

DO OPTIMISTS HAVE BETTER LIVES?  
A QUASI-EXPERIMENTAL OPTIMISM, LIFE SATISFACTION,  
AND QUALITY-OF-LIFE STUDY

By

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To Dr. Christine Stopka.

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Abstract of Thesis Presented to the Graduate School  
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Deficits exist in the research base that links optimism with life satisfaction and quality of life. Although all three of the above constructs are widely studied in their respective fields, optimism and life satisfaction seem to be used more diversely than quality of life. Using the general population's quality of life in research has been severely neglected in favor of populations with chronic illnesses. In addition, optimism, while a respected and widely used construct, is seldom used to assess individuals' more global perceptions of life. It is mostly used in describing specific situations and perceptions. For these reasons, our purpose was to discern whether a causal link exists between optimism and life satisfaction and quality of life scores in a large university setting. Participants were undergraduate students at a large southeastern university. Optimism (the independent variable) was assessed using Scheier and Carver's Life Orientation Test (LOT). The dependent variables (quality of life and life satisfaction) were measured

using Flanagan's Quality-of-life Scale and Diener and colleagues' Satisfaction With Life Scale. The scales were administered in the form of a pencil-and-paper survey to 367 students. Two separate one-way independent groups analyses of variance (ANOVAs) were conducted to determine whether optimists and pessimists differed across scores on the Quality of Life Scale, and to examine whether optimists and pessimists differed across scores on the Satisfaction With Life Scale. Students identified as optimists scored significantly higher on quality of life and life satisfaction scales than did students identified as pessimists.

## INTRODUCTION

A general consensus is that optimists look at specific situations more positively than pessimists do. Does this situation-specific outlook generalize to people's overall life satisfaction and quality of life? Are optimists actually more likely than pessimists to see their entire lives as being satisfying and having better quality?

Optimism is defined as “the inclination to expect favorable life outcomes” (Marshall et al., 1992, p. 1067). This definition implies that optimism is a way of seeing future events (and perhaps present situations) in a certain positive light. Whether optimism is situation-specific or generalizes to larger states of being is unclear. Thus, research is needed to discern whether optimism influences a more-complete view of an individual's entire life, not just a specific moment or situation.

According to Lazarus (2002, p. 667), “The prime objective of basic research is to understand life and the world in which it exists.” Although optimism, quality of life, and life satisfaction are well known and widely studied constructs, there is a deficit in research concerning linking the three. Quality of life studies tend to focus on people with chronic illnesses and life satisfaction has broader applications, yet neither quality of life nor life satisfaction has been widely studied with regard to physically and mentally healthy persons. Optimism and pessimism are thought of as relevant dimensions of personality and are often studied in relation to stress and coping but research linking optimism and pessimism to a more general outlook is lacking. Optimism, quality of life, and life satisfaction have never been combined to find common ground. It is worth

investigating whether optimists only perceive circumstances with more positive conceptual wording than pessimists. If optimists and pessimists have feel the same about their lives and merely use different words for the same feelings, there should be no difference in their self-reported quality of life or life satisfaction scores. If pessimists merely use more-negative words to describe the same baseline emotional level, then their lives are not actually less satisfying or of a lower quality than optimists' lives.

### **Related Research and Theory**

Optimists are aware that the cherries of life have pits, but they are prepared to remove them. Their minds do not dwell on the pits, but on the sweetness of the cherries. --Anonymous

**Optimism.** A broad research base exists concerning optimism and pessimism, especially regarding its influence on other aspects of life. Dispositional optimism affects physical and psychological well-being (Scheier et al., 1994), and accounts for individual differences in psychological well-being (Turkum, 2005). The more optimistic the individual, the lower the individual's perceived stress (Segerstrom et al., 1998). People with higher levels of optimism show lower levels of perceived stress (Turkum, 2005). Optimism has been negatively correlated with depression in pregnant women (Carver & Gaines, 1987). Optimistic women respond better to unsuccessful in vitro fertilization (Litt et al., 1992). Optimists are also less likely to suffer from postpartum depression (Carver & Gaines, 1987). Optimistic students adjust more easily and with less distress to the first semester of college (Aspinwall & Taylor, 1992). Students who are under stress cope better and are more successful later, in their careers, if they are optimists rather than pessimists (Aspinwall & Taylor, 1992). The belief is becoming more widespread that stress is a major causal factor in illness (DeLongis et al., 1988). Optimists show lower average ambulatory blood pressure (Raikkonen et al., 1999), and recover more quickly

from coronary artery bypass surgery (Scheier et al., 1989). A variety of studies show that optimism can influence the effectiveness of treatments for AIDS and recovery rates from heart attacks (Carifio & Rhodes, 2002). A commonly used and accepted measurement tool for measuring optimism is the Life Orientation Test (LOT; Scheier & Carver, 1985), which is a “measure of the extent to which individuals possess favorable expectations regarding life outcomes” (Marshall et al., 1992, p. 1068).

**Quality of life.** Quality of life (QOL) has generated great interest from researchers and theorists alike in many diverse fields (Zullig, 2005). The earliest commonly reported quality of life conceptualization was by Aristotle, who considered the “good life,” or happiness, a result of a life of virtue (Morgan, 1992). More recently, psychologists and sociologists have described quality of life in terms of an individual’s expectations and goals in life, and whether these aspirations are realized (Anderson & Burckhardt, 1999).

As time has passed, definitions of quality of life have taken several different routes. The concept of QOL has been identified as very complex, and to further complicate the matter, many studies do not operationally define their conceptualization of quality of life, as in a literature review of 75 articles, only 15, or 11% of reviewed articles with the term “quality of life” in the title conceptually defined QOL (Gill & Feinstein, 1994). One of the reasons, among others, for the overall confusion with defining quality of life stems from different authors approaching the complicated term from a range of varied perspectives (Leplege & Hunt, 1997). Philosophers examine the nature of human existence, economists focus on the allocation of resources to achieve alternative goals, nurses, while taking a broad view of quality of life as is dictated by their discipline’s

holism, are waylaid by disease-specific issues, and physicians focus solely on physical health and illness-related variables (Anderson & Burckhardt, 1999).

The seemingly most common definition of quality of life is an individual's experienced personal satisfaction with areas of life that are considered important to the individual (Bowling, 1997). In 1990, Oleson defined quality of life as the subjective perception of happiness or satisfaction with life in domains of importance to the individual. Anderson and Burckhardt (1999) defined quality of life using a similar idea; "individuals' perceptions of satisfaction with life in various domains" (p. 304).

Anderson and Burckhardt (1999) argued that quality of life is often confused with concepts such as symptoms, mood, functional status and general health status. Although there are similarities between quality of life and the above concepts, it remains unique and distinct from other health-related concepts.

