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The effects of quality of social networks on psychological well-being in the visually impaired elderly

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THE EFFECTS OF QUALITY OF SOCIAL NETWORKS ON PSYCHOLOGICAL WELL-BEING IN THE VISUALLY IMPAIRED ELDERLY

A Thesis

Presented to the

Faculty of

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in

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ABSTRACT

One challenge faced by many elderly is a decline in vision. Approximately 1.8 million community dwelling elderly report having some difficulty with basic activities due to a vision impairment. These numbers will increase dramatically as our population of elderly grows. Research has shown that a quality support network can significantly affect an individual's adjustment to vision loss and their ability to age successfully. Just how a supportive environment increases an individual's ability to adapt to and cope with the stressors of vision loss has been a subject of debate. The purpose of this study was to examine the relationships between several theory based strategies for adaptive coping and well-being in a community of visually impaired elderly. We examined the explanatory power of Balte's theory of Selective Optimization with Compensation; the Stress Buffering Hypothesis; and Carstensen's Socioemotional Selectivity theory. Based upon these theories, we attempted to clarify those social support factors which affect psychological well-being in the visually impaired elderly. Quality of social supports was measured by an adaptation of a

questionnaire (Rook, 1987) which assesses reciprocity levels in social support exchanges. An equity index of social support exchanges was used to measure reciprocity levels among different types of relationships. Also assessed was degree of relationship closeness. Psychological well-being was measured by a multidimensional construct of well-being developed by Ryff (1987). We hypothesized that there would be a negative relationship between the equity index of social support exchanges and psychological well-being and that this negative relationship would be less strong for close kin relationships. A correlation approach was adopted to test the relationships between 1) the equity index of social support exchanges and each of the well-being scores, and 2) perceived closeness of the relationship and each of the three well-being scores. In addition, t tests for independent groups were used to test between group differences of the elderly individuals' well-being scores based on relationship role and type of social exchange relationship. A significance level of $p=.05$ was adopted to conclude statistical significance for the results.

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CHAPTER ONE

INTRODUCTION

An Aging Society

As our population continues to age, there are increasing concerns regarding how successfully our elders are meeting the challenges. The number of Americans 65 years or older has increased by 3.3 million or 10.6% since 1990. In addition, the older population itself is aging. Between 1990 and 1999, the 65-74 age group increased eight-fold. The 75-84 age group increased 16 times, and the 85+ age group became 34 times larger! Between the years 2010 and 2030, the baby boom generation is expected to reach age 65. Thus, by the year 2030, there will be approximately 70 million persons over 65. This is twice their number in 1999 (Administration on Aging, 2000). Our growing numbers of aged will have major implications for families, policy makers, service providers and society in general.

One challenge faced by many elderly is a reduction in sensory functioning. Sensorimotor losses have been shown to have significant effects on a number of domains (e.g., cognitive functioning, well-being, and self-care)

(Lindenberger & Baltes, 1994; Mariske, Klumb & Baltes, 1997). Not only do sensory impairments decrease independence, but they affect an individual's physical, emotional and social well-being. Of specific concern is the growing numbers of elderly with visual impairments. Almost 37% of all visits to physicians' offices for eye care are made by persons 65 years of age or older (Desai, Lentzrer, & Robinson, 2001). Approximately 1.8 million community dwelling elderly report having some difficulty with basic activities due to their visual impairment. An individual with a visual impairment also has an increased risk of falling and being admitted to a hospital or nursing home (Desai et. al., 2001). A visual impairment can negatively affect many aspects of an individual's daily life. The resources which the individual has available to help deal with the negative consequences of a vision impairment can have significant implications for the individual's ability to cope and age successfully. The purpose of the present study is to examine the relationships between several theory based strategies for adaptive coping and well-being in a community of visually impaired elderly.

Successful Aging Defined

Unfortunately, to date there has been very little consensus among researchers as to what constitutes "successful aging" and what variables have the greatest influence on its occurrence. Criteria previously used to predict successful aging (e.g., life satisfaction; self-concept; self-esteem; adaptation and coping) have not been able to adequately predict this multidimensional construct Ryff & Keyes, 1995), in part because there is no agreed-on definition of successful aging. Accordingly, for the purpose of this study, we defined successful aging as psychological well-being. Specifically, we used Ryff's (1995) multidimensional construct of psychological well-being (stemming from research on life satisfaction, affect balance, self-esteem, internal locus of control and late-life morale) to define successful aging. Of specific interest in this study were those factors indicative of psychological well-being and successful aging in the visually impaired elderly. We examined the explanatory power of three related theories of adaptation and coping (specifically: Baltes' theory of Selective, Optimization with Compensation; the Stress Buffering Hypothesis; and

Carstensen's Socioemotional Selectivity theory). Based upon these theories, we attempted to clarify those factors which affect psychological well-being in the visually impaired elderly.

CHAPTER TWO

VISION IMPAIRMENT: A SPECIAL CHALLENGE OF AGING

Vision impairment can be defined as vision loss that cannot be corrected by glasses or contact lenses alone. Many older adults undergo normal age-related vision changes (e.g., a decline in visual acuity, a declining ability to function in low light or adapt to the dark, difficulty judging distances and a declining ability to discriminate between colors)(Branch, Horowitz & Carr, 1989). These normal age-related vision changes usually begin in mid-life and progress gradually. They are often corrected with glasses or contact lenses and do not usually cause any major functional impairments for the individual.

Unfortunately, more and more older people are experiencing visual impairments that result from vision diseases that are not solely due to the natural aging process (e.g., macular degeneration). Such visual impairments often leave the person "legally blind". Legal blindness can be defined as visual acuity of 20/200 or worse in the better eye. While only about 1% of the

elderly 70-74 years of age (and 2.4% of those 85 and older), meet the criteria for legal blindness, many more individuals can be classified as "visually impaired". Visual impairment is often defined as an inability to read regular newspaper print that cannot be corrected by glasses or contact lenses alone (Desai et al., 2001). Visual impairments affect 13% of the non-institutionalized elderly (National Center for Health Statistics, 1986). Most estimates of the number of visually impaired excludes the institutionalized elderly. According to Kirchner (1985), rates of vision impairment among nursing home residents are estimated to be at least four times higher than those of community dwelling elderly.

Eye diseases common in the elderly include macular degeneration, cataracts, glaucoma, and diabetic retinopathy. The elderly often experience more than one eye disease at the same time and the severity of impairment typically increases with age.

Most elderly persons are already making difficult adjustments in their lives. They may have experienced loss of family or friends through death; loss of their career through retirement; or they may be experiencing one of a

variety of physical ailments. The addition of a visual impairment can compound these other losses. An elderly person experiencing loss of vision will have many additional adjustments to make.

