Karmakar, Anjan Datta, Kaushik Nag and Kaushik Tripura (2018) in rural areas of Madhpur, Sepahijala district, Tripura. The population contained 76 persons aged 60 years and above which depicted a higher mean QOL score in social relationships domain in comparison to other domains, but in contrast, psychological domain was worstly affected in the presented population. More researches can be done to explore the factors affecting the psychological domain.

A community-based cross-sectional study was conducted in Ormanjhi, Ranchi, Jharkhand for a period of 6 months by Santosh Kumar Soren, Anju Prabha Kumari, Anit Kujur, Shalini Sunderam, Shashi Bushan Singh and Mayank Raj (2022) A total of 206 geriatrics aged between 60 to 69 years were assessed and it was found that the overall QOL was good to excellent. It was concluded that many factors affect quality of life. More researches need to be done on specific domains of quality of life.

Life satisfaction of university students was examined by Dr Murat Gokalp and Dr Temel Topal (2019) consisting of 229 males and 321 females. The researchers observed that life satisfaction of university students vary according to income levels and place variables. For future researches, different life satisfaction tools can be used or the questionnaire can be expanded which will benefit the reliability and validity of the research. Also, equal sample size of both males and females can be taken which will increase the measurability and generalizability of the research.

Ibrahim Tas and Murat Iskender (2017) examined variables- meaning in life, satisfaction with life, self-concept and locus of control among 363 teachers (114 women and 219 men). A positive relationship was found between experienced meaning in life and satisfaction with life and self-concept while a negative relationship was found between experienced meaning in life and locus of control. It was also concluded that expected meaning in life, satisfaction with life and locus of control were found to differ by gender and expected meaning in life and self-concept differed by marital status. Researches can be done with equal number of male and female participants so as to increase the generalizability of research and a different variable can be studied with meaning in life and satisfaction with life, for example, quality of life to find how these correlates with the given population.

A cross-sectional study on life satisfaction and depressive symptoms of mentally active older adults in Poland was studied by Katarzyna Van Damme-Ostapowicz, Mateusz Cybulski, Monika Galczyk, Elzbieta Krajewska-Kulak, Marek Sobolewski and Anna Zalewska (2021) The number of participants were 125 of whom 78.3% were female and 21.7% were males.It was found that men rated higher levels of satisfaction than women. Life satisfaction did not differ on the basis of sex, age, or education. Level of depression and life satisfaction were found to be inversely proportional.

A community-based cross-sectional study on satisfaction with life and associated factors among elderly people living in two cities in northwest Ethiopia was conducted by Habtamu Sewunet Mekonnen, Helena Lindgren, Biftu Geda, Telake Azale and Kerstin Erlandsson (2022). Through systematic random sampling, 816 elderly people aged 60 years and above were taken. The level of satisfaction found to be was: 17.2% were dissatisfied, 63.8% were moderately satisfied and 19.0% were well-satisfied. Future researches can be done in other areas except households, such as, religious places, rural residents, streets or temporary settlements, which would be more representative of elderly living in the two cities of Ethiopia.

Life satisfaction Index among elderly people residing in Gorgan and its correlation with certain demographic factors in 2013 was examined under Maryam Chehregosha, Amir Bastaminia, Fatemeh Vahidian, Azam Mohammadi,Aliakbar Aghaeinejad, Ensiyeh Jamshidi, and Afsaneh Ghasemi (2016). Through convenience sampling method, 250 elder people (age 60 and above) most of them being males, were collected for four months. It was found that only 40 percent of the participants were satisfied with their lives. Hence, the researchers concluded that new plans must be devised to reform social

attitudes toward the phenomenon of aging and respect for elderly on a family and societal level. Further researches can be done by taking equal number of male and female participants.

