A social work perspective on the socio-emotional experience of older persons with visual impairments

by

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature Date

SUMMARY

An exploratory research design together with a qualitative research approach was chosen in order to obtain knowledge, insight and understanding regarding the socio-emotional experience of older persons with visual impairments. The motivation for this study resulted from a lack of recent research related to the socio-emotional experience of older persons with visual impairments. The researcher became aware of this lack of recent literature during a preliminary literature investigation. The need for updated research in this field was confirmed by the Department of Social Work and the Department of Ophthalmology at Tygerberg Hospital. The goal of the study is therefore to gain a better understanding of the socio-emotional experience of older persons with visual impairments in order to provide guidelines for social work intervention with these older persons.

The literature study firstly focused on the life-stage of older persons in order to gain a better understanding of the developmental needs and tasks during old age focussing especially on the significance of visual competency in this life-stage. The literature study also included the theoretical framework that guides the social worker's task, in this study the focus was on the ecological perspective. Primarily, the literature study explored the socio-emotional experiences of older persons affected by visual impairments and the social work interventions that are available for older persons with visual impairments.

The researcher decided to involve ten older persons (65 years of age or older) with visual impairments who are from the service-area of Tygerberg Hospital in the research. A qualitative investigation was carried out by means of conducting semi-structured interviews with the aid of an interview guide.

The results of the investigation largely confirmed the findings of the literature study namely that visual impairment severely impacts the daily functioning of older persons. These socio-emotional challenges include: aspects related to family and/or friends; psychosocial implications of vision loss on daily activities like: driving, shopping, sport, television, needlework/ knitting, and reading; and a lack of knowledge regarding available services for older persons with visual impairments.

The results therefore gave a good indication regarding social work interventions for this target group: talking to someone; distributing information regarding visual impairment; distributing information regarding available services; participating in a support group; and learning to cope with daily activities.

The recommendations were aimed at services related to prevention, assessment and intervention with this vulnerable group. The recommendations also include further research in order to develop social work programmes that increase awareness among social workers regarding this issues and specifically addresses this issues, for example in Old Age Homes, in order to decrease negative stereotypes regarding older persons and visual impairment, and increase the functioning of older persons with visual impairment.

OPSOMMING

‘n Verkennende navorsingsontwerp sowel as ‘n kwalitatiewe benadering was gekies om kennis, insig en begrip rakende die sosio-emosionele ervaring van ouer persone met beperkte visie te verkry. Die motivering vir hierdie studie het na vore gekom weens die leemte rakende kennis oor die sosio-emosionele ervaring van ouer persone met beperkte visie. Die navorser het van hierdie leemte bewus geword tydens ‘n volledige voorondersoek en hierdie leemte is deur die Departement Maatskaplike Werk sowel as die Departement Oogheelkunde te Tygerberg Hospitaal bevestig. Die doel van die studie was dus om inligting in te samel aangaande die sosio-emosionele ervaring van ouer persone met beperkte visie ten einde riglyne daar te stel vir maatskaplike werk intervensie.

Die literatuurstudie het eerstens gefokus op die lewensfase van ouer persone ten einde ‘n beter begrip vir die ontwikkelingsbehoeftes en take gedurende hiderdie tydperk te ontwikkel. Die literatuurstudie het spesifiek gefokus op die belangrikheid van visie geuredne hierdie lewensfase. Die literatuurstudie het ook die teoretiese perspektief wat die maatskaplike werker se taak rig ingesluit en daar is op die ekologiese perspektief gefokus. Die literatuurstudie het hoofsaaklik gefokus op die sosio-emosionele ervarings van ouer persone met beperkte visie en die maatskaplike intervensies wat beskikbaar is vir ouer persone met beperkte visie.

Daar is besluit om tien ouer persone (65 jaar oud of ouer) met beperkte visie wat vanuit die Tygerberg Hospitaal se diensarea afkomstig is, by die ondersoek te betrek. ‘n Kwalitatiewe ondersoek is onderneem deur semi-gestruktureerde onderhoude met behulp van ‘n onderhoudskedule te voer.

Die resultate van hierdie ondersoek het tot ‘n groot mate die bevindinge van die literatuurstudie bevestig naamlik dat beperkte visie ‘n beduidende invloed op die daaglikse funksionering van ouer persone het. Hierdie sosio-emosionele uitdaagings sluit in: kwessies rakende familie en/of vriende; psigososiale implikasies van beperkte viesie op daaglikse aktiwiteite soos: bestuursvermoëns, aankope, sport, televisie, naaldwerk/breiwerk, en lees; en ‘n te kort aan kennis rakende beskikbare dienste vir ouer persone met beperkte visie.

Die resultate het dus ‘n aanduiding gegee van wat die inhoud van intervensieprogramme vir hierdie teikengroep hoort te wees: verskaf iemand om mee te praat; versprei inligting rakende beperkte visie; versprei inligting rakende beskikbare dienste; bied ondersteuningsgroepe aan; en leer ouer persone hoe om daaglikse aktiwiteite makliker uit te voer.

Die aanbevelings het gefokus op dienste rakende voorkoming, assessering en intervensie. Die aanbevelings sluit in verdere navorsing ten einde maatskaplike werk programme te ontwikkel wat daarop fokus om maatskaplike werkers in te lig omtrent die spesifieke kwessie en ook programme wat die kwessie direk aanspreek, byvoorbeeld in Ouetehuise, ten einde die negatiewe denkwyses rakende ouer persone en beperkte visie aan te spreek, en die funksionering van ouer persone met beperkte visie te verbeter.

RECOGNITION

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TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

CHAPTER 2
AN OVERVIEW OF THE OLDER PERSONS' LIFE-STAGE AND THE SIGNIFICANCE OF VISUAL COMPETENCY FOR OLDER PERSONS

CHAPTER 3
THE SOCIO-EMOTIONAL EXPERIENCE OF OLDER PERSONS WITH VISUAL IMPAIRMENT FROM AN ECOLOGICAL PERSPECTIVE

CHAPTER 4

SOCIAL WORK INTERVENTION FOR OLDER PERSONS WITH VISUAL IMPAIRMENTS FROM AN ECOLOGICAL PERSPECTIVE

CHAPTER 5

EXPLORATION OF THE SOCIO-EMOTIONAL EXPERIENCE OF OLDER PERSONS WITH VISUAL IMPAIRMENTS

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

FIGURES

CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

Older persons constitute the fastest growing segment of the population in many nations around the world. Naleppa and Reid (2003:3-5) report that some European countries are currently referred to as the 'aging countries' due to the rapid increase of older persons in their population. Older persons are reaching ever-higher ages than in the past. In the year 2000, every one out of ten persons worldwide were 60 years or older. It is estimated that by the year 2050 one in every five persons will be 60 years or older (Keigher, Fortune & Witkin, 2000: xiii).

There have been certain trends that have been associated to this occurrence. A decrease in mortality, due to the reduction of acute health problems, is one of these recognised trends. On the other hand, there seams to be an increase in the prevalence of chronic health problems, as people become older and are alive longer. This often has a direct influence on the performance of daily activities by older persons. Older persons are becoming increasingly dependent on family members for financial and physical care (Naleppa & Reid, 2003:3-5; Stuen, 1991:166).

Some of the chronic health problems older persons suffer from, e.g. diabetes, cause visual impairment. Other health problems that are associated with aging, e.g. cataracts, also cause visual impairment. As stated by Lupsakko, Mantyjarvi, Kautiainen and Sulkava (2003: 573-574) this phenomenon is one of the conditions that most frequently lead older persons to require assistance from family members or care givers for performing daily activities like cooking. According to Branch, Horowitz and Carr (1989: 359) visual impairment is the second most prevalent physical impairment among older persons and Stuen (1991:166) indicates that it ranks third among the physical impairments that restrict daily activities of older persons most. Vaughan and Hobson (1990:370) agree that visual impairment, particularly after a lifetime of normal vision, has a profound effect on the quality of life for many older persons contributing to an increase dependency on others.

Authors (Crews, 1991:138; Rogers & Long, 1991:154) are of the opinion that there will be a dramatic increase in the number of visually impaired older persons in the next 50 years as more people in the population continue to grow older. According to several authors (Branch, Horowitz & Carr, 1989: 359; Cherry, Keller & Dudley, 1991:100; Goodman, 1985:155.) the risk of severe visual impairment increases with age. Various causes of blindness like diabetes, glaucoma, macular degeneration and cataracts are due to biological aging and therefore more common in older people (Cherry et al., 1991:100). Consequently, it is not surprising that age is the most dominant predictor of the occurrence of visual impairment (Goodman, 1985: 155).

In addition to visual impairment, older persons struggle from other physical deficits like deafness, arthritis, and other infirmities associated with old age (Cherry et al., 1991:100; Du Pre, 1982:365). Despite this, Asch (1995: 2461- 2467) indicates that blindness is considered the health condition that limits their activities most. Visual impairment is often undiagnosed and untreated (Lupsakko et al., 2003: 573-574). Moreover, it increases the risk of older persons to become unnecessarily institutionalised due to a lack of rehabilitation and training services with regards to adjusting to visual impairment (Vaughan & Hobson, 1990: 370).

In a community survey conducted by Ferreira, Gillis and Moller (1989:113) 150 coloured persons over the age of 65 years in Cape Town, South Africa, indicated that visual impairment contributed markedly towards functional incapacity in this age group.

As noted by Horowitz and Reinhardt (1998:30) the onset of visual impairment, for older persons who have been fully sighted their entire lives, is an enormous experience requiring adjustment in psychosocial and functional aspects of their lives. For example, (Cherry et al., 1991:100) on psychological level, older persons who experience loss of vision have a poorer self-image than those who can see. Fagerström (1994: 458-461) adds that even though some older persons maintain an over all positive self-image despite visual impairment, they still tend to feel gradually more tense, anxious, and lacking in energy when compared to those that can see.

According to Cherry et al. (1991:100) for many older persons visual impairment is a new experience that they need to learn how to cope with, in addition to the normal challenges of aging. Very few older persons ever expected to become visually impaired. This is a very emotional event for individuals who lived a previously normal life (Du Pre, 1982:365). Rosenbloom (1982:210) describes that these older persons may experience intense feelings of grief accompanied by confusion, self-pity, doubt and decreased self-confidence. These feelings are often accompanied by anger, fear, anxiety, depression, loss of control, and loss of self-esteem (Branch et al., 1989:360).

The White Paper for Social Welfare (Ministry for Welfare and Population Development, 1997: 78-79) identifies older persons with disabilities, including blindness, as especially vulnerable. One of the elements identified in the Draft policy framework of developmental social welfare, is care and enablement. This element describes services focusing on enabling individuals and their families to achieve optimal levels of functioning (Directorate Developmental Social Welfare, 2001: 33).

Visual impairment does not only affect the individual but also those who care for and about the older person. This is not an isolated event, but one that concerns family, support systems and social structures (Crews, 1991:138). With the detection of visual impairment the individual and family members experience changes in family life, relationships, work, recreation and finances. In order to facilitate the adjustment process to these changes, Asch (1995: 2461- 2467) notes that there is a need for social workers to render multi-dimensional services to older persons and their families in order to ensure optimal social functioning.

