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Psychosocial Adaptation to Visual Impairment

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<http://dx.doi.org/10.5772/intechopen.70269>

Abstract

Acquired visual impairment evoked several psychological reactions. A person's adaptation to these reactions and their associated characteristics such as degree of vision loss, membership of a specific demographic, and impact on personality had been investigated. Socio-environmental variables also had an impact on psychological adjustment, and adaptation to vision loss had been explained using psychoanalytic models and stage models. Previous research had thus developed adjustment models incorporating the variables of anxiety, depression, self-esteem, self-efficacy, locus of control, acceptance of disability, attitudes toward blindness, and attributional style, among other influences. However, effective types of treatment based on these variables had not been empirically demonstrated. While grief work had been commonly used in intervention strategies, and there was now more information available about group counseling in this field, their evaluation had been insufficient. As an alternative, we implemented a structured group counseling program to decrease psychological distress in adults with visual impairment. The results indicated that participants who engaged in individual therapy in addition to group counseling showed decreased depression, fatigue, and confusion, and a significantly improved acceptance of their disability. The group counseling combined with individual cognitive therapy could be the effective tool to improve social influences and internal self of the person with visual impairment.

Keywords: visual impairment, rehabilitation, adaptation, group counseling, cognitive therapy

1. Introduction

It was known that acquired visual impairment evoked several psychological reactions, including shock, depression, grief, resentment, shame, self-derogation, a resigned attitude, feelings of inadequacy, and feelings of excessive guilt (e.g., see [1, 2]). People's reactions to visual impairment were lack of understanding, misconceptions, and/or prejudice. In this chapter, we

focused on the acquired visual impairment that occurs in adults. In this discussion, we provided an overview of the theories and empirical studies relating to the psychosocial problems that were commonly experienced by the visually impaired.

1.1. Causes of visual impairment

Visual impairment might result in serious difficulties, because human beings depended on visual perception to get most of their information from the world around them. It might also trigger a psychological crisis that could promote an intention to seek “death,” as Carol described [3]. In Japan, an approximately 310,000 people suffered from visual impairment. However, this number was only those who had a certified disability; there were more people suffering from visual impairment than were on official lists. Visual impairment was brought about by various causes such as eye disease, systemic disease, encephalopathy, and traumatic injury. Eye diseases include glaucoma, retinitis pigmentosa, optic atrophy, macular degeneration, retinopathy of prematurity, and so on, while systemic diseases include diabetic retinopathy and Behcet disease. Encephalopathy includes visual impairment caused by brain injuries, and postoperative impairment from brain tumors.

The aspects of psychological distress resulting from these situations were different, depending on the time of onset and the type of visual impairment experienced.

2. Psychosocial problems

Though visual impairment might differ depending on country and age, there was still a paucity of empirical research concerning psychosocial adaptation to acquired visual impairment [4, 5].

2.1. Demographic variables, degree of visual loss, personality, and adaptation

Some studies had investigated client adaptation to these problems, as well as the associated features of clients, including their demographic and personality characteristics, and their degree of vision loss. Though some studies showed that psychological reactions differ depending on the degree of visual loss, the studies, which suggest that there was a positive correlation between residual vision and adaptation, were those by Fitzgerald et al., Lukoff and Whiteman, and Wulsin et al. [6–8]. Against these studies, Teitelbaum et al. failed to find such a relationship [9].

Bauman examined the relationships between psychological adaptation and a client’s visual, medical, personal, social, educational, and vocational histories, through structured interviews incorporating a comprehensive test battery [10]. The segmented data from this study showed that their well-adjusted group (37% of 400 persons) was (a) independence, (b) mostly mobile, (c) maintained satisfactory home and community activities, and (d) had a successful work history. On the other hand, their identified maladjusted group (29%) was (a) dependence, (b) mobility-dependent on others, (c) engaged in only limited home and community

activities, and (d) had no recorded work history. They were also able to show that the well-adjusted group demonstrated higher scores on intelligence, manual dexterity, emotional stability, and realistic acceptance of their visual impairment, and attained higher educational levels than the maladjusted group. However, no differences were found between these two groups on the degree of vision loss, health indices, or the level of social interaction. A follow-up study carried out 14 years later showed that these characteristics had been retained [11].