Factors Affecting Adjustment to Vision Loss

The visually impaired person may experience a loss of control over the management of their day to day lives. They may need help with housework, transportation, shopping, and getting around in unfamiliar environments. Of particular concern to many visually impaired individuals is the loss of privacy they must become accustomed to. They may need someone to read their mail, help pay bills, balance their checkbook and help with personal correspondence. Deciding on a reader can be a difficult decision. Not being able to identify faces, identify food items on their plate or take part in nonverbal feedback during conversations may make the visually impaired person so uncomfortable in social situations that they retreat to the privacy and seclusion of their residence. This seclusion can negatively influence well-being and make future adjustment much more difficult.

There are many factors which influence a person's ability to successfully adjust to and cope with these challenges. Health status, availability of and satisfaction with services, and a socially supportive environment all have an influence on an individual's adjustment and psychological well-being.

Health Status

Of primary concern is the elderly individual's physical well-being. Among the elderly visually impaired, two-thirds have at least one other chronic illness or disability. The most common of these conditions are arthritis, heart disease, hypertension, diabetes, and post stroke symptoms (Blake, 1984). Many of these conditions require the elderly individual to carefully monitor diet, medications, weight and physical activity. The loss of vision can make doing so difficult.

Of further concern is the number of elderly with hearing impairments. In 1995, one third of all community dwelling elderly 70 years of age or older were hearing impaired. Having a hearing impairment significantly affects the individual's functioning. However, only 76% of persons 70-74 years of age with a hearing impairment had

seen a doctor about their hearing problems. This number increased to 84% for those 85 years or older. This is compared to 98% of those with vision impairments who had seen their doctor about their vision problems (Keller, Morton, Thomas & Potter, 1999). The loss of vision creates many additional challenges for the individual (physical, psychological and social). When an individual experiences both a loss of vision and hearing, or the addition of any other chronic illness, their ability to cope is often dependent upon the environmental resources available to them.

Availability of Services

Unfortunately, very little federal funding has been allocated for the provision of services and the rehabilitation of the older visually impaired person (Orr, 1991). Too often the older visually impaired person falls through the cracks of two service delivery systems. Often, an area agency on aging will make a referral for the visually impaired elder to an agency serving the blind. However, the visually impaired individual may still need additional services from the agency on aging (meals on wheels, health screenings, the ability to participate in

senior center activities). The older visually impaired person may have difficulty finding such services accessible due to a reluctance on the part of aging services staff, lack of staff training and lack of confidence on the part of the visually impaired elder (Orr, 1991). The visually impaired elder needs to be viewed as a client of both the aging and the blind service delivery systems.

In a study by Branch (1989), visually impaired seniors and seniors with constant vision were compared on the use of social services, use of health services, physical function, social function, emotional function and perceived health status. After controlling for age and gender, they found that individuals who were visually impaired had compromised physical, social and emotional functioning compared with those who had good vision. Further, the visually impaired reported lower self perceptions of overall health. Despite an obvious need for services, the visually impaired elderly did not report more frequent use of social or health services. Failure to make use of available aging, social and blind service programs could have significant implications for the elderly person's

adaptation to their visual impairment and successful aging in general.

A Supportive Environment

Adjusting to a visual impairment is significantly affected by a supportive network of peers and family members (Orr, 1991). Oppegard and his colleagues (1984) reported that in individuals with low levels of social support, sensory loss was often associated with increased depression and anxiety. A supportive environment not only enables the visually impaired individual to retain a sense of self-worth and self-confidence, but it helps to facilitate the provision of needed services to the visually impaired person. Research has shown that individuals under stress are more likely to seek social support than individuals who are not experiencing stressful situations (Barrera, 1986). Just how a supportive environment increases an individual's ability to adapt to and cope with the stressors of vision loss has been a subject of debate.

CHAPTER THREE

THEORIES OF ADAPTATION AND COPING

For many researchers, successful aging is considered to be a process of adaptation and coping. Adaptation and coping are actually more than just adapting oneself to fit a situation or environment. Adaptation and coping theories, like the multidimensional construct of psychological well-being, are based upon a number of different theories (environmental theories, models concerned with physical health, models looking at cognitive abilities, and personality characteristics, to name a few).

Old age involves various types of losses (health, mobility, social relationships, roles, etc.) which challenge an individual's ability to adapt and cope. Research has found that the negative impact of these losses will be less dramatic and occur at later ages in individuals who are rich in resources (Baltes, 1991). According to Baltes, sensorimotor, cognitive, personality and social resources are important to aging successfully. Resource rich individuals (those with a variety of social

supports and personality strengths) are more likely to have adequate resources to compensate for the age-related losses they may be experiencing. Thus, the availability of resources provides a safety net, compensating for age-related losses and buffering the individual from the negative effects of aging. Such resources can include help with activities of daily living (housework, transportation, finances), professional support services (care management, support groups), or one's own personal assets (health, cognitive status, motivation).

Baltes Theory of Selective Optimization with Compensation

According to Baltes (1991), having adequate resources facilitates three adaptive processes: selection, optimization, and compensation. Using these processes, Baltes has developed a "meta-theory" of successful aging. This meta-theory offers a framework for applying basic developmental theories to identify factors which influence successful aging.

Baltes' theory of Selective Optimization with Compensation (SOC) is a contemporary theory containing elements of activity and disengagement theories as well as

the environmental press model. Like Activity theory (Cumming & Henry, 1961; Havighurst, 1963). Baltes has linked successful aging with continued activity; however, this activity does not have to be a continuation of those activities of middle age. Like Disengagement theory (Cumming & Henry, 1961), Baltes acknowledges that elders do appear to withdraw from activity; however, this withdrawal does not necessarily mean total disengagement. Instead, Baltes stresses the notion of becoming selectively involved in various activities, thus continuing to meet one's personal goals. Baltes also acknowledges the tremendous impact the environment plays (e.g., the quality and availability of resources) in how well an individual is able to successfully adapt and thus age well. As in the Environmental Press Model (Lawton, 1989; Lawton & Nahemow, 1972), Baltes agrees that most individuals can age successfully so long as the resources of the individual match the demands of the environment.

Baltes' model takes into consideration the diversity of aging individuals, their unique circumstances, and life histories. These differences are evident in the different goals or activities which take priority for each

individual. Successful aging is defined in terms of successful goal attainment. According to Baltes (1991), if an individual is to age successfully, they must shift their available resources away from goals emphasizing growth and use these resources to maintain their functional status and regulate any losses. Thus, the individual must maximize their "gains" in those goals or outcomes they deem to be desirable. Baltes proposes that individuals use three strategies (selection, optimization, and compensation) to successfully meet their individual goals.

Components of the Model

Baltes' model consists of three components (selection, optimization, and compensation). Each of these three components represents a strategy which an individual can use to increase the likelihood of aging successfully. According to the model, individuals with many resources (social, cognitive, sensorimotor or personality) are better able to make use of these strategies to delay some of the decline associated with increasing age. Individuals with fewer resources are less likely to make use of these strategies. Consequently, they will have a narrower range

of environments in which they can meet their goals for successful aging.

