



Optimism as Predictor of Good Life

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ABSTRACT

The present study attempts to ascertain the role of optimism in good life of an individual. The study was carried out with 426 participants. Males and females of 15 to 70 years age were drawn from Varanasi district, INDIA. The respondents were given the 26 items WHOQOL- BREF scale, that measures four domains of quality of life (QOL) namely, physical health, psychological states, social relationships and environment, and also a 5 items Satisfaction with Life Scale (SWLS), which measures the overall satisfaction of an individual. Along with these scales, 10 item Life Orientation Test – Revised (LOT - R) was also given to respondents for assessing the level of optimism. Analysis of the responses showed that optimism, life satisfaction and different domains of QOL were positively correlated with each other. Results also indicated that, after controlling all demographic variables, optimism was significantly contributing in the prediction of life satisfaction and QOL of people living in urban and rural settings.

Keywords: Optimism, life satisfaction, quality of life, demographic variables

Introduction

The concepts of optimism and pessimism have been acknowledged for a long time. The roots of their use in contemporary psychology go back to the beginning of the modern period of philosophy in the 17th century (Domino & Conway, 2001). At that time, philosophers commonly maintained that the successful application of the rationalization of the cosmos needed either an optimistic or a pessimistic philosophical outlook. These outlooks were seen as opposing positions with regard to the universe: as favorable to the aims and aspirations of human beings or as generally resistant to the flourishing of human beings and civilizations. Moving from the emergence of optimism and pessimism in the writings of Rene Descartes (1596-1650) (Descartes, 1628/1985) to 19th and 20th centuries and the work of psychologist-philosophers such as William James (1842-1910) (James, 1902), the focus of the discussion shifted gradually from the cosmos to the subjective element of human experience (Domino & Conway, 2001).

During the past thirty years, mainly as a legacy of Scheier and Carver's (1985) pioneering research on generalized outcome expectancies, and Seligman's (1975) influential work on learned helplessness, psychologists have actively examined optimism and pessimism in our lives. Even though most contemporary researchers agree with the general conceptualizations that optimism reflects an expectation that good things will happen, whereas pessimism reflects an expectation that bad things will happen, there are differences in operationalization. Most of the disagreement arises from the theoretical frameworks from which these terms are derived.

Scheier and Carver (1985) defined dispositional optimism and pessimism as generalized outcome expectancies of good vs. bad outcomes in one's life. Their definition stems from the more general model of the self-regulation of behavior that assumes that peoples' actions are greatly influenced by their beliefs about the probability of those actions. Expectancies are seen as a major determinant of the disjunction between two general classes of behavior: continued striving vs. giving up. Accordingly, individuals who hold positive expectations for the future are assumed to believe that good things will occur in their lives, and tend to see desired outcomes as attainable and to persist in their goal-directed efforts. In contrast, individuals who hold negative outcome expectations for their future are assumed to expect bad things to happen, and tend to

withdraw effort more easily, become passive and finally to give up on achieving their goals (Scheier & Carver, 1985).

Scheier and Carver (1985) also suggested that outcome expectancies *per se* are the best predictors of behavior, rather than the basis from which the expectancies are derived. In other words, it is not important *why* people expect good things to happen in their lives (e.g., having good luck, being favored by God, working hard); *what is important is the generalized optimistic or pessimistic orientation itself* (Scheier & Carver, 1987). Further, Scheier and Carver suggest that these generalized expectancies are relatively stable across time and in different contexts, and that they form the basis of an important personality trait (Scheier & Carver, 1985; Scheier et al., 1994).

Relationship of Optimism with Well-being

Well-being is an essential component of mental health. Well-being reflects a favorable judgment of the quality of a person's life. Schweizer, Beck-Seyffer, & Schneider (1999) observe that optimism can influence an individual's sense of well-being. It is logical that an intimate relationship would exist between the nature of a person's expectations of the future and how the person would evaluate his or her own life. Strassle, McKee and Plant (1999) mentioned that optimism is positively correlated with "life satisfaction, positive physical and mental health, lower frequencies of mental disorders, and self-esteem" (p. 191). Avia (1997) suggested that positive emotions are essential to overall well-being, and that good mood, optimism and satisfaction with one's life are vital aspects of a healthy personality. Marshall et al. (1992) reported optimism to be highly associated with positive affect, and Peterson (2000) refers optimism to be linked to good mood. In respect of the psychological or mental benefits, optimism has been found to buffer the effects of daily stressors on self-esteem and burnout in woman executives (Fry, 1995).

