

Psychosocial Adaptation and Vision Loss: Assessment to Intervention



Psychosocial Adaptation and Vision Loss

Learning Objectives

- By the end of the session, learners will:
 1. Understand the affect of vision loss, aging and co-morbidities
 2. Describe positive coping strategies
 3. Describe strategies to enhance positive coping strategies
 4. Be able to administer, score and interpret mental health screens
 5. Describe interventions to address psychosocial issues experienced by those with vision loss

Aging and Vision Loss

- Age-related vision loss doesn't take place in a vacuum
- Occurs within the broader context of aging
- Occurs at a time when the person is coping with the multiple changes that simply come with aging



Aging and Vision Loss

- The older adult with vision impairment makes 2 simultaneous adjustments to losses that occur due to
 - The **chronic progressive** nature of **vision loss**
 - The **chronic progressive** nature of **aging**

Aging and Vision Loss

- Low vision is just **one** of many client factors that influence the older adult's ability to age successfully
 - Physical ability
 - Cognitive ability
 - Sensory abilities
 - Psychological make up
 - Emotional fortitude
 - Family and community support
 - Financial resources

Losses due to Aging

- Financial losses
 - Loss of income
 - Loss of **control over** personal finances
- Loss of identity
 - Loss of prestige following retirement
 - Experience identity crisis
 - Loss of driving privileges

Losses due to Aging

- Loss of home when decision is made to move into retirement center
- Loss of social outlets/diminished family life
 - Face loss of family and friends with greater frequency than younger adults

Losses due to Vision Loss

(O'Connor et al. 2008)

- Low vision is a significant contributor to lost independence among older adults
- Level of ADL impairment directly related to level of vision impairment
 - Moderate vision impairment
 - **4x** more likely to experience severe limitations in ADL performance
 - Severe vision impairment
 - **17x** more likely to experience severe limitations

Health-Related Quality of Life

(Brown et al. 2005)

- Decline in Health-Related Quality of Life (HRQoL) is directly related to level of vision impairment
 - Persons with severe vision loss experience equivalent quality of life as
 - Person living with end-stage prostate cancer or
 - The effects of a catastrophic stroke

Other Losses

- Impact of vision loss is compounded by other losses that accompany aging
- Spousal loss can be especially devastating
 - Lose companionship **and independence** if spouse performed activities person can no longer do
 - **And** can also lose access to social outlets

Challenges for Families

- Persons with low vision present an “ambiguous social situation for others” (Fletcher et al 1991)
- Vision loss is a **hidden** impairment
 - Persons do not carry outwards signs of disability
 - White cane, dark sunglasses, dog guide
 - They look no different than when they were fully sighted
 - An older adult with vision impairment looks just like an older adult

Challenges for Families

- Families mistake vision loss as cognitive or motor impairment
- LV behaviors associated with cognitive impairment
 - Slowness in responding
 - Confusion
 - Missing details
 - Misunderstanding directions, etc.
- LV behaviors associated with motor impairment
 - Slowness, uncertainty in walking
 - Clutching and holding onto others
 - Stumbling
 - Fear of falling



Challenges for Families

- Person's visual disability is often inconsistent
 - Person with AMD may be able to navigate a maze of obstacles in a grocery store but be unable to identify a can of soup
- Because of ambiguities and contradictions, family/friends often don't know how to react to the person
 - May expect too little or too much
 - May attribute limitations to dementia, depression, or just “not trying”

Challenges for Families

- Family members may experience fear regarding person's safety
 - Children may experience desire to reverse roles and do everything for parent
 - Family members may feel burdened with responsibilities and worries
- Family/friends may be uncertain whether to talk about vision loss with the person
 - Becomes the elephant in the room that nobody talks about

Do not seek Rehabilitation Services

- Estimated that only a fraction of older adults who need low vision rehabilitation receive services Many reasons for this including
 - Limited awareness among ophthalmologists and other health providers
 - Lack of services and transportation
- BUT even when these barriers do not exist, persons still do not seek services

