Aging is life-spanning process of growth and development from birth to death. As age increases, new worries occupy the mind. One may have outlived many of one’s relatives specially spouse, or long time companion and friends. Loneliness and grief may at times be overwhelming. One may find oneself worrying about losing one’s independence or mobility and may have serious concerns about how this may affect one’s quality of life.

Quality of Life (QOL)

Gee (2000) examined the role of living arrangements in the quality of life of community-dwelling Chinese elders (aged 65 and over) currently residing in Vancouver and Victoria, British Columbia. Three dimensions of quality of life – satisfaction, well-being and social support – are examined for married men and women [living with spouse alone, living intergenerationally] and widowed women [living alone, living intergenerationally]. Few differences are found for married persons, especially women; for widows, living alone significantly reduces quality of life in a number of areas.

Bowlinga, Banistera, Suttonb, Evansc & Windsora (2002) defined the constituents and indicators of quality of life (QOL) in older age, in order to offer a more multidimensional and useful model of quality of life, based on the perspectives of older people them. This paper focuses on the extent to which self-evaluations of global QOL are influenced by health, psychological and social variables, and social circumstances. The main independent predictors of self-rated global quality of life were: social comparisons and expectations, personality and
psychological characteristics (optimism-pessimism), health and functional status and personal and neighbourhood social capital. These variables explained the highest proportion of the variance between groups in their quality of life ratings.

Beaumont and Kenealy (2004) reported a study of the influence of healthy older people's type of residence and social comparison strategies on their quality of life perceptions. Participants were classified by their type of residence, and their quality of life was assessed by the Schedule for Evaluation of Individual Quality of Life: Direct Weighting (SEIQOL-DW). Among the reported social comparison judgments, the dominant strategy was 'Downward Contrast'. It was the sole strategy for 78 per cent of those studied, and was significantly associated with a higher perceived quality of life. Among other statistically significant findings, it was found that positive orientation, optimistic orientation, and the use of Contrast rather than Identification comparisons associated with a better reported quality of life.

Neumann and Byrne (2004) assessed the quality of life in depressed older people and found that quality of life scores were strongly correlated with severity of depression. In another study Gabirel and Bowling (2004) assessed the quality of life (QOL), based on 999 people aged 65 or more years living in private households in Britain. The main QOL themes that emerged were: having good social relationships, help and support, living in a home and neighbourhood that is perceived to give pleasure, feels safe, is neighbourly and has access to local facilities and services including transport i.e. engaging in hobbies and leisure activities (solo) as well as maintaining social activities and retaining a role in society; having a positive psychological outlook and acceptance of circumstances which cannot be changed; having good health and mobility; and having enough money to meet basic needs, to participate in society, to enjoy life and to retain one's independence and control over life. The results have implications for public
policy, and supplement the growing body of knowledge on the composition and measurement of quality of life in older age.

Chang et al. (2006) compared the quality of life (QOL) between elderly with depressive disorder and control subjects. A significantly greater number of physical diseases (p<0.001), more severe depression (p<0.001), lower QOL (p<0.001) score were noted in patients with depressive disorder than in controls. In the depression group, depression severity was negatively correlated with four domains of the WHOQOL-BREF (p<0.005, p<0.001, p<0.05, p<0.001).

Wood, Goesling and Aveller (2007) found that married people live longer and enjoy better physical health than adults who are never married, widowed or divorced. Butler and Ciarrochi (2007) found that lapse of age and its impacts like psychological deterioration enhance the dependence on others and reduce the psychological QOL among widowed elderly.

Ravindranadan and Raju (2008) examined the quality of life and emotional intelligence of parents of children with special needs on a sample of 200 parents, of which 100 are parents of normal children and found that the parents of children with special needs are significant different from the parents of normal children on quality of life and emotional intelligence. In another study Bowling (2008) found that the maintenance of social life, participation at leisure activities and contacts with friends and relatives have been deteriorated, hence affecting the social QOL in widowed elderly as compared to married elderly.

Kirchengast and Haslinger (2008) found that elderly women live 6-8 years longer than the men, exhibit lower QOL because they are socially inactive, have a tiny income and have many health problems so feel disappointed with life. In a similar study Kowalski and Bondmass (2008) found that elderly women have lower QOL and more loneliness than men.

Yalcin, Karahan, Ozcelik and Lgde (2008) investigated the effect of an emotional intelligence program on the health related quality of life and well being.
of individual with type-II diabetes. They found that the emotional intelligence program may have positive effect on quality of life and well being of individual with type-II diabetes.

Manderscheid et al. (2010) noted that well being is the degree to which people feel positive and enthusiastic about themselves and life. In another study Thomopoulou, Thomopoulou and Koutsouki (2010) found that elderly married had higher scores at all the four subscales of QOL than widowed and divorced.