Burke, Joyner, Czech, & Wilson (2000) reported that optimists, as opposed to pessimists, display better physical health. Peterson (2000) cited several studies that report positive correlation between optimism and good health. In terms of physical benefits, optimism as a personality attribute has been found to be a significant mediator or moderator of stress levels. Scheier and Carver (1987) proposed that the causal link between optimism and physical health or

well-being may be due to the use of more effective coping strategies by optimists when dealing with stress. Other researchers have found that chronically stressed subjects are less optimistic than controls and that both optimism and pessimism are “influenced by environmental circumstances and life experiences” (Robinson-Whelan, Kim, MacCallum, & Kiecolt-Glaser, 1997, p. 1351). In summary, it is evident that empirical research strongly supports the proposition that optimism is positively correlated with physical and psychological well-being. The empirical evidence is rapidly accumulating and different areas of human functioning are constantly being investigated in so far as the benefits of optimism and other resistance resources are concerned.

As indicated earlier optimism may be defined as a generalized positive expectation for the future (Scheier & Carver 1985; Scheier et al. 1994). Due to the positive relationships between (dispositional) optimism and many physical and psychological outcomes (Scheier & Carver, 1993), there has been an increased interest in understanding how different demographic variables affect individuals’ dispositional optimism. It was interesting to find out that age and gender of an individual significantly predicts the level of optimism. Several studies conducted to explore the effect of age on optimism have shown significant results. However, the findings in this respect are inconsistent. For example, a longitudinal study found that future attitude at age 13 had a positive but weak association with dispositional optimism at age 43 (Daukantaite & Bergman, 2005). Lennings (2000) revealed an age-related increase in dispositional optimism in samples aged 55 to 99 years. Chapin (2001) found that age was negatively associated with self-protective pessimism toward health risks in a community sample with age ranging from 14 to 78 years. These findings indicate a positive relationship between age and dispositional optimism.

Scheier, Carver and Bridges (1994, p. 1075) found “differences in correlations between men and women to be negligible”. Shukla (2010) conducted a study to assess the level of optimism of male and female students belonging to two different settings. Results revealed that male students have higher level of optimism than female students. Pradhan, Samal and kumar (2008) had compared the level of optimism of 30 HIV infected and 30 healthy people. They found that male participants from both groups (HIV infected and healthy) have higher level of optimism than female participants. Even in the absence of systematic gender difference and in the levels of dispositional optimism and pessimism, Chang (1998) and Rääkkönen, Matthews, Flory, Owen and Gump (1999) argued that they may exist in the developmental paths.

The study

The main focus of present study is to ascertain the role of optimism as predictor of one's good life. Although it has been studied earlier that optimism does have significant effect on good life, but significance of this variable was established along with the combined effect of other related variables. In the present study we tried to calculate the unique effect of optimism on good life with controlling other related variables.

Method

The basic idea to conduct the present study was to assess good life experience of an individual with the combined outcome of perception of one's life quality at both levels (social and individual). To assess the perception of one's quality of life and feeling of satisfaction with life both variables were conceptualized separately. Quality of life of an individual was operationalized as defined by World Health Organization (1995). According to this definition QOL is individuals' perception of their position in life in the context of culture and value system in which they live, and in relation to their goals, expectations, standards, and concerns. At the individual level QOL is a broad-ranging concept incorporating one's physical health, psychological states, level of independence, social relationships, personal beliefs, and the salient features of the environment. Feeling of satisfaction with his/her life was operationalized with the definition given by Shin and Johnson (1978). They defined life satisfaction as "global assessment of one's life quality according to his/her chosen criteria" (p. 477). Keeping in mind these two variables the study was conducted to ascertain the role of optimism in one's good life.