A study conducted by Cherry et al. (1991:99-123) indicated that the needs of older persons with visual impairments differ from younger persons with visual impairments in several ways. For example, older persons have greater difficulties with activities of daily living like housekeeping, cooking, and grocery shopping. They suggested that further studies in the field of service needs for older persons with visual impairments should be conducted in order to determine older persons' specific

needs relating to visual impairment and what services can be designed in order to meet these needs.

Rogers and Long (1991:154) stated: “We believe that every older person experiencing vision loss should have the opportunity and the necessary resources available to achieve and to maintain with minimal interruption the ability to continue meaningful life experiences.” In order to make this statement a reality, social workers need to empower older persons to adjust successfully to visual impairment.

However, as Orr and Rogers (2001:670) point out, despite the increased awareness of the growing need and demand for services for older persons who are visually impaired, over the past four decades, the development of such services have been adversely influenced by inadequate funds and qualified personnel; a growing and aging population; and an increasingly diverse population with diverse needs (Orr & Rogers, 2001:683).

In the ecological perspective, Germain and Gitterman (1980:77-79) describe that life-transitions can act as a source of stress for any person. All life-transitions are accompanied by biological changes that interact with psychological, social and cultural factors as well as physical settings that cause increasing demands and stress for the individual. In order to adapt to new life-stages, the individual and his/her environment need to reach a goodness-of-fit. According to Germain and Gitterman (1980: 77-79 & 130-131) the social workers’ function is to assist both individuals and their environment to attain this goodness-of-fit by employing various social work roles, e.g. enabler, teacher and facilitator (Germain & Gitterman, 1980: 77-79 & 130-131).

From the above it can be deduced that social workers have an important role to play in facilitating the adjustment process of older persons to visual impairment, as it not only effects their physical functioning, but also their social interaction with their environment. However, there are few recent guidelines for social workers to follow when working with older persons affected by visual impairment.

As a noteworthy lack of recent research (Branch et al., 1989:360; Yeadon, 1991:185;) related to the socio-emotional experience of older persons with visual impairment was confirmed by the Head of the Ophthalmology Department at Tygerberg Hospital, the need for updated research in this field was identified and permission to conduct this study was granted.

1.2 PROBLEM STATEMENT

Literature (Crews, 1991:138; Rogers & Long, 1991:154) confirms the increase in the number of older persons and authors (Branch et al., 1989: 359; Cherry et al., 1991:100; Goodman, 1985:155.) validate that the risk of severe visual impairment increases with age. Furthermore, researchers (Branch et al., 1989: 359; Lupsakko et al., 2003:573-574; Stuen, 1991:166; Vaughan & Hobson, 1990:370) are of the opinion that visual impairment, especially after a lifetime of normal vision, has an intense effect on the quality of life for many older persons contributing to an increase dependency on others. As Orr and Rogers (2001:670) point out, there is an increased awareness of the growing need and demand for support services for older persons who are visually impaired.

1.3 AIM OF THE RESEARCH

The **goal** of the research was to *gain a better understanding of the socio-emotional experience of older persons with visual impairments in order to provide guidelines for social work intervention with these older persons*. In order to achieve this goal the following **objectives** were devised:

- To present an overview of the older persons' life-stage and to describe the significance of visual competency for older persons.
- To describe the socio-emotional experience of older persons with visual impairments from an ecological perspective.
- To describe social work intervention for older persons with visual impairments from an ecological perspective.
- To explore the socio-emotional experience of older persons with visual impairments.
- To present guidelines for social work intervention with older persons who have visual impairments.

1.4 CLARIFICATION OF KEY CONCEPTS

For the aim of this study the following concepts were clarified:

1.4.1 Older persons (Elderly)

The Older Persons Bill (Minister of Social Development, 2003:3) states that women 60 years of age and men 65 years of age are defined as 'older persons'. Old is also defined as the latter period of life (The Shorter Oxford English Dictionary 1978:1443). Both the United Nations and the World Health Organisation define the elderly as people older than 65 years (Raubenheimer, Louw, Van Ede & Louw, 1998:588). For the purpose of this study, the terms 'older person' and 'elderly' was used interchangeably to refer to people who are **65 years of age or older.**

1.4.2 Visual Impairment

In Webster's Encyclopedic Unabridged Dictionary of the English Language (1989:1597), the concept 'visual' is described as an adjective pertaining to seeing or sight. The concept 'impairment' is defined in several ways: firstly, "…to make, or cause to become, worse; diminish in value, excellence; weaken or damage…" (Webster's Encyclopedic Unabridged Dictionary of the English Language, 1989:713) or secondly "…any loss or abnormality of psychological, physiological, or anatomical structure or function…" (Crews, 1991:139).

According to the World Health Organisation (Congdon, Friedman & Lietman 2003:2057-2060), visual impairment is defined as: "…the best vision of less than and equal to 20/400 in the better eye…".

However, for this study, a more social definition was applicable. Moenestam and Wachtmeister (2002:1087) define a major decline in vision as the **"…visual inability to read, to watch television or to orientate one-self in unfamiliar surroundings…"** Therefore, for the purpose of this study this definition, which includes blind older persons, was applicable.

1.4.3 Adjustment/Adaptation to visual impairment/vision loss

For this study, the attainment, by a visually impaired older person, of an **environment** in which they are **optimally constructive and minimally incapacitated** by their visual impairment, was defined as adjustment to visual impairment (Cambert, West & Carlin, 1981:193).

According to Cambert et al. (1981:193) the *environment* consists of physical, social, psychological, behavioural, and relational elements, and an individual is adjusted to blindness if the *environment* in which he/she lives accords him/her status and roles that is beneficially rewarding despite his/her visual impairment.

Horowitz and Reinhardt (1998:30) conceptualised psychosocial adaptation to age-related vision loss on a continuum ranging from acceptance and functional compensation to denial, dependence or despondence. Furthermore, these researchers (Horowitz and Reinhardt, 1998:31) pointed out that psychosocial adaptation to age-related vision loss includes three general domains:

- Acceptance of the vision loss (in a realistic manner),
- Positive attitudes toward rehabilitative training (willingness to learn new skills), and
- Positive attitude toward relationships with family members and friends (acceptance of assistance when needed and not becoming overly dependent on others).

1.5 RESEARCH METHODOLOGY

1.5.1 Research approach

A qualitative research approach was employed for the purpose of obtaining the goal of the research. According to De Vos, Strydom, Fouché and Delport (2002:79) the qualitative approach aims to understand social life and the meaning people attach to everyday life. In a broad sense, qualitative research refers to research that obtains participant accounts of meaning, experience or perceptions. The outcome of qualitative research is in the form of descriptive data in the participant's own words, thereby identifying the participant's beliefs and values that underlie the phenomena.

De Vos et al. (2002: 79) explains that a qualitative researcher is interested in:

- Understanding rather than explanation;
- Naturalistic observation rather than controlled measurement; and
- Subjective exploration of reality from the perspective of an insider as opposed to an outsider perspective.

Consequently, a qualitative study is concerned with non-statistical methods and small samples often purposively selected (De Vos et al., 2002: 79).

In view of the abovementioned description of a qualitative approach to research, the researcher concluded that this approach was well suited for realising the goal of this study. The latter was formulated as follows*: To gain a better understanding of the socio-emotional experience of older persons with visual impairments in order to provide guidelines for social work intervention with these older persons.*

1.5.2 Research design

As indicated by De Vos et al. (2002: 109) exploratory research is conducted to gain insight into a situation, phenomenon, community or individual. The necessity for this kind of study develops from a lack of basic information on a new area of interest, or in order to become acquainted with a situation so as to formulate a problem or develop a hypothesis. The answer to a 'what' question would, constitute an exploratory study. In general exploratory research has a basic research goal, and researchers frequently use qualitative data (De Vos et al., 2002: 109).

As the intention of this study was to explore the socio-emotional experience of older persons with visual impairments, and relatively little recent literature (Branch et al., 1989:360) regarding this topic was available, an exploratory design was chosen. This kind of research design was chosen in order to gain insight and collect information regarding the topic of interest (De Vos et al., 2002: 109). This design corresponded well with the research approach, as the goal of this kind of research design is best met by utilising qualitative data (De Vos et al., 2002: 109).

1.5.3 Research method

1.5.3.1 Literature study

According to De Vos et al. (2002:127), it is necessary to conduct a literature study in order to gain a clearer understanding of the nature and meaning of the research field. Furthermore, Mouton (2001:87) points out that a literature study aims to avoid duplication and suggest possibilities in the research field to explore.

A literature study was conducted concerning the research field in order to establish a reference framework from which to proceed with the research and to form a basis for comparison of the research findings. The literature study focused on the following aspects: the life-stage of older persons; the significance of visual competency in this life-stage; the ecological perspective; the socio-emotional experience of older persons affected by visual impairments; and social work intervention for older persons with visual impairments. Both local and international literature was utilised in order to gain an understanding of older persons' experience. Literature from both the social and medical sciences was incorporated in order to conduct the investigation.

1.5.3.2 Population and sampling

The universe is defined as "…all potential subjects who possess the attributes in which the researcher is interested…" (De Vos et al., 2002:198). This term (universe) therefore sets boundaries on the study units. The population is the total set out of which individuals for the study are chosen (De Vos et al., 2002:198; Tutty, Rothery & Grinnell, 1996: 28).

The population for this study was defined as all the patients, 65 years and older, from the Ophthalmology Outpatients Department at Tygerberg Hospital, who experienced visual impairment, and visited the Department during the month of August 2005.

These patients come from within the service-area of Tygerberg Hospital, which includes the following areas within the Western Cape Province: Belhar; Bellville; Bellville South; Boland and Overberg regions; Brackenfell; Caledon; Durbanville; Gordon's Bay; Hermanus; Macassar; Malmesbury; Mfuleni; Somerset West;

Stellenbosch; Strand; Winelands/West Coast regions. Tygerberg Hospital also renders services to rural areas within the Western Cape where specialised services are not available. It is not possible to include all older persons suffering from visual impairment within the service-area of the Hospital. Reasons for this arise from the fact that Tygerberg Hospital is a state hospital that renders services to state patients. Results can therefore only be generalised within this population group.

De Vos et al. (2002:334) indicate that in qualitative studies non-probability sampling methods are utilised and, specifically, purposive sampling techniques rather than random sampling methods. Qualitative researchers seek out individuals, groups and settings where the specific processes being studied are most likely to occur (De Vos et al., 2002:334).

A particular case is chosen in purposive sampling because it exemplifies some aspect that is significant for the study. Parameters for the population have to be set carefully according to which the sample must be chosen. It is vital to devise specific criteria for selection of the participants (De Vos et al., 2002:334).

A specific sample size could not be determined at the onset of the study, but the number of participants included was determined by data saturation, that is, when the information being gathered becomes repetitive (De Vos et al., 2002:336).

On average, 50 patients, that meet the criteria for inclusion of the study, visit the clinic during a month. At the conclusion of the study, the sample consisted of ten participants selected by means of a purposive sampling method (De Vos et al., 2002:334). The criteria for inclusion (Ritchie & Lewis, 2003:98) were the following:

- Male and female patients;
- Older persons over the age of 65 years; and
- Older persons who are visually impaired (i.e. the inability to read, watch television or to orientate one-self in unfamiliar surroundings).

