



Social support and depression of adults with visual impairments



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ABSTRACT

Relatively little research exists with regard to the relationship between social support and depression among adults with visual impairments. Such a gap is noteworthy when one considers that individuals become more dependent on others as they enter middle and late adulthood. The present research will examine the association between social networks, social support and depression among adults with visual impairments. Seventy-seven adults with visual impairments participated in the study. Depression, social network and emotional/practical social support were measured with self-report measures. Additionally, the degree to which emotional/practical social support received were positive or negative and the ability of respondents to self-manage their daily living were assessed. Less than a third of respondents scored above the threshold for depressive symptoms. Depressive symptoms were not related to gender or vision status. Depression was correlated with age, educational level, less positive practical support, more negative practical support and more negative emotional support, with lower perceptions of self-management representing the most robust predictor of depression. Age moderated the relationship between depression and self-management, and between depression and negative emotional support. Lower perceptions of self-management and negative emotional support were significantly associated with depressive symptoms.

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1. Introduction

Depression is a common response for individuals who have underwent significant vision loss (Evans, Fletcher & Wormald, 2007; Hayman et al., 2007; Horowitz, Reinhardt, Boerner & Travis, 2003). Adults with visual impairments report more depressive symptomatology than sighted adults (O'Donnell, 2005). Older adults with visual impairments are also more likely to suffer from depression than the general population (Hayman et al., 2007). Indeed, depression becomes even more

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significant as adults with visual impairments grow older, with prevalence rates for depression among older people ranging from 25 to 45% compared to <20% among those with normal vision (Evans et al., 2007). However the question of whether severity of visual impairment is associated with depression is not clear. It is noted that visual acuity is not significantly associated with depression for adults with visual impairments, which leads to the suggestion that the degree of severity of their disability may not influence their well-being (Guerette & Smedema, 2011). It is also suggested that although visual function is associated with depressive symptoms for older adults with severe visual impairment, visual acuity is not (Hayman et al., 2007). On the other hand Branch, Horowitz, and Carr (1989) report a positive correlation between the decline of visual acuity for elderly individuals with visual impairment and the increase of the depressive symptoms (Branch et al., 1989). The picture is mixed, but longitudinal research indicates that vision loss is a robust predictor of both the onset and persistence of depression, even beyond dual sensory loss (Chou, 2008). Given that social relationships can influence the well-being of people (Ibarra-Rovillard & Kuiper, 2011), social support represents a potential mechanism by which the connection between vision loss and depression can be better understood.

There is considerable debate as to the appropriate way to define social support (e.g., Shinn, Lehmann, & Wong, 2010). In general social support, which has been defined in many different ways, refers to the type of assistance/help that individuals receive or expect to receive from those who come into contact with them in any way (Papakonstantinou & Papadopoulos, 2010). Social support and social network composition represent potential avenues by which researchers can better understand the link between depression and vision loss. On the positive side, social support includes; perceived support, the belief that social support will be available when needed (Lindorff, 2005), and received support, the support an individual actually receives or has reported receiving in a specific situation or in a specific period from specific persons. However, social support can also be perceived negatively. Thus, the idea that care is available might be comforting (Bolger, Zukerman & Kessler, 2000), while the provision of help might be potentially disabling in that it highlights the level of dependence (Bolger et al., 2000). In the present study, social support was measured by first asking respondents to identify their support networks, and then asking them to rate these networks in terms of both emotional and practical support (both positive and negative) and their satisfaction with the support received.

More specifically, in terms of the present study, practical support is defined as informational support, as well as the provision of services and materials (Chang & Schaller, 2000) and tangible resources, such as physical aids and transportation. Emotional support is defined as affective support and includes expressions of concern or feelings of being accepted, respected, included and having one's emotions acknowledged (Brough and Pears, 2004; Chang & Schaller, 2000).

1.1. Previous research among individuals with visual impairments

There is relatively little research that specifically assesses the relationship between social support and depression among adults with visual impairments. In general social support appears to be an 'affective buffer' against depression as a result of vision loss (Burmedi, Becker, Heyl, Wahl, & Himmelsbach, 2002). Guerette and Smedema (2011) suggested that low levels of social support lead to higher levels of depression for adults with visual impairment. Longitudinal research indicates that friendship support is associated with better adaption and less depression over a three year rehabilitation period (Reinhardt, Boerner, & Horowitz, 2009). Reinhardt and Blieszner (2000) found that for older adults with visual impairments having a spouse was associated with higher perceived affective and instrumental family support. Conversely, social support can be experienced negatively whereby individuals experience support as insensitivity, overprotection (Chang & Schaller, 2000; Cimarolli & Boerner, 2005), criticism, anger, hostility (Ruehlman & Karoly, 1991) or inappropriate help. Not surprisingly, negative social support is associated with depression (Cimarolli, 2006; Cimarolli & Boerner, 2005). For people with visual impairments, perceived overprotection can lead to a less optimal adjustment and lower levels of 'environmental mastery' (Cimarolli, Reinhardt, & Horowitz, 2006). The way that our social networks evaluate us plays a significant role with regard to the types of social support that we receive. Not surprisingly, people with disabilities are more likely to be socially stigmatized and therefore negatively regarded (Carter & Feld, 2004).

Finally, the degree to which individuals with visual impairments can handle their world is of critical importance to their quality of life. In the present study, the degree to which individuals can self-manage will be assessed. Our approach to self-management is rooted in the definitions of Lorig and Holman (2003), who define it as being characterized by an individual taking an active role in decisions that affect their health and demonstrating responsibility for the day-to-day management of their lives.

The aim of the present study is to examine the relationship between depression and social networks/social support of adults with visual impairments. Specifically, the present study will investigate the relationship between depression and social networks, received support and satisfaction from received support.

2. Method

2.1. Participants

The participants were selected from the members of the Panhellenic Association of the Blind. Initially, a random selection of 110 adults with visual impairments was contacted by phone in order to invite them to participate in the study. From this group 77 (47 men and 30 women) individuals agreed to participate. Respondents were aged 18–56 (mean = 33.47,

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