Participants

The present study was carried out with 426 participants drawn from the urban and rural settings of Varanasi. Male (N = 212) and female (N = 214) participants, aged 15 to 70, were included in the present study. The total sample consists of 208 participants from urban and 218 participants from rural settings. A quasi random sampling procedure was used to select the participants for the present study.

Measures

In the present study Hindi version of World Health Organization Quality of Life Questionnaire (1998) and translated version of Satisfaction with Life Scale was used to assess the meaning of good life of the participants. Life Orientation Test – Revised was used to assess the level of optimism of the participants. This scale was also back translated in Hindi version before data collection.

World Health Organization Quality of Life (WHOQOL- BREF) Questionnaire

WHO group (1995) was developed this questionnaire to assess the QOL of an individual. The original scale contains 100 items, which assess six domains of QOL. The WHOQOL-BREF is a shorter version of the original WHO scale. The Hindi version of the scale used in this study was developed by Saxena, Chandiramani and Bhargava (1998). This scale contains 26 items, which measure four domains of QOL, namely physical health, psychological states, social relationships, and environment. Out of 26 items of the scale, only 24 items are scored. Items 1 and 2 are used as fillers, and not scored. The reliability ($r = \text{Cronbach's Alfa}$) of this scale was calculated and it ranges from .59 to .85. Confirmatory factor analysis (CFI) revealed a very high validity index of physical health (0.957), psychological states (0.982), social relationships (0.972) and environment (0.922) domains.

Satisfaction with Life Scale (SWLS)

This scale was developed by Diener, Emmons, Larsen and Griffin (1985) to measure the life satisfaction of an individual. The scale contains 5 items that assess satisfaction with life as a whole. This scale was given to participants to know how satisfied they were with their life. All 5 items are keyed in positive direction. The inter-item correlations for the five items were: 0.81, 0.63, 0.61, 0.75, and 0.66.

Life Orientation Test – Revised (LOT-R)

This test was developed by Scheier, Carver and Bridges (1994). The test measures a respondent's degree of optimism or pessimism. The LOT-R is a short instrument consisting of 10 items. Only 6 of the 10 items are used to derive an optimism score. The remaining 4 items, (numbers 2, 5, 6 and 8) are filler items. Of the 6 items, 3 are keyed in the positive direction, and

3 in the negative direction. Items 3, 7 and 9 are reverse coded before scoring so as to avoid response bias. Scheier et al. (1994) report that item-scale correlations range from .43 to .63. Cronbach's alpha for all six items was .78, reflecting an acceptable level of internal consistency. Test-retest reliability was reported to be .68 (4 months), .60 (12 months), .56 (24 months) and .79 (28 months).

Besides collecting data with above mentioned scale, information regarding the participant's age, residence, family background, mobility and participation in various activities were also obtained. Socio-economic status of the participants was also assessed using Hindi version of SES scale developed by (Dubey & Nigam, 2005; 2007).

Procedure

Each participant was informed about the study, and consent for participation in the study was taken. Besides a few dropouts, there was genuine support from the participants. The researcher was individually present throughout the session to make necessary clarification in case there were confusions and queries from the participants.

The scales addressed the issues related to people's life and their satisfaction with it. These issues are prone to encourage social desirability, because participants are emotionally involved with them. Though it was difficult, sincere attempts were made to control this factor to the maximum possible extent. To do this the researcher established rapport with the participants. They were assured of the confidentiality of their responses. They were also told that their names will not be revealed to anyone at any stage of the study. Participants were also told that there was no 'right' or 'wrong' answer, and hence, no evaluative judgments regarding their personality, intelligence, or morality would be made on the basis of their answers. So, they should feel free to give their honest responses.

After the data collection was over, scoring of the responses was done according to the given coding procedure and data files were prepared for analysis. Gender, background, family structure, age, cultural activities, contact with village/city, and socio-economic status of the respondents were finalized as variables of interest for the current study.