Although it has previously been within the realm of mental and psychological health and wellness, modern health care has evidenced an increased interest in evaluating quality of life as a treatment outcome (Archenholtz & Burckhardt, 1999). The World Health Organization defines health as not merely the absence of disease or infirmity, but as a concept that incorporates notions of well-being or wellness in all areas of life: physical, mental, emotional, spiritual, and social, and therefore transforms health from a more narrowed physical view to a broad concept that encompasses the entire spectrum of wellness and disease (Anderson & Burckhardt, 1999).

Cantril (1965) created a scale based on subjective, individual standards that participants in his study created about the self and the environment, therefore guiding behavior and defining satisfaction. He viewed his central problem as learning "what these

standards are in a person's own terms and not by our own standards." To remedy this, Cantril allowed respondents to define his/her own assumptions, perceptions, goals, and values. As a result, he found that Americans' major concerns (expressed in over 10% of responses) consisted of maintenance of the status quo, old age, leisure time, personal and family health, children, a decent standard of living, and housing. Other documented concerns included worries about war, continued employment, working conditions, resolution of religious problems, attaining emotional maturity, being accepted, and having modern conveniences. These findings help illustrate that Americans experienced a wide variation in individualized concerns, covering all facets of life.

Later, Dalkey et al (1972) concluded that a similarly broad spectrum of situations determine the quality of people's lives. Dalkey et al hypothesized that, since they believed that the basic components of QOL are shared by all people, the emphasis placed on these components varied among individuals because of value judgments concerning the amount of each component they were currently receiving. Through their Delphi studies, the researchers identified thirteen characteristics rated by respondents: love and affection; self-respect and self-satisfaction; peace of mind; sexual satisfaction; challenge and stimulation; social acceptance; achievement and job satisfaction; individuality; involvement and participation; comfort, economic well-being and good health; novelty and change; dominance, superiority, and independence; and privacy.

Within the same decades as the two previously mentioned studies, other investigations were also examining the quality of life concept (Andrews & Withey, 1976, Shin & Johnson, 1978, Michalos, 1986). These studies encompassed slightly different ideals describing the definition and domains of quality of life, however, they did develop

similar definitions concerning the subjectivity to the person's perspective who is describing their quality of life, the numerous domains or dimensions of life that influence the global perception of quality of life, and contentment with one's life being determined by whether one's perceived expectations, needs, and/or aspirations are actually being achieved.

Revicki et al. (2000, p. 888) defined QOL as "a broad range of human experiences related to one's overall well-being. It implies value based on subjective functioning in comparison with personal expectations and is defined by subjective experiences, states and perceptions. QOL, by its very nature, is idiosyncratic to the individual, but intuitively meaningful and understandable to most people." Although it has been considered of particular interest for the health sciences for years, as a United States federal mandate concerning cancer treatment over two decades ago encouraged the exploration of similar outcome measures for health care (Johnson & Temple, 1985), QOL continues to be somewhat controversial, as whether it is an appropriate outcome variable for the health care disciplines is still being explored in recent research (Anderson & Burckhardt, 1999).

In the mid-1970's, development of the Quality-of-life Scale (QOLS; Flanagan, 1978) was undertaken by an American psychologist named John Flanagan. Approximately 3,000 Americans from varying backgrounds, ethnic groups, and ages were asked to contribute experiences that were important or satisfying to them. Flanagan purposefully included ethnic minorities, senior citizens, low socioeconomic groups, and rural inhabitants, because, as Flanagan (1978, p. 138) stated, "the purpose of using the regional samples and diverse groups was not to obtain accurate estimates of frequencies but rather to insure that differing points of view and types of experience were

represented.” A scale of 15 items was developed representing five domains Flanagan’s team derived from over 6,000 critical incidents (Burckhardt & Anderson, 2003).

After developing the 15-item scale, Flanagan surveyed 3,000 people across the nation aged 30, 50, and 70, using 5-point scales of “needs met” and “importance.” The results revealed that the majority of participants felt that the items were important to them, as well as confirming that the majority was satisfied that their needs were being met in all areas (Flanagan, 1982).

Although the original QOLS used two five-point scales of “importance” and “needs met” to determine content validity in the initial study (Burckhardt et al, 1989), reliability of this scaling had not been reported at the time. A seven-point scale with responses of “delighted” (7), “pleased” (6), “mostly satisfied” (5), “mixed” (4), “mostly dissatisfied” (3), “unhappy” (2), and “terrible” (1) was adopted, as Andrews and Crandall (1976) had suggested that the seven-point scale was more sensitive and less negatively skewed than a 5-point satisfaction scale for a quality-of-life assessment, probably because it allowed for a wider variation of affective responses to QOL items (Burckhardt & Anderson, 2003).

In 1981 Flanagan gave permission to adapt the scale for patients with chronic illnesses, as he believed that adaptations may be needed for that population, and that different scales may produce divergent results (Flanagan, 1982). A subsequent study by Burckhardt et al (1989) verified the domain structure identified by Flanagan’s 1978 study with an addition of “a concern with maintaining independence” (Anderson & Burckhardt, 1999). A similar item was subsequently added to the scale for the adaptation for individuals with chronic illnesses – independence, or the “ability to do for oneself” (Burckhardt et al., 2003). Since the adaptation, the QOLS has all but exclusively been

utilized to gather information about people with chronic or incurable illnesses. Utilization of the adapted QOLS for research has become more common than research concerning the original scale, and illnesses studied include diabetes mellitus and osteoarthritis (Burckhardt et al., 1989), chronic obstructive pulmonary disease (COPD; Burckhardt et al., 1993), fibromyalgia syndrome (FMS; Anderson, 1995; Neumann & Buskila, 1997), heart disease (Motzer & Stewart, 1996), and spinal cord injury (Hans, 1995), among many others.

In the past 2 decades, additional QOL scales have been developed. However, nearly all of these instruments actually measure what Fayers and colleagues (1997a, 1997b) have named causal indicators of quality of life rather than quality of life itself (Burckhardt & Anderson, 2003).

Some researchers have partially based their central conceptualization and measurement of life quality on symptoms of specific diseases (Laborde & Powers, 1980, Ferrans, 1990, Ferrell et al 1992). Albeit the fact that when several researchers have asked participants with various physical ailments about the meaning of quality of life, the same types of responses are elicited as those obtained from more general populations (Padilla et al., 1990, Ferrell et al., 1992, Drummond, 1995), the disproportionately large amount of QOL research concerning people with illnesses far outweighs the amount of current research on the QOL of people without chronic illnesses. Many theorists have recently argued that the QOLS should be expanded to include the absence of physical or mental illnesses (Zullig, 2005), which indicates the possibility that the adapted QOLS has become so popular that some are unaware that the initial scale, before the adaptation, was

designed to examine populations devoid of illness. It seems apparent that more QOL research is needed centering on more general populations.