The researcher obtained identifying particulars of potential participants from the secretary at the Ophthalmology Department at Tygerberg Hospital, and then selected potential participants according to the criteria for inclusion.

1.5.3.3 Method of data collection

- **Preparation for data collection**

The researcher began the process of data collection by making contact with the potential participants while they awaited treatment. During this contact, the researcher introduced herself to the potential participants and explained the purpose and procedures of the research study. The researcher then established their readiness to participate in the research study. Permission was obtained from willing participants to tape-record the interview (Tutty et al., 1996:67). Participants were informed about the confidential nature of the tape recordings and transcripts of the interview. The researcher then explained that if they decided to voluntarily participate in the study, they would be requested to sign a consent form. Where participants were indeed willing to take part, the researcher proceeded with the interview.

- **Research instrument**

Data was collected by means of a semi-structured interview with the aid of an interview guide (Tutty et al., 1996: 52). This qualitative method was chosen in order to identify participants' experience in their own words (Ritchie & Lewis, 2003:36-37), and due to the reality that participants experienced difficulty reading and writing as a result of their visual impairment.

The semi-structured interview made use of questions that were contained in an interview guide with a focus on the issues to be covered. Questions about each issue were asked in an open-ended manner and at a time when it seemed to fit with each participant's narrative. All the interviews were conducted in the home-language of the participant (either English or Afrikaans) and audiotaped with the consent of the participants (De Vos et al., 2002: 302-303).

The researcher conducted the interviews according to the guidelines given by De Vos et al. (2002: 303). First, the participant was made to feel comfortable and at ease. Then the researcher facilitated and guided him/her through the interview. The researcher memorised the guide in advance in order to concentrate on what the participant was saying and only occasionally monitored the coverage of the guide. The researcher did not necessarily ask every question on the schedule depending on the flow of the conversation, but obtained a watchful balance by not deviating too far from it. Participants had the opportunity at the end of the interview to ask questions regarding any uncertainties or express any feelings caused by the interview. As a registered social worker, the researcher was able to offer debriefing were necessary (Tutty et al., 1996: 78-79).

1.5.3.4 Method of data analysis

Data analysis, according to De Vos et al. (2002: 339) is the process of structuring and assigning meaning to the mass of collected data. This process is described as "…messy, ambiguous, time-consuming, creative and fascinating…" (De Vos et al., 2002: 339). Qualitative data analysis does not progress in a linear way; it rather occurs in analytic circles by searching for general statements about relationships among categories of data (De Vos et al., 2002: 340; Tutty et al., 1996:90).

When the data collection process reached the point of data saturation, the process of data analysis began. First the tape-recoded interviews were transcribed. The data was then analysed in the following way: first the transcriptions was organised in computer files, then the researcher read the transcriptions and sorted the data according to categories and themes (Tutty et al., 1996: 92). The researcher then summarised and interpreted the data in the research report by comparing it to existing data from the literature review. Finally, the data was presented in narrative, tabular or figure form (De Vos et al., 2002: 339-344).

1.5.3.5 Method of data verification

Authors (De Vos et al., 2002: 351) note that all research must answer to norms that stand as criteria against which the trustworthiness of the project can be evaluated. These norms are credibility, transferability, dependability, and confirmability.

According to De Vos et al. (2002: 351) these norms establishing the 'truth value' of the study, i.e. its applicability, consistency and neutrality.

- **Credibility**

The goal of credibility is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al., 2002: 351). The researcher made use of various interviewing techniques during the interview, e.g. probing, verbal and non-verbal expressions, restating and summarising in order to enhance the credibility of the study. The researcher also gained input from her supervisor who advised the researcher with regards to qualitative research.

- **Transferability**

A qualitative study's transferability or generalisability is the degree to which the findings can be applied to other contexts and settings or to other groups (De Vos et al., 2002: 351). In order to achieve transferability, the researcher provided a dense description of the research methodology employed.

- **Dependability**

This is the alternative to reliability in quantitative research, in which the researcher attempts to justify changing conditions in the occurrence chosen for study, as well as changes in the design created by an increasingly refined understanding of the stetting. Positivist ideas of reliability assume an unchanging universe where investigation could, quite logically be replicated. This assumption of an unchanging social world is in direct contrast to the qualitative/interpretive assumption that the social world is always being constructed, and the concept of replication is itself problematic (De Vos et al., 2002: 351).

- **Confirmability**

This captures the traditional concept of objectivity (De Vos et al., 2002: 351). Authors stress the need to ask whether the findings of the study could be confirmed by another study. By doing so, they remove evaluation from some inherent characteristic of the researcher and place it squarely on the data. Thus the

qualitative criterion is: Do the data help confirm the general findings and lead to the implications? This is the appropriate qualitative criterion.

1.5.3.6 Ethical considerations

As a registered social worker, the researcher was bound by the ethical code of social workers (Tutty et al., 1996:40-43). According to De Vos et al. (2002: 351) ethics are defined as:

> "Ethics is a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and participants, employers, sponsors, other researchers, assistants and students."

In agreement with the above, the following ethical conditions were relevant to be considered in conducting this study:

- **Informed consent**

  The researcher ensured that participants were competent to give informed consent, i.e. they were in a sound state of mind to make independent decisions. To this end participants were provided with sufficient information about the study to allow them to decide for or against participation. The participants were not coerced in any way. Informed consent forms were given to participants once they had been provided with all the information pertaining to the research and expressed their willingness to voluntarily participate in the research.

- **Confidentiality**

  The researcher ensured that confidentiality was maintained by keeping all information about participants confidential, unless where participants had given written permission to reveal the information. Soliciting and recording only personal information that was necessary for the study to achieve its purpose further ensured confidentiality. The study information was stored in a safe place where participants' identities would not be revealed. This information was accessible only to the researcher, and the supervisor.

- **Debriefing**

  The researcher remained aware of the fact that the interview could upset the participants and that they may have uneasy feelings afterwards. In order to compensate for this, the researcher set time aside at the end of the interview for debriefing. As a qualified and registered social worker, the researcher was capable of debriefing participants where needed.

1.5.3.7 Limitations of the study

Limitations arising that should be considered include the following:

- There is limited recent literature in the field of social work with visually impaired older persons.
- The majority of the available literature is dated back 20 years or more.
- The study relied heavily upon Germain and Gitterman and this could be seen as a limitation.
- Older persons felt reluctant to participate in a research study.
- Hospital setting was very formal and morbid which is not ideal for an open sharing interview.
- The older persons were willing to talk about their own experience, but closed-up during the last part of the interview that focussed on social work intervention, possibly due to uncertainty regarding this area.

In order to compensate for these limitations:

- Great effort was made to explore as much recent literature regarding this topic in social work as possible.
- The available literature was utilised despite the fact that it was documented several years ago, as it may still be relevant today.
- The researcher established a good rapport with the participants in order to motivate them to take part in the research study.

1.6 PRESENTATION

The research report will include several chapters. Chapter one will serve as an introduction. Chapter two will present an overview of the older persons' life-stage

and describe the significance of visual competency for older persons. In chapter three the socio-emotional experience of older persons with visual impairments will be described from an ecological perspective. Chapter four will then describe social work intervention for older persons with visual impairments from an ecological perspective.

In chapter five the data of the empirical investigation will be depicted in order to relay the socio-emotional experience of older persons with visual impairments from an ecological perspective. Based on the findings of the empirical investigation, chapter six will provide guidelines, conclusions and recommendations for social work intervention with older persons who have visual impairments.

CHAPTER 2

AN OVERVIEW OF THE OLDER PERSONS' LIFE-STAGE AND THE SIGNIFICANCE OF VISUAL COMPETENCY FOR OLDER PERSONS

2.1 INTRODUCTION

The purpose of this chapter is to meet the first objectives of the study. Firstly, the chapter will present an overview of the older persons' life-stage. Then a description of the significance of visual competency for older persons will be given.

2.2 OLDER PERSONS' LIFE-STAGE

Various communities have often viewed older persons in different ways. Therefore many different views exist regarding this life-stage. Many people fear aging due to the visible physical deterioration, but on the other hand they regard aging as a process of acquiring wisdom (Raubenheimer et al., 1998:588).

Poindexter (1999:204-205) point out some of the **myths** regarding this life-stage. The following stereotypes exist: all older people are alike; older people cannot learn; older people are senile; all older persons are in nursing homes; all older persons are sick and hopeless; older persons become more religious as they age; and olden age is a 'Golden Age'. However, these stereotypes are not necessarily true. Due to the great individualistic nature of aging, it is not possible to generalise these experiences. Bellos and Ruffolo (1995:165) argue that older persons are not a homogeneous group, and negative stereotypes are not a true representation of this age group.

Interdisciplinary perspectives on the interaction between biological, psychological, social and cultural processes of an aging individual were originally developed in the 1970's (Tepper, 1994:30-31). Adult development involves significant role changes that influence psychosocial life. Many **developmental theories** have been created to explain the processes influencing aging. Erik Erikson was the first developmental theorist to develop one of these theories. Erikson classified eight stages of

development each represented by a crucial turning point when the individual must face a specific challenge. The final stage in Erikson's classification is: *Integrity vs. Despair*. The challenge of this stage is to look back over one's life, remembering both the positive and negative aspects, and ultimately find meaningful outcomes (Tepper, 1994:30-31).

Complimentary to this perspective there are also different **social theories** of aging (Poindexter, 1999: 206). The *disengagement theory* proposes that individuals withdraw from society as they grow older and in turn society withdraws from them. This is seen as a normal course of events. Secondly, the *activity theory* suggests that individuals who are active in old age seem more satisfied and well adjusted than those that withdraw from society. The *continuity theory* holds that not many changes occur, as an individual grows older. It is one's personality that determines how one will cope with growing older (Poindexter, 1999: 206).

In order to gain a clearer understanding of older persons and the challenges they face within their life-stage, it is essential to explore this life-stage. All people strive towards competency in all areas of life, for example, work, family, or functional ability. Older persons need to adjust certain aspects in their daily lives to increase their overall competency in this life phase. Health status plays and important role in the quality of life in older age (Dunkle & Norgard, 1995:144).

This section of the chapter will firstly define older persons and give an overview of their demographic characteristics before discussing their physical and social features.

2.2.1 Defining older persons

Aging is the normal process of gradual changes in the physical composition of a person (Poindexter, 1999:202). However, every person undergoes this process in a unique way. Raubenheimer et al. (1998:589) argue that there are other factors besides merely physical aging to consider when assessing someone's age:

- Psychological age – How old does the person feel?
- Social age – What are the social roles and habits of the person?

However, there is need for a defined starting point to when someone can be considered as an older person. To simplify this process, **65 years** has been marked as the starting point for most people into their journey of becoming an older person (Raubenheimer et al., 1998:588).

During all life-stages changes take place on all levels (physical, cognitive and social). For older persons, however, these changes often involve loss or deterioration that requires adjustment (Raubenheimer et al., 1998:589).

Germain and Gitterman (1980:79) emphasise that each life-stage contains phase-specific adaptive tasks that need to be met by both the individual and his/her environment in order for personal growth and social benefit to transpire. There are eight developmental tasks for older persons listed by Raubenheimer et al. (1998:589). These tasks should be achieved in order to successfully adjust to this specific life-stage. The **developmental tasks** for older persons are listed as the following:

- Adjustment to physical changes,
- Maintaining intellectual vitality,
- Adjustment to retirement and changes in income,
- Establishment of satisfactory housing and physical life circumstances,
- Adjustment to changes in the spouse and to his or her death,
- Re-channelling energy to new roles and activities,
- Fulfilment of social and community obligations, and
- Establishment of affiliation with peers.