Joffe and Bast examined the relation of ego functioning and adaptation of 101 men with a visual impairment using the California Psychological Inventory (434 items' questionnaire that include 18 scales. Each scale measures interpersonal adequacy, character, intellectual efficiency, interests, etc.) and extensive structured interviews [12]. In this study, occupational status and mobility were used as the index of adaptation. No differences were found between the employed and the unemployed groups on measures such as educational level, age, degree of vision, and several psychological attributes such as defense and coping. However, by combining occupational status with mobility, the study examined the differences between accommodators (employed and high-mobility skills) and non-accommodators (unemployed and poor mobility skills). The researchers found that accommodators used extensive coping strategies, such as mature, adaptive, flexible, purposive, present-oriented, and reality-based behaviors. Accommodators also included objectivity, intellectualization, suppression, and tolerance of ambiguity as techniques to overcome visual impairment problems. By contrast, non-accommodators tended to rely on defensive strategies such as immature, non-adaptive, rigid, past-oriented, and irrational reactions, and used projection, regression, fantasy, displacement, rationalization, and doubt in their reactions.

2.2. Individual factors of emotional and psychological reactions to visual impairment

The individual variables that acted in specific situations to exacerbate or reduce the differences in each of these reactions, and determined the degree of further psychological adaptation, had been explained from the various viewpoints of different schools of thought. A sketch of this material is discussed in the next section.

2.2.1. Psychoanalytical and psychodynamic models

One of the earliest theoretical approaches that emphasized the importance of vision in personality development and later adult life was developed by psychoanalysts. Blank maintained that reactions to visual impairment could often be traced to the unconscious significance of (1) the eye as a sexual organ, (2) the eye as a hostile, destructive organ, and (3) blindness as a punishment for sin (like castration) [13].

Traditional psychodynamic models emphasize the importance of concepts such as loss, mourning, and grief. In this context, Carroll maintained that the losses forced on the blinded person were many [3]. They interlocked; they overlapped one another. Any one of them was severe enough in itself. Together, they made up the multiple handicaps that were blindness. Each loss involved a painful farewell (a "death"), then, and Carroll identified 20 types of losses from blindness in his classic writing. These were (loss of) (1) physical

integrity, (2) confidence in the remaining senses, (3) reality contact with environment, (4) visual background, (5) light security, (6) mobility, (7) techniques of daily living, (8) ease of written communication, (9) ease of spoken communication, (10) informational progress, (11) visual perception of the pleasurable, (12) visual perception of the beautiful, (13) recreation, (14) career, vocational goal, job opportunity, (15) financial security, (16) personal independence, (17) social adequacy, (18) obscurity, (19) self-esteem, and (20) loss of total personality organization. Since a blind person lost such a lot, Carroll emphasized that rehabilitation had to provide effective substitutes.

2.2.2. *Stage model*

Carroll's loss model had been further developed. A stage model, which insisted that emotional psychological reactions to trauma occur in stages, was one such development. This theory explained that the psychological reactions experienced after acquired visual impairment might pass through the stages of (1) shock, (2) depression, and (3) recovery [1, 13]. Another stage model proposed by Allen suggested three adaptation processes: (1) pre-impact phase, (2) impact phase, and (3) learning to live with impairment [14].

Related to the stage models, there were some studies of the impact of denial on the process of adaptation. Dover recognized the importance of denial as a defense to ward off anxiety [15]. She emphasized that denial was frequently manifested through a search for new medical discoveries and magical treatments. Shulz, in distinguishing between denial of the severity of the condition and denial of the affective content or meaning of the visual loss, considered that the latter could interfere with the process of adaptation [16].

3. Personality and adaptation

3.1. Anxiety

There were some studies that have focused on the relationship between personality traits and adaptation to visual impairment. These studies were called disposition (or trait) theories. The first personality trait that affected rehabilitation was anxiety. As stated above, Dover recognized that denial was a defense to ward off anxiety; in the phase of anxiety, people with visual impairment often did not participate in rehabilitation, or reject to participate. They denied visual impairment of themselves because of anxiety [15]. Moreover, anxiety resulted in lowered attention spans and decreased the ability to use cues of environment, influenced learning, and performance in personal rehabilitation [17]. In addition, the learning of the person with high anxiety was slower, and the retention of what was learned was less [18]. That was why treating anxiety was significant in rehabilitation for visual impairment in which Braille, mobility techniques, and the techniques of daily living were acquired.