**Life satisfaction.** According to Pavot and Diener (1993), “life satisfaction is a conscious cognitive judgment of one’s life in which the criteria for judgment are up to the person” (p. 164). Shin and Johnson (1978) defined life satisfaction as “a global assessment of a person’s quality of life according to his chosen criteria” (p. 478). Increasingly during the past few decades, research has explored subjective well-being (SWB; Diener, 1984; Diener & Larsen, 1992), of which life satisfaction is the cognitive component (Andrews & Withey, 1976). Life Satisfaction was assessed using the Satisfaction With Life Scale (SWLS; Diener et al., 1985), and this is a currently accepted assessment tool. The limitation of many other scales used to define constructs such as life satisfaction is that the authors of the scales weight different aspects of life such as wealth or recreation. According to Diener (1985), “the judgment of how satisfied people are with their present state of affairs is based on a comparison with a standard which each individual sets for him or herself; it is not externally imposed” (p. 71). The SWLS is superior to other measures in that it allows respondents, instead of researchers, to weight aspects of their own lives and in terms of their own values to achieve a global view of their individual life satisfaction.

### **Purpose**

The purpose of this quasi-experimental study was to expand the knowledge base concerning general mood, life satisfaction, and quality of life by comparing individuals’ optimism levels with self-reported life satisfaction and quality of life, using a sample population of undergraduate students at a large southeastern university. The independent

variable was individuals' optimism and pessimism scores using the LOT, and the dependent variables were scores on the SWLS and the QOLS.

### **Hypothesis**

It was hypothesized by the researcher that participants who fall into the "optimism" category according to the LOT would score higher on the QOLS, therefore exhibiting a higher QOL. Optimists were also hypothesized to score higher on the SWLS, exhibiting a more subjectively satisfying life, than would participants falling into the "pessimism" category.

## METHODS

### **Research Design**

The Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), the Life Orientation Test (LOT; Scheier & Carver, 1985), and the Quality-of-life Scale (QOLS; Flanagan, 1978) was administered to undergraduate students at a large southeastern university to measure optimism, life satisfaction, and quality of life. A quasi-experimental design was used to estimate the relationship of the scores from the LOT as the independent variable with scores from the SWLS and the QOLS as dependent variables.

### **Participants and Setting**

Undergraduate students at a large southeastern university were recruited subsequent to requests made by the researcher. The study obtained 367 participants total. One hundred thirty-seven males and 231 females participated in the study. A small percentage of extra credit for classes was awarded to undergraduate students who participated in the study, as a part of optional extra credit points allotted by the instructor for participation in various types of community service and/or research. Cohen's statistical power analysis was calculated and revealed an adequate sample size (Cohen, 1977).

The measures were given in classrooms and offices within the university. Surveys were completed individually. Both male and female participants were included in the study, and the ages of participants ranged from 18 to 60 years.

## **Procedures**

Upon receiving approval from the University's Institutional Review Board, participants were contacted by the researcher and invited to participate in the study. Prior to receiving the scales, each participant was given an informed consent form and asked to carefully read and sign.

The LOT, SWLS, and QOLS were combined into a paper-and-pencil survey that was photocopied and distributed by the researcher to subjects, with the order of the scales being randomized. Briefing instructions for the participants regarding the completion of the scales was written on the cover page of each copy as well as presented verbally prior to beginning the survey. In addition, a short demographic questionnaire was included to gather information pertaining to age, education level, gender, and occupation. The survey took between 10 minutes and 20 minutes to complete. Upon completion of the survey, participants were debriefed by the researcher in the form of a written letter.

## **Measures**

Dispositional optimism and pessimism was measured using the Life Orientation Test (LOT; Scheier & Carver, 1985). Satisfaction with the participant's life as a whole was measured using the Satisfaction With Life Scale (SWLS; Diener et al., 1985). The participants' self-reported quality of life was measured using the Quality-of-life Scale (QOLS; Flanagan, 1978).

### **Life Orientation Test (LOT)**

The LOT was administered to measure each participant's dispositional optimism as well as pessimism by assessing generalized positive outcome expectancies (Scheier & Carver, 1985). There are 12 total items, with four counting towards optimism, four counting towards pessimism, and four filler items (Table 1). Responses range from "I

agree a lot” to “I disagree a lot” on a 5-point Likert scale. Items scoring pessimism are scored in the same direction as optimism items, therefore when scoring high pessimism scores will indicate low actual pessimism. Using the LOT, optimism and pessimism are considered two separate constructs, so an individual will have an optimism score and a pessimism score, with predetermined scores delineated by the author of the scale discerning whether an individual is considered an “optimist” or a “pessimist” (Scheier & Carver, 1985). LOT has been found to show predictive validity and to be a “viable instrument for assessing people’s generalized sense of optimism” (Scheier et al., 1994, p. 1071).

Table 1: Life Orientation Test categories (Scheier & Carver, 1985)

---

*Optimism*

“I’m always optimistic about my future.”

“In uncertain times, I usually expect the best.”

“I always look on the bright side of things.”

“I’m a believer in the idea that ‘every cloud has a silver lining.’”

*Pessimism (reverse-scored)*

“If something can go wrong for me, it will.”

“I hardly every expect things to go my way.”

“I rarely count on good things happening to me.”

“Things never work out the way I want them to.”

*Filler Items*

“It’s easy for me to relax.”

“I enjoy my friends a lot.”

“It’s important for me to keep busy.”

“I don’t get upset too easily.”

---

Terrill et al (2002) found the LOT to provide “a viable measure of optimism” (p. 560). Internal consistency, temporal stability, and convergent and discriminant validity have been supported by internal validation studies (Scheier & Carver, 1985), as the LOT related, though did not appear to be redundant, with self-report measures of social

anxiety, alienation, perceived stress, depression, hopelessness, self-esteem, and internality (Terrill et al., 2002).

### **Quality-Of-Life Scale (QOLS)**

The QOLS was administered to measure each participant's self-perceived quality of life, by measuring five conceptual domains of quality of life; material and physical well-being, relationships with other people, social, community, and civic activities, personal development and fulfillment, and recreation (Table 2). There are 15 items in the QOLS, and responses are reported by a seven-point Likert scale, ranging from "delighted" to "terrible." The QOLS is scored by adding up the score on each item to yield a total score for the instrument. Scores can range from 16 to 112, with a higher score indicating a higher quality of life (Burckhardt & Anderson, 2003).