From the above it is clear that developmental tasks of older persons include both physical and social aspects. With this definition of older persons in mind, the next section will focus on the demographic characteristics of older persons.

2.2.2 Demographic characteristics of older persons

The demographic characteristics of older persons include aspects such as: population distribution, gender, race, marital status, socio-economic status and

longevity. In the following section the above-mentioned characteristics will be presented.

2.2.2.1 Population distribution in South Africa

Older persons can be defined as individuals over the age of 65 years. According to this definition **5.5%** of the **South African** population can be described as older persons. In the **Western Cape 5.2%** of the population are older persons. The majority of these older persons are females **(60%). Kwazulu-Natal and the Eastern Cape**, especially in the rural areas, have the highest concentration of older persons (Census 2001: http://www.statssa.gov.za/census01).

2.2.2.2 Gender

Older persons form a demographically heterogeneous group. In general women live longer than men and therefore seem to outnumber men in this age group. The ratio is roughly **one male for every two or three females.** Due to this phenomenon, women experience greater challenges in old age. More women are widowed and economically disadvantaged compared to the number of males experiencing these challenges. Older women also tend to experience higher levels of morbidity and functional limitations (Census 2001:http://www.statssa.gov.za/census01**;** Dunkle & Norgard, 1995:143).

2.2.2.3 Race

The majority of older persons in South Africa are **Black (68,9%).** The second largest group are **White (21.5%)** and the third group are seven point two percent **(7,2%) Coloured** older persons in South Africa. The smallest proportion **(2.3%)** of older persons in South Africa is **Indian or Asian** (Census2001: http://www.statssa.gov.za/census01).

2.2.2.4 Marital status

According to Dunkle and Norgard (1995:143) most men remain married until they die. However, the difference between men and women with regard to widowhood increases with age. Almost **half of women are widowed** in old age compared to men. This is mostly due to the shorter life expectancy of men. Men are also more likely to re-marry after the death of a spouse. Due to the fact that more women are

widowed in old age, they are at a greater risk of negative experiences related to widowhood like: depression, mortality, economic hardship, and unexpected changes in their social life (Dunkle & Norgard, 1995:143-144).

2.2.2.5 Socio-economic status

The economic welfare of older persons is affected by age, gender, race, ethnicity, and marital status. **Older, black, women tend to be the poorest** regardless of marital status (Dunkle & Norgard, 1995:144).

2.2.2.6 Longevity

Kail and Cavanaugh (2000:488-490) are of the opinion that the number of older persons in industrialised countries is rapidly increasing mainly due to better health care and the reduction of women's morality during childbirth. The increase of older persons intensifies the pressure on the social service systems. Older persons constitute a diverse group of people – differing in gender, education and ethnicity. The term longevity describes the **number of years a person can expect to live.** Longevity is determined by both genetic and environmental factors. Longevity largely depends on a person's genetics. One of the best predictors of long life is whether or not one's parents lived a long life or not. Sometimes chronic diseases are hereditary and may decrease life expectancy. On the other hand, environmental factors also play a role in longevity. These factors are especially relevant to poor people who tend to be exposed to more negative influences, for example: diseases, poor sanitation, and pollution (Kail & Cavanaugh, 2000:491).

These demographic characteristics paint a clearer picture regarding older persons in South Africa. From the above we can conclude that older persons are mostly poor, widowed, black females living in the Eastern Cape or Kwa-Zulu Natal.

2.2.3 Physical characteristics

In this section the following physical characteristics of older persons will be briefly outlined and discussed: muscles and skeleton; the brain; cardiovascular and respiratory systems; other internal organs; sensory changes (eyesight, hearing, other senses); health (illnesses, sleep, nutrition); mental health (depression, dementia);

and sexuality. In order to gain a better understanding of older persons life-stage, it is important to gain a better understanding regarding their physical characteristics.

2.2.3.1 Muscles and skeleton

As a person grows older, one of the changes that takes place is a **decrease in muscle size, tone, flexibility, strength, elasticity and endurance**. This results in an increase risk for older persons of falling and getting hurt (Poindexter, 1999: 212). As Raubenheimer et al. (1998: 594) point out, it has been established that regular exercises can largely prevent the deterioration of muscles. Exercise also adds to a person's general life quality by creating a feeling of general well-being.

Women experience rapid bone loss after menopause and are therefore at a greater risk of developing **osteoporosis** (Belsky, 1997:79). Osteoporosis is an age-related skeletal disorder in which the bones become porous, brittle, and fragile. Perlmutter and Hall, (1992:88-89) observe that bone fractures, like **hip fractures**, tend to be very common in older persons due to the bone being more brittle. Exercise is one of the best preventative factors of osteoporosis as it increases the bone density considerably (Raubenheimer et al., 1998: 594).

2.2.3.2 The brain

A significant change occurs in the brain. There is a **10%** decrease in the weight of the brain (Poindexter, 1999: 212). Structural changes also occur in the neurons – neurofibrallary tangles, dendritic changes, and neuritic plaques. These changes weaken the neurons' ability to send out information. This results in a **decline of reaction time and reflexes**. These changes are a normal part of aging, but when they occur at an accelerated rate, they could cause many problems and have been associated with **Alzheimer's** or related diseases (Kail & Cavanaugh, 2000:496; Poindexter, 1999: 212).

2.2.3.3 Cardiovascular and respiratory systems

The normative changes that occur include a slow deterioration of the heart tissue and a loss of elasticity in the aorta. Arteries begin to harden and shrink, blood circulation is poor and the blood pressure declines (Poindexter, 1999: 213; Raubenheimer et al., 1998: 595).

The incidence of **cardiovascular diseases** increase with age, although, death rates from these diseases have decreased due to changes in life-style (Kail & Cavanaugh, 2000:497-498). Normative changes that add to these diseases begin in earlier life and occur regardless of life-style. The most well-known cardiovascular diseases are **heart attacks, irregular heartbeat, strokes and hypertension** (Kail & Cavanaugh, 2000:497-498).

Raubenheimer et al., (1998: 595) explain that one of the ways to improve cardiovascular health of older persons is to encourage **regular exercise** that can increase fitness levels and prevent cardiovascular disease.

Changes also occur in the respiratory system (Raubenheimer et al., 1998: 595-596). **Shortness of breath** is one of the aspects associated with aging. This is due to the weakening of the lung tissue's elasticity that in turn decreases the lungs capacity and the amount of oxygen consumption. Poindexter (1999: 211) explains that **smoking** during earlier years of life often causes diseases like **emphysema, asthma, and lung cancer** in older persons. However, **exercise** can play an important role in improving the lung capacity in older age (Raubenheimer et al., 1998: 595-596).

The brain, cardiovascular and respiratory systems include the most prominent internal organs and systems that undergo changes with aging, however, there are other internal organs and systems that also undergo changes like the bladder, immune system and the kidneys.

2.2.3.4 Other internal organs

Older person's **bladder** capacity decreases by roughly 50%. This results in an increase in the frequency of urinating (Raubenheimer et al., 1998: 596; Poindexter, 1999: 211). Furthermore, the effectiveness of the **immune systems** radically lessens causing older persons to develop illnesses and diseases more easily. A loss of antibodies impairs the body's ability to fight infections as easily as before (Poindexter, 1999: 214; Raubenheimer et al., 1998: 596). There is also a decrease in the functioning of the **kidneys**, affecting the body's ability to dispose of unwanted toxins (Poindexter, 1999: 211).

2.2.3.5 Sensory changes

As physical changes occur in older age, certain sensory changes also occur. Sensory systems tend to become less sensitive to stimulation from the environment with age. This curtails access to knowledge of the world and sometimes hinders the ability to communicate with others (Perlmutter & Hall, 1992:185; Raubenheimer et al., 1998: 596).

Changes in eyesight and hearing are most well-known, but changes in other senses also occur.

- **Eyesight**

During adulthood normal changes in eyesight occur. A decrease in peripheral vision and elasticity of the lens can occur. The pupil's ability to change size and adjust to changes in light and dark diminishes. People also tend to become more **farsighted** as they age. As Poindexter (1999:209) notes, these are however all normal changes that occur. Abnormal changes that may occur can be caused by **cataracts, glaucoma and diabetic retina deterioration** (Poindexter, 1999: 209).

Kail and Cavanaugh (2000:499) further describe that in older persons the lens in the eye becomes thicker, yellowish and less transparent and more sensitive to glare. This results in changes in vision for older persons, as the eye takes longer to adapt to changes in illumination and needs more light to see. According to Raubenheimer et al. (1998: 596) at the age of **70 years**, most individuals will experience **some degree of cataracts**. Most visual problems in older persons can be corrected by surgery, but despite this, half of all blind people are older persons (Raubenheimer et al., 1998: 596).

- **Hearing**

Environmental factors may influence the loss of hearing in old age, e.g. constant exposure to loud noise. Other causes of hearing loss may be **injury, infection** or a **build-up of wax** in the ear (Poindexter, 1999: 209).

One of the conditions most severe in older adults is **presbycusis**. This is a condition where there is a substantial loss in a person's ability to hear high-pitched tones (Kail & Cavanaugh, 2000:499). It may become very difficult for someone with presbycusis to understand speech as consonants and vowels tend to differ much in pitch (Poindexter, 1999: 209).

- **Other senses**

After the age of 70 years there is a significant age **decline in smell** (Kail & Cavanaugh, 2000:499). Older persons are less sensitive to different smells and cannot distinguish between smells as easily as before. This poses a danger, as older persons may not be able to smell smoke or gas right away (Poindexter, 1999: 210).

Poindexter (1999: 210) further notes that with a decrease in the sensitivity of the smell sense, a **decrease in taste** also occurs. For example, older persons cannot judge taste differences as accurately as before, especially saltiness. This could lead to an increase of salt intake that may not be nutritionally healthy for the person

The intensity and sensitivity of the **touch sense decreases**. This could lead to serious problems when older persons cannot detect hot and cold sensations accurately and may become burnt more easily e.g. in the bath (Poindexter, 1999: 210).

As emphasised by Kail and Cavanaugh (2000:499) these sensory changes affect the daily life of older persons. Changes in vision can often be corrected by wearing glasses, as changes in hearing can be diminished by wearing a hearing aid. However, the **combination of these changes** is more serious as it could cause accidents when driving or in and around the home. A safer home environment needs to be created.

2.2.3.6 Health

Another aspect of older persons physical characteristics is their overall health. Health is influenced by illness, sleep and nutrition. In this section aspects regarding illnesses, sleep, and nutrition will be discussed.

- **Illnesses**

Acute illness tends to decreases with age as **chronic illness** tends to **increase**. Illnesses like **heart disease, stroke and cancer** occur frequently in older persons, and lead to roughly **75%** of deaths in older persons. Many other illnesses that cause significant suffering and hardship are also prominent in older persons, for example, **arthritis** (Perlmutter & Hall, 1992:151; Raubenheimer et al., 1998: 596-597).