Galhardo, Magalhaes, Blanes, Julians and Ferreira (2010) evaluated health related quality of life and depression in older patient with pressure ulcers who were living at home and found a high rate of depression with lower health related quality of life.

Brett, Gow, Corley, Pattie, Starr and Deary (2011) investigated the determinants of differences in quality of life in old age and to include a wide range of possible predictors. The present study investigated the determinants of quality of life in two groups of older adults for whom there was an unusually informative set of possible predictor variables. Linear regression analyses revealed that HADS depression had the greatest influence on quality of life. Personality traits, most notably Emotional Stability, also predicted quality of life to varying degrees, along with factors reflecting current life circumstances. Personality traits and minor depressive symptoms have an important influence on self-reported quality of life in old age.

Baernholdt, Hinton, Yan, Rose and Mattos (2011) examined the association between the 3 dimension of QOL and needs and health behaviours in a nationally representative sample of adults 65 years and older. The difference in association with different dimension of QOL confirms that this is a multidimensional concept. Since depression, memory problems, and ADL function were all associated with some dimension of QOL.
Optimism

Taylor *et al.* (1992) found that optimism is positively related to psychological well being and lowers the level of depression than pessimism.

A study on personal control over development, identity formation, and future orientation as components of life orientation was investigated by Pulkkinen and Ronka (1994). They studied two components of life orientation on 145 men and 142 women at 26: (a) positive orientation (PO) (b) motivated questioning (MQ). In comparison with MQ, PO was more strongly associated with variable involved in adaptive psychological functioning: personal well being, broad range of goals, social acceptance, and socially constructive ends. Life orientation in men was more dependent on current variables involved in adaptive psychological functioning.

Whelen *et al.* (1997) studied confirmatory factor analysis revealed that the Life Orientation Test (LOT) consisted of separate Optimism and Pessimism factors among middle-aged and older adults. Although the two factors were significantly negatively correlated among individuals facing a profound life challenge (i.e., caregiving), they were only weakly correlated among noncaregivers. Caregivers also expressed less optimism than noncaregivers and showed a trend toward greater pessimism, suggesting that life stress may affect these dispositions. Pessimism, not optimism, uniquely predicted subsequent psychological and physical health; however, optimism and pessimism were equally predictive for stressed and nonstressed samples. By exploring optimism and pessimism separately, researchers may better determine whether the beneficial effects of optimism result from thinking optimistically, avoiding pessimistic thinking, or a combination of the two.

Isaacowitz and Seligman (2001) examined two senses in which pessimism might be a risk factor for depressive mood among older adults. The first was that a pessimistic explanatory style would predict changes toward depressive mood
when combined with stressful life events. The second was that predictive pessimism by thinking that bad events would happen in the future, would predict changes in depressive symptoms. We found an interaction between explanatory style and life stressors, but it was the optimists who were at higher risk for depressive symptoms after negative life events. We also found support for predictive pessimism, however, as a predictor of depressive symptoms over time.

Wrosch and Scheier (2003) found that dispositional optimism facilitates well being and good health. In another study according to Moyer et al. (2003) the construct of HRQOL is one valuable thing that has been linked to optimism/pessimism in past research. Pessimists had significantly worse HRQOL scores than optimists.

Kung et al. (2006) examined the relationship between optimism-pessimism and quality of life (QOL) in survivors of head and neck and thyroid cancers. They found that optimism was associated with a higher quality of life on both the mental and physical component. In another study Moor, Engquist, Kudelka, Bevers and Cohen (2006) investigated whether situational and dispositional optimism were protective against dimensions of distress and aspects of health-related quality of life (HR-QOL) in patients with ovarian cancer undergoing chemotherapy. Both measures of optimism were positively associated with baseline anxiety, perceived stress, and depression.

Groota and Brinkb (2007) examined self-reported measures of life satisfaction may be biased by optimistic or pessimistic dispositions of respondents. The results suggest that the realistic values of life satisfaction are closer to the pessimistic values than to the optimistic ones. It is further found that men are relatively more optimistic and less pessimistic than women. Cardiovascular disease makes people both less optimistic and less pessimistic.

Mannix, Feldman & Moody (2009) investigated the relationship between optimism and health related quality of life in adolescents with cancer and it was
found that optimism was correlated with less reported pain, better communication
with doctors, higher reported psychological functioning and higher overall QOL.

Peleg, Barak, Harel and Rochberg (2009) investigated the extent in which
two coping variables—hope and dispositional optimism—was related to
depression and severity amongst individuals who have sustained traumatic brain
injury (TBI). They found that high levels of depression were experienced in the
study sample, while hope and dispositional optimism were significantly lower in
comparison to the general population. The correlation patterns indicate that both
hope and dispositional optimism negatively correlated with participants’
depression levels and those showed significant positive correlations with each
other.