ANALYSIS

Controls

In the present study all demographic variables were used as control variables for the analysis. Gender (Male = 0, Female = 1), background (Urban = 0, Rural = 1), family structure (Joint = 0, Nuclear 1), cultural activities (Yes = 0, No = 1), contact with village/city (Yes = 0, No = 1) were entered as dummy variables. Age and socio-economic status of the participants was also controlled for the analysis of the data.

Results

Analyses were designed to first examine the relationships among optimism, life satisfaction and QOL measures. After that the role of optimism in life satisfaction and QOL was also examined.

Product Moment correlation was computed to understand the relationships among optimism, life satisfaction, different domains of QOL. The correlation coefficient among these variables with regard to total sample is present in Table 1.

Table 1:

Descriptive statistics and Correlations among Optimism, Life satisfaction and QOL for total sample

Variables	Mean	SD	Optimism	PH	PS	SR	En	OQOL
LS	23.34	5.94	.146**	.148**	.395**	.232**	.299**	.383**
Optimism	21.02	3.56		.188**	.216**	.246**	.025	.222**
PH	14.88	2.44			.353**	.158**	.286**	
PS	14.60	2.61				.453**	.463**	
SR	9.85	2.63					.310**	
En	14.20	2.30						

Note: Abbreviations (LS = life satisfaction, PH = physical health, PS = psychological states, SR= social relationships and En = environment, OQOL = overall quality of life)

* p < .05, ** p < .01,

Table 1 shows that optimism is positively correlated with life satisfaction and all domains of QOL namely, physical health, psychological states, social relationships and environment. Optimism is positively related with physical health, psychological states, and social relationships domains not with environment domain of QOL. Domains of QOL are also found significantly inter-correlated.

Table 2 presents the outcomes of hierarchical regression analysis of socio-demographic factors and optimism for life satisfaction measure.

Table 2:
Results of Hierarchical regression analysis for predicting satisfaction with life from optimism (N = 426)

Satisfaction with life				
	Model 1		Model 2	
Predictors	B	β	B	β
Settings	1.054	.089	.952	.080
Gender	-.415	-.035	-.551	-.046
Age	.538	.102*	.584	.110*
Family Structure	.225	.018	.259	.021
Participation in Cultural Activities.	-.321	-.025	-.319	-.024
Contact with village or city	.543	.032	.619	.036
Socio-economic status	.059	.143**	.050	.121*
Optimism			.193	.116*
R		.165		.200
R²		.027		.040*
ΔR^2		.027		.013
df 1 & 2		7, 418		1, 417
ΔF		1.67		5.49*

Note: five socio-demographic variables (*settings, gender, family structure, participation in cultural activities and contact with village or city*) were entered as dummy variables.

p < .05**, *p < .01**

For the hierarchical regression examining predictors of life satisfaction (see Table 2), analysis revealed that R was not significantly different from zero at the end of the first step. After step two, with all predictors in the equation, R was significant ($F 1, 417 = 5.49, p < .05$). After the first step R^2 change was not significant but two socio-demographic measures (age and socio-economic status) were significantly contributing to R . After step two R^2 change was significant with optimism and significantly adding to the total variance in prediction of SWL. The overall model is predicting a significant effect of dispositional optimism on satisfaction with life ($F= 18.57, p < .01$) and explaining 4.0% of variance (optimism added 1.3% above the control variable, $p < .05$). Result indicated that those who displayed higher level of optimism have higher level of satisfaction ($\beta = 0.116, p < .05$).

Table 3 presents the outcomes of hierarchical analysis of socio-demographic factors and optimism for different domains of QOL measure. Scores of the different domains of QOL were combined to analyze the prediction of QOL of the participants.

Table 3:
Results of Hierarchical regression analysis for predicting Overall QOL (N = 426)

Overall QOL				
Predictors	Model 1		Model 2	
	B	β	B	β
Setting	-.300	-.021	-.495	-.035
Gender	-1.135	-.080	-1.393	-.098
Age	-.264	-.042	-.176	-.028
Family Structure	.895	.061	.960	.066
Participation in Cultural Activities.	-.904	-.058	-.900	-.057
Contact with village or city	-1.228	-.060	-1.082	-.053
Socio-economic status	.135	.274**	.117	.239**
Optimism			.368	.184**
R	.328		.374	

R^2	.108**	.140**
ΔR^2	.108	.032
df 1 & 2	7, 418	1, 417
ΔF	7.21	15.52**

Note: five socio-demographic variables (settings, gender, family structure, participation in cultural activities and contact with village or city) were entered as dummy variables.