3.2. Self-concept and self-esteem

Self-concept was defined as "a collection of thoughts and feelings one about oneself," [19] and self-esteem had been used as an affective dimension of the self-concept [20]. The reason that

self-concept was related to rehabilitation and adaptation was that human beings tend to initiate behavior to reduce the discrepancy between “the present self” and “the ideal possible self” [21], and seek feedback that was consistent with their self-concept, but avoided information that was contradictory [22]. Therefore, the self-concept idea related to whether the individual with visual impairment could initiate new behavior and how he/she could adjust to their new life. In other words, psychological reactions might differ depending on how much his/her self-concept was defeated. If a person shaped negative self-concept by acquiring visual impairment, and resisted change, it could become very difficult to advance toward the goals of a more independent self in rehabilitation [23].

Tuttle had produced many examples of possible discrepancies that persons with visual impairment might encounter between the way they saw themselves and how they were seen by significant others [20]. These discrepancies needed much effort to resolve and had major impacts on their personal adjustment [23]. This was why there were some studies that had made considerable efforts to establish empirical evidence of the differences in self-concept and self-esteem between people with vision loss and sighted people [24]. However, these studies produced contradictory results because they involved confounding variables, such as inappropriate measuring instruments, the length of time that people with visual impairment had experienced vision loss, and the diverse range of coping strategies they used [23]. Still, self-concept and self-esteem were not closed traits in an individual. Also, their relationships with the people around them should not be ignored. We will discuss this issue later.

3.3. Self-efficacy

Another concept that is related to rehabilitation and adaptation was self-efficacy. In the past, the concept of confidence and motivation was widely used in the field of rehabilitation, because one of the problems rehabilitation personnel had been struggling with was low confidence or unmotivated clients. However, since the widely used concept of motivation was so simple, Dodds outlined the usefulness of the concept of self-efficacy for rehabilitation [25]. The concept of self-efficacy, originally proposed by Bandura, was based on the notion that “our expectations have effect on our motives and behavior” [26].

Moreover, Dodds et al. developed an adjustment structural model comprising anxiety/depression, self-esteem, self-efficacy, locus of control, acceptance of disability, attitudes toward blindness, and attributional style by using the LISREL (linear structural relation) model (the statistical methods to formulate theoretical model for manifest variables and latent variables from collected data) [27]. Additionally, two factors, which were not assessed directly but appeared in latent form, were identified. These factors were “self as agent” and “internal self-worth,” and seemed to explain the high interrelationships found among above seven factors assessed by the adjustment structural scale (**Figure 1**). Based on this, Dodds et al. asserted that successful adaptation was multidimensional and includes (1) low levels of anxiety and depression, (2) high levels of self-esteem and self-efficacy, (3) a high sense of personal responsibility for recovery, (4) a positive attitude toward visual impairment, and (5) acceptance of one’s own visual disability. They also suggested that the process of adaptation was inclusive of changes in both negative aspects (decreasing anxiety and depression) and positive aspects (improvement of self-concept, sense of mastery, and self-control) [27].