Internal consistency and high test-retest reliability for the QOLS with general populations has been recorded in the first studies using the scale as well as subsequent studies (Burckhardt, 1989). Convergent and discriminant construct validity in chronic illness groups have been demonstrated using the Life Satisfaction Index-Z and the Arthritis Impact Measurement Scales, and Burckhardt and colleagues later offered evidence that the QOLS was valid in different populations, including healthy as well as chronically ill adults (Burckhardt et al 1989, Meenan et al, 1980). The QOLS has been used in studies of healthy adults and patients with rheumatic diseases, fibromyalgia, chronic obstructive pulmonary disease, gastrointestinal disorders, cardiac disease, spinal cord injury, psoriasis, urinary stress incontinence, posttraumatic stress disorder, and diabetes (Burckhardt & Anderson, 2003).

### **Satisfaction With Life Scale (SWLS)**

The SWLS was administered to assess each participant's "overall judgment of their life in order to measure the concept of life satisfaction" (Diener et al., 1985, pp. 71-72). The SWLS is a 5-item, 7-point Likert scale ranging from "delighted" to "terrible" (Diener et al., 1985). Responses range from "strongly disagree" to "strongly agree" on a 7-point Likert scale. Scores are added, and the sum represents the degree of life satisfaction (Table 3).

After a factor analysis was completed, criterion validity coefficients were obtained to determine a life satisfaction rating. Diener et al. (1985) found that "the item total correlations for the five SWLS items (.81, .63, .61, .75, and .66) showed a good level of internal consistency for the scale" (p. 74). Furthermore, the SWLS (Diener et al., 1985) "shows discriminant validity from emotional well-being measures" (Pavot & Diener, 1993, p. 164).

**Table 2: Quality of life categories in five domains (Flanagan 1978)**

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<i>Physical and material well-being</i>
Material well-being and financial security
Health and personal safety
<i>Relations with other people</i>
Relations with spouse
Having and raising children
Relations with parents, siblings or other relatives
Relations with friends
<i>Social, community and civic activities</i>
Activities related to helping or encouraging other people
Activities relating to local and national governments
<i>Personal development and fulfillment</i>
Intellectual development
Personal understanding and planning
Occupational role
Creativity and personal expression
<i>Recreation</i>
Socializing
Passive and observational recreational activities
Active and participatory recreational activities

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Table 3: SWLS score ranges (Diener et al., 1985)

31–35	Extremely Satisfied
26–30	Satisfied
21–25	Slightly Satisfied
20	Neutral
15–19	Slightly Dissatisfied
10–14	Dissatisfied
5–9	Extremely Dissatisfied

### Data Analysis

When initially determining the distinction between optimistic participants and pessimistic participants using their scores on the LOT, a quartile split was performed to clearly delineate the separation in scores. Only the first (optimistic) and fourth (pessimistic) quartiles were used in order to include clearly identifiable optimists and pessimists, and therefore avoid confusion stemming from similar, more centralized scores.

A multivariate analysis of variance (MANOVA) was conducted using scores on the LOT as independent variables, and using the QOL subscales as well as the SWLS as dependent variables. Simple effects tests with Bonferroni corrected alpha levels were used to evaluate significant interactions. Furthermore, since quality of life has been defined in previous research in terms of life satisfaction (Burckhardt, 1985, Ferrans & Powers 1985, Sexton & Munro 1988), the SWLS served as a convergence test for the QOLS. Pearson product-moment correlation coefficients were used to correlate between the SWLS with scores from the QOLS.

Finally, internal consistency of the LOT, as well as individual group scores on the LOT and the SWLS, were estimated using alpha reliability (Chronbach, 1951). All

statistical analyses were run with the significance value set at  $p = .05$ . The Statistical Package for Social Sciences (SPSS) was utilized for the analyses of data in this study.

## RESULTS

The scores from the QOL subscales (physical and material well-being, relations with other people, social, community and civic activities, personal development and fulfillment, and recreation) as well as SWLS scores were used as the dependent variables when comparing differences in the mean scores for optimists and pessimists. According to the assumption of homogeneity of variance, the variances of the dependent variables should not be significantly different across both levels of the independent variable (Grimm, 1993). No significant ( $p > .05$ ) difference was found in the variances for optimists or pessimists for any of the dependent variables; therefore the assumption for homogeneity was met. Box's M test was performed with results being insignificant at the .01 level. There were no significant gender differences [Wilk's  $\Lambda = .93$ ,  $F(5, 185) = 2.79$ ,  $p > .01$ ]. After the quartile split, 97 optimists and 96 pessimists were discovered, with 69 being male and 124 being female ( $N = 193$ ; Table 4). The results of between subject analyses revealed that optimists scored higher on the QOLS subscale of personal development and fulfillment [ $\eta = .05$ ,  $F(1, 192) = 10.03$ ,  $p < .01$ ] and on the SWLS [ $\eta = .09$ ,  $F(1, 192) = 18.14$ ,  $p < .01$ ].

As for the MANOVA, there was a main effect for optimism [Wilk's  $\Lambda = .89$ ,  $F(5, 185) = 4.71$ ,  $p < .01$ ]. The QOLS subscale of physical and material well-being was dropped from the main analysis because it had questionable reliability ( $\alpha = .67$ ). Participants classified as optimists scored higher for the QOLS subscale of personal

development and fulfillment ( $\alpha = .78$ ), and recreation ( $\alpha = .73$ ), as well as for the SWLS ( $\alpha = .89$ ). The other subscales of the QOLS were not significant.

A positive correlation was found between satisfaction with life as measured by the SWLS and quality of life as assessed by the QOLS, which was significantly ( $r = .551$ ,  $r^2 = .304$ ,  $p < .01$ ) greater than zero (Table 5). The quality of life score from the QOLS explained 30% of the variability in the SWLS scores.

The internal consistency reliability of both the LOT and the SWLS were examined using alpha reliability (Chronbach, 1951). The overall alpha reliability scores for the LOT and the SWLS were .842 and .902, respectively. Separate alpha reliability scores for optimists ( $n=97$ ) and pessimists ( $n=96$ ), as well as individual group optimism differences were also calculated. The alpha reliability scores were .820 (LOT-determined optimists) and .859 (LOT-determined pessimists).

Table 4: Descriptive Statistics

	Gender	Optimist or Pessimist	Mean	Standard Deviation	N
Personal Development and Fullfillment	Male	Optimist	5.30	1.27	34
		Pessimist	5.03	1.28	35
		Total	5.16	1.28	69
	Female	Optimist	5.76	1.05	63
		Pessimist	5.01	0.84	61
		Total	5.39	1.02	124
	Total	Optimist	5.60	1.15	97
		Pessimist	5.02	1.01	96
		Total	5.31	1.12	193
Satisfaction With Life Scale	Male	Optimist	26.79	6.67	34
		Pessimist	22.40	7.77	35
		Total	24.57	7.53	69
	Female	Optimist	28.51	6.33	63
		Pessimist	24.67	5.49	61
		Total	26.62	6.22	124
	Total	Optimist	27.91	6.47	97
		Pessimist	23.84	6.47	96
		Total	25.89	6.77	193

Table 5: Pearson Product-Moment Correlation Coefficients for the Relationship of QOLS and SWLS (N = 367)

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QOLS	SWLS
QOLS	– .551( $p < .05$ )

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## DISCUSSION

This study was conducted to determine whether individuals classified as optimists would correspondingly self-report higher quality of life and life satisfaction scores than would pessimists. Optimism, or “the inclination to expect favorable life outcomes” (Marshall et al., 1992, p. 1067), was measured by the Life Orientation Test (LOT; Scheier & Carver, 1985). Quality of life, or an individual’s judgment of whether his or her personal life aspirations and achievements are being realized, was assessed using Flanagan’s Quality-of-life Scale (QOLS; 1978). Satisfaction with life, or “a global assessment of a person’s quality of life according to his chosen criteria” (Shin & Johnson, 1978, p. 478), was determined using the Satisfaction With Life Scale (SWLS; Diener et al., 1985).