Baba Gnanakumar, Gita P.C., Baby, M.K. and John Pradeepkumar (2021) did a qualitative study on life satisfaction among old age homes in Bengaluru through structured interview method to collect quantitative data and in-depth interview to collect qualitative data. The population includes geriatrics above age 60, government health providers and private health care providers. It was found that the stress levels of geriatrics are associated with family size, marital status quo and disability. Lack of community support and separation from families because of disputes causes difficulty to sustain alone. Age, gender, occupation and income were not stress causing factors.

Justyna Mróz & Wojciech Sornat (2023) researched shame and guilt proneness and self-compassion as predictors of self-forgiveness on 300 participants. The results showed that self-compassion mediated the link between shame-proneness and self-forgiveness, shame-proneness and self-forgiving feeling and, shame-proneness and self-forgiving beliefs. Shame activated during an unlawful act leads to less understanding, clemency and compassion toward oneself. This attitude hinders self-forgiveness.

Research conducted on 354 undergraduates by Chelsie M. Young, Clayton Neighbors, Angelo M. Dibello, Zachary K. Traylor and Mary Tomkins (2016) studies variables shame and guilt proneness as mediators of association between general causality orientations and depressive symptoms. Results indicated that shame and guilt proneness associate with self-determination and depressive symptoms. Another research can be conducted by taking up the same model with longitudinal data.

Research on physical self-concept and shame and guilt proneness as predictors of body-related shame and guilt was examined (2011) based on Tracy and Robins' (2004) model of self-conscious emotions. 284 female participants participated whose mean age were 20.6 ± 1.9 years. The study provided partial support for the model for predicting shame and little support for predicting guilt. Also, shame proneness and physical self-concept were significant predictors of body shame.

Y.Martin, Professor P. Gilbert, K. McEwan & C. Irons explored the relation of entrapment, shame and guilt in 70 caregivers of patients with dementia. They found that behavioral disturbances were not found to be significantly associated with entrapment, shame and guilt variables unlike other studies which showed high relation between experience of entrapment and depression.

4. Methodology

4.1 Aims

The researcher is doing a correlational study to investigate the differences in Quality of Life, Guilt Proneness and satisfaction with life of working and non-working geriatric population. Geriatrics are individuals above 60 years of age by using three different questionnaires for the same.

4.2 Objectives

1) To study the Quality of Life of working and non-working geriatric population above 60 years of age.
2) To study the Guilt Proneness of working and non-working geriatric population above 60 years of age.
3) To study the Satisfaction with Life of working and non-working geriatric population above 60 years of age.

4.3 Hypothesis

Null Hypothesis: There would be no significant difference between Quality of Life of working and non-working geriatric population.

Alternate Hypothesis: There would be a negative correlation between non-working geriatrics and Quality of Life.

Null Hypothesis: There would be no significant difference between Guilt Proneness of working and non-working geriatric population.

Alternate Hypothesis: There would be a positive correlation between non-working geriatrics and guilt proneness.

Null Hypothesis: There would be no significant difference between Satisfaction with Life of working and non-working geriatric population.

4.4 Sample and its selection

The study was conducted on the urban population of Lucknow, Uttar Pradesh who were above 60 years of age as on 1st March,2023. The sample contains 66 individuals: 33 working and 33 non-working individuals. Working individuals are those who are currently employed/self-employed or salaried. Non-working individuals are those who are either pensioned or non-salaried. The data was collected via semi-interview method in the month of March.

4.5 Description of tools employed

Quality of Life of participants was conducted via Older People's Quality of Life (OPQOL-35) developed by Ann Bowling of University of London, Great Britain. It consists of 35 questions, spread over nine domains: life overall; health; social relationships; independence, control over life, freedom; home and neighborhood; psychological and emotional well-being; financial circumstances; leisure and activities; religion and culture. The questionnaire is based on 5-point Likert scale where the participant is asked the extent to which he/she agrees on every single statement. The score ranges from 1 to 5 on every stem. Higher scores indicate better QOL. The final score can be between the range of 35, depicting worst QOL and 175, depicting best QOL. The tool has a good test-retest reliability and a Cronbach's alpha coefficient of 0.78. Good discriminant validity and criterion validity was found.