Selection. The selection component helps provide a direction or focus for an individual's limited resources. Selection is the process of selecting a behavioral domain or goal for further development (Mariskeet, 1995). With increasing age and limited resources, selection becomes an important strategy of aging. Selection enables the aging individual to manage their limited resources in such a way that they can still meet those goals they deem most important.

Optimization. Optimization is the process of maintaining and enhancing existing skills in order to achieve the goals selected by the individual (Baltes & Baltes, 1990; Mariske, Lang, Baltes & Baltes, 1995). The optimization strategy involves making use of those resources available to the individual, whether personal or environmental.

Compensation. Compensation involves making use of resources to compensate for skills that have been lost or have become inadequate, thus allowing the continued meeting of goals.

Conditions that can lead to the need for compensation (Baltes & Baltes, 1990):

1. personal limitations
2. the individual does not have the skills in the domain where their goal lies
3. the individual has lost capabilities that can't be regained through optimization
4. the environment has changed - changing challenges or opportunities.

Baltes (1990) gives an example to illustrate the integration of these three strategies. Baltes tells how the concert pianist, Rubenstein, begins to notice a decline in his ability to play (primarily due to a loss of speed and dexterity in his fingertips with age). Rubenstein reacted to this loss of speed by concentrating on a few select pieces of music (selection); he increased his practice time (optimization) and changed the tempo of the songs in such a way as to give the illusion of playing faster those sections meant to be played fast (compensation). Baltes elaborates by noting that this example is very general. Environmental factors, physical abilities, sensorimotor functioning and motivation all

combine to influence the individual's use of the three strategies. Successful use of the strategies results in the attainment of a goal and goal selection can vary widely from individual to individual.

Utilization of the above strategies may be conscious or subconscious. Moreover, as previously mentioned, successfully integrating these three components to meet goals requires that there be adequate resources in the sensorimotor, cognitive, personality and social domains of functioning (Baltes, 1991). Those rich in resources have more opportunities to compensate for losses and optimize remaining strengths and abilities. Thus resource-rich people age more successfully because they are able to use available resources (either sensorimotor, cognitive, personality or social) to delay or compensate for decline.

The SOC model gives us a framework in which to relate various developmental theories (cognitive, emotional, social, etc.) to the construct of "successful aging". While the SOC model does not specifically define the goals that are to be selected, or the compensatory strategies or type of optimization to be used, it does leave room for other more domain-specific theories to do so (Carstensen,

Isaacowitz & Charles, 1999). Thus, other domain specific theories (e.g., cognitive, social and biological) can be fit to Baltes' framework to bring a more complete understanding to the challenges of aging. One such theory, "the Stress Buffering Hypothesis" illustrates the emphasis Baltes places on the need to have a resource rich environment.

Stress Buffering Hypothesis

According to the "Stress Buffering Hypothesis", individuals with strong social support systems are less likely to suffer from the effects of life stresses than those without adequate social supports (Krause, 1987). Kaplan (1975) hypothesized that a reduction in psychological well-being from the negative effects of stressful events, such as vision loss, results from an erosion of feelings of self-worth. Kaplan (1975) argues that it is the need to maintain self-esteem that motivates individuals to seek out the support of others.

Thoits (1985) has hypothesized that turning to socially supportive others in times of stress helps maintain and enhance the individual's self-esteem because

narrowing social support networks in old age are typically composed of family and friends. These relationships are often predictable, safe, and emotionally supportive. By relying on a network of supportive individuals who know the elderly individual well, they can affirm the individual's sense of self as well as provide the needed emotional support (Field & Minkler, 1988; Antonucci, 1980, 1991). These social relationships often include a long history of social support exchanges between the members. Such reciprocal relationships can help the elder feel needed by others and feel as if they are a contributing member of the group (Carstensen & Lang, 1976). It is extremely important for the visually impaired individual to be in an environment which supports their need for continuing independence. A supportive environment not only enables the visually impaired individual to retain a sense of self-worth and self-confidence, but helps to facilitate the provision of needed services to the visually impaired person.

The above discussion on social supports shows how a narrowing of social supports, especially a dependence on family relations and close friends, can help buffer the

effects of vision loss. Such narrowing of social supports with age is consistent with Baltes' (1991) SOC model of successful adaptive aging. As previously mention, Baltes hypothesizes that in order to successfully adapt to life challenges, an individual must draw upon available resources. This entails a shift in the allocation of resources away from growth to the maintenance and regulation of losses. One theory that fits well into the framework provided by Baltes' SOC model is that of Socioemotional Selectivity Theory (SES) (Carstensen, 1991). SES addresses the underlying reason for reduced rates of social interaction in later life (Carstensen, 1992). As in the SOC model, individuals according to SES theory, must concentrate their efforts to meet their most important life goals. Individuals must target their emotional and physical resources to maintain those relationships that are most important, supportive and rewarding.

Socioemotional Selectivity Theory (SES)

Like the SOC model, SES theory proposes that successful adaptation, and thus successful aging, is based on using limited resources to meet individual goals.

Specifically, SES proposes that in the social realm, two goals are of primary importance: information seeking and emotion regulation (Carstensen, 1991; Carstensen, 1999). How an individual perceives their future and the constraints placed on them determines whether or not the individual will place more emphasis on current, emotional goals or more emphasis on future oriented, long term, information seeking goals (Fredrickson & Carstensen, 1990). It is when the future is seen as limited (e.g., as in the case of aging and its associated losses and challenges) that individuals begin to focus more on emotionally fulfilling, present-oriented social relationships with close family and friends.

According to Socioemotional Selectivity Theory (SES), gradual life course changes in the selection of social networks result in reduced rates of interaction in later life. This process can be compared to Baltes' selection component in his three strategies of successful aging. Beginning in early adulthood, individuals begin to selectively reduce social contact with casual acquaintances, relying more and more on emotionally close, rewarding groups of family and friends. These reduced

rates of interaction allow the aging individual to develop social networks that provide the most benefits at the least costs (in terms of time, energy and risks). According to Baltes' SOC theory, this could be considered a form of compensation.

SES theory proposes that it is an individual's perceived satisfaction with their social networks, rather than actual size of the network or frequency of contact with network members that influences an individual's well-being (Carstensen, 1990, 1991, 1992). The desired size of the network and frequency of contact with members can change, depending on the life events of the individual. Moreover, Carstensen (1990, 1991, 1992) proposes that in times of stress, relationships with emotionally close network members are more fulfilling than more casual relationships.