***p < .05, **p < .01**

For the hierarchical regression examining predictors of overall QOL (see Table 3), analysis revealed that R was significantly different from zero at the end of each step. After step two, with all predictors in the equation, R was significant ($F 1, 417 = 15.52, p < .01$). After the first step R^2 change was significant with only one socio-demographic measure (socio-economic status) and significantly contributing to R . After step two R^2 change was significant with optimism and significantly adding to the total variance in the prediction of overall QOL. The overall model is predicting a significant effect of optimism on overall QOL ($F = 18.57, p < .01$) and explaining 14.0% of variance (optimism added 3.2% above the control variable, $p < .05$). Result indicated that those who displayed higher level of optimism have higher level of QOL ($\beta = 0.374, p < .01$).

Discussion

The present study was aimed to ascertain the role of optimism in well-being of an individual. Analyses revealed that optimism was positively correlated with life satisfaction and three domains of QOL. Hierarchical regression analysis showed that age was significantly contributing only for life satisfaction of total sample and socio-economic status have significant contribution to both criterion variables (life satisfaction and QOL). It also seems that, after controlling all the demographical variables, optimism significantly contributes to the total variance for both criterions (life satisfaction and QOL).

Findings of the present study can be explained with the help of relevant studies carried out in different places. The positive effect of optimism has been attributed to the strategies that optimists use to cope with stress (Carver, Pozo, Harris et al., 1993; Edgar, Remmer, Rosberger, & Fourmere, 2000; Epping-Jordan, Compas, Osowiecki et al., 1999; King, Kenny, Sheill, Hall, & Boyages, 1998; Matthews, Raikkonen, Shuton-Tyrrell, & Kuller, 2004; Segerstrom, Taylor, Kemeny, & Fahey, 1998). Studies indicate that optimists generally used acceptance and active

coping strategies (e. g., appraisal). A positive relationship of optimism with life satisfaction, positive physical and mental health, lower frequencies of mental disorders, and self-esteem has been explained in these terms (Strassle, McKee, & Plant, 1999).

Lipkus et al. (1993) indicate that optimists believe that negative events are less likely to occur in the near future, may serve a vital function. By doing so, optimists tend to engage in activities, which will increase their chances of experiencing positive outcomes. Scheier and Carver (1987) reported that optimists were more likely to use active (problem-focused) coping strategies, especially those who felt that the stressful situation was potentially controllable. In situations where problem-focused coping is not possible, optimists tend to use adaptive emotion-focused strategies, such as acceptance, humor, and positive reframing of the situation (Scheier et al., 1994). Optimists then differ from pessimists in their stable coping tendencies and in the kinds of coping responses that they spontaneously generate when given hypothetical coping situations (Scheier et al., 1986). McKenna (1993) reported that a “positive orientation to events can result in greater effort and persistence with resulting greater success” (p.47).

Schweizer et al. (1999) pointed to another possibility. They argued that optimism can influence an individual’s sense of well-being. A relationship can be predicted between the nature of a person’s future expectations and his/her evaluation of own life, and Schweizer et al. (1999) study supports this assumption.

Peterson (2000) cites several studies that report positive correlation between optimism and good health. In terms of physical benefits, optimism as a personality attribute has been found to be a significant mediator or moderator of stress levels. Optimism has been reported to “moderate the deleterious effects of daily hassles on physical health (Fry, 1995). Smith (cited in Fry, 1995) found that optimism moderated and predicted coping responses to stressful events. Scheier and Carver (1987) propose that the causal link between optimism and physical health or well-being may be due to the use of more effective coping strategies by optimists when dealing with stress. Other researchers have found that chronically stressed subjects are less optimistic than controls and that both optimism and pessimism are “influenced by environmental circumstances and life experiences” (Robinson-Whelan, et al., 1997, p. 1351).