Participation Influenced by Perspectives

- Estimated that only a fraction of older adults who need low vision rehabilitation receive services Many reasons for this including
 - Limited awareness among ophthalmologists and other health providers
 - Lack of services and transportation
- BUT even when these barriers do not exist, persons still do not seek services

Older Adult Perspective

- Findings from study on 550 older adults (Lee & Brennan, 2006)
 - Rely more strongly on **personal resources** than social or environmental resources
 - Take great pride in independent lifestyle and feel shame with need to rely on others
 - Stoically prefer to keep feelings to self and not bother others
- These findings may suggest another reasons for their reluctance to seek low vision rehab services and support groups
 - May be more willing to accept counsel of someone from socially similar background

Family Perspective

- Age-related eye disease doesn't cause a sudden crisis that family must deal with
 - Often difficult for person and family to discern boundary between normal visual changes due to age and beginning of vision impairment
- Low vision is also often just one of many conditions affecting the persons ability to complete ADLS and live independently

Low Vision Rehabilitation

- Must work hard to get older adults into low vision rehab but the payoff/outcome is worth the effort
- Older adults who lose vision want to continue activities that are important to them
 - They will often go to great lengths to continue an important activity (Watson, 2001)
- Their ability to use compensatory strategies to continue valued activities is quite good
 - You **can** teach an old dog a new trick-even a **very** old dog and a lot of complicated tricks

Low Vision Rehabilitation

- Ability to continue a few valued activities can significantly improve or sustain quality of life
 - Goal setting must be client-driven
 - Older adults give up activities for a variety of reasons and may be satisfied with this
- Rehabilitation outcome must be measured in two domains:
 - Occupational performance
 - Quality of life

Low Vision Rehabilitation

- Successful rehabilitation outcomes require that we address limitations/influences beyond those caused directly by low vision
- Older adults require a holistic approach that considers the entire person and family in designing the intervention
- Low vision rehabilitation should more properly be considered a critical component of good **geriatric rehabilitation**
 - Requires broadening our focus and scope

When it happens makes a difference

(Boerner & Wang, 2010, 2012; Popivker et al., 2010)

- Psychological impact of vision loss depends on life context/demands
 - Affects persons differently at different stages of life
- It is well established that depression risk is high for older adults with vision impairment **BUT**
- Risk maybe even higher for middle-aged adults

Young vs Old

- Younger Adults
 - Chronic health condition like vision loss is a less expected occurrence
 - Considered an “off-time” event
- Older Adults
 - Chronic health conditions including vision loss are more common
 - Considered an “on-time” event

Differences in Areas of Concern

• Younger Adult

- Typical Concerns
 - Career/Financial stability
 - Parenthood
 - Marriage
 - Managing a household
 - Balancing work and family
- Strong desire for independence in **all** activities

• Older Adult

- Typical Concerns
 - Remaining in home
 - Maintaining health
 - Maintaining Leisure activities to fill time
 - Caregiving*
- Strong desire to complete a **few valued** occupations

Reaction to Vision Loss

• Younger Adults	• Older Adults
<ul style="list-style-type: none">• Vision loss viewed more dramatically<ul style="list-style-type: none">• Experience more changes to lifestyle and changes are more pronounced• Limitations in ADLs are attributed to vision loss• Associated with greater<ul style="list-style-type: none">• Diminishment of self worth• Sense of vulnerability• Greater depression	<ul style="list-style-type: none">• Vision loss is associated with aging• One of many losses occurring<ul style="list-style-type: none">• Experience less dramatic change in daily activities• Changes in ADLS are attributed aging as well as vision loss• Associated with increased sense of aging and mortality

Common Reactions to Vision Loss

- **Fear**
 - Vision loss presents an unfamiliar view of daily life
 - Person lacks knowledge how to cope, adapt and adjust to performing tasks with less vision
 - Uncertainty about the future
- **Frustration**
 - Tasks take more time and more energy
 - Makes more errors
 - Loss of control for how and when tasks are performed
- **Diminished self-confidence/self-efficacy**
 - Due to struggle in completing activities and errors
 - Over protection from friends and family