Dunkle and Norgard (1995:144) point out that older **men** seem to experience more acute illnesses (**coronary heart disease**) compared to more chronic illnesses experienced by **women** (**arthritis and osteoporosis**).

Authors (Kail & Cavanaugh, 2000:500; Perlmutter & Hall, 1992:152) are of the opinion that **life-style factors** influence the risk of chronic disease. They indicate that up to 50% of premature deaths are due to unhealthy life-styles. There is a need for an increase in health promotion in older persons in order to prevent life-style related illnesses.

- **Sleep**

Older persons often experience more problems with sleeping. They often complain of **not falling asleep as easily** and **waking up several times** during the night. They also tend to feel **tired and drowsy during the day**, and many older persons supplement their lack of sleep at night, with a nap during the day. Compared to younger persons, they experience more negative effects due to loss in sleep. These changes have various causes, for example, physical disorders, stress, side effects from medication, the use of caffeine or nicotine (Kail & Cavanaugh, 2000:500; Perlmutter & Hall, 1992:115-116).

- **Nutrition**

As current literature by Kail and Cavanaugh (2000:501) explain, older persons that eat a well-balanced diet seem to be nutritionally healthy. However, if they cannot eat a well-balanced diet they may need to take **vitamin supplements**. The body metabolism does tend to decline with age, but this does not mean that older persons

should eat less. Older persons still need to eat the same amount of proteins and carbohydrates as before, as there are changes in how easily the body extracts the nutrients from these foods. A **vitamin B12** deficiency sometimes occurs in older persons due to an unbalanced diet.

2.2.3.7 Mental health

The health status of older persons does not merely depend on their physical health, but also on their mental health. Raubenheimer et al. (1998:597-599) report that **10%-20%** of older persons suffer from a mental disorder that requires professional help.

There tends to be an alarming proneness to **suicide** in this age group. The reasons for this are not clear, but depression, illness, role changes, or lack of social support seem to play a role (Poindexter, 1999: 214).

Two of the most prominent mental illnesses in older persons are **depression** and **dementia**.

- **Depression**

One of the greatest myths concerning older persons is that they are all depressed or demented. This often causes older persons to become neglected and remain untreated (Kail & Cavanaugh, 2000:514). Among older persons, **depression is the most common mental disorder**. Some of the symptoms of depression include: intense sadness, decrease in interest and activity, significant weight loss, too much or to little sleep, less positive self-image, excessive or inappropriate guilt feelings, lack of concentration or indecisiveness, and recurrent thoughts of death. Raubenheimer et al. (1998:597-599) report that one of the conclusions drawn from a study that was conducted in South Africa among older persons in townships was that the differences in the prevalence of depression among older persons could possibly be associated with stress caused by poor socio-economic conditions.

The causes of depression can either be biological/ physiological or psychosocial factors. **Biological/physiological factors** that cause depression are imbalances in specific neurotransmitters. Due to the decline of neurotransmitter levels in older

persons, it is often believed that depression in older persons is a biochemical problem that can be rectified by medication. **Psychosocial factors** that lead to depression differ, but are often associated with loss, for example, the loss of a spouse. Depression is related to how the person interprets this loss and not necessarily the loss itself, and can be treated by means of therapy (Kail & Cavanaugh, 2000:515).

- **Dementia**

This includes several mental disorders that are caused by the degeneration of the brain. These disorders are usually found in older persons. The best-known example of dementia that occurs in older persons is **Alzheimer's** disease. Memory loss is the most outstanding symptom of Alzheimer's disease and has a serious and widespread impact on the functioning of the individual (Raubenheimer et al., 1998:597-599).

2.2.3.8 Sexuality

The final physical characteristic of older persons to be outlined in this section is sexuality. In both male and female reproductive systems, the **manufacturing of hormones is diminished** in old age. **Sexual arousal may be slowed** but it does not come to a complete standstill. Many myths regarding sex in old age exist. One of these myths incorrectly assumes that older persons are sexually inactive. Contrary to this belief, older persons have sexual needs, capacity and interests even in old age. There are however, some age-related sexually inhibiting factors like, both physical and emotional, that may lead to a decline in sexual activity e.g. illness, decreased physical attraction, over familiarity, and the loss of a marriage partner (Perlmutter & Hall, 1992:104; Poindexter, 1999: 214; Raubenheimer et al., 1998:597-599).

The above outline of the physical characteristics of older persons adds to a better understanding regarding the physical development and functioning of older persons during this life-stage. Next, the social characteristics of older persons will be discussed.

2.2.4 Social characteristics

Despite what is believed by some, older persons still enjoy the social context of relationships with family and friends. Their social context continues to determine their role responsibilities and their life satisfaction. Older persons continue to have meaningful social contacts, and are not necessarily socially isolated (Raubenheimer et al., 1998:631).

In this section the following aspects will be discussed: religion; retirement; relationships with friends and family (friends, siblings, marriage, divorce, widowhood, remarriage, children, grandchildren); social issues (frail older persons; old-age homes; neglect and abuse); and death. An overview of older persons' social characteristics will add to a clearer understanding of this life-stage.

2.2.4.1 Religion

Several authors (Kail & Cavanaugh, 2000:538-539; Perlmutter & Hall, 1992:423) point out that **religion or spiritual factors** play a very important role in older persons' lives in terms of support. Older persons tend to rather use their religion or faith in dealing with difficulties instead of other support systems e.g. friends or family. The importance of spiritual support in times of stress for older persons remains equally important regardless of cultural differences.

2.2.4.2 Retirement

Retirement is a complex process of withdrawing from full-time participation in an occupation. However, it is often not a clear-cut event, but rather a **gradual process**. Retirement also means different things to different people in different cultures. The decision to retire is often complex and influenced by many factors like financial or health factors. Men and women are also influenced by different factors. Not all people choose to retire. Some self-employed people are not affected by compulsory retirement. Unlike many people believe, the majority of people choose to retire voluntarily and not because they have to (Kail & Cavanaugh, 2000:540-541; Perlmutter & Hall, 1992:405; Raubenheimer et al., 1998:618).

Retirement coincides with the experience of **loss**, as there is a decline in the rewards work offer like income, status, power, and social identity. On the other

hand, it offers people the freedom of choice in terms of where they would like to live and how they spend their time. Retirement is nevertheless a very important life transition to which older persons must adjust. Older persons' adjustment to retirement is influenced by **various factors**: financial security; voluntary retirement and health; attitude of others; attitude towards work; and the preparation for retirement. Older persons who have support networks, financial security, and health tend to feel positively about retirement. **High personal competence** has also been associated with retirement, possibly due to their ability to optimise their level of environmental press (Kail & Cavanaugh, 2000:542-543; Raubenheimer et al., 1998:618-619).

As mentioned above, the process of retirement is a gradual one with varying phases, but it is very individualistic in nature and cannot be linked to a specific age. Not everyone advance through all the stages, or through all the stages in the same sequence. The following **phases** have been identified by Raubenheimer et al. (1998:619-620): pre-retirement phase, honeymoon phase, disenchantment phase, reorientation phase, stability phase, and termination phase.

Retirement is always influenced by the interpersonal relationships that exist in the person's life. Supportive social relationships improve older persons adjustment to retirement. One's relationship with one's spouse and with one's community impacts significantly on one's adjustment to retirement (Kail & Cavanaugh, 2000:544).

Older persons that are **married** tend to be more satisfied with retirement. However, many stressors arise with retirement that impact on the marriage relationship. Retirement influences interactions and daily routines. For example, a new division of household chores could lead to new stressors in the relationship. One of the changes that married couples find difficulty adjusting to is the fact that both spouses are constantly around. It takes time for both partners to adjust to this sudden change (Kail & Cavanaugh, 2000:544-545; Raubenheimer et al., 1998:621).

Kail and Cavanaugh (2000:545) describe how the **social environment** plays an important role in older persons' adjustment to retirement. The social environment provides older persons with the opportunity to maintain old ties and form new ones.

Many organisations are dedicated to providing older persons with such opportunities, for example, senior centres and clubs. Older persons also maintain community ties through voluntarism. Helping others in various ways is an important aspect of remaining connected to the community.

2.2.4.3 Relationships with friends and family

One of the most important social characteristics of older persons are relationships with friends and family. This category can be divided into the following sub-sections: friends, siblings, marriage, divorce, widowhood, remarriage, children, and grandchildren.

- **Friends**

To many older persons, the most significant phenomenon in life is their relationships with friends and family. Several authors (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al., 1998:642) clarify this statement by explaining that relationships keep older persons connected to those around them. Often by the time a person reaches late life, he or she has certain friends they have known many years. These **friendships** are often **more significant** than relationships with younger family members because friends fulfil the role of confidant and act as a source of support in a way that younger family members cannot.

The qualities of these friendships above the quantity are very important. Older persons need at least one close friend in whom they can confide and count on for support throughout the adjustments in this life-stage. A number of older persons claim that they enjoy the time spent with friends more than time spent with family. **Women seem to have more friends than men do**, and especially find comfort in these friendship networks when their spouses pass away. Older adults generally have fewer friends. They tend to prefer **long-term friendships** instead of initiating new friendships. This is due to the reality that friends that have known each other a long time can share their life experiences of the past unlike new friends could (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al., 1998:642).

- **Siblings**

According to Kail and Cavanaugh (2000:548) older persons also maintain relationships with their siblings. These vary from **intimate to hostile**. However, ties between **sisters** seem to remain the strongest in later life.

- **Marriage**

Older persons who have been married for several decades tend to describe their entire marriage as happy and experience a higher degree of marital satisfaction. Older couples seem to engage in **less marital conflict** and obtain more pleasure from marriage. They seem to have learnt to avoid conflict and to enjoy the same things (Kail & Cavanaugh, 2000:549; Perlmutter & Hall, 1992:321-322).

The main changes in the marriage relationship for older persons, is retirement from work and the shift from emphasis on the children. The focus in the relationship is on **shared life experiences** that seem to make couples more compatible and more satisfied with their relationship. Their daily activities change from work to being in each other's company and shared decision-making. The communication between spouses tends to improve considerably. Older persons who are **married** tend to be physically and psychologically more healthy and appear to **live longer** than their unmarried counterparts. It is possibly due to spouses providing each other with both physical and emotional support during times of illness or difficulties (Raubenheimer et al., 1998:631-636).

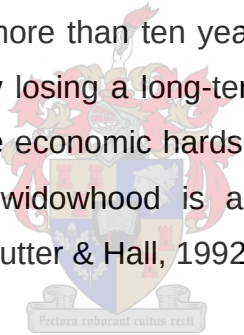
Often older couples have to deal with one of the partners becoming very ill. Illness comes without warning and changes the day-to-day life drastically as the other partner then takes on the role of carer. These changes cause new challenges and stress in the relationship. The caregiver may experience the relationship as less satisfying. Some caregivers report a loss of intimacy and companionship due to this new role. However, the higher the quality of the marriage is perceived, the less stresses are reported (Kail & Cavanaugh, 2000:549-550).

- **Divorce**

Statistics show that older persons **do not seem to get divorced as often** as younger adults do. However, divorce during this life-stage is a shattering experience as the deep-rooted life patterns, habits and self-esteem are acutely disrupted. In South Africa the percentage of older persons who are divorced is relatively low. Older persons who are divorced seem to have more physical and psychological problems and less social and life satisfaction (Raubenheimer et al., 1998:633).