It was hypothesized that participants who fell into the “optimism” category according to the LOT would exhibit a higher quality of life evidenced by higher scores on the QOLS, and that optimistic participants would also report a higher satisfaction with life through higher scores on the SWLS, than would participants who fell into the “pessimism” category. This hypothesis was supported in the study, with optimists scoring significantly higher than pessimists on both the SWLS and the QOLS subscale of personal development and fulfillment. There were no significant differences in optimism scores related to the gender, weekly activity level, or age of participants. This finding corresponds with other studies concerning various measures of individual’s content or

happiness compared with optimism, in which optimism tends to correlate with better coping styles, as well as higher levels of overall psychological and physical well-being (Myers & Steed, 1998),

An interesting finding in the current study was the generally high level of optimism, life satisfaction, and quality of life in the sample, made up of undergraduate college students. This corresponds with a 1998 study by Bailey & Miller, where it was determined that the majority of college students in a sample of  $n = 243$  were generally satisfied with their lives, and with Moller's 1996 study, in which "twice as many students described themselves as satisfied rather than dissatisfied with their lives" (p. 21). However, the mean QOLS score for optimists, which was higher, was only 84.13, which is less than the normal healthy population's score of 90, especially considering that many quality of life instruments tend to have negatively skewed means with most patients reporting some degree of satisfaction across domains (Burckhardt & Anderson, 2003).

**Limitations.** The current study did contain some limitations, one of which was the population that the sample was taken from. Participants consisted of undergraduate students at a large southeastern university. The findings from this study may not be generalizable to other populations and/or other geographical areas. There are also questions on the QOLS that may not pertain to this population, such as questions concerning relationships with children and spouse. Another possible limitation concerns the use of the LOT to measure optimism. There have been criticisms of the LOT describing its effects to positive response bias (Scheier et al., 1994), and researchers have also found that the LOT may be confounded with neuroticism or negative affectivity (Terrill et al., 2002). It is possible that more research needs to be undertaken concerning

the LOT's applicability and that it may need to be improved over time in order to quell the skepticism voiced by researchers. In addition, this study has a possible limitation stemming from the nature of the Likert scales used in the scales for the current study. The Likert scale for the LOT is labeled in the opposite direction (1-delighted; to 5-dissatisfied) compared to the SWLS (1-strongly disagree; 7-strongly agree) and the QOLS (1-terrible; 7-delighted). There is a possibility that this could cause confusion for participants completing this particular combination of measures as a result of the varying directions.

It seems fitting that having a more joyful outlook on the world would serve to improve the quality of life and satisfaction with life. Because quality of life seems to be a concept that overlaps from the psychological arena into the more medical one, it is interesting to note that the results provided in this study may be worth studying from a more medical and purely physical standpoint.

The possible implications of this study could be expanded upon to quite a large degree. It seems that in recent years, a more holistic view of mental as well as physical health has begun to come into the limelight of modern living. If it could be clearly determined that having a more subjectively positive or optimistic outlook on one's life could unwaveringly improve an individual's overall health and wellness, the next logical step seems to be discovering whether it is possible to alter an individual's outlook to become more positive, and if so, how that is to be effectively undertaken, in order to improve the human experience.

### **Summary**

This study hypothesized that optimists would report a better quality of life and satisfaction with life than pessimists would report. The population consisted of

undergraduate students at a large southeastern university, comprised of 135 males and 231 females. The Life Orientation Test (LOT; Scheier & Carver, 1985) was used to determine optimists and pessimists, quality of life was measured by the Quality-of-life Scale (QOLS; Flanagan, 1978), and life satisfaction was measured using the Satisfaction With Life Scale (SWLS; Diener et al., 1985).

The LOT, QOLS, and SWLS were combined into a paper-and pencil survey and administered to 367 students. After entering LOT scores, a quartile split was performed, with the outer quartiles representing optimism and pessimism so to avoid ambiguous separations between the two groups, that could potentially have arisen considering the original scale's cutoff of one point between the two groups. The results of this study supported the hypothesis by indicating that individuals who were identified as optimists did have higher self-reported quality of life scores as well as life satisfaction scores than did individuals identified as pessimists.

### **Conclusion**

The results of the current study supported the notion that optimists enjoy their lives more than pessimists do. Optimists scored higher on measures of life satisfaction and quality of life. These findings help to further expand the views of psychological constructs such as optimism and pessimism into more applicable ideals. This study clearly demonstrates that there is a correlation between perceptions and quality of life, as well as life satisfaction.

**Implications for Future Research.** Future research should be undertaken in order to expand the general knowledge on how outlook affects the human experience. The LOT has received criticisms concerning its susceptibility to positive response bias (Scheier et al., 1994), so more research should be amassed to confirm its reliability as well as

validity. In addition, similar research should be undertaken for other populations, so findings can become more generalizable.

## APPENDIX A INFORMED CONSENT

### **Please Read This Entire Document Carefully Before Agreeing to Participate**

TO: All Research Participants  
FROM: Charis M. Brown  
RE: Informed Consent

**Study Title:** Do Optimists Actually Have Better Lives? A Quasi-Experimental Optimism, Life Satisfaction, and Quality of Life Study

**Purpose of the study:** The purpose of this study will be to expand the knowledge base concerning general mood, life satisfaction, and quality of life by comparing individuals' optimism levels with self-reported life satisfaction and quality of life.

**What you will be asked to do:** If you agree to participate in the study, you will be asked to participate in 3 surveys that will take approximately 10 minutes to complete. Your answers on the survey will be kept completely confidential to the extent permitted by law.

**Time required:** Approximately 10 minutes.

**Risks and Benefits:** There are no risks expected from participating in this study. A benefit in the form of class extra credit may be awarded by your instructor/professor if appropriate. If so, you will be informed by your instructor prior to participating in the study.