Adjustment to Vision Loss

(Bergeron & Wanet-Defalque, 2012)

- Person's Initial reaction may be **denial**
 - Refusal to believe a "stressor exists/acting as though the stressor is not real"
- Behaviors
 - Rationalizes disbelief based on past vision
 - "I've had good vision all of my life"
 - Believes a medical cure is just around the corner or being kept from him
 - Refuses to stop/modify activities even when at risk for harm to self or others
 - For example continues to drive despite multiple near misses or accidents



Denial

(Bergeron & Wanet-Defalque, 2012)

- More likely to occur initially following diagnosis and continue 1-2 years after diagnosis
- Gradually subsides as person becomes used to living with vision loss
- Associated with greater depression
- Can be a significant barrier to seeking LVR services



Stages of Grief

(Ross, 1969)

- Move from denial to anger to bargaining to depression to acceptance
- Later stage may be characterized by **acceptance**
 - Learns to move forward and live with vision loss
 - Positively correlated with wellness (sense of well being)
 - Attitude and expectations change
 - More likely to express acceptance 2 or more years after onset
 - May be more willing to participate in LVR at this point

Support System

- Support system includes family, friends, caregivers, peers
- Social support
 - Social relationships of older adults with low vision are not different from older adults with normal vision (Wahl, 2013)
 - Older adults in both groups count about 5 family members and 3 friends as part of their “inner circle” (Reinhardt, 1996)
- Closest family members (Reinhardt & Blieszner, 2000)
 - Children (38%), Spouses (33%), Other relatives (29%)

Depression

(Horowitz, 2004)

- One of most common co-morbidities in older adults with low vision
 - 2 to 5 times more likely to develop depression
 - Greater than other common age-related conditions
 - 1/4 to 1/3rd experience clinically significant symptoms of depression
 - About 7% meet the criteria for major depressive disorder, according to the *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition*

Depression

(Rovner, et al., 2006)

- Person with **minimal** impairment **is just as likely** to develop depression as person with severe impairment
- For example older adults who are legally blind in one eye have increased risk of developing depression
 - Impairment in one eye may produce uncertainty and apprehension about future visual abilities and possible ongoing changes

Depression Exacerbates Disability

(Jones et al. 2009)

- More likely to engage in poor health behaviors
 - 1.6X more likely to smoke
 - 1.9X more likely to be obese
 - 3X more likely to be physically inactive
- Report poorer health
 - linked to level of depression
 - Mild- 6x risk
 - Moderate -18x risk
 - Severe-27x risk

Depression and Vision Loss

- Link between low vision and depression occurs due to **limitations in ability to complete valued activities**
 - Low vision reduces participation
 - Reduced participation causes depression
 - Older adults don't separate mood from activity
- “depression and activity limitations perpetuate and amplify the adverse effects of one another” (Jones, et al. p 168)
 - Supports both the need for OT intervention and defines our primary approach- e.g. facilitating adjustment through occupation

Depression

- Even minimal depression is harmful
 - Rovner et al (2006) found that patients who did not meet the dx standards for clinical depression but showed minimal depression
 - Reported significantly worse functional vision
 - Demonstrated worse acuity and CSF than would be expected by the severity of their eye disease or general medical issues

Depression in South Africa

Population Group	Prevalence Estimation	Study Period
General Adults (PHQ-9)	25.7% (range 14.7- 38.8). Higher rates in Northern Cape, Eastern Cape, Western Cape, Gauteng and Mpumalanga	2002 National Survey
General Adults (DSM-IV)	4.9% (12 month), 9.7% (lifetime)	2002-2004 South African Stress and Health Study
Adolescents	33.5% (aged 10-14)	2002, Western Cape
University Student	48.2%, undergrads, PHQ-2)	2001, Johannesburg
Older Adults (50+) (ICD-10 criteria)	2.7% mild depression (12 months)	2007-2009 WHO SAGE
Older Adults, regional, GDS, CES-D, PHQ-9	10-30 % have depressive symptoms	2007-2012