- **Widowhood**

According to Raubenheimer et al. (1998:634) the death of a spouse is the most traumatic event some older persons will ever experience. Although this could happen at any stage in life, it most often occurs in late adulthood. Losing an intimate relationship is characterised by intense grief and long periods of readjustment. **Women have a longer life expectancy than men**, and therefore the average wife can expect to live more than ten years as a widow. Losing a spouse has a greater impact than merely losing a long-term companion. Often this loss is accompanied by other factors like economic hardship, social isolation and decrease in status. For many women, widowhood is accompanied by poverty (Kail & Cavanaugh, 2000:552-553; Perlmutter & Hall, 1992:329-330).



Both widows and widowers are physically and psychologically more prone to problems after the loss of a spouse. Men however, are inclined to have a greater risk of dying sooner after their spouses have passed away. A possible explanation for this could be that a **wife usually is a man's only close friend**. Men also tend to feel unequipped to deal with the daily tasks like housekeeping (Kail & Cavanaugh, 2000:552-553; Raubenheimer et al., 1998:634).

- **Remarriage**

There has been an **increasing tendency** among older persons to remarry after the death of a spouse or after divorce. The main reasons seem to centre on the need for companionship and financial security. Remarriage decreases the levels of emotional distress, and helps older persons cope better with the loss of a spouse**. Older men are more likely to remarry than women**. Many older women enjoy

their newly discovered independence and are unwilling to sacrifice it, however, marriage is still more preferable to some than being alone (Kail & Cavanaugh, 2000:552-553; Raubenheimer et al., 1998:635).

- **Children**

Many myths regarding the different ways in which children treat their elderly parents exist in South Africa. It is wrongly assumed that Western-oriented families are unwilling to care for their older persons and leave them isolated and alone. On the other hand, it is also mistakenly assumed that African families are always willing to care for their elderly. Both Western-oriented and African families cannot always care for older persons even if they want to. Often the family needs assistance in caring for their elderly parents. The important issue at hand is the extent to which the family is willing to be involved (Raubenheimer et al., 1998:636).

The nature of the relationship between children and their elderly parents has several aspects: **mutual support, regular contact, and mutual affection**. All three these aspects are not always equal in the relationship, and differences among cultures do occur (Raubenheimer et al., 1998:637).

- **Grandchildren**

The media has stereotyped grandparents into fun-loving, grey-haired old people that spoil their grandchildren. Contrary to this idea, the role of grandparents is somewhat undefined in modern society. Different grandparenting styles have been listed by several authors (Perlmutter & Hall, 1992:367-368; Raubenheimer et al., 1998:638):

- **The distant style:** There is both a geographic an emotional distant between the grandparents and the grandchildren. The grandparents are merely a symbolic figure.
- **The companionship style:** There is a large amount of interaction between grandparents and their grandchildren. They spent a lot of time together and fulfil a companionship role. They do not interfere regarding how their children choose to raise their grandchildren.
- **The involved style:** As with the companionship style, the grandparents spend a lot of time with their grandchildren. However, they are not merely

companions to the children but also fulfil a parent role. They are involved in raising the children and sometimes even substitute the parents who are unmarried, divorce or employed outside the home.

Among Black South Africans grandparents tend to increasingly play the role of parent. Especially in the rural communities and townships. Due to the increase in **HIV/AIDS** a new phenomenon is arising, the skip-generation, where parents die due to AIDS and grandchildren are left with their grandparents who now have to bear the full responsibility of raising their grandchildren (Raubenheimer et al., 1998:642).

2.2.4.4 Social issues

Social characteristics of older persons cannot be discussed without addressing the social issues that accompany these characteristics. These include: frail older persons; old-age homes; and neglect and abuse of older persons. In this section these issues will be discussed.

- **Frail older persons**

Kail and Cavanaugh (2000:555) remind us that not all older persons are healthy, cognitively competent, financially secure, and have good family relationships. Some are **very ill**, have **physical disabilities** and sometimes **cognitive or psychological disorders**. Often older persons become frail to the extent that they cannot perform one or more basic self-care tasks like eating, bathing, walking, or dressing. Other activities of daily living require intellectual competence and planning like shopping, paying bills, telephone calls, and taking medication. Frailty becomes more likely with an increase in age, especially during the last years of life.

- **Old-age Homes**

In 1998, there were **801** old-age homes in South Africa that served more than 53 000 older persons. For any older person, moving to an Old-age Home is very traumatic experience. Sometimes older persons feel as if they have been forced to do something against their will. They **feel isolated, alone and rejected**. They have to often leave behind treasured belongings and friendships. The lack of privacy and individual attention lead some older persons to develop a condition known as

institutionalism. They demonstrate automaton-like behaviour and have an overall sense of apathy. Even though their physical needs are being met, they often feel emotionally rejected and worthless. In order to help older persons adjust to this change, they need a lot of **emotional support** from friends and family who should try and visit as regularly as possible (Perlmutter & Hall, 1992:455; Raubenheimer et al., 1998:652).

- **Neglect and abuse**

Recently there has been an increased awareness of neglect and abuse of older persons (Kail & Cavanaugh, 2000:560-561). Eckley (1999:10) identifies that **15-30%** of all older persons in South Africa are **at high risk of abuse**. Usually victims of abuse are between the ages of 70-80 years. There are more female victims than males. Older persons who require permanent supervision or care are at greater risks of suffering abuse. The newly compiled Older Persons Bill recognises the need for legislation regarding this occurrence in South Africa.

2.2.4.5 Death

The last and most difficult task for older person in their life-stage is to accept that they will die soon. In society today, death has become increasingly removed from everyday life. When people become ill they tend to be isolated from society. With the increase in technology and improved medication, the death rate has declined considerably. There tends to be a **denial of death** in society today, and the topic is rarely discussed with older persons. There has been an increased desensitisation to death due to the increase of violence on television (Raubenheimer et al., 1998:659).

Older persons are less apprehensive about death. People who are more religiously inclined tend to be **less afraid** of death than those who are less religious. Death has acquired a negative connotation and is feared by most people due to the following fears: fear of physical suffering; fear of isolation and loneliness; fear of non-being; fear of cowardice and humiliation; fear of failing to achieve important goals; fear of the impact of death on those who outlive you; fear of punishment or of the unknown; fear of the death of others (Raubenheimer et al., 1998:660).

Elizabeth Kübler-Ross was one of the researchers that made a great contribution in understanding the needs of dying individuals. She identified different **stages** in the **dying process**: denial, anger, bargaining, depression and acceptance. Everyone does not experience all the stages or all in the same sequence. She also emphasised the importance of communicating to dying individuals about their feelings and experience (Raubenheimer et al., 1998:661-662).

In this section the social characteristics and issues regarding the older persons life-stage have been outlined and discussed in order to gain a better understanding of this life-stage. In the next part of the chapter the significance of visual functioning in this life-stage will be outlined.

2.3 SIGNIFICANCE OF VISUAL FUNCTIONING IN THIS LIFE-STAGE

In this section the significance of visual functioning for older persons will be discussed by utilising **Corn's model of visual functioning** (1983:373-376).

Corn (1983:373-376) developed a theoretical model for individuals with low vision. According to this model visual functioning is determined by multiple factors: **visual abilities, available resources and past experiences**. Visual functioning is highly individualistic in nature. Corn's Model of Visual Functioning (1983:374) lists five components under each factor that plays a role in visual functioning; they are summarised in table 2.1.

Table 2.1 Corn's model of visual functioning

1. Visual Abilities	2. Stored and Available Individuality	3. Environmental cues
Acuity	Cognition	Colour
Visual Fields	Sensory Developmental Integration	Contrast
Motility	Perception	Time
Brain Functions	Psychological make-up	Space
Light & Colour Reception	Physical make-up	Illumination

Firstly, Corn's Model of visual functioning (1983:373-376) is divided into three areas: visual abilities; stored and available individuality; and environmental cues. Each of these three areas includes five aspects. Visual abilities include: acuity, visual fields,

motility, brain functions, and light and colour reception. The second area, stored and available individuality, includes: cognition; sensory developmental integration; perception; psychological make-up; and physical make-up. The final area, environmental cues, includes aspects like: colour; contrast time; space; and illumination.

In order to maintain or maximise visual functioning, each component (minimal amount) of **all three factors must be present** at any given moment. For example, there must be one of the aspects of visual ability (e.g. light and colour reception), one of the aspects of stored and available individuality (e.g. perception) and one of the aspects of environmental cues (e.g. colour). An interaction of these different components and factors result in visual functioning. Clearly visual functioning is very individualistic and different components may need to be enhanced for different older persons in order to maximise their visual functioning (Corn, 1983: 373-376).

Rogers, Menchetti and Lai (2000:338) suggest that older persons require visual functioning in order to accomplish tasks in five skill domains: **Independent activities of daily living (IADL); Activities of daily living (ADL); text access, mobility and cooking**. These domains included the tasks as outlined in table 2.2.

Table 2.2 Tasks in five skill domains

Independent activities of daily living (IADL) • Accessing locks and keys • Hearing normal speech • Managing locks and keys • Entering and exiting doors • Placing and receiving phone calls • Identifying and organising money • Using clocks and watches	***Mobility*** • Travelling safely in the neighbourhood • Identifying signs and house numbers • Travelling to and from stores • Walking up and down steps • Riding a distance • Walking on uneven terrain • Walking holding a package • Walking up a series of steps
Activities of daily living (ADL) • Using a bath and shower • Toileting • Changing posture • Lifting, bending, reaching • Eating tasks • Travelling safely around home • Walking on a flat surface	***Cooking*** • Cooking • Pouring • Cutting and chopping • Spreading • Drinking from a glass or cup • Serving and scooping • Cleaning up the kitchen
Text access • Reading or accessing personal letters and handwritten notes • Reading or accessing printed materials, such as books, magasines, the Bible, and newspapers	

From table 2.2 it is clear that older persons require visual functioning in order to perform numerous tasks. For example, older persons require visual functioning in order to go to a shop, read the label on a tin, purchase the food by identifying money, travel home, prepare the food, and eat it, which is vital for anyone's survival.

According to the National Eye Health Education Program, (1997) older persons require visual functioning in order to perform **daily activities** like: the performance of physical tasks; recognition of important features in the environment; and continuous participation in social life. Older persons require vision to perform **physical tasks** like reading, writing, household, chores, knitting, sewing, gardening, shopping, cooking, and travelling. In order to **recognise important features** in the environment like people (facial expressions), places, signs, and objects, older persons require visual competency. In order to maintain an active **social life** like participating in sport, watching movies, visiting friends older person require visual competency (National Eye Health Education Program, 1997).

As summarised above, visual functioning is very significant in older persons' lives. Without it, they would experience difficulty in performing many of the tasks outlined above. Visual functioning is therefore a significant part of life in this life-stage.

2.4 CONCLUSION

This chapter explored aspects concerning the life-stage of older persons. First, the term older person was defined and the demographic characteristics, including: population distribution, gender, race, marital status, socio-economic status and longevity, of older persons in South Africa outlined.