Mazanec, Dalg, Douglas and Lipson (2010) examined the relationship
between dispositional optimism and health related quality of life (HRQOL) in
newly diagnosed adult cancer patients. They found that optimism was
significantly correlated with spiritual well-being, anxiety, depression, and
HRQOL. In another study Egitim and Bilim (2010) assessed the life orientation
among 427 students (214 females and 213 males) and found that faculty, age and
academic achievement did not predict the life orientation.

Depression

Dean, Kolody, Wood & Matt examined (1992) the mental health effects of
living alone on elderly persons are not well known. Using multiple regression
models, the authors attempted to distinguish the influence of living alone on
depressive symptoms from the influence of other highly relevant variables: social
support, stressors, age, sex, and marital status. The authors find that elderly
persons who live alone have higher levels of depressive symptomatology. The
depressive influence of living alone is greater on men than women. Undesirable
health events have a stronger impact on those who live alone, particularly women.
Marital status influences depression indirectly through its influence on living alone.

The relationships between physical and social functioning and depression in old age are described by Kivela (1994) and gave the evidence that disturbed physical and social functioning can predispose individuals to depression. Having poor emotional relations with one's wife predicted depression within five years among the initially non-depressed men, and not living alone among the women. From a preventive viewpoint, the independence of the elderly and social roles that support self-esteem in old age should be stressed.

Achat, Kawacho and Spizo (2000) examined that depressive symptoms among older people are associated with reduced levels of functioning across all the domains in health related quality of life.

Snowden and Lare (2001) found the rate of depression in elderly adults is twice of being depressed in institutionalized people than those living with their families and quality of life score were significantly high in HH (household) group than the RH (retirement homes).

Blazer (2003) examined the depression is perhaps the most frequent cause of emotional suffering in later life and significant decrease quality of life in older adults.

Huisani, Cumming, Kilbourne and Roback (2004) estimated that 20% of the community dwelling elders experience symptoms of depression and the prevalence rate for depression in older women is twice that of men. He further stated that late life depression can have serious repercussions, mortality and disability, higher health care utilization and longer hospital stays.

Antunesl, Stellall, Santosl, Buenol and Mellol (2005) examined the effects of fitness-endurance activity in depression, anxiety and quality of life scores in seniors. Comparing the groups after the study period, there found a significant decrease in depressive and anxiety scores and an improvement in the quality of
life in the experimental group, but no significant changes in the control group. In another study Freyne, Fahy, McAleer, Keogh, Wrigley (2005) investigated the relationship between social network type and depression over time. They found that depression severity at baseline and at follow-up times differed according to subjects’ social network. Those with more socially integrated networks had the best outcome and those who had more dependent networks had a poorer outcome.

Chan, Chiu, Chien, Thompson and Lam (2006) investigated the self rated quality of life of community dwelling elderly people diagnosed with depression and found low rating of quality of life when compared with healthy persons.

Mathur (2009) examined the predictors of depression among ageing women (n = 400). The results showed that the level of economic status followed by education and social support are the prime factors contributing depression in aged women. Findings also suggest that the change in life style and spiritual health are the means to achieve holistic health.

Yadav (2010) examined the depression in advanced age. It was a comparative study of ashram and family life of aged person. The results indicated that the aged people who were living in families were found to be more depressed than their counterparts. Depression has been found to be greater in 70+ people as compared to group of 60 to 65 years. In another study according to Barua, Ghosh, Kar and Basilo (2010) depression in the geriatric population found to be among older age group and female gender. Risk factors for depression in geriatric population were identified as low SES, loss of spouse, living alone, cognitive impairment, co-morbidities and bereavement and restricted activities of daily living.

Rashid, Manan & Rohana (2011) determined the prevalence of depression among the elderly Malays living in rural Malaysia. Geriatric Depression Scale was used to screen for depression among the participants. The prevalence of depression was 30.1%. Being unmarried (OR 2.06), unemployed (OR 1.81),
earning less than RM 600 (OR 2.16) and living alone (OR 2.32) were significantly associated with the risk of being depressed. Being unemployed (1.82) and earning less than RM 600 (OR 1.79) were significant predictive variables. Conclusions suggested that employment opportunities which can provide reasonable income are important for the elderly.

**QOL, Optimism and Depression**

Hanaokaa and Okamuraa (2004) evaluated the mid-term efficacy of life review activities on the quality of life (QOL) of the elderly by conducting a randomized controlled trial, and to identify the factors that should be taken into consideration when conducting life review activities. Regarding the factors that were associated with depression and hopelessness, 3 months after completion of the intervention, depression and hopelessness of a more severe nature at baseline and having greater unresolved conflicts in the past were extracted by multiple regression analysis. Conclusions suggested that group life review activities have a role in assisting the developmental stage of old age and supporting mental health, and have mid- to long-term effectiveness in maintaining and improving the QOL of the elderly.