When studied with optimism, life satisfaction has been found to correlate positively (Cummins & Nistico, 2002; Uskul & Greenglass, 2005). Chang, Maydeu- Olivares, and D’Zurilla (1997) found optimism and pessimism were predictors of individual difference in life

satisfaction. While studying optimism/age association, Isaacowitz (2005) reported that although older people reported higher dispositional optimism scores, there was no age X optimism interaction predictive of depression or life satisfaction, and that the dispositional optimism/age differential was eliminated when covariates were controlled. However Chang (2002b) found that an optimism X stress effect on life satisfaction was present in younger groups but was absent among older respondents. Though age may not moderate the optimism/life satisfaction association, it is plausible that in addition to stress other well-being components may influence the degree to which optimism associates with particular well-being indicators.

Studies of physiological indicators of well-being using self-rated assessment and evaluation by others indicate a number of physical benefits associated with optimism. Scheier and Carver (1985) reported that dispositional optimism was associated with lower levels of physical symptoms than was pessimism. In a review of literature studying physiological associations with optimism, many of which were longitudinal studies, Peterson and Bossio (2002) indicated that most relevant studies report a .20 to .30 correlation coefficient between optimism and good health.

Scheier et al. (1990) reported that optimists are more likely to report feeling rested after sleeping and less likely than pessimists to report early morning awakenings. This may relate to optimism's association with reduced anxiety reported by Scheier, Carver, and Bridges (1994). In an attempt to better understand how optimistic beliefs benefit physical health, Fournier, De Ridder, and Bensing (2002) studied unrealistic expectations of patients as opposed to positive efficacy expectancies. They found that unrealistic beliefs, at time present in dispositional optimism, are helpful when patients were faced with uncontrollable disease where self-care options were limited. They also reported that positive efficacy expectancies, more similar to strategic optimism and perceived personal control, are helpful when a patient faces a controllable disease where self-care efforts are more likely to be effective. These findings may indicate that although optimism is beneficial in physiological issues, there are types that better match specific situations, and could perhaps be encouraged to "optimize" benefit.

Part of the details of how optimism affects physical health can be explained by its influence on behavior. Steptoe, Wright, Kunz-Ebrecht, and Iliffe (2006) used separate and combined optimism/pessimism scores in a study of 128 men and women between 65 and 80 years of age. They reported that optimism was positively related to self-reported health status

independent of healthy behaviors, and that physical health status was associated with optimism independent of social demographic, clinical condition, negative affect or body mass, but that the effect was “attenuated when health behaviors were taken into account” (p. 71). The authors further specified that the findings were only evident when combining LOT scores, and that LOT subscales showed less consistent findings. Although, other studies support the indirect relationship of optimism with health status through associations with healthy behavior (DeKeukelaere, 2006; Lin & Peterson, 1990; Taylor et al. 2004), the Steptoe et al. (2006) findings further imply that even when controlling for healthy behaviors, optimism positively correlates with health, which had been suggested by Gottlieb and Rooney (2004).

Regression analysis also showed that age was significantly predicting the life satisfaction and socio-economic status was significantly contributing to the QOL of the respondents. Researches regarding the role of age in optimism indicated that determinants and mechanisms of happiness or life satisfaction like income (Clark, Frijters, & Shield, 2008; Easterlin, 2001), social support (Haller & Hadler, 2006), adaptation processes (Frederick & Loewenstein, 1999), and the balance between aspiration and attainments (Plagnol & Easterlin, 2008) can explain the relationship of age with SWB. Numerous studies have documented that lower SES is associated with poorer health status (Anderson & Armstead, 1995; Marmot, Kogevinas, & Elston, 1987; Williams & Collins, 1995). Lower SES is linked to multiple types of health outcomes, including higher rates of disease-specific morbidity and mortality (Adler et al., 1994; Marmot et al., 1987), poorer physiological indicators of health (Kubzansky, Berkman, Glass, & Seeman, 1998; Seeman & McEwen, 1996), and less adaptive psychological characteristics (Cohen, Kaplan, & Salonen, 1999; Taylor & Repetti, 1997). The findings of the present study provide significant evidence in this respect, and they go with the findings of other studies.