Key Summary Points

Rates depend heavily on measurement tool

- Screening instruments like the PHQ-9 tend to yield higher prevalence estimates (25–30% or more) than structured diagnostic interviews

Socio-demographic factors increase risk

Poverty, adverse childhood experiences (ACEs), low education, widowed/divorced status, and urban residence all correlate with a higher likelihood of depression

Treatment access is limited

- Only about **25% of those with probable depression receive treatment**

Factors affecting Depression Rates in South African Older Adults

- Poverty and food insecurity
- Social isolation or living alone
- Chronic disease (especially diabetes, heart disease, stroke)
- Functional disability or vision loss
- Bereavement or caregiving stress
- Poor access to health services
- Rural older adults have fewer resources, poorer access and higher unmet mental health needs

Depression and Vision Loss in South Africa

Data Source/Context	Population	Prevalence Estimates
SANHANES-1 (South Africa)	Individuals with vision impairment (15+)	Elevated distress reported; no percent figure
Multi- country LMIC Study	Older vs. Depressed	No significant vision difference in South African Subgroup
Visual Impairment Cohort	Age-stratified global sample	10-20% prevalence
International Systematic Reviews	Visually Impaired Older Adults	32% report depressive symptoms vs 12% general population

*South African National Health and Nutrition Examination Survey (SANHANES-1)

Key Summary Points

- **Formal South Africa-specific prevalence estimates for depression among those with vision loss are lacking.**
- Existing data confirm that **visual impairment significantly increases risk of depression and emotional distress** in older adults, consistently shows older adults with VI have 1.5 to 2X greater risk of depressive symptoms compared to those without
- Global benchmarks suggest a likely range of **10–20% prevalence of depressive disorders** among visually impaired older adults, though it may be higher if screening instruments are used.
- SANHANES-1 results indicate a clear association with distress, but do not quantify prevalence.
- Some report rates around **32%** reporting depressive symptoms versus ~12% in the general population.

Psychological Screens

- Should always be part of the initial evaluation of the client
- Should screen for
 - Factors influencing the persons adjustment to low vision
 - Depression, stress, anxiety, social support
 - Premorbid psychological conditions including use of medications

Screens

- Self-report assessments
 - Ask about current mood
- Identify **RISK** for mental health conditions, we do not diagnose
 - Depression, anxiety, stress
- Guide referral to mental health professions

Geriatric Depression Scale

- Screen-short form, widely used screen
 - Gold standard assessment in research
- Assesses mood over past week
- 15 yes/no self-report questions
 - 1 point for every affirmative answer
- Score > 5 risk for depression

Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life?	yes	no
2. Have you dropped many of your activities and interests?	yes	no
3. Do you feel that your life is empty?	yes	no
4. Do you often get bored?	yes	no
5. Are you in good spirits most of the time?	yes	no
6. Are you afraid that something bad is going to happen to you?	yes	no
7. Do you feel happy most of the time?	yes	no
8. Do you often feel helpless?	yes	no
9. Do you prefer to stay at home, rather than going out and doing things?	yes	no
10. Do you feel that you have more problems with memory than most?	yes	no
11. Do you think it is wonderful to be alive now?	yes	no
12. Do you feel worthless the way you are now?	yes	no
13. Do you feel full of energy?	yes	no
14. Do you feel that your situation is hopeless?	yes	no
15. Do you think that most people are better off than you are?	yes	no

Total Score _____

1 Tools may be copied without permission

Geriatric Depression Scale- Abbreviate (GDS-A)

- Shorter version of GDS
 - Administered the GDS to 70 older adults with low vision
 - Found that 4 questions discriminated risk for depression with .7 sensitivity and .88 specificity
- Can incorporate the 4 questions into initial screening
 - Are you basically satisfied with your life?
 - Have you dropped many of your activities and interests?
 - Do you often feel helpless?
 - Do you feel that you have more problems with memory than most?
- Answering yes to 2 or more indicates risk for depression

Patient Health Questionnaire- 9 (PHQ-9)

Multi-purpose instrument for screening, diagnosing, monitoring
And measuring the severity of depression

Assign Numerical Values:

Each response option on the PHQ-9 is assigned a numerical value:

- Not at all: 0
- Several days: 1
- More than half the days: 2
- Nearly every day: 3

Scoring and interpretation:

0-4: Minimal depression, may not require treatment.