**Compensation:** No compensation will be provided.

**Confidentiality:** **Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number, and individuals will not be identified by name but by the assigned code number. The list connecting your name to this number along with all data will be kept in a locked file in my faculty supervisor's office. When the study is complete and the data have been analyzed, the list will be destroyed. Your name will not be used in any report, and the data analysis is anonymous.**

**Voluntary participation:** **Your participation in this study is completely voluntary. There is no penalty for not participating.**

**Right to withdraw:** **You have the right to withdraw from this study at any time without consequence.**

Whom to contact if you have questions about the study: **Charis M. Brown, B.S., Masters Student, Department of Health Education and Behavior, 110 Florida Gym, Box 118207, Gainesville, FL, 32611, 359-0580 x1374.**

Whom to contact about your rights as a research participant in the study: **UFIRB Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; ph 392-0433.**

Study Supervisor: Christine Boyd Stopka, Associate Professor, Department of Health Education and Behavior, 100 Florida Gym, Box 118210, Gainesville, FL, 32611-8210, phone-392-0583 x1259, [cstopka@hhp.ufl.edu](mailto:cstopka@hhp.ufl.edu)

Agreement:

**I have read the procedure above. I voluntarily agree to participate in the procedure and I have received a copy of this description.**

Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

APPENDIX B  
DEMOGRAPHICS QUESTIONNAIRE

1. Please indicate your gender.

Male

Female

2. Please indicate the age range in which you fall.

Under 21 21-34 35-44 45-54 55-64 65 +

3. Please indicate approximately how often you engage in at least 30 minutes of moderate physical activity per week.

Less than 1 1-3 4-6 7 +

4. Please indicate which college your major is currently a part of.

Agricultural and Life Sciences Business Administration

Design, Construction and Planning Dentistry

Education Engineering

Fine Arts Health and Human Performance

Journalism and Communications Law

Liberal Arts and Sciences Medicine

Nursing Pharmacy

Public Health and Health Professions Veterinary Medicine

APPENDIX C  
LIFE ORIENTATION TEST

Indicate the degree to which each of the items represents your feelings according to the following code.

1 - Delighted

2 - Pleased

3 - Mostly Satisfied

4 - Mixed

5 - Dissatisfied

- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 1.  | I'm always optimistic about my future.                             | 1 | 2 | 3 | 4 | 5 |
| 2.  | In uncertain times, I usually expect the best.                     | 1 | 2 | 3 | 4 | 5 |
| 3.  | I always look on the bright side of things                         | 1 | 2 | 3 | 4 | 5 |
| 4.  | If something can go wrong for me, it will.                         | 1 | 2 | 3 | 4 | 5 |
| 5.  | It's easy for me to relax.   | 1 | 2 | 3 | 4 | 5 |
| 6.  | I hardly ever expect things to go my way.                          | 1 | 2 | 3 | 4 | 5 |
| 7.  | I enjoy my friends a lot.  | 1 | 2 | 3 | 4 | 5 |
| 8.  | It's important for me to keep busy.                                | 1 | 2 | 3 | 4 | 5 |
| 9.  | I rarely count on good things happening to me.                     | 1 | 2 | 3 | 4 | 5 |
| 10. | I'm a believer in the idea that "every cloud has a silver lining." | 1 | 2 | 3 | 4 | 5 |
| 11. | I don't get upset too easily.                                      | 1 | 2 | 3 | 4 | 5 |
| 12. | Things never work out the way I want them to.                      | 1 | 2 | 3 | 4 | 5 |

APPENDIX D  
QUALITY-OF-LIFE SCALE

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

7 - Delighted

6 - Pleased

5 - Mostly Satisfied

4 - Mixed

3 - Dissatisfied

2 - Unhappy

1 - Terrible

1.	Material comforts home, food, conveniences, financial security	1	2	3	4	5	6	7
2.	Health - being physically fit and vigorous	1	2	3	4	5	6	7
3.	Relationships with parents, siblings & other relatives-communicating, visiting, helping	1	2	3	4	5	6	7
4.	Having and rearing children	1	2	3	4	5	6	7
5.	Close relationships with spouse or significant other	1	2	3	4	5	6	7
6.	Close friends	1	2	3	4	5	6	7
7.	Helping and encouraging others, volunteering, giving advice	1	2	3	4	5	6	7
8.	Participating in organizations and public affairs	1	2	3	4	5	6	7
9.	Learning- attending school, improving understanding, getting additional knowledge	1	2	3	4	5	6	7
10.	Understanding yourself - knowing your assets and limitations - knowing what life is about	1	2	3	4	5	6	7
11.	Work - job or in home	1	2	3	4	5	6	7
12.	Expressing yourself creatively	1	2	3	4	5	6	7
13.	Socializing - meeting other people, doing things, parties, etc	1	2	3	4	5	6	7
14.	Reading, listening to music, or observing entertainment	1	2	3	4	5	6	7
15.	Participating in active recreation	1	2	3	4	5	6	7

APPENDIX E  
SATISFACTION WITH LIFE SCALE

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below indicate your agreement with each item by circling the appropriate number. Please be open and honest in your responding.

7 - Strongly agree

6 - Agree

5 - Slightly agree

4 - Neither agree nor disagree

3 - Slightly disagree

2 - Disagree

1 - Strongly disagree

- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1. In most ways my life is close to my ideal.                   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. The conditions of my life are excellent.                     | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I am satisfied with my life.                                 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. So far I have gotten the important things I want in life.    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. If I could live my life over, I would change almost nothing. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## LIST OF REFERENCES

- Anderson, K. (1995). The effect of chronic obstructive pulmonary disease on quality of life. *Research in Nursing and Health, 18*, 547-556.
- Anderson, K., Burckhardt, C. (1999). Conceptualization and measurement of quality of life as an outcome variable for health care intervention and research. *Journal of Advanced Nursing, 29*(2), 298-306.
- Andrews, F., and Crandall, R. (1976). The validity of measures of self-reported well-being. *Social Indicator Research, 3*, 1-19.
- Andrews, F., & Withey, S. B. (1976). *Social indicators of well-being: America's perception of life quality*. New York: Plenum Press.
- Archenholtz, B., Burckhardt, C., & Segesten K. (1999). Quality of life of women with systemic lupus erythematosus or rheumatoid arthritis: Domains of importance and dissatisfaction. *Quality of Life Research, 8*, 411-416.
- Aspinwall, S., & Taylor, S. (1992). Modeling cognitive adaptation: A clinical investigation of the impact of individual differences and coping, adjustment, and performance. *Journal of Personality and Social Psychology, 71*(3), 989-1003.
- Bailey, R., & Miller, C. (1998). Life Satisfaction and Life Demands in College Students. *Social Behavior and Personality, 26*(1), 51-56.
- Bowling, A. (1997). *Measuring Health. A Review of Quality of Life Measurement Scales*. Buckingham: Open University Press.
- Bradbury, V., & Catanzaro, M. (1989). The quality of life in a male population suffering from arthritis. *Rehabilitation and Nursing, 14*, 187-190.
- Burckhardt, C. (1985). The impact of arthritis on quality of life. *Nursing Research, 34*, 11-16.
- Burckhardt, C., & Anderson, K. (2003). The quality of life scale (QOLS): Reliability, validity, and utilization. *Health and Quality of Life Outcomes, 1*, 60.
- Burckhardt, C., Anderson, K., Archenholtz, B., & Hagg, O. (2003). The Flanagan quality of life scale: Evidence of construct validity. *Health and Quality of Life Outcomes, 1*, 60.