It has been suggested by different sociologists that poverty has far-reaching negative consequences for quality of life. People from lower SES group are more likely to be exposed to stressful life events (e. g., unemployment, crime victimization, and illness) than others. They also live with chronic strains such as economic hardship, job dissatisfaction, and frustrated aspirations (Kessler, 1979; Liem & Liem, 1978; Ross & Huber, 1985; Williams, 1990). These experiences are likely to lower people's self-esteem and diminish their sense of control over life (Pearlin, Menaghan, Lieberman, & Mullan, 1981; Mirowsky & Ross, 1989). These people also appear to have relatively few social resources to draw on. Compared with individuals at high income

levels, the poor have smaller social networks, less organizational involvement, and less frequent contact with friends and family (Cochran, Lerner, Riley, Gunnarsson, & Henderson, 1990; House, Umberson, & Landis, 1988). This is partly because people living in poverty lack the economic resources to maintain extended networks.

Furthermore, low SES individuals find their relationships less useful in coping with stress than high SES individuals (House et al., 1988; Liem & Liem, 1978). Poverty is also associated with lowered support from immediate family members, poor quality marital relations, increased risk of divorce, and general dissatisfaction with family life (Conger, Elder, Lorenz, Conger, Simons, Whitbeck, Huck, & Melby, 1990; Voydanoff & Donnelly, 1988). Some studies suggest a positive relationship between people's SES or income status and psychological well-being or life satisfaction (Dohrenwerd & Dohrenwerd, 1969; Douhitt, Macdonald, & Mullis, 1992; Moller, 1992; Ying, 1992). These findings were also reported in several studies conducted in western European countries and also in U.S.A. The association between SES and health follows a common pattern (Hemingway, Nicholson, & Marmot, 1997; Mackenbach, 1997; Marmot, Smith, Stanford et al., 1991), the lower the socioeconomic status the poorer the health. Similar results have been obtained from different countries in respect to cultural background or economic growth (Nicholson, Bobak, Murphy, Rose, & Marmot, 2005; Thumboo, Fong, & Machine et al., 2003).

In an attempt to describe the impact of socioeconomic status (SES) on health outcomes, researchers have summarized six categories of variables that might affect the association between SES and health: socio demographic, economic, environmental, behavioral and psychological, physiological and health outcome variables (Anderson & Cheryl, 1995). Pappa, Kontodimopolous, Papadopolous and Niakas (2009) studied the impact of SES on health of Greek people of 18+ age and results showed that females and older people were associated with impaired HRQOL. Disadvantaged SES i. e. primary education and low total household income was related to important decline in HRQOL and a similar relation was identified among men and women.

Conclusions

It may be concluded from the results that, SWB, QOL, and optimism are positively correlated with each other. People with higher level of optimism experience more life satisfaction and better QOL than people of lower level of optimism. Older people are more satisfied with their life than adults and younger ones, and respondents from high socio-economic status have higher life satisfaction and report better QOL than those from middle and low socio-economic status. Life-span developmental psychologists recognize adulthood as a time when changes take place in important psychological processes. For example, according to socioemotional selectivity theory (Carstensen, 1992; Carstensen, Isaacowitz, & Charles, 1999), when endings are made salient to individuals, they reorganize their social goals and prioritize emotionally salient goals over other ones. Getting older is the strongest cue that time is finite and that the most important ending is approaching. This theory suggests that individuals may become more optimistic with age, insofar as they are proactively regulating their socioemotional world.

Therefore, the complex of psychological processes surrounding emotional experience and well-being may change across life-span. Optimism has been a widely studied predictor of individual differences in affect (Scheier & Carver, 1993; Seligman, 1990). It seems that results obtained from the present study supports the cognitive models of affectivity which describes optimism as a predictor of well-being due to the habitual frames of processing information have ramifications for affect (Beck, 1967).

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