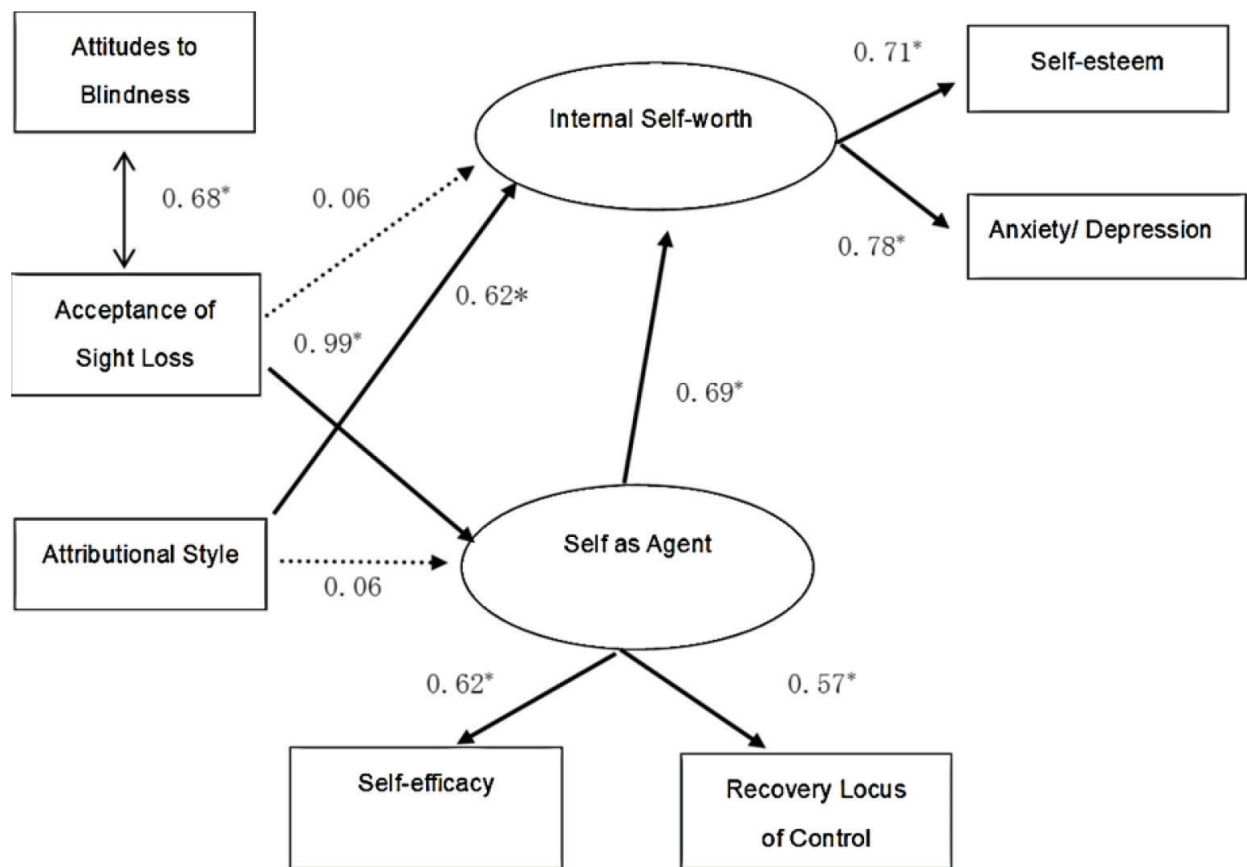


Figure 1. LISREL structural model with path coefficients (* $P < 0.05$). Reprinted with permission of the publisher from Dodds et al. [27]. Copyright © 1994 by American Foundation for the Blind. All rights reserved.

Furthermore, based on the results of the LISREL analysis, they suggested that these factors might influence rehabilitation practice. For example, attributional style had a direct effect on “internal self-worth,” and “internal self-worth” was related to anxiety/depression and self-esteem. Acceptance of sight loss was also strongly related to “self as agent.” “Self as agent” reflects a belief in one’s ability to control future goals and tasks, was related to self-efficacy and recovery locus of control, and directly related to “internal self-worth.” From these results, Dodds et al. concluded that, while counseling might not directly lead to measurable improvements in self-worth, it might improve the motivation for an individual to act in ways that brought about successful adjustment outcomes [27].

4. Social factors

4.1. Socio-environmental influences

These theories and studies mentioned earlier had been developed from the standpoint that emotional and psychological reactions and adaptation varied according to the individual factors. However, there were studies from the alternative standpoint that the reactions of individuals with visual impairment were the consequence of influence from other people. Thus,

socio-environmental influences such as prejudice and interactions with others also had an impact on psychological adjustment.

Cutsforth, a blind psychiatrist, was the first to assert the influence of society on such reactions [28]. He stated that the characteristic of emotional disturbances was that they were evoked from the social situations that blindness created and not from the sensory deprivation itself. Thus, it was difficult to find any evidence that blindness itself was productive of emotional disturbances. Chevigny and Braverman described that society included the beliefs, feelings, and consequent expectations that sighted persons inflicted upon the blind person [29]. They stated that every blind person reacted to this environment, either consciously or unconsciously, and resentment was a primary reaction that emerged from this social situation. Thus, a major issue in other people's reactions to blindness was "lack of understanding and misconceptions." The core of the self-concept of persons with visual impairment was the stereotypical attitudes and expectations of sighted people around them, which became the rules by which persons with visual impairment sculpted their thoughts, feelings, and daily actions. It was thus impossible for persons with visual impairment to ignore these beliefs, and they had no choice but to respond to them. The result was a feeling of shame, inadequacy, and self-derogation [30, 31].