Participants administered Five-Item Guilt Proneness scale (GP-5) developed by Kim Cohen and A.T. Panter in Carneige Mellon University of Pittsburgh. The scale contains five situations that a person may encounter in day-to-day life, followed by reactions to those situations. The participant has to imagine what they would do in such situations and indicate the likelihood in the manner in which they would react. It is a Likert scale where 1 indicates Extremely unlikely and 5 indicates Extremely Likely. Higher scores indicate higher guilt proneness. The scale represents adequate reliability and validity and ahs been used widely.

Satisfaction with Life scale developed by Diener, Larsen and Griffin was developed in 1985 and has been used widely for measuring global cognitive judgments of one's life satisfaction. It is to be noted that the scale is not a measure of positive or negative affect. The participants were given the instructions carefully for the 5-item scale. It uses a 7-point scale that ranges from 7 strongly agree to 1 strongly disagree.

4.6 Procedure

The responses were collected majorly through snowball sampling and by paying visits to schools, shops, religious places and parks. Individuals above age 60 years were asked if they would like to contribute in the research conducted on life satisfaction of geriatrics. Upon their agreement, they were made comfortable and were seated in a well-lit room with minimal distractions. They were told that their responses will be kept confidential and were made to sign a consent form in which it was mentioned: "I understand that my participation is solicited (asked for), yet strictly voluntary and all information will be kept confidential and may be used solely for research purpose. I hereby give my informed consent for participation." Their name, age and whether they are working or non-working were asked. Firstly, they were asked about various dimensions about their life and questions from the questionnaire were read out aloud by the researcher. Several other questions related to their health and daily routine were asked. For example, "What diseases/body pains do you have?", "How many times do you go out in a week?" and other miscellaneous questions pertaining to the subject's responses. After the completion of the tests, the subject was thanked for their time and contribution to the research. Also, they were recommended to go to therapy sessions if they felt any psychological or emotional disturbances for the same.

4.7 Statistical Analysis

The data collected was typed out on an MS Excel Sheet. Both the responses of working and non-working persons were inserted and scored as per the scoring criteria in the tool's manual. After this, IBM SPSS Statistics software was used to find the correlation between the variables.

At first, a test for normality and homogeneity of variance was run to check whether the data satisfies the assumptions for running a parametric test (e.g., Pearson's correlation coeeficient) or not. If not, a non-paramtric test (e.g. Mann-Whitney U Test) can be used. Normality was checked by statistical test and also by visually inspecting the normal probability plots. Homogeneity of variance was checked using Levene's test for Equality of Variances.

As the data rejected the assumptions of normality and homogeneity of variance, a non-paramteric test is used.

5. Analysis of Results

It was found in the tests of normality that the assumptions were not met for "guilt proneness" and "Satisfaction with Life" variables, except for "quality of life" for working population. Levene's test result indicated that there is no significant difference in variables between the two groups: working and non-working for all three variables.

As both the necessary assumptions weren't met, hence, parametric test could not be run for the data and hence, Spearman's rank correlation coefficient was used to find correlation among variables. Table 1 shows the result of the data entry.

			Working & Non-Working	Quality of Life	Guilt Proneness	Satisfaction with Life
Spearman's rho	Working & Non-Working	Correlation Coefficient	1.000	-.363*	-.202	-.406**
		Sig. (2-tailed)	.	.003	.103	<.001
		N	66	66	66	66
	Quality of Life	Correlation Coefficient	-.363*	1.000	.460**	.608**
		Sig. (2-tailed)	.003	.	<.001	<.001

		N	66	66	66	66
	Guilt Proneness	Correlation Coefficient	-.202	.460**	1.000	.188
		Sig. (2-tailed)	.103	<.001	.	.132
		N	66	66	66	66
	Satisfaction with Life	Correlation Coefficient	-.406**	.608**	.188	1.000
		Sig. (2-tailed)	<.001	<.001	.132	.
		N	66	66	66	66

Table 1 representing the correlational analysis of the data.