Empirical Support for Socio-Emotional Selectivity Theory

Carstensen and her colleagues (Carstensen, 1992; Fredrickson & Carstensen, 1990; Lang & Carstensen, 1994) have conducted an extensive research program using a

variety of methods to show support for SES. The following findings are of particular interest:

- Older adults are more satisfied with their current social networks than are younger adults. Younger adults are more likely to say they would like to have more acquaintances (Carstensen, 1990).
- In a longitudinal study, Carstensen (1992) found that the frequency of interaction and the satisfaction with casual acquaintances declines as individuals aged from 18 to 50 years. It was also found that with close friends, although the frequency of interaction declined with age, emotional closeness did not.
- Young persons living with a terminal illness made choices similar to those made by older persons with constraints on their futures (Fung, Carstensen & Lutz, 1998).
- When the future is made to appear limited, older people preferred familiar social partners but younger persons did not. When the future was made to appear more limitless, older people no longer

showed preferences for only familiar social contacts (Carstensen, 1992).

Thus, SES is a life-span theory based on social goals (emotion focused or knowledge focused). The motivation to achieve a particular type of social goal is dependent on the environmental conditions which the individual perceives. In times of stress, relationships with emotionally close network members are more fulfilling, and thus more sought after than more casual relationships. In sum, Carstensen's SES theory provides an explanation as to how many elderly maintain their self-esteem, remain satisfied with their relationships, and consequently increase their psychological well-being. However, what aspects of these social relationships cause them to be satisfying and thus more beneficial has not been fully researched.

CHAPTER FOUR

QUALITY OF SOCIAL RELATIONSHIPS

Social support is a complex construct. While a positive relationship between social support and well-being have been repeatedly demonstrated, we know very little about how this relationship comes about. Based on prior research (Antonnucci, 1985; Walster, Walster & Berscheid, 1978; Rook, 1987), we know that in examining the various aspects of social support, it is important to discuss not only the receipt of support but the amount of support provided. Such "reciprocity" in social relationships is an important indicator of the quality of the relationships and is especially important in the elderly (Antonnuci, 1985). Many of the losses associated with old age tend to decrease independence and to reduce the elder's capacity to participate in reciprocal relationships (Circirelli, 1983). Additionally, old age is a time when social relationships become increasingly important to the well-being of the individual. Unfortunately, it has been found that some elderly, afraid they won't be able to reciprocate support may actually be reluctant or refuse to seek the social support they may need (Riley & Eckenrode, 1986). Walster,

Walster and Berscheid (1978) propose that inequitable social exchanges can cause feelings of unfairness, guilt, shame and feelings of declining self-sufficiency. Dimatteo and Hays (1981) found that feelings of indebtedness or guilt reduce the benefits of receiving social support. Gottlieb (1984) argues that receiving social support may be beneficial to self-esteem and well-being only when it is offered within a relationship with equitable social exchanges.

Walster and his colleagues (1978) have suggested that variations in reciprocity have different meanings in different types of relationships. They suggest that an individual's tolerance for inequities in the relationship differ in casual and close relationships, family and peer relationships. Rook (1987) has found reciprocity to be an important determinant of satisfaction with social support. Specifically, Rook showed that the number of reciprocal exchanges and thus satisfaction with social support varies as a function of the type of social exchange (companionship, emotional support, instrumental support). She also found that tolerance for inequities differed by the type of relationship examined.

Rook (1987) further found that relationships with adult children are less likely than relationships with friends to be voluntary and less likely to be dissolved despite existing inequities in support. She also found that satisfaction with these kin relationships (specifically, adult children) was less dependent on reciprocity than was satisfaction with peer relationships. Thus, the strength of family relations and their ability to endure can provide benefits to the aging individual's psychological well-being.

Another interesting finding stemming from Rook's research was that in relationships with their adult children, elderly women reported that they were more likely to provide companionship and emotional support than they were to receive it. However, this did not seem to affect their satisfaction with their relationships. Furthermore, and not surprising considering the losses many elderly experience, the elderly women reported receiving more instrumental help from their children than they provided. However, the receipt of this support, and the resulting inequities in their relationships, did not seem to be detrimental to their satisfaction with such relationships.

Instead, the more instrumental help they received from their children, the greater their satisfaction with the relationship. This relationship was true only for the receipt of instrumental help from adult children. No significant relationship was found for the provision of instrumental support by friends.

Summarizing the foregoing discussion, our increasing numbers of elderly are making it imperative that we identify what factors contribute to their ability to adapt to and cope with the challenges they will be facing. These individuals will be facing many losses (health, mobility, social relationships, roles, etc.). One primary concern, addressed in this paper, has been the loss of vision. Adjustment to this challenge can be affected by the individual's health status, availability of services, and their environment. In line with our earlier discussion of Baltes' SOC principles, aging individuals are going to have to make wise use of the resources available to them to maintain their functional status and regulate their losses. Through the act of "selection" (e.g., focusing on just a few tasks instead of many) they can focus their energies on becoming adept at these tasks (optimization). Through

"compensation" they can make use of resources in new and more efficient ways (e.g., using visual aids and training from community resources to complete tasks) to continue to age successfully. One way that many individuals can make better use of their social support systems is to focus on those relationships they find most important, supportive and rewarding. As noted earlier, research (Antonnucci, 1985; Walster et. al., 1978; Riley & Eckenrode, 1986; Rook 1987), shows that the reciprocal nature of these relationships can significantly influence their effectiveness. Carstensen's Socioemotional Selectivity theory proposes that while the individual may experience reduced rates of interaction, the interactions remaining are more beneficial. This form of "compensation" enables the aging individual to maintain their self-esteem, remain satisfied with their support systems, and thus possibly increase their psychological well-being.

CHAPTER FIVE

THE PRESENT STUDY

How social support systems work and the factors which make them beneficial are complex. Rook (1987) has attempted to clarify the social support construct by examining the role of reciprocity in relationships between widowed elderly women, their adult children, and their friends. As mentioned previously, this research did find some significant relationships between the number and type of reciprocal exchanges and satisfaction with the relationship. By further examining the effects of reciprocity on various types of relationships (specifically, types of roles and perceived closeness of these role relationships), I hoped to gain additional insight into how relationship characteristics influence psychological well-being.

Hypotheses

Hypothesis 1

For visually impaired elderly, a negative relationship will be observed between the equity index of SSE and each

of the following three psychological well-being (PWB) scores: self acceptance, positive relations with others, and environmental mastery (where SSE stands for social support exchange and PWB stands for psychological well-being). Specifically, the higher the equity index of SSE (i.e., the more inequitable the exchange), the lower the PWB self-acceptance; the higher the equity index of SSE (i.e., the more inequitable the exchange), the lower the PWB positive relations with others; and the higher the equity index of SSE (i.e., the more inequitable the exchange), the lower the PWB - environmental mastery.