Steele and Wade (2004) determined whether the relationship between optimism and depressive symptoms was mediated by self-reported quality of life (QOL) in acute coronary syndrome patients. They found that the relationship between optimism and depressive symptoms was partially mediated by functional QOL and symptom QOL.

Zenger, Glaesmer, Hockel and Hinz (2011) investigated the predictive value of optimism/pessimism for anxiety, depression and health-related quality of life in female cancer patients. They found that the degree of self-assessed pessimism was significantly associated with anxiety, depression and health-related quality of life. Especially, women with a high level of pessimism are at risk for
higher levels of anxiety and depression in addition to lowered health-related quality of life in the course of the disease.

**Quality of Life, Optimism and Depression among widowed people**

The degree of adjustment encountered by widowed people in the transition to their new status varies by developmental stages. The death of a marital partner in young marriages is relatively uncommon, nevertheless, when it does occur it is apt to make bereavement and the survivor role much more difficult to accommodate than in later life "because of unfulfilled hopes and dreams, the lack of fit with other couples at the same life phase, and the lack of models of the same cohort" undergoing this experience (Walsh and McGoldrick, 1991).

Typically there has been little or no emotional preparation for the shock and isolation of early widowhood. Being suddenly left alone to rear young children can be extremely trying, and at the same time impedes the process of personal and familial recovery. The immediate and growing financial and caretaking obligations of single parenthood can interfere with the tasks of mourning (Levinson, 1997). Married couples cope with stress better since they can share their problems with one another. Married people feel better and are more optimistic in life than widowed people (Levinson, 1997). Adult friends and relatives can and often do provide assistance with everyday chores, are more apt to receive these kinds of practical support than bereaved wives.

Older people adapt more readily to widowhood because losing a spouse at advanced age is more the norm and often anticipated thus making acceptance of the loss somewhat easier. Lichtenstein et al. (1996) found those who have been widowed for extended periods of time were more depressed than there married twins. Research on surviving spouses over age sixty-five revealed that those who were more dependent upon their spouses show higher levels of anxiety, low QOL and depression than those who were not (Carr et al. 2000). Several studies suggest that widowers can be prone to depression after the death of their wives, especially
when they are compared with their non bereaved married counterparts (Carr *et al.* 2000).

Adjustment to widowhood is a changing process with bereaved spouses showing considerable difference in their levels of depression and QOL (Robin, 2002). Marriage is associated with improved well being and reduced levels of depression. Widowed who securely attached to their spouses, this attachment provides them with a secure base with which they face life problems. Death of spouse is linked to reduce psychological well being. Main reasons of depression in men are separation after married, widowed or divorce. Married men have lower rates of depression than widowed men. More women are depressed than men (Lee *et al.* 2001). Individuals who became widowed reported more depressive symptoms than individuals who remained married. The effects of divorce on depression appeared to be more significant for women than for men (Robin, 2002).

**Sex differences**

There has been considerable controversy as to whether widowhood is a more difficult experience psychologically for men or for women. Widowhood is generally a problem financially for women than men and economic difficulties can lead to lower psychological well being (Schuster and Butler, 1989). The weight of the evidence at this point seems to favour the argument that widowhood is more difficult for women.

Although there is a natural tendency to draw comparisons between widows and widowers, some features of “widower hood” are unique and warrant special attention. The process of adaptation to the loss of their wives is rarely linear and is more aptly described as one of oscillation between good and bad days or even moments within a single day. Some cope more successfully than others who experience greater difficulty, however, there is a plethora of evidence that
suggests that many ultimately demonstrate a high degree of resilience as time passes (Walsh and McGoldrick, 1991).

Often times widower’s experiences are affected by a variety of factors including their age, the relationship with their children and how much emotional and material support is available from others (Lichtenstein et al. 1996). While women who lose their husbands often speak of feeling abandoned or disserted, widowers tend to express the loss as one of “dismemberment”, as if they had lost something that kept them organized and whole. Widowers who experience the same emotions as widows but were raised with the belief that emotional control is a sign of strength often find themselves confronting an inner conflict about how to respond to a loss (Levinson, 1997). In another study it was found that on average married men are less likely than married women to be depressed (Carr et al. 2000).

However, Lee et al. (2001) found widowed men find housework to be more daunting. Their dislike of housework combined with the necessity of doing, it is associated with greater depression than married men. Men are more advantaged by married than women in terms of psychological well being. Widowhood is also more depressing for men because married men are the least depressed of any sex/marital status group.

There is a lot of information suggesting that the level of QOL, optimism and depression is different for widowed and married people keeping in view this background and above literature now the problem, objectives and hypotheses for the present investigation will be formulated.