The chapter then examined the physical and social characteristics of older persons. The physical characteristics outlined in the chapter included: muscles and skeleton; the brain; cardiovascular and respiratory systems; other internal organs; sensory changes (eyesight, hearing, other senses); health (illnesses, sleep, nutrition); mental health (depression, dementia); and sexuality. The social characteristics that were described were: religion; retirement; relationships with friends and family (friends, siblings, marriage, divorce, widowhood, remarriage, children, grandchildren); social issues (frail older persons; old-age homes; neglect and abuse); and death.

Finally, Corn's model of visual functioning was utilised in order to outline the significance of visual functioning in this life-stage. In the following chapter the socio-

emotional experience of older persons affected by visual impairment will be outlined from an ecological perspective.

CHAPTER 3

THE SOCIO-EMOTIONAL EXPERIENCE OF OLDER PERSONS WITH VISUAL IMPAIRMENT FROM AN ECOLOGICAL PERSPECTIVE

3.1 INTRODUCTION

Visual impairment impacts on all aspects of older persons lives. In order to gain a clearer understanding of how older persons with visual impairment function from day to day, it is necessary to outline both their social and emotional experiences as related to their visual impairment. In the previous chapter older persons' life-stage was discussed and the significance of visual impairment for older persons outlined. This chapter will aim to meet the second objective of the study, which is to describe the socio-emotional experience of older persons with visual impairments from an ecological perspective. Firstly, an introduction to the ecological perspective as practice perspective will be given. Then the ecological perspective will be utilised to outline the socio-emotional experience of older persons with visual impairments.

3.2 THE ECOLOGICAL PERSPECTIVE AS PRACTICE FRAMEWORK

This section aims to give an introduction to the ecological perspective as practice framework in social work. It will furthermore discuss the adaptation between person-and-environment. Then the intervention process in social work (from an ecological perspective) will be outlined by focussing on the areas that cause stress. Next an explanation follows of the social work roles that can be utilised during intervention in these areas:

- Life transitions (enabler, teacher, facilitator)
- Environmental problems and needs (mediator, advocate, organiser).
- Maladaptive interpersonal processes of relationships and communications.

Finally this section will give an overview of Welch's Concentric Model that can be applied when identifying the socio-emotional experience of older persons with visual impairment.

3.2.1 Introduction to the ecological perspective

The ecological metaphor was first used in science for plants and later for animals. In 1920 the metaphor was applied to human communities and since 1970 ecology is used to describe and understand relationships between individuals and their environments.

The study of ecology, according to Germain and Gitterman (1980:28), seeks to **understand the reciprocal relations between organisms and environments**. Several authors (Compton & Galaway, 1984; Garvin & Seabury, 1984; Germain & Gitterman, 1986; Welch, 1987) note that ecology, applied as metaphor, appears to be a more useful metaphor than the older medical-disease metaphor that was inclined to view human beings and environment as reasonably separate entities. As social work is committed to empowering older persons and to promoting more benevolent environments, this metaphor seems to be more useful as the ecological perspective provides an adaptive, evolutionary view of older persons in constant interchange with all aspects of their environment (Germain & Gitterman, 1980:28).

3.2.2 Adaptation between person-and-environment

Payne (1997:145) summarises that the ecological perspective views individuals as constantly adapting in an exchange with many different aspects of their environment. Both the individual and the environment experience change, as one gives and the other takes, or visa versa. **Reciprocal adaptation** occurs when individuals develop through change and the environment supports this change.

For example, older persons that gradually experience loss of vision and cannot read the small print in books so easily acquire reading glasses. On the other hand, publishers note older persons' difficulty in reading small writing and instead publish large print books that are easier for older persons with visual impairments to read to encourage them to continue buying books.

However, **social problems** (such as poverty, discrimination or stigma) pollute the social environment, which reduces the likelihood of reciprocal adaptation. Living systems (individuals and groups) strive to maintain a good fit with their environment.

In order to establish a goodness-of-fit with the environment, older persons need appropriate resources (Payne, 1997: 145).

As transactions between people and environments are very complex, disruptions in the normal adaptive balance or goodness-of-fit often occur. These disruptions represent the **stress** caused by inconsistencies between needs and capacities vs. environmental qualities (Payne, 1997: 145).

As Germain and Gitterman (1980:28-30) suggest, **stress** arises in three interconnected areas of living:

- **Life transitions** (developmental and status changes, crisis events);
- **Environmental pressures** (unresponsive organisations, social networks or physical structures); and
- **Maladaptive interpersonal processes** of relationships and communications.

From the above it can be noted that stress is a psychosocial state resulting from a discrepancy between needs and abilities of individuals on the one hand, and environment characteristics on the other.

3.2.3 The purpose of social work intervention

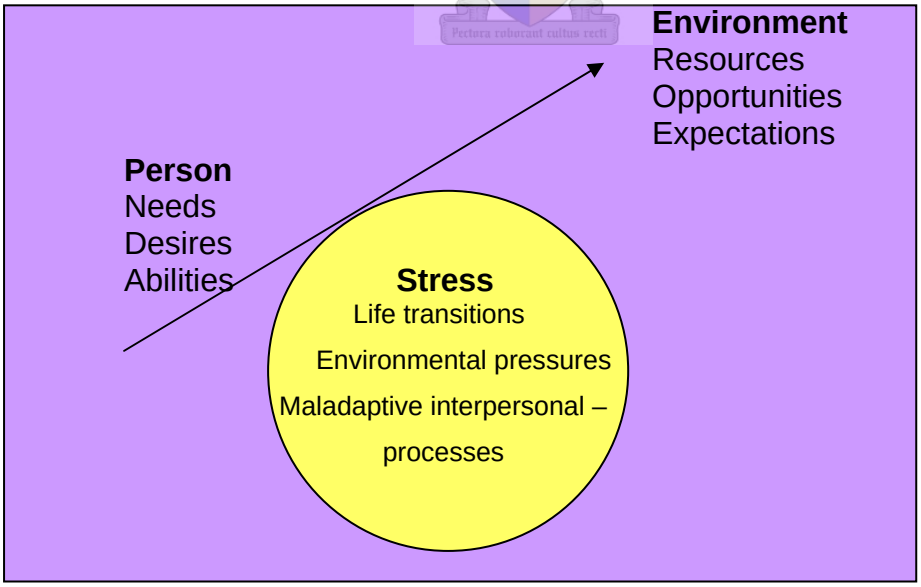


Figure 3.1 Goodness-of-fit between person and environment

Figure 3.1 illustrates the interaction that takes place between person-and-environment. On the one side is the person with his/her individual needs, desires

and abilities. On the other side is the environment with its resources, opportunities and expectations. When there is an imbalance between these two systems (person and environment), stress occurs. In several areas – life transitions, environmental pressures, and maladaptive interpersonal processes, stress arises. These transactional problems can create serious barriers in the helping process that can negatively influence the fit between the individual and the environment.

According to the ecological perspective the **purpose of social work** is therefore to enhance adaptive capacities of individuals and groups (older persons), and to manipulate environments so that transactions will encourage growth and development. Features of the ecological perspective are based on this conceptualisation of the purpose of social work (Germain & Gitterman, 1980:28-30)

The **perception** of individual's needs or problems largely determines what action will be taken. When needs or problems are situated on the border between person and environment, then intervention aims to address the reciprocal processes between person and environment. The purpose of intervention will be to enhance adaptive capacity and increased environmental responsiveness (Germain & Gitterman, 1980:28-30).

3.2.4 The intervention process

The next section will discuss the intervention process from an ecological perspective, by outlining the three areas in which stress arises and the social work roles that can be utilised during intervention in these areas:

- Life transitions (enabler, teacher, facilitator)
- Environmental problems and needs (mediator, advocate, organiser).
- Maladaptive interpersonal processes of relationships and communications.

Germain and Gitterman (1980:28-30) explain that the ecological perspective consists of three phases: the initial, ongoing and ending phases. During the **initial phase**, the social worker prepares to enter the client's life by considering the objective and subjective possibilities of the need/problem. Exploration and contracting skills are used in the first session to formulate a mutual agreement with the client regarding

the nature of the problem and objectives. Next, they focus on and plan the tasks involving the client's problems regarding life transitions, environmental issues, and maladaptive interpersonal processes. During the **ongoing phase**, professional roles such as enabler, teacher and facilitator are utilized for several interventions such as strengthening the client's motivation, helping the client learn problem-solving skills and mobilising environmental supports. Finally, during the **ending phase**, the social worker prepares for and executes the termination process (Germain & Gitterman, 1980:28-30; Payne, 1997: 148).

As summarised by Payne (1997: 145-147), during the **ongoing phase** of the ecological perspective, the intervention process focuses on change in one or more of the three areas of living where stresses arise:

- **Life transitions** (developmental changes, changes in status and role, restructuring of life space);
- **Environmental pressures** (unequal opportunities, harsh and unresponsive organisations); and
- **Interpersonal processes** (for example, exploitation, inconsistent expectations).

These will now be discussed in more detail.

3.2.4.1 Life transitions

According to Germain and Gitterman (1980:130-131) **developmental stages** across the life cycle arise from biological changes interacting with psychological, social and cultural forces, and physical settings. In each stage there are specific **demands** that need to be met and these can generate **stress**. If a developmental stage is not passed through successfully, difficulties may be experienced at a following stage due to remaining distrust, shame, guilt, inferiority, and identity diffusion. Both families and groups may be subjected to stress in completing one stage and meeting the challenges of a new stage. Where a family's or group's tasks at one stage are not successfully met, unmet needs are carried over to the next stage, and these increase the adaptive demands on all members of the family or group (Germain & Gitterman, 1980:130-131).

Status-role demands can also be stressful. The definitions of statuses and roles as assigned by society are changing at a rapid pace. This results in individuals experiencing uncertainties regarding expectations and perceptions. Individuals with too many statuses find that these conflict and compete for their time and energy. Those that have few statuses may experience unsatisfactory stimulation and purpose. The way in which status-role demands and expectations are perceived, and the amount of stress that goes with it, are influenced by individual characteristics like perception, motivation, and adaptive patterns. Sometimes society devalues and stigmatises certain statuses that lead to an additional adaptive burden for the individuals bearing the status (Germain & Gitterman, 1980:130-131).

Furthermore, **transitional changes** also lead to an increase in stress as these may coincide with developmental changes. Transitions may come too early or too late in the life cycle and increase the likelihood of stress, for example as in adolescent pregnancy or as with grandparents assuming the parenting function (Germain & Gitterman, 1980:130-131).

Lastly, **crises events** also lead to stress. Germain and Gitterman (1980:130-131) identify crises events as sudden changes characterised by the immediacy and enormity of coping tasks. These are often severe losses that cannot be met by the usual adaptive patterns a person has. When a crisis occurs, individuals are likely to use **defense mechanisms** like denial, projection, and regression to fend off the grief and anxiety they feel. These defense mechanisms are adaptive initially as they help the individual to continue functioning, however, they can prolong stress if they carry on too long and interfere with effective coping (Germain & Gitterman, 1980:130-131).

As Germain and Gitterman (1980:99-102) describe, the **role of the social worker** is to help individuals who experiencing stresses arising from life transitions, to meet the specific life tasks (culturally appropriate) that are associated with developmental stages, status and role demands, and crisis events.