Though empirical studies had been conducted to discover how other people regard visual impairment, the findings were confounded. This was caused by the variety of using psychological tests, different eliciting stimuli, and confusion regarding whether the research was measuring people's attitudes toward visual impairment, or toward people with visual impairment [32]. However, many of the confusing and discrepant findings suggested that people's attitudes toward visual impairment were not unidimensional, but were instead multidimensional [23]. Whiteman and Lukoff [33] identified five dimensions of other people's attitudes toward visual impairment or people with visual impairment: (1) personal attributes reflecting a negative view of the emotional life and general competence of people with visual impairment; (2) social attributes reflecting a readiness for interaction with people with visual impairment, and a positive view of the social competence of people with visual impairment; (3) evaluation of visual impairment that showed the degree to which visual impairment was perceived as threatening and uniquely frustrating to one's self and others; (4) non-protectiveness, reflecting a lack of protectiveness and sympathy; and (5) interpersonal acceptance, reflecting an emotional acceptance of people with visual impairment in interpersonal situations.

In addition to these studies, there were researchers who insisted that the attitudes of other family members had a strong impact. Versluys [34] and Featherstone [35] noted that families who communicated positive attitudes helped stabilize their visually impaired relative's self-concept. Large noted that the attitudes of family members, especially parents, had a powerful influence and, depending on whether the influence was positive or negative, had lasting effects [36]. The reason why the family had such a strong influence was that it served as the major source of interpersonal influences that affected what visual impairment meant to the person suffering from this, and what he/she did with it [37].

Vision loss was likely to cause disturbances in an individual's balance between independence and dependence. The affected person had to now depend to a greater degree on others to

assist him/her in performing the many tasks of daily living and especially for help in travel until he/she learned techniques for functioning without vision. Therefore, this could lead to serious problems if an individual had dependency conflicts throughout his/her life [23]. Thus, we needed to understand the influence of the family from the viewpoints of dependence and independence, and the roles in the family formerly occupied by the visually impaired person that had changed.

4.2. Combination of individual and socio-environmental factors

There were some researchers who attached great importance to both individual and socio-environmental factors in addition to these socio-environmental variables. Bauman and Yoder, for example, recognized the impact of both the situation and the reaction of family members, friends, and medical personnel on the adjustment of newly visually impaired person [11]. Roberts stated that visual impairment presented the human organism with one of the most sweeping environmental adaptations conceivable, and the views of other people made it necessary for the visually impaired person to reexamine and often to redefine his/her own self-concept as well as his/her previously established roles and procedures [38]. Yeadon and Gryson stated that reactions to visual impairment steamed for two main sources: the attitudes of the person and others, and the age at the onset of visual impairment [39]. Tuttle also thought that both “physiological loss of vision” and “society’s prevailing attitude” had an equally important impact on the reactions of an individual [20].

4.3. Prejudice by interaction with others

Many visually impaired people were stigmatized when they were living in various locations. In this context, the stigma is referred to “some deviation from a norm or standard” [23]. Persons with visual impairment were often stigmatized by their appearance or by the equipment (white cane, special glasses) they used. The problem of stigma, however, did not reside in the person who possesses the stigma, nor in the persons who reacted to the stigma, but in the interaction between them [40, 41]. People who were stigmatized elicited atypical reactions and behaviors from the public. These reactions could impact on the self-concept of the person with the disability, as well as on his/her behavior [23].

Understanding these interactions, Barker et al. suggested the concept “A new psychological situation” [42]. This was a concept that covered the fact that a person would engage in behaviors that attracted and repelled, trial and error, and experienced frustration, then withdrew to the safety of the old in the situation where the location of positive goals and the path by which they could be reached were clear. Visually impaired persons frequently experienced this “new psychological situation” when lacking a necessary tool for dealing with the situation, or when confronting the reactions of others.

Another concept that might be important was the one of “overlapping roles.” If the person with visual impairment had no problems in their limbs, they might find themselves more torn between the roles of independent and dependent than the persons with physical disability. This condition might result in the feeling of being a “marginal man,” and this “marginal individual”

might have ambivalent feelings about his/her new identity, such as “Am I an independent person or a dependent person?,” and might wish to reject it.