Burckhardt, C., Archenholtz, B., & Bjelle A. (1992). Measuring quality of life of women with rheumatoid arthritis or systemic lupus erythematosus: A Swedish version of the quality of life scale (QOLS). *Scandinavian Journal of Rheumatology*, *21*, 190-195.

Burckhardt, C., Clark, S., & Bennett, R. (1993). Fibromyalgia and quality of life: A comparative analysis. *Journal of Rheumatology*, *20*, 475-479.

Burckhardt, C., Woods, S., Schultz A., & Ziebarth, D. (1989). Quality of life of adults with chronic illness: A psychometric study. *Research in Nursing and Health*, *12*, 347-354.

Cantril H. (1965). *The Pattern of Human Concerns*. New Brunswick: Rutgers University Press.

Carifio, J., & Rhodes, L. (2002). Construct validities and the empirical relationships between optimism, hope, self-efficacy, and locus of control. *Work: Journal of Prevention, Assessment, & Rehabilitation*, *19*(2), 125-136.

Carver, C., & Gaines, J. (1987). Optimism, pessimism and postpartum depression. *Cognitive Therapy and Research*, *11*, 449-462.

Chang, E. (1998a). Does dispositional optimism moderate the relation between perceived stress and psychological well-being?: a preliminary investigation. *Personality and Individual Differences*, *25*, 233-240.

Chang, E. (1998b). Dispositional optimism and primary and secondary appraisal of a stressor: controlling for confounding influences and relations to coping and psychological and physical adjustment. *Journal of Personality and Social Psychology*, *74*(4), 1109-1120.

Cheng, H., & Furnham, A. (2003). Attributional style and self-esteem as predictors of psychological well being. *Counselling Psychology Quarterly*, *16*(2), 121-130.

Chronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, *16*, 297-334.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2<sup>nd</sup> ed.). Hillsdale, NJ: Erlbaum.

Dalkey, N. C., Rourke D. L., Lewis. R., & Snyder D. (1972). *Studies in the Quality of Life*. Lexington: Lexington Books.

DeLongis, A., Folkman, S. (1988). The impact of daily stress on health and mood: Psychological and social resources as mediators. *Journal of Personality and Social Psychology*, *54*(3), 486-495.

- Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 542-575.
- Diener, E., Emmons, R., Larsen, R., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75.
- Diener, E., & Larsen, R. J. (1993). The subjective experience of emotional well-being. In M. Lewis & J. M. Haviland (Eds), *Handbook of emotions*. (pp. 405-415) New York: Guilford Press.
- Drummond, N. (1995). The quality of life for asthma patients: a qualitative study. *The Western Journal of Medicine*, 125, 1-2.
- Fayers, P. M., Hand, D. J. (1997). Factor analysis, causal indicators and quality of life. *Quality of Life Research*, 6, 139-150.
- Fayers, P. M., Hand, D. J., Bjordal, K., & Groenvold, M. (1997). Causal indicators in quality of life research. *Quality of Life Research*, 6, 139-150.
- Ferrans, C.E. (1990). Quality of life: conceptual issues. *Seminars in Oncology Nursing* 6, 248-254.
- Ferrans, C. E., & Powers, M. J. (1985). Quality of life index: development and psychometric properties. *Advances in Nursing Science*, 8, 15-24.
- Ferrell, B., Grant, M., Schmidt, G.M., et al. (1992). The meaning of quality of life for bone marrow transplant survivors. Part 1. The impact of bone marrow transplant on quality of life. *Cancer Nursing*, 15, 153-160.
- Flanagan, J. C. (1978). A research approach to improving our quality of life. *American Psychologist*, 33, 138-147.
- Flanagan, J. C. (1982). Measurement of the quality of life: Current state of the art. *Archives of Physical and Medical Rehabilitation*, 33, 56-59.
- Geers, A., Helfer, S, Kosbab, K., Weiland, P., & Landry, S. (2005). Reconsidering the role of personality in placebo effects: dispositional optimism, situational expectations, and the placebo response. *Journal of Psychosomatic Research*, 58, 121-127.
- Gill, T., Feinstein, A. (1994). A critical appraisal of the quality of the Quality-of-life measurements. *Journal of the American Medical Association*, 8, 619-626.
- Grimm, L. G. (1993). *Statistical applications for the behavioral sciences*. New York: John Wiley and Sons.

Hagg, O., Burckhardt, C., Fritzell, P., & Nordwall, A. (2003). Quality of life in chronic low back pain: A comparison with fibromyalgia and the general population. *Journal of Musculoskeletal Pain, 11*, 31-38.

Harrington, R., & Loffredo, D. (2001). The relationship between life satisfaction, self-consciousness, and the myers-briggs type inventory dimensions. *The Journal of Psychology, 135*(4), 439-450.

Huprich, S., & Frisch, M. (2004). The depressive personality disorder inventory and its relationship to quality of life, hopefulness, and optimism. *Journal of Personality Assessment, 83*(1), 22-28.

Isaacowitz, D. (2005). The gaze of the optimist. *Personality and Social Psychology Bulletin, 31*(3), 407-415.

Johnson, J.R., & Temple, R. (1985). Food and Drug Administration requirements for approval of new anticancer drugs. *Cancer Treatment Reports 69*, 1155-1157.

Laborde, J.M., & Powers, M.J. (1980) Satisfaction with life for patients undergoing hemodialysis and patients suffering from osteoarthritis. *Research in Nursing and Health, 3*, 19-24.

Lazarus, R. (2000). Toward better research on stress and coping. *American Psychologist, 55*(6), 665-673. Leplege, A., & Hunt, S. (1997). The problem of quality of life in medicine. *JAMA, 278*, 47-50.

Liedberg, G., Burckhardt, C., & Henriksson, C. (2005). Validity and reliability testing of the Quality of Life Scale, Swedish version in women with fibromyalgia – statistical analyses. *Scandinavian Journal of Caring Sciences, 19*, 64-70.

Litt, M. D., Tennen, H., Affleck, G., & Klock, S. (1992). Coping and cognitive-factors in adaptation to in vitro fertilization failure. *Journal of Behavioral Medicine, 15*, 171-187.