5-9: Mild depression, clinical judgment needed regarding treatment.

10-14: Moderate depression, clinical judgment needed regarding treatment.

15-19: Moderately severe depression, treatment with antidepressants and/or psychotherapy is recommended.

20-27: Severe depression, treatment with antidepressants and/or psychotherapy is recommended.

The image shows a scan of the Patient Health Questionnaire-9 (PHQ-9) form. At the top, it is titled "PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)". Below the title, there is a set of instructions: "Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use 'x' to indicate your answer)". The form consists of nine numbered items, each with a horizontal line for a response and a scale of four options: "Not at all", "Several days", "More than half the days", and "Nearly every day". The items are: 1. Little interest or pleasure in doing things; 2. Feeling down, depressed, or hopeless; 3. Trouble falling or staying asleep, or sleeping too much; 4. Feeling tired or having little energy; 5. Poor appetite or overeating; 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down; 7. Trouble concentrating on things, such as reading the newspaper or watching television; 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual; 9. Thoughts that you would be better off dead or of hurting yourself in some way. Below the items, there is a line for "For each circle, add ___ + ___ + ___ + ___" and a line for "Total Score: ___". At the bottom, there is a question: "If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?". Below this question are four options: "Not difficult at all", "Somewhat difficult", "Very difficult", and "Extremely difficult", each with a checkbox.

Anxiety and Stress

- Mood changes may be more characterized by anxiety and stress rather than or in combination with depression
 - Or person may experience all three
- Depression Anxiety & Stress Scale (DASS-21)
 - 21 self report questions cover the 3 areas
 - Provides separate scale for each:
 - 7 self-report questions depression, 7-anxiety, 7

– stress

DASS21		Name:	Date:
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week . There are no right or wrong answers. Do not spend too much time on any statement.			
The rating scale is as follows:			
0	Did not apply to me at all		
1	Applied to me to some degree, or some of the time		
2	Applied to me to a considerable degree or a good part of time		
3	Applied to me very much or most of the time		
1 (s)	I found it hard to wind down	0	1 2 3
2 (a)	I was aware of dryness of my mouth	0	1 2 3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1 2 3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1 2 3
5 (d)	I found it difficult to work up the initiative to do things	0	1 2 3
6 (s)	I tended to over-react to situations	0	1 2 3
7 (a)	I experienced trembling (e.g. in the hands)	0	1 2 3
8 (s)	I felt that I was using a lot of nervous energy	0	1 2 3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1 2 3
10 (d)	I felt that I had nothing to look forward to	0	1 2 3
11 (s)	I found myself getting agitated	0	1 2 3
12 (s)	I found it difficult to relax	0	1 2 3
13 (d)	I felt down-hearted and blue	0	1 2 3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1 2 3
15 (a)	I felt I was close to panic	0	1 2 3
16 (d)	I was unable to become enthusiastic about anything	0	1 2 3
17 (d)	I felt I wasn't worth much as a person	0	1 2 3
18 (s)	I felt that I was rather touchy	0	1 2 3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1 2 3
20 (a)	I felt scared without any good reason	0	1 2 3
21 (d)	I felt that life was meaningless	0	1 2 3

Depression Anxiety & Stress Scale (DASS-21- short form)

- Person Indicates how much the questions applied to them over the past week
 - Options: never, sometimes, often, almost, always
- Far right column-indicates whether response assesses depression, anxiety or stress
- Produces a score for each area-depression, anxiety, stress
 - Normal, mild, mod, severe, extremely severe

MOS Social Support Scale

- Brief scale developed for study on patients with chronic conditions
 - Medical Outcomes study
 - 17 items
- How often are the following kinds of support are available to you?
 - None of the time, a little, some, most , all
 - Emotional/informational, tangible, affectionate