Then, there was the concept of “passing,” which often affected persons with low vision, not those with total visual impairment. They were passed up the fact of vision loss by people around them in almost all living situations. This might have an impact on the identity of the person with low vision and on the decision of when to disclose their visual disability.

5. Interventions for psychosocial adjustment

As described earlier, the difficulties in, and the complexity of, the psychological adaptation of people with visual impairment were caused by the interaction of personal factors, environmental factors, and individual behavior. Therefore, the methods of support intervention had also varied, depending on the differences in the understanding of the cause of psychological reactions or of the difference of the purpose of the intervention.

5.1. Individual psychotherapy

5.1.1. *Grief therapy*

Treatments that were effective against the psychological reactions to acquired visual impairment had not been widely empirically demonstrated [4]. Grief work had been one commonly used intervention strategy, although empirical evidence of its efficacy is lacking.

Choldon stated that the therapist should be a relatively fixed, nonthreatening, and warm figure [1]. It was fruitful to point out to a patient conscious side which he/she did not accept the disability, and situations where they could avoid the difficulties that visual impairment brought. But as, in the shock stage, any readjustment effort was not effective, it would seem unwise to do so. After this stage, the reactive depression stage began, which was a period of mourning for their eyes, in which the patient had to die as a sighted person and was an important and necessary phase in the reorganization process. The patient needed to experience this depression before they could accept the reality of visual impairment; efforts to prevent or abort it should not be made. In this stage, it was better to let them alone to cry. After this, it was possible to hasten the movement out of the depressed state by the judicious use of activities and training tasks in the rehabilitation. Having successfully accomplished some task believed difficult at first might lift their mood, but if an overambitious task that they could not accomplish was presented, their depression might be intensified.

5.1.2. *Cognitive therapy: maladjusted belief*

Needham and Ehmer categorized the 16 maladjusted belief statements that visual impaired people often made into four categories [43]. These were that (1) blind people were different from sighted people in their self-worth and value (e.g., an individual's worth was dependent upon his/her physical adequacy. So, blind person was of little value); (2) blind people had a

unique psychological constitution (e.g., blind people had to be either gifted or defective in their intellectual functioning); (3) blind people had a special relationship with other people and society in general; and (4) there were magical circumstances about blindness (e.g., blindness would be cured by a new scientific discovery, or new products of engineering would solve the problems of blindness).

Additionally, they suggested that maladjusted beliefs mentioned earlier about blindness could affect and limit the lives of visually impaired people. The mythologies and irrational beliefs about visual impairment were part of our general culture and were just as prevalent among sighted as among visually impaired people. This meant, therefore, that any single irrational belief statement that had a potential to cause much unhappiness for a visually impaired person would become the self-defeating thought that could limit their living. Hence, the appropriate intervention included uncovering an individual's irrational beliefs by direct inquiry, knowing their peer group's different capabilities, and seeking views on their impairment in rehabilitation settings or in psychotherapy.

Within the therapeutic milieu (rehabilitative or psychological), the person with visual impairment should be regarded as a student and a learner rather than as a patient, be contacted with objective and realistic attitudes of their condition, and be able to test the accuracy or inaccuracy of their own beliefs. It was possible to bring about cognitive changes through such interventions. Modifying maladjusted beliefs by effective intervention (cognitive therapy) and acquiring coping techniques for visual impairment (e.g., mobility technique, Braille, daily living technique) would make it possible for visually impaired persons to engage in a limited but many activities, to have dreams that lend themselves to real fulfillment, and to experience the pleasures that were indeed possible even though they were blind. It was important for the therapist to know what mythology existed and what could be accomplished to change this through rehabilitation.

5.1.3. Group counseling

In contrast to the paucity of information regarding the efficacy of individual psychotherapies for the visually impaired, more information was available regarding the usefulness of group counseling. In general, group treatment approaches had been more effective than individual treatment [44]. However, group treatment had been even more effective when used concurrently with individual counseling [45].