Marshall, G., Wortman, C., Kusulas, J., Hervig, L., & Vickers, R. (1992). Distinguishing optimism from pessimism: Relations to fundamental dimensions of mood and personality. *Journal of Personality and Social Psychology, 62*(6), 1067-1074.

Meenan, R., Gertman P., & Mason, J. (1980). Measuring health status in arthritis: The arthritis impact measurement scales. *Arthritis Rheumatology, 23*, 146-152.

Michalos, A. C. (1986). An application of multiple discrepancies theory to seniors. *Social Indicators Research, 18*, 349-373.

Moller, V. (1996). Life satisfaction and expectations for the future in a sample of university students: a research note. *South African Journal of Sociology, 27*(1), 16-26.

- Morgan, M.L. (1992). *Classics of Moral and Political Theory*. Indianapolis: Hackett
- Motzer, S., & Stewart, B. (1996). Sense of coherence as a predictor of quality of life in persons with coronary heart disease surviving cardiac arrest. *Research in Nursing and Health, 19*, 287-298.
- Myers, L., & Steed, L. (1999). The relationship between dispositional optimism, dispositional pessimism, repressive coping and train anxiety. *Personality and Individual Differences 27*, 1261-1272.
- Neumann, L., & Buskila, D. (1997). Measuring the quality of life of women with fibromyalgia: a Hebrew version of the quality of life scale (QOLS). *Journal of Musculoskeletal Pain, 5*, 5-17.
- Oleson, M. (1990). Subjectively perceived quality of life. *Journal of Nursing Scholarship, 22*, 187-190.
- Padilla, G. V., Ferrell, B., Grant, M. M., & Rhiner, M. (1990). Defining the content domain of quality of life for cancer patients with pain. *Cancer Nursing, 13*, 108-115.
- Parkerson, G., Gehbach, S., Wagner, E., James, S., Clapp, N., & Muhlbaier, L. (1981). The Duke-UNC health profile: An adult health status instrument for primary care. *Medical Care, 19*, 806-828.
- Pavot, W., Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment, 5*(2), 164-172.
- Perry, M. (2002). *Examining the relationship between dispositional and specific expectation optimism/pessimism and their effects on task performance*. Manchester, Saint Anselm College. (M. A. in Psychology)
- Peterson, C., Park, N., & Seligman, E. (2005). Orientations to happiness and life satisfaction: the full life versus the empty life. *Journal of Happiness Studies, 2*, 25-41.
- Raikkonen, K., Matthews, K. A., Flory, J. D., Owens, J. F., & Gump, B. B. (1999). Effects of optimism, pessimism, and train anxiety on ambulatory blood pressure and mood during everyday life. *Journal of Personality and Social Psychology, 76*, 104-113.
- Revicki, D., Osoba, D., Fairclough, D., Barofsky, I., Berzon, R., Leidy N., & Rothman M. (2000). Recommendations on health-related quality of life research to support labeling and promotional claims in the United States. *Quality of Life Research, 9*, 887-900.
- Scheier, M. F., & Carver, C. S. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. *Health Psychology, 4*, 219-247.

Scheier, M. F., & Carver, C. S. (1993). On the power of positive thinking: the benefits of being optimistic. *Current Directions in Psychological Science*, 2(1), 26-30.

Scheier, M. F., Carver, C. S., & Bridges, M. (1994). Distinguishing neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the life orientation test. *Journal of Personality and Social Psychology*, 67, 1063-1078.

Scheier, M. F., Matthews, K. A., Owens, J. F., Macgovern, G. J., Sr., Lefebvre, R. C., Abbott, R. A. (1989). Dispositional optimism and recovery from coronary artery bypass surgery : The beneficial effects on physical and psychological well-being. *Journal of Personality and Social Psychology*, 57 1024-1040.

Seegerstrom, S. C., Taylor, S. E., Kemeny, M. E., & Fahey, J. L. (1998). Optimism is associated with mood, coping, and immune changes in response to stress. *Journal of Personality and Social Psychology*, 74, 1646-1655.

Sexton, D. L., & Munro, B. H. (1988). Living with a chronic illness: the experience of women with chronic obstructive pulmonary disease. *Western Journal of Nursing Research*, 10, 26-44.

Shin, D. C., & Johnson, D. M. (1978). Avowed happiness as an overall assessment of the quality of life. *Social Indicators Research*, 5, 475-492.

Smith, T., Pope, M. K., & Rhodewalt, F. (1989). *Journal of Personality and Social Psychology*, 56(4), 640-648.

Tennen, H., & Affleck, G. (1987). The costs and benefits of optimistic experiences and dispositional optimism. *Journal of Personality*, 55(2), 377-393.

Terrill, D. R., Friedman, D. G., Gottschalk, L. A., & Haaga, D. A. (2002). Construct validity of the life orientation test. *Journal of Personality Assessment*, 79(3), 550-563.

Turkum, A. S. (2005). Do optimism, social network richness, and submissive behaviors predict well being? Study with a Turkish sample. *Social Behavior and Personality*, 33(6), 619-628.

Wahl, A., Burckhardt, C., Wiklund, I., & Hanestad, B. (1997). The Norwegian version of the quality of life scale (QOLS-N). A validity and reliability study in patients suffering from psoriasis. *Scandinavian Journal of Caring Sciences*, 12, 215-222.

Wood, V., Wylie, M., & Sheafor, B. (1969). An analysis of a short self-report measure of life satisfaction: Correlation with rater judgements. *Journal of Gerontology*, 24, 465-469.

Zullig, K. (2005). Using CDC's health-related quality of life scale on a college campus. *American Journal of Health Behavior*, 29(6), 569-569.

## BIOGRAPHICAL SKETCH

Growing up in a small town in Virginia, I seemed to be the resident go-to person for everyone's problems, hard times, and advice. My interest in the way the mind and emotions worked followed me up through grade school, along with my passion for volunteer work and community service.

My interest in individuals' perceptions and subjective experiences led me to pursue a bachelor's degree in psychology at the University of Central Florida. During my years at UCF, I was a research assistant under a swimming teacher, who taught aquatic survival skills to small children with a wide range of disabilities. I fell in love with that area of work, and decided to pursue a Master's degree at the University of Florida, with a specialization in Adapted Physical Activity. Once at the university, my interests broadened to a more holistic type of psychological and physical health, which has led me to have the desire to acquire knowledge on the effects that mental states have on previously-thought unrelated views of human experience.

I believe that western culture is on the brink of a new paradigm concerning the more internal world as just as important as the external world. My experiences and training at the University of Florida have been invaluable and I feel incredibly fortunate to have amassed the opportunities and education that I have received from this program. I look forward to being able to say that I am a proud alumna of UF, and to carry that with me into my future, where I hope to be able to give back what has been so graciously awarded to me by my experiences.