MOS SOCIAL SUPPORT SURVEY

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Choose one number from each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone to help you if you were confined to bed	1	2	3	4	5
2. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
3. Someone to give you good advice about a crisis	1	2	3	4	5
4. Someone to take you to the doctor if you needed it	1	2	3	4	5
5. Someone who shows you love and affection	1	2	3	4	5
6. Someone to have a good time with	1	2	3	4	5
7. Someone to give you information to help you understand a situation	1	2	3	4	5
8. Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
9. Someone who hugs you	1	2	3	4	5
10. Someone to get together with for relaxation	1	2	3	4	5
11. Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
12. Someone whose advice you really want	1	2	3	4	5
13. Someone to do things with to help you get your mind off things	1	2	3	4	5
14. Someone to help with daily chores if you were sick	1	2	3	4	5
15. Someone to share your most private worries and fears with	1	2	3	4	5
16. Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
17. Someone to do something enjoyable with	1	2	3	4	5
18. Someone who understands your problems	1	2	3	4	5
19. Someone to love and make you feel wanted	1	2	3	4	5

March 2020

Vision loss does not automatically cause dependency and disability

(Kleinschmidt 1999)

- Successful adjustment to vision loss depends in part on success in handling past life crisis
- “Older adult who has coped with challenges in life and arrives in old age with a strong ego and self concept likely will accept challenges of vision loss and remain independent”



Self-Regulatory Theory and Aging with Vision Loss

(Wahl, Becker, Burmedi, Schilling, 2004; Wahl, 2013)

- Persons have a toolbox of emotional self-regulatory strategies that help them adjust to critical life situations
- They use the strategies to maintain **primary control** of their environment so they can achieve important life goals
 - Primary control focuses on using strategies that allow one to master a situation/task/activity

Self-Regulatory Theory and Aging with Vision Loss

- Because of its impact on ability to complete everyday activities, vision loss often forces the person to put great effort into maintaining primary control
- This ultimately challenges the person's fundamental motivation to maintain primary control
 - Forces the person to consider and adopt **secondary control strategies** to adapt to vision loss

Secondary Control Strategies

- **Disengaging** from activities that can no longer be successfully completed
 - e.g. deciding to retire from driving, stop attending church etc.
- **Reinterpreting** life priorities
 - e.g. travel is no longer important to me, my church service is televised on
Sunday mornings
- They enable the person to focus energies on continuing highly valued occupations

Aging and Vision Loss

- Older adults will work hard to maintain ability to complete basic ADLS and reading even in a challenging environment (primary control strategy)
- But will often let I-ADLS go especially if vision loss is significant and person is faced with a barrier rich environment (secondary control strategy)
 - But they will continue with **highly valued** I-ADLS
 - Which is why it maybe difficult to get them to stop driving

Aging with Vision Loss

- Personal decision to disengage from an I-ADL is viewed as a **positive form of emotional self-regulation**
 - Known as **accommodative coping**
 - Person is exercising control over the decision to drop activities that no longer are fulfilling and focus energy on more valued occupations

Positive Coping Strategies

(Boerner, Reinhardt, Horowitz, 2006)

Problem-focused coping

Aimed at managing or altering the problem

More likely to be used when person believes the stressor or problem can be changed

Men more likely to use this approach

Emotion-focused coping

Aimed at regulating emotions related to the problem

More likely to be used when the stressor/problem is not amenable to change

Women more likely to use this approach

Problem- Focused Coping

- Actively work to change or manage what is causing the stress
 - Employ information gathering
 - e.g. . may want to learn about how the eye disease is managed, treatments, outcomes, prognosis, course, clinical trials etc.
 - These individuals may respond well to detailed education/information seeking, creating lists, time management, boundary setting



Emotion-Focused Coping

- Manage the emotional aspect of the stressor, rather than eliminating the stressor
- Seek emotional support, crying, talking about feelings
- These individuals may respond well to activities such as journaling, mindfulness, religious practices, distraction through hobbies, reappraisal of thinking, manage emotions before acting