The above table represents the Spearman's rho correlation coefficient values and their significance level for three variables and the respective groups: 1) Working/Non-working and Quality of Life, 2) Working/Non-working and Guilt Proneness, 3) Working/Non-working and Satisfaction with Life.

For Working/Non-working and Quality of Life pair, the correlation coefficient is -0.363 which indicates a negative correlation at 0.01 level of significance, with a p-value of 0.003. This tells that there is a negative correlation between working and non-working status and quality of life, indicating that higher levels of work or non-work may be associated with lower quality of life.

For Working/Non-working and guilt proneness pair, the correlation coefficient was found to be -0.202, which is not significant at 0.05 level of significance, with a p-value of 0.103, suggesting that there is no significant relationship between working and non-working status and guilt proneness.

For working and non-working and Satisfaction with Life pair, the correlation coefficient is -0.406, which is statistically significant at the 0.01 level, with a p-value of <0.001, which suggests a negative correlation, hence, indicating the higher levels of work or non-work may be associated with lower satisfaction with life.

6. Discussion

The data provided explains that non-working geriatrics have lower quality of life and satisfaction with life as compared to working geriatrics. Based on the data, we cannot provide sufficient evidence as to whether working geriatrics or non-working have higher guilt proneness. But if we view individual scores of both data, we can say that most of the respondents from both statuses showed higher guilt proneness.

Working geriatrics reported greater quality of life and life satisfaction as they have a daily routine to follow. Being busy in physical and mental activity leads to better health, more freedom and improved psychological and emotional well-being. Having a job also leads to a regular schedule every day which offers control over life, better levels of self-confidence and self-esteem, sense of authority, and improved social relationships as individuals can interact to various people every day. Working after retirement also provides even higher financial stability as the individual need not rely solely on pension. Also, keeping all these factors, it can also be said that working geriatrics feels less lonely, as they reported it. Balance in different life domains results in better life satisfaction of working geriatrics. A disciplined life offers them greater leisure time and also less time to overthink about different life situations. Not only are they able to meet different life challenges but are also able to meet their needs on a daily basis. This assurance keeps them psychologically and emotionally fitter. Loneliness is rarely seen in working geriatrics. They are alert and always on the move. Many of them also showcase prosocial behavior and altruism, hence, showing higher guilt proneness.

7. Summary and Conclusion

Geriatrics are a boon to the present generation. Not only can they equip us with knowledge of the past but can also hold a guiding light for us in the present and the future. We all will be old one day and will share similar experiences to that of the elderly. As youth, we must become changemakers and create a healthier and safer environment for those elder to us. Research findings tell us that if we can provide better health facilities, there would be less casualties. More work needs to be done over employing the older generation so that they don't feel left out and the whole society can bear the benefits of their years of experience. But working after 60 must not be a compulsion as excess of it may lead to stress and burnout, hence causing psychological and emotional distress.

Various government and non-government organizations need to realize the urgency of understanding various needs and life challenges faced by the geriatrics and bring about government schemes and/or policies for the welfare of this sector of population. Every individual, irrespective of age or gender, needs to be educated about various bodily, mental, emotional and social changes that they may have to go through at every age's milestone so as to increase adaptability of change and decrease overwhelm and misery brought due to it. Setting up of mental health clinics that also caters to issues of geriatrics needs to be set up in India so that better care related to memory-related diseases, like, Dementia or Alzheimer's disease can be provided.

Limitations of this research study are that the sample size is small and does not include populations from hospitals or old age homes, hence, reducing the measurability and generalizability to some extent. Also, gender, as a variable can also be explored with other variables. Happiness and Quality of Life within the same population can be studied. It is also important to note that correlation does not always imply causation, so, many other factors can influence the variables. Further analysis or interpretation would be needed to make definitive conclusions about the variables under study.

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