This tradition began with Choldon [1], followed by Herman [46], Ross and Anderson [47], Goldman [48], Manaster [49], Roessler [50], and McCulloh et al. [51]. Group counseling approaches were not uniform, however, and had different theoretical bases, goals, and intervention techniques. Moreover, there could be differences in economic status and educational level between clients. These differences could influence original adaptation level of the clients. Furthermore, in nearly all the studies, outcomes were evaluated based solely on therapists' impressions. Only Roessler used a control group while evaluating outcomes using objective indicators such as the standardized self-esteem scale and the locus of control scale [50]. The structured group counseling that he named "Personal Achievement Skills Training (PAS)" included communication skills, value

clarification, problem-solving skills, and self-modification. Control group participants were involved in group counseling focusing on personal feelings and adjustment to disability. PAS group ($n = 16$) and control group ($n = 18$) were randomly assigned. The participants in PAS group showed significantly higher self-esteem and goal achievement than the control group.

Van der Aa et al. conducted a meta-analysis of 22 studies of psychological intervention implemented between 1981 and 2015 [5]. These studies included group-based cognitive-behavioral intervention, self-management programs, problem-solving treatment, psycho-education, relaxation training, and behavioral activation. Fourteen studies were randomized control trials (RCTs), while in 15 studies, the participants' mean age was over 60. The studies demonstrated that intervention reduced depressive symptoms significantly, but anxiety symptoms, mental fatigue, psychological stress, and psychological well-being were not improved significantly. Given the higher age of participants, the effects on depressive symptoms, psychological stress, and psychological well-being were small.

5.1.4. Structured group counseling combined with individual cognitive therapy

Considering the interaction of personal factors, environmental factors, and behavior in the psychological adaptation of persons with acquired visual impairment, we implemented a structured group counseling program as part of a Living Skills Training Program [52]. A quasi-experimental study design was used to compare the outcomes of a 6-month group counseling program with and without individual cognitive therapy, which included a control group. The group counseling program was based on weekly 90-min sessions consisting of three components: (1) talking about experiences and feelings; (2) psycho-education about disability, eye diseases, and social resources; and (3) relaxation and meditation.

Individual cognitive therapy was scheduled once a week for 45 min. Clients talked mostly about how they felt and what they thought during the group counseling sessions, and compared other group participants' responses to their own expectations and beliefs. When distorted negative cognitions were identified, these were explored and modified during individual therapy sessions based on the actual attitudes of the other participants.

The control group was taken from the participants of the Living Skills Training Program. This program consisted of orientation and mobility training, writing and reading Braille, house cleaning, cooking, sports, recreation, and computer training. The programs were held 5 days per week, and the course ran for 6 months. The results indicated that participants in skills training alone ($n = 32$) improved significantly in acceptance and attribution style, while also showing a trend of improvement in tension anxiety and self-esteem. However, participants with high levels of psychological distress (who indicated a T -score of Profile of Mood States Test over 60, $n = 10$) did not show any such improvements. Nevertheless, highly distressed participants that participated in group counseling ($n = 18$) showed significant improvement in their attitudes toward visual impairment and reported decreased anxiety. Moreover, participants that chose to engage in individual therapy in addition to group counseling ($n = 9$) also showed a decrease in depressive mood, fatigue, and confusion, as well as significantly increased acceptance of their visual disability.

5.1.5. Case example

Mr. O was a 34-year-old man who had acquired a visual impairment due to pigmentary retinal degeneration and had participated in the Living Skill Training program. Before participating in this program, he had attempted suicide. At first, he had a thought that “there is no meaning in the life with loss of vision.” As treatment progressed, he began to clearly recognize the negative beliefs regarding his disability such as “people think that visually impaired person can do nothing.” Hearing his peers’ thoughts in group counseling, experiencing others attitudes in mobility training, and through cognitive modification in individual therapy, he could modify negative beliefs and have positive beliefs, such as “I’m not so poor.” and “I don’t want to be back to healthy person. I’m OK as I am now.” The outcome was that there was improvement in his depression, attitudes, and acceptance of his disability. After this program, he began to live independently as a practitioner of acupuncture [53].

6. Conclusion

Psychological distress and reactions to visual impairment were caused by the interaction of personal factors and social factors. Therefore, it was difficult to solve these problems by single intervention. Although acquiring independent skills was effective for psychosocial adaptation, group counseling combined with individual cognitive therapy could be the effective tool to improve social influences and internal self of the person with visual impairment.

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