Positive Coping Strategies

- Great variability among persons, may employ both
- Personal and situational factors influence adoption of one or the other approach
 - Personality and past experiences
 - Nature of vision loss
 - Other disabilities
 - Family support
- Problem-focused is thought to be a better strategy when the situation is can be changed and Emotion-focused better strategy when the situation cannot be changed

Intervention

- Pay attention to the strategy that the client employs and align/attune intervention approach to that strategy
- **Provide information** to the client that uses a problem-focused strategy
 - Nature of eye condition, successful interventions, etc.
 - Types of technologies, devices and techniques that solve problems
- Provide **examples of successful ways people live with vision loss** to the client who uses a emotion-focused strategy
 - Connect person to other persons successfully living with vision loss
 - Provide resources for support groups, books, personal accounts, journaling

Our Role

(Horowitz, 2005)

- **Isolation and inactivity** are two of the most challenging problems facing individuals with low vision
 - Both shown to negatively impact adjustment
- Therefore, a **primary provider role in facilitating adjustment** is to enable the client to **maintain or improve ability to participate in valued occupations and social activities**
 - **We facilitate adjustment through activity engagement**
 - Depressive symptoms decline over time when persons receive low vision services, optical devices and counseling services

Interventions

- Educate the client and family
- Provide evidence-based psychosocial interventions
 - Cognitive-behavioral approaches
 - Problem-solving /behavior activation therapies
- Support groups
- Work with family/friends to provide positive support to client
- Provide resources to assist with adjustment
- Refer to mental health providers as needed



Educational Interventions

- Educate the client about the disease/condition
 - Helps alleviate confusion and fear
 - Empowers the client to take control of the disease
- Types of education
 - Face-to-face **accessible** education for client and family on nature of the disease, rehabilitation options
 - OT, O and M- review printed information from eye care specialists
 - Identify and provide reputable internet sources
 - Identify and provide community resources

Problem Solving Therapy

(Rovner et al.,2007)

- A cognitive-behavioral intervention
- Active participation in skills training can create self-efficacy, a form of internal control
- Skills are taught in session and implemented and refined through “homework” and follow-up sessions
- Shown to be effective in preventing depression and loss of valued activities

Cognitive-Behavioral Approaches

- Focus on identifying **maladaptive** thoughts that evoke emotional distress and negative behaviors.
- Helps client replace maladaptive, unrealistic thoughts with realistic and adaptive thoughts and appraisals of the problem
 - Adopting realistic and adaptive thoughts facilitates positive emotional reactions and productive behaviors
 - Guide client in evaluating maladaptive thought patterns and help them identify successful behavior patterns to apply to future situations

Problem Solving Therapy Steps

Introduction to PST

Familiarize client with treatment rationale. Provides opportunity to identify client's current problem-solving skills, educate client as to how problem-solving can positively affect functional abilities.

Problem Orientation

Define and identify the client's attitude towards solving problems, identify thinking errors (maladaptive thinking) that can impede problem-solving

Problem Identification, Definition, & Selection

Client identifies prevalent problem(s), breaks down problem components in detail, chooses a particular problem to focus on and work through

Generation of Alternatives & Brainstorming

Client produces list of potential solutions for the targeted problem-the list should be exhaustive and non-judgmental

Decision Making & Solution Selection

Client evaluates list of solutions according to their ability to achieve short and long-term goals and identified any effects & consequences the solution may have on self and others (pros and cons). Client selects preferred solution

Solution Implementation and Verification

Client implements the chosen solution and verifies it's effectiveness in reaching goals. If solution was not effective, client revisits stage 4 to select and proceed with an alternative solution

Behavioral Activation

- Also a cognitive behavioral approach
- Focuses on training and engaging client in activities, then ensuring client remains engaged through homework combined with activity monitoring until incorporated into daily routine
- Rovner et. al (2014) showed that OT intervention using this approach reduced depression by 50% in persons with low vision



Support Groups

Provide:

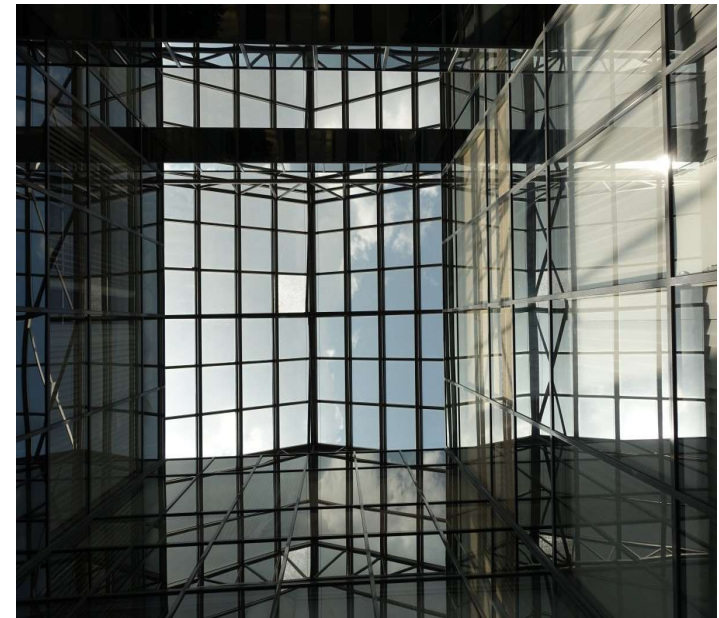
- Empathy and encouragement
- Education
- Peer support
- Community resources
- Examples of adjustment and adaptation
- Forum for communication
- Opportunities for social networking



Support Groups

Vary in structure

- **Consumer** generated
 - Persons with low vision organize, facilitate and support the group
- **Professionally** generated
 - Group is organized, facilitated, and supported by physician, occupational therapist, mental health practitioner, nurse, social worker, or other health educator



Working with Families

Emotional vs. physical support

- Providing **positive emotional** support assists person in adjusting to vision loss
- Providing physical help often **challenges** adjustment
 - Older adult may realize that they need physical help but they won't necessarily feel good about receiving it

Working with Families

(Horowitz, Goodman, & Reinhardt, 2004)

Counsel family to:

- Provide emotional support as well as physical support
- Allow the person (client) to describe to family exactly what they can and cannot see and do
 - Respect person's autonomy to complete high value task
 - e.g. back off and allow person to continue to complete a valued activity independently even if it is difficult to perform

AUTONOMY
THE DESIRE TO BE
SELF DIRECTED



Working with Families

- Strongly encourage family not to **OVER PROTECT** loved one
 - Over protection is always associated with
 - Lower levels of adjustment
 - Greater sense of negative well being
 - Heightened anxiety
 - Puts constraints on person's "true" functional abilities and reduces competence even further
 - Over time it leads to depression



Importance of Reciprocity

(Reinhardt, Boerner, Horowitz 2006; Boerner & Reinhardt, 2003)

- Find ways to enable the person to **reciprocate** and **provide support** to family
 - Facilitates a **more equitable** relationship
 - Makes it easier for the client to accept help if h/she can also give back
 - Family must accept and acknowledge the client's contributions



Provide Resources to Client and Family

- Adjustment process continues after therapy ends; arm the client and family with resources to facilitate ongoing adjustment
 - Contacts for mental health providers
 - Support groups for persons with low vision
 - Community centers with programming for older adults
 - Accessible recreation facilities for older adults
 - Books on adjustment
 - Websites like
 - South African National Council for the Blind
 - Blind South Africa

Facilitating Referrals

- To licensed mental health providers
- VERY important whenever assessment shows risk for clinical depression



Remember...

- No two people age the same way

“There is infinite variety among individuals, whether visually impaired or sighted. Neither chronological age nor functional disability determines behavior” (Hendricks 1992)

- One becomes more **heterogeneous** with age
 - Shaped by many experiences
- Helping older adults adjust to vision loss demands a client centered approach
 - Characterized by careful observation and listening to the client and family concerns

The background is a blurred image of a document. It features several lines of text, some of which are partially legible as 'E', 'P', and 'P'. A prominent green horizontal line is visible near the bottom of the page. The overall tone is dark and out of focus.

Questions?