Individuals who experience more inequitable social support exchanges may feel a sense of inadequacy. They may be unhappy with who they are and their life circumstances. These individuals may feel that they are not capable of dealing with recent losses (e.g., loss of vision, loss of independence, loss of roles). They become self-critical, dwelling upon their losses rather than focusing their attention on the positive things going on in their lives.

Individuals with a number of inequitable social support exchanges may feel frustrated, shamed, and feel a sense of indebtedness. Such feelings could decrease the

likelihood of their seeking out other social relationships. They may feel that they are no longer capable of providing support to others. They may become isolated, losing out on the stress-buffering benefits of having close, emotionally satisfying relationships.

Individuals with a number of inequitable social support exchanges may experience a blow to their self-esteem and sense of adequacy. They may feel that they are unable to adequately care for themselves. They may feel as if they have lost control over their every day affairs and their environment.

Hypothesis 2

The type of social exchange relationship experienced by the visually impaired elderly will have a significant impact on psychological well-being. Hypothesis two expands upon hypothesis one by differentiating between two categories of relationships. Primary exchanges include those relationships between the participants, their spouses and their adult children. Secondary exchanges include those relationships between the participants and their siblings, grandchildren, friends, and professionals. Compared to those elderly individuals who have been

experiencing a greater amount of support from secondary relationships than primary relationships, the elderly individuals who have been experiencing a greater amount of support from primary relationships than secondary relationships will show significantly higher scores on each of the three dimensions of psychological well-being: self-acceptance, environmental mastery, and positive relationships with others. This will be true no matter whether the elderly individuals have been playing the role of a provider or a recipient during the social exchanges.

Typically, primary relationships such as those involving spouses and adult children have a long history of give and take. These relationships, with their long histories of social support exchanges, are often predictable, safe and emotionally supportive. Such relationships, where the individuals know one another well, help to affirm the person's sense of self. These long-term relationships provide many opportunities for exchange. Even if the individual may not be able to contribute much to the relationship in the present, they may feel that in such a long-term relationship, inequitable exchanges are bound to occur but because of the commitment and long-term

nature of the relationship, things will even out in the future. These long histories of give and take strengthen the relationships, making them more successful at buffering the stressors of aging and improving the various aspects of psychological well-being.

Hypothesis 3

Closeness of social exchange relationships experienced by the visually impaired elderly will have a significant impact on psychological well-being. The greater the number of social exchange relationships perceived as being close the higher the scores on each of the three dimensions of psychological well-being: self acceptance, environmental mastery, and positive relationships with others.

These predictions are based on the work of both Baltes and Carstensen (Baltes 1991; Carstensen 1991; Carstensen 1992). Both researchers describe a narrowing of social networks, allowing individuals to focus on those relationships which are deemed most supportive and emotionally fulfilling. By focusing on such "close" relationships, individuals can use their limited resources to maintain relationships that they find the most satisfying and beneficial. The predictability of these

safe, emotionally supportive, and typically long-term relationships helps to maintain the individual's sense of self-worth, promote feelings of adequacy, allow satisfying relationships with others and improve their overall psychological well-being.

CHAPTER SIX

METHOD

Design

To test the first and the third hypotheses, a correlation approach was adopted. The predictor variables for the first and the third hypotheses were the "equity index of SSE" and the "closeness of social exchange relationships", respectively. The criterion variables were the three PWB scores: (1) PWB Self Acceptance, (2) PWB Environmental Mastery, and (3) PWB Positive Relationships with Others. The variable "equity index of SSE" was measured by a questionnaire developed by Rook (1987) and "closeness of social exchange relationships" was obtained by a subscale of Rook's reciprocity questionnaire (Rook 1987). The three PWB scores were measured by three subscales of Ryff's multidimensional assessment of psychological well-being (Ryff & Keyes, 1995). The predictor and the criterion variables are quantitative variables.

To test the second hypothesis, a between-subjects two group design was adopted. The independent variable was

type of social exchange relationship. According to the relative number of two types of social exchange relationships experienced by elderly individuals, primary relationships (e.g., spouses or adult children) versus secondary relationships (e.g., siblings, grandchildren, friends, or professionals), elderly individuals were classified into two groups: (1) those who have been experiencing a greater amount of support from primary relationships than secondary relationships (hereafter, the p>s group) and (2) those who have been experiencing a greater amount of support from secondary relationships than primary relationships (hereafter, the s>p group). The dependent variables were the three above-mentioned PWB scores.

Participants

Forty-six visually impaired elderly persons were recruited from the Braille Institute, a community group providing services to the visually impaired. The participants were at least 65 years of age, not institutionalized and currently living alone or with family members in the general community. Participation was voluntary.

Materials and Scoring

In this study, the following materials were used: an informed consent form (see Appendix A); a questionnaire developed by Rook (1987) to assess reciprocity levels in friendships and family relationships (see Appendix B); Ryff's multidimensional assessment of psychological well-being (short form - see Appendix C)(Ryff & Keyes, 1995); a demographic sheet (see Appendix D); and a debriefing statement (see Appendix E).

Informed Consent Form. The informed consent form (see Appendix A), included the following information: identification of the researchers, explanation of the nature and purpose of the study, the research method, duration of research participation, description of how confidentiality and/or anonymity will be maintained, mention of participants rights to withdraw their participation and their data from the study at any time without penalty, information about the reasonable foreseeable risks and benefits, the voluntary nature of their participation and who to contact regarding questions about the study results or inquiries.

Reciprocity Levels in Family and Peer Relationships.

Rook's questionnaire (1987) utilized an adaptation of a method of network assessment developed by Fischer (1982). This 12 question survey enables the respondent to give information about three types of social support received by the respondent and provided by the respondent to others. There are two subscales (number of social exchanges received and number of social exchanges provided) each consisting of six questions. For each subscale, the respondent was asked to identify an individual who participates the most in that particular social support exchange. They were then asked to identify the role of the support person named (spouse, adult child, sibling, grandchild, friend, professional) as well as rate them on how close they felt to the person named.

Based on previous research (Caplan, 1979; Heller & Swindle, 1983; house, 1981), Rook (1987) felt comfortable that these questions represented those types of social support exchanges that contribute to psychological well-being. To confirm this, subjects (Rook, 1987) were asked in an open ended question to name any other person important to them. Only 40% the 120 subjects named anyone

not named prior. Typically only one person was named, a grandchild.

Unfortunately, reliability and validity data are not available for this questionnaire. Due to the small numbers of studies on the effects of reciprocity on psychological well-being, there has been no consensus on how best to measure the construct (Van Tilburg, Van Sonderen & Ormel, 1999). Much of the research in this area is still of an exploratory nature.

Scoring. For each social exchange item a score of one was given if the subject named at least one person and a score of zero was given if no one was named. The scores obtained included (1) the total number of social support exchange items received overall, (2) the total number of social support exchange items provided overall, (3) total number of social support exchange items received within each type of role relationship, (4) total number of social support exchange items provided within each type of role relationship, and (5) how close the subject perceives each relationship to be.

These scores give the researcher the actual number of social exchanges performed rather than the total number of

people engaged in the exchanges. Thus, the actual size of the network will not influence the scoring. A subject with a small network can possible engage in as many different types of exchanges as a subject with a larger network. For each subscale, scores can range from zero to six.

The researcher can also obtain an overall difference score. This score is computed by subtracting the number of positive scores (one's) provided from the number of positive scores received for each subscale. These scores can range from -6 to +6 with a score closer to zero representing a more equitable pattern of exchange between the subject and the members of their social network. Positive scores show us that the subjects receive more than they provide. A negative score shows us that they provide more than they receive. For the purpose of this study, the absolute value of these overall difference scores was utilized to obtain an equity index of social support exchange. The higher the equity index of SSE (e.g., absolute SSE scores), the more inequitable the exchange.

Subjects were asked to rate their feelings for each person named as "especially close to" or "comfortable with". By making these relationship distinctions we can

better identify the moderating effects of relationship closeness and satisfaction on psychological well-being.

Psychological Well-Being. Ryff's multidimensional assessment of psychological well-being (short version - Ryff & Keyes, 1995) was used to assess psychological well-being. This questionnaire can assess psychological well-being in the following domains: self acceptance (positive evaluations of ones self and ones past life); personal growth (a sense of continued growth and development as a person); purpose in life (the belief that one's life is purposeful and meaningful); positive relations with others (the possession of quality relations with others); environmental mastery (the capacity to manage effectively one's life and the surrounding world); and autonomy (a sense of self-determination). The original scale included 20 items for each of the six dimensions of well-being (for a total of 120 items) and has been established to be both reliable and valid (Ryff, 1989). The shortened 18-item scale (Ryff & Keyes, 1995) contains three items for each of the dimensions of well-being. These items were selected from the original scale on the basis of how well they represented the original scale and how well they

represented the underlying theories of the original scale. Each of the items in the shortened version correlates strongly and positively with the original scale. The reliability of the larger 120 item scale is high (Cronbach alpha coefficients range from 0.86 to 0.93; Ryff 1989). However, reliability in the shorter 18-item version ranges from 0.33 to 0.56. Ryff and Keyes (1995) hypothesize that this is due to the smaller number of indicators used for each scale.

For the purpose of this study, we will focus on three of the six domains: self acceptance; positive relations with others; and environmental mastery. For each domain there are three questions. Responses can range from 1) strongly disagree to 6) strongly agree. In the final scoring, responses to negative (-) items are reversed. The scores for each subscale range from 3 to 18. Thus, with each domain, high scores are indicative of high well-being.

Demographic Sheet. In the demographic sheet (see Appendix D), we asked for the following information: participants age, gender, marital status, number of years of work experience, ethnicity; education, type of visual impairment; age at onset of visual impairment, length of

time in Braille Institute program, number of other programs attended and length of time, and perceived health status.

Debriefing Statement. In the debriefing statement (see Appendix E) participants were informed of the major research questions addressed in the study, who they could contact if they experience distress due to the study and/or if they want to discuss or obtain the results of the study. Moreover, to insure the validity of the study, the participants were requested not to discuss the details of the study with potential participants.

Procedures

Participants were contacted in person at each of Braille Institute's three regional outreach centers. Participants were informed about the general nature of the study. Participation was strictly voluntary and participants could choose to resign from the study at any time. Participants were asked to give informed consent, and with the help of the researcher, completed a questionnaire assessing reciprocity levels in peer and family relationships, the short version of Ryff's multidimensional assessment of psychological well being, the demographic sheet and the debriefing form. Data was

collected through the use of individual face to face interviews and prescheduled phone interviews. Each interview consisted of the researcher reading the research question, giving the available answer options or requesting the subject's responses, and then recording the answers. The interviews lasted approximately 45 minutes. At the end of the study, participants were debriefed about the major research questions of the study, told who they could contact if they experienced distress due to the study/or to discuss or obtain the results of the study. To insure the validity of the study, participants were requested not to discuss the details of the study with potential participants.

Analyses

Two sets of Pearson product-moment correlation coefficients were calculated and their significance was tested. Specifically, Set 1 calculated the correlation coefficients between the equity index of SSE and each of the three well-being scores (e.g., PWB Self Acceptance, PWB Environmental Mastery, and PWB Positive Relationships with Others) and Set 2 calculated the correlation coefficients between the closeness of social exchange relationships and

each of the three well-being scores (e.g., PWB Self Acceptance, PWB Environmental Mastery, and PWB Positive Relationships with Others). In addition, t-tests for independent groups were used to test between-group differences of the elderly individuals' well-being scores. A significance level of p=.05 was adopted to conclude statistical significance for the results.

CHAPTER SEVEN

RESULTS

Table 1 summarizes the results regarding the relationship between the equity index of SSE and each of the three well-being scores (e.g., PWB Self Acceptance, PWB Environmental Mastery, and PWB Positive Relationships with Others. As can be seen from Table 1, the relationships between the equity index of SSE and the score of each of the three psychological well-being scales were negative; that is, the more inequitable the exchange, the lower the PWB Self Acceptance, PWB Environmental Mastery, and PWB Positive Relationships with Others. However, none of the relationships were statistically significant.

Table 1. Correlation Between the Equity Index of Social Support Exchanges and Each of the Three Well-Being Scales

The Well-Being Scales	The Equity Index
Self Acceptance	-.043
Environmental Mastery	-.063
Positive Relationships with Others	-.224

While significant correlations between the equity index of SSE scores and each of the three psychological

well-being scores were not obtained, the results were in the predicted direction. Our findings point to the possibility that inequities in social exchanges between older individuals and their social support members may lead to distress.

Table 2 summarizes the results regarding the impact of type of social exchange relationship (SER) on the visually impaired elder's psychological well-being. When the elderly individual was playing the role of provider, compared to the "s>p" group, those in the "p>s" group indicated higher scores on PWB-Positive Relationships with Others, but lower scores on PWB-Self Acceptance and PWB-Environmental Mastery. However, the difference for the three PWB scores between these groups ("s>p" and "p>s") was not significant. When the elderly individual was playing the role of recipient, a slightly different pattern was observed. Compared to the "s>p" group, those in the "p>s" group indicated higher scores on PWB-Positive Relationships with Others, but lower scores on PWB-Self Acceptance and PWB-Environmental Mastery. While the difference between these groups for PWB-Positive Relationships with Others and PWB-Self Acceptance was not significant, the difference for

PWB-Environmental Mastery was significant ($t(44)=2.26$, $p=.03$).

Table 2. Psychological Well-Being Scores by Type of Social Exchange Relationships Experienced by the Elderly Individuals and the Role the Elderly Played in These Relationships

The Psychological Well-Being Scales	Provider		Recipient	
	P>S	S>P	P>S	S>P
Self Acceptance				
M	11.00	11.37	10.96	11.44
SD	1.27	1.38	1.23	1.42
Environmental Mastery				
M	10.52	11.53	10.43	11.72*
SD	1.97	1.90	1.85	1.96
Positive Relationships				
M	9.07	8.26	9.04	8.28
SD	1.20	2.28	1.14	2.40

*$p<.05$

Table 3 summarizes the results re: the impact of "closeness of social exchange relationships" experienced by the visually impaired elderly on PWB. As indicated in Table 3, consistent with our prediction, with the elder as provider, the greater the number of SER's perceived as

close, the higher the PWB-Self Acceptance. However, contrary to our prediction, we found that the greater the number of SER's perceived as close, the lower the scores on both PWB-Environmental Mastery and Positive Relations with Others. The same pattern was observed with the visually impaired elder as recipient. Overall, closeness of SER's experienced by visually impaired elders had no impact on PWB scores.

Table 3. Correlation Between Each of the Three Well-Being Scales and Close Relationships

Well-Being scales	Provider in a Close Relationship	Recipient in a Close Relationship
Self-Acceptance	.08	.07
Environmental Mastery	-.16	-.18
Positive Relations With Others	-.03	-.01

CHAPTER EIGHT

SUMMARY AND DISCUSSION

We began this study with the expectation that the perception of equity in social exchanges, type of social exchange, and closeness of social exchange would all be related to positive levels of self-acceptance, environmental mastery, and relations with others. When the initial analysis yielded non-significant results for all three PWB dimensions, we looked further at hypothesis two, which involved social exchange type. This hypothesis predicted that type of social exchange relationship (primary or secondary) would differentially impact psychological well being, with primary social exchanges having a stronger positive impact on PWB than secondary. This result was not obtained, but we reasoned here that it might not be enough to simply distinguish relationship type in measuring the impact of social exchange relationships (SERs) on PWB; *relationship role* may be an equally important factor. Accordingly, in a second analysis for this hypothesis, we looked at the impact of primary versus secondary SERs when the visually impaired elder was in the role of provider, and then with the visually impaired elder

as recipient. This analysis yielded a significant result on one PWB dimension: When the visually impaired elders were recipients of help in secondary relationships, they showed higher levels of environmental mastery. While we had expected this to be true for the visually impaired elders receiving help from primary relationships, finding this result for visually impaired elders receiving help from secondary relationships may also be explained: When help from primary relationships is not forthcoming, personal initiative and resilience are required to secure help beyond the individual's immediate circle. The result may be personal growth in the form of Environmental Mastery.

Although social support has long been recognized as a multidimensional concept, there is still limited understanding of its dimensions and how these dimensions combine to buffer the stressors of aging. Based on the findings of this study, there are three specific areas where improvements need to be made in social support research, specifically, reciprocity research. The first is the need for more reliable measures. Reliability data for most of the measures now used is not available. Many of the measures currently being used are vague and arbitrary,

as we found when we tried to distinguish between "close" and "comfortable" relationships for hypothesis three. Secondly, researchers need to look at the social support networks of individuals in the context of the past as well as the present. Longitudinal studies are needed to gain a greater understanding of the dynamic nature of many support relationships. Third, because of the complex nature of social support networks, it is clear that researchers must look at variables in addition to type of relationship and perceived closeness of relationship participants. We also need to identify elders' expectations for support services and their tolerance for inequitable exchanges in specific circumstances. The impact of ethnic and cultural values on social networks and caregiving norms must also be accounted for.

While our knowledge of what constitutes quality social support systems continues to grow, there are several things practitioners can do now to enhance the lives of our elderly population and their network members. First, when providing assistance to our seniors, we need to identify not only the needs for that individual, but their adaptive capacities as well. Too often, in a desire to help,

providers give so much assistance that elders' remaining abilities and willingness to reciprocate are ignored. Second, beyond identifying an elder's strengths, we need to give them opportunities to use them. One way to do this is to broaden opportunities for senior volunteerism. Providing more opportunities where our elderly are valued and called upon to make meaningful contributions to their communities would not only increase the psychological well-being of our elders, but would make use of an often forgotten valuable community resource.

Finally, we need to address the issue of training. Individuals working with the elderly need to be trained regarding the specific needs of the visually impaired. Professionals need to know how the needs of the visually impaired and the sighted differ and how they are similar. Many elements which constitute a quality social support network for the sighted elderly are the same elements required for elderly with a visual impairment. Like their sighted peers, the visually impaired may need assistance from "meals on wheels", transportation services, visiting nurses, etc. Like their sighted peers, they also need to

have their strengths and capabilities recognized and valued.

In addition to knowing how the visually impaired elderly are similar to their sighted peers, professionals will need to recognize the special needs of this population. Visually impaired elderly will require additional time to orient themselves to unfamiliar surroundings and may require ongoing assistance with mobility and meeting transportation needs. Recognizing new people and feeling comfortable in social situations is also crucial for the visually impaired elder's adjustment. When the visually impaired elder feels uncomfortable in social situations, they may reduce their numbers of social contacts, negatively affecting their ability to obtain necessary social supports. All these issues must be addressed if visually impaired seniors are to be included as volunteers.

Our growing numbers of aged, and specifically those aged with vision impairments, will have major implications for families, policy makers, providers, and society in general. As we have discussed, having a visual impairment can negatively affect many aspects of an individual's daily

life. Availability of resources can have significant implications for an individual's ability to cope and adjust to their loss of vision. If the visually impaired individual encounters difficulty in assessing needed resources, or finds such resources unavailable, they may find it necessary to alter their support seeking strategies, possibly relying more heavily on remaining personal strengths and abilities (i.e., Balte's theory of Selective Optimization with Compensation). An individual's motivation to seek out other sources of support may be influenced by how limiting they perceive their immediate future to be (Carstensen, 1991). Our research looked at the effects of type of relationship exchange, relationship role and relationship closeness on psychological well-being. Our findings suggest that the factors influencing psychological well-being in the visually impaired elderly are complex. Such factors as the type of social support exchange (whether it be companionship exchanges or exchanges involving instrumental support), the personal strengths of the individual, relationship expectations, etc. can all work together to influence psychological well-being in the visually impaired elderly and the elderly population in general.

APPENDIX A:

INFORMED CONSENT FORM

INFORMED CONSENT FORM

TITLE OF THE STUDY: The Effects of Quality of Social Networks on the Psychological Well-being of the Visually Impaired Elderly

RESEARCHERS:

Dee Dee Cole, Masters Candidate, Psychology Department, California State University, San Bernardino

Joanna Worthley, PhD., Department of Psychology, California State University, San Bernardino, (909)880-5595

We would like to invite you to participate in a study conducted by Dee Dee Cole under the supervision of Dr. Joanna Worthley. This study has been approved by the Human Subjects Review Board at California State University, San Bernardino. The purpose of this study is to look at the effects of different social relationships on the aging process. You are being asked to participate in this study if you are at least 65 years of age and are visually impaired.

If you decide to volunteer, you will be asked a series of questions regarding your social network and general health. The interview should take about 45 minutes. There are no known risks associated with participating in this study; however, if you feel upset or uncomfortable you can decide to stop answering the questions at any time. While the results of this study may not benefit you directly, the information will be valuable in our understanding of the aging process.

The information gathered in this study is completely anonymous. Nowhere on the survey do we ask for your name or any other information that could identify you. All questionnaires will be given a code, and the answers that you provide will be kept by that code only. All results of the study will be reported in group form only.

The survey is completely voluntary. You are free to withdraw your participation at any time. If you have any question or concerns about the study, please feel free to contact us. The results of the study should be available after September 15, 2002. Please feel free to contact us if you would like a summary of the results.

By placing a mark in the space below, you acknowledge that you have been informed of and understand the nature of the study, and you freely consent to participate. You understand that the answers you provide will be totally anonymous and that you can withdraw your consent at any time.

I agree to participate in this study.

_____ _____

APPENDIX B:

RECIPROCITY QUESTIONNAIRE

RECIPROCITY QUESTIONNAIRE

Instrumental Support Items

1. To whom do you turn for help during times of illness?
2. To whom do you turn for help with financial matters?

Emotional Support Items

3. To whom can you confide personal problems or concerns?
4. To whom can you turn to when you are feeling depressed?

Companionship Items

5. With whom do you get together with to socialize?
6. Who can you call on to enjoy a telephone conversation?

The above six questions are also asked with regard to who relies upon the subject for such type of support.

Role of Individual Named

The role of the individual named in coded according to:

1) spouse 2) adult child 3) grandchild 4) friend 5) professional 6) other

Perceived Satisfaction with the Relationship

The perceived satisfaction with the above named relationship is rated on a scale of 1 (not very satisfied) to 6 (very satisfied).

Perceived Closeness of the Relationship

Subjects are asked to indicate whether they view the above relationship as being:

1) I feel especially close to this individual
2) I feel comfortable being myself with this individual

Presentation Format and Scoring

Type of Support items are mixed to make one survey. Each type of support item is also coded for role, perceived

satisfaction with the relationship and perceived closeness of the relationship. Scores obtained include:

1) the total number of social support exchange items *received* overall
2) the total number of social support exchange items *provided* overall
3) equity index of social support exchange
4) the type of role of each relationship named
5) subject's perceived closeness of each relationship named
6) subject's perceived satisfaction with each relationship named

APPENDIX C:

RYFF'S MULTIDIMENSIONAL ASSESSMENT OF PSYCHOLOGICAL WELL-BEING

RYFF'S MULTIDIMENSIONAL ASSESSMENT

OF PSYCHOLOGICAL WELL-BEING

Presentation Format and Scoring

Items from each scale are mixed to make one self-report instrument. Responses can range from 1) strongly disagree, 2) moderately disagree, 3) slightly disagree, 4) slightly agree, 5)moderately agree, 6)strongly agree. In the final scoring, responses to negative scored items (-) are reversed. Thus, within each dimension, high scores indicate high self-ratings.

Autonomy

(-)1. I tend to be influenced by people with strong opinions.

(+)2. I have confidence in my opinions, even if they are contrary to the general consensus.

(+)3. I judge myself by what I think is important, not by the values of others.

Environmental Mastery

(+)1. In general, I feel I am in charge of the situation in which I live.

(-)2. The demands of everyday life often get me down.

(+)3. I am quite good at managing the many responsibilities of my daily life.

Personal Growth

(+)1. I think it is important to have new experiences that challenge how you think about yourself and the world.

(+)2. For me, life has been a continuous process of learning, changing, and growth.

(-)3. I gave up trying to make big improvements or changes in my life a long time ago.

Positive Relations with Others

(-)1. Maintaining close relationships has been difficult and frustrating for me.

RYFF'S MULTIDIMENSIONAL ASSESSMENT
OF PSYCHOLOGICAL WELL-BEING CONT.

(+)2. People would describe me as a giving person, willing to share my time with others.

(-)3. I have not experienced many warm and trusting relationships with others.

Purpose in Life

(-)1. I live life one day at a time and don't really think about the future.

(+)2. Some people wander aimlessly through life, but I am not one of them.

(-)3. I sometimes feel as if I've done all there is to do in life.

Self-Acceptance

(+) 1. When I look at the story of my life, I am pleased with how things have turned out.

(+)2. I like most aspects of my personality.

(-)3. In many ways, I feel disappointed about my achievements in life.

APPENDIX D:

DEMOGRAPHIC AND HEALTH STATUS QUESTIONNAIRE

DEMOGRAPHIC AND HEALTH STATUS QUESTIONNAIRE

1. When were you born? _____

2. What is your marital status?

   (1) married If so, for how long? ____

   (2) widowed If so, for how long_____ how long married? _____

   (3) single

   (4) divorced

3. Sex: Male _____ Female _____

4. What is the highest level of schooling you have completed?

(1) less than eight years

(2) some high school

(3) completed high school or technical school

(4) some college

(5) completed college

(6) MA, MS or Ph.D.

Which best describes your ethnic identity?

1. White

2. Black

3. Asian

4. Hispanic

5. Native American

6. Other

7. What type(s) of visual impairment do you have?

8. How long have you been a participant in Braille Institute Programs?

9. What other programs have you attended? ____ For how long _____

10. Please indicate your answer to the following question:

When considering my general health, I feel:

1. terrible 2unhappy 3 mostly unsatisfied

4. mixed- half satisfied, half unsatisfied

5. mostly satisfied 6. pleased 7. delighted

APPENDIX E:

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

I would like to thank you for your participation in this research project. Your participation in this study will assist us in identifying ways to help our seniors (especially those with visual impairments) to live more fulfilling lives.

All of your responses to this survey will remain confidential. It is anticipated that the group results of this study will be available after September 15, 2002. Please contact Dee Dee Cole or Dr. Joanna Worthley at (909)880-5595 if you are interested in the outcome of the study or if you have any other questions. Should your participation in this study raise any concerns that we are unable to address, the following resources are available to help you:

Braille Institute Desert Ctr.
70-251 Ramon Road
Rancho Mirage, CA 92270
(760) 321-1111

Lighthouse for the Blind
762 North Sierra Way
San Bernardino, CA 92410
(909) 884-3121

Senior Information & Assistance
455 North D Street
San Bernardino, CA 92410
(909) 388-4555

Agewise Senior Outreach
850 East Foothill Blvd.
Rialto, CA 92376
(909) 421-9470

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