These authors (Germain & Gitterman, 1980:130-131) further note that the **environment** act as a critical force in life transitions. For example, the development of adaptive skills necessitates sufficient preparation and training in culturally

acceptable problem-solving skills by society's training institutions like families and schools. For adaptation to transpire, motivation is required. The environment provides the incentives for motivation, and rewards or punishes coping behaviour (Germain & Gitterman, 1980:130-131).

Therefore, the function of the social worker is to **empower** older persons to move through stressful life transitions in such a way that their adaptive capacities are supported or strengthened, and the environment's responsiveness to coping needs is increased. In order to fulfill this function the social worker utilises three roles (Payne, 1997:148):

- **Enabler** (for example, strengthening the client's motivation, validating and supporting the client, helping to manage feelings);
- **Teacher** (like helping clients learn problem-solving skills, clarifying perceptions, offering appropriate information, modeling behaviour); and
- **Facilitator** (such as maintaining, clients' freedom of action from unreasonable constraints, defining the task, mobilising environmental supports).

In the following section these roles will be discussed in more detail.

(a) Role of enabler

The New Social Work Dictionary (1995: 21, 24) defines the enabler role as:

> *"ROLE in SOCIAL WORK where tasks are carried out with the purpose of encouraging or facilitating self-sufficient action of CLIENT SYSTEMS which will promote the INTERACTIONS between individual and environment."* (The New Social Work Dictionary, 1995:21).

The social worker utilises the enabler role to carry out the task of **promoting** and **sustaining** or **strengthening** individual's motivation to deal with stress associated with life transitions (Germain & Gitterman, 1980:130-131).

The enabler role utilises the following **skills** (Germain & Gitterman, 1980:130-131):

- Eliciting, identifying, and managing feelings;
- Responding to signals of distress;

- Providing legitimate support;
- Identifying transactional patters;
- Legitimising concerns;
- Validating strengths;
- Conveying hope;
- Reducing ambivalence and resistance;
- Providing rewards for coping efforts;
- Partialising problems; and
- Maintaining focus on the work.

All these skills require the active participation of the client.

Potgieter (1998: 169) explains that the enabler role aims to help individuals discover their **own strengths** and **resources** to make the needed changes and reach their goals. Garvin and Seabury (1997:314) are of the opinion that the principle of **maximising client involvement** is central to client empowerment. The emphasis is solely on the client – his/her abilities, involvement, strengths, and efforts (Potgieter, 1998: 169). The helper only plays a supporting and empowering role. The client's concern or unease utilised to release his/her potential and provide the drive to sustain the change effort (Zastrow, 2004:77). The enabler only provides the structure to keep the change effort in the right direction. The enabler aims to empower the client i.e. help the clients to help themselves (Potgieter, 1998: 169). The enabler helps an individual carry out an activity otherwise not possible (Johnson & Yanca, 2004:265).

Compton and Galaway (1994: 431) further describes some of the ways in which this role can be employed:

- Encouraging expression of thoughts and feelings,
- Providing for ventilation of feelings,
- Examining relationship patterns,
- Offering support and encouragement, and
- Engaging in logical discussion and rational decision-making

These five techniques, along with the skills mentioned above, allow the enabler to fulfill his/her tasks successfully.

This role is very relevant in working with older persons as they need a lot of support and encouragement in order to try new coping strategies.

(b) Role of teacher

The purpose of the teacher role, as outlined by Sheafor, Horejsi and Horejsi et al. (2000:58) is to provide clients or communities with **knowledge and skills** required to **prevent problems** or **improve social functioning**. Zastrow (1999:15) explains that the teacher role involves **giving information** to clients and **teaching** them **adaptive skills**. In order to accomplish this, the social worker must be well informed and be a good communicator(Zastrow, 2004:78).

In the role of teacher, the social worker, in general, carries out the function of teaching adaptive skills through (Germain & Gitterman, 1980:130-131):

- Clarifying perceptions;
- Providing pertinent information in the appropriate cognitive mode and at the appropriate rate for effective cognitive-perceptual processing;
- Offering advice or suggestions;
- Identifying alternatives and their likely consequences;
- Modeling desired behaviours; and
- Teaching the steps in problem solving.

These skills enable the social worker to successful fulfill the purpose of the teacher role. When working with older persons it is essential to teach them coping strategies that can effectively enhance their functioning.

An important component in adaptation and in the management of stress is problem-solving behaviours. Successful **problem solving** includes the following steps (Germain & Gitterman, 1980:130-131):

- Recognising the problem or need;
- Scanning its nature, likely consequences, and the tasks it poses;
- Considering alternative solutions and likely outcomes of each;
- Selecting the goal(s) or solutions;
- Planning the actions to be taken;

- Undertaking the actions;
- Evaluation the outcome, and
- Returning to adaptive balance, or planning next steps for additional work on the problem.

These steps help solve problems in order to manage stress and enhance adaptation.

The teacher role makes use of learning strategies to improve the clients' knowledge framework in order to empower them for growth. **Education** is a powerful tool in mastering life's tasks and can help the client system improve role performance (Miley, O'Melia & DuBois, 2004:19). The **three functions** of the teacher role as listed by Sheafor et al. (2000:58) are: teach social and daily living skills; facilitate behaviour change; and primary prevention.

Information can assist older persons in making informed decisions and help them gain access to needed resources. Educating the older person with regards to everyday **life skills** can help strengthen interpersonal relationships by improving the older persons' assertiveness and teaching them how to resolve conflicts. The teacher role can further me utilised to convey to older persons the necessary knowledge needed during this developmental life phases to ensure smooth transition from adulthood to late adulthood (Potgieter, 1998: 167-168).

Compton and Galaway (1994: 432) point out that the teacher role is aimed at giving information, and must be clearly distinguished from giving **advice**. When the social worker gives advice, there is an underlying belief that the social worker knows best, however, when information (i.e. data, input, or knowledge) is shared with the older person, it is up to the him/her to decide what is best. The social worker utilising the role of teacher should be cautious of giving their own opinion to the clients in such a way that it may come across as facts. When giving one's own opinion it should be clearly described as such (Compton & Galaway, 1994: 433).

(c) Role of facilitator

The New Social Work Dictionary (1995: 21, 24) defines facilitator as:

> *"ROLE of the SOCIAL WORKER to expedite the process of social change by 1) bringing together people and communication structures, 2) stimulating activities, developing and channelling RESOURCES and 3) ensuring access to expertise."* (The New Social Work Dictionary, 1995:24).

As explained by Zastrow, (1999: 14) the social worker facilitates the older person to **express his/her needs** and **identify problems**. The older person can explore feasible solutions and then develop the ability to cope with daily stressors more effectively on his/her own. Miley et al. (2004:16) suggest that social workers acting out this role are merely **change agents** that use different methods to create the required circumstances for clients to meet their own needs.

According to Germain and Gitterman (1980:130-131) the facilitator carries out the tasks of assuring freedom of action, and mobilising and supporting capacities for competence. In order to carry out these tasks, the facilitator utilises **skills** in:

- Providing opportunities for successful action and decision-making;
- Defining tasks and mobilising the environment supports,
- Including the information and resources needed for successful task accomplishment;
- Regulating the pace and rhythm of the work; and
- Managing issues of passivity and dependence-independence.

These skills empower the social worker to successfully carry out his/her role as facilitator.

3.2.4.2 Environmental problems and needs

Germain and Gitterman (1980:196-198) further explain that the environment contains the potential to cause stress. One aspect of the environment, social networks, has been identified as an important source of strength in life; unfortunately, this can also lead to stress. The way in which social networks cause stress is related to the way in which their boundaries are defined. When **boundaries** in a social network are too rigid, the members tend to feel isolated from the outside world. If the boundaries are too loose or poorly defined, social networks are unavailable to the client for concrete

or emotional support. Some individuals do not have a social network and are isolated and lonely. Certain life transitions such as divorce or job change causes a loss of attachment and feelings of loneliness. Especially in old age, social network relations decrease and the attainment of new social networks is limited (Germain & Gitterman, 1980:196-198).

The **physical environment** further affects human behaviour (Germain & Gitterman, 1980:196-198). As an individual's sense of self is derived partly from familiar and cherished places and structures that comfort and protect, stress arises when one has to leave a familiar surrounding.

The social worker focuses on the behavioural border between older persons and environments in order to help in the stress that arises. The social worker's function is to help older persons use their adaptive and coping capacities to obtain available and accessible **environmental resources** in order to decrease stress. The aspects to focus on to improve transactions between older persons and their networks are (Germain & Gitterman, 1980:196-198):

- Mobilising or strengthening 'real life' ties;
- Finding new linkages and re-establishing old ones;
- Enlisting the aid of natural helper's; and
- Helping clients disengage from maladaptive affiliations.
- Establishing adequate housing and furnishings;
- Helping with territorial needs;
- Increasing perceptual and sensory stimuli in total institutions;
- Manipulating spatial arrangements, design, and use;
- Attending to the temporal aspects of family and institutional life;
- Providing opportunities for growth and renewal to urban dwellers in the natural world of countryside, seashore, park, or for rural dwellers in the built world of a nearby city such as museums, and concert halls; and
- Using pets and plants.

These tactics can help improve transactions between older perosns and their networks.

Germain and Gitterman (1980:196-198) remind social workers of the importance of **mutual assessment** and agreement concerning the interest and practicality of the older persons' assuming the responsibility for the tasks involved in influencing social and physical environments. Where the older person is capable of taking action on the environment it is an important means of enhancing his/her coping skills. If the older person cannot accomplish it on his own, a joint decision must be made regarding who is to take action: client and worker together, or worker alone with client continually updated on the process. The social work function in this regard is carried out by employing the three roles in social work specific to helping with environmental pressures. These roles are: **mediator, advocate, and organiser**. However, as work with environmental issues is usually synchronised with work on life transitions, these roles are used in conjunction with those of enabler, facilitator and teacher, as the situation demands (Germain & Gitterman, 1980:196-198).

In order to determine the cause of stress between the older person and the environment continuous problem definition, exploration, and contracting needs to be employed. When the cause of stress lies in the older person's unwillingness or inability to use available resources, the roles of enabler, teacher and facilitator are utilised (Germain & Gitterman, 1980:196-198).

However, if the cause lies in the environment's inability to provide the necessary resources, the social worker utilises the following roles (Payne, 1997:149):

- **Mediator** (for example, helping the client and the system meet and deal with each other in rational and reciprocal ways);
- **Advocate** (for instance, pressurising other agencies or individuals to intervene, including taking up social action);
- **Organiser** (such as putting the client in contact with creating new social networks).

These roles will now be explained.

(a) Role of mediator

The role of the social worker that views to **mediate** where disagreement between people or groups exist is defined as the mediator role (The New Social Work Dictionary, 1995:39).

If the cause of stress lies in **distorted communications** or **interaction**s between older persons and the organisation the role of mediator carries out the function of helping older persons and social system reach out to each other in more realistic, rational, and reciprocal ways. In order to carry out this role, the mutual skills of **intercession, persuasion**, and **negotiation** are utilised. When stress arises from the social network, the social worker can utilise the mediator role to establish greater understanding regarding the older persons's needs or for obtaining emotional and material resources (Germain & Gitterman, 1980:196-198).

This role is effective when helping two or more parties reach a mutually satisfying understanding. The mediator negotiates between the parties by carefully listening and identifying facts and feelings of both sides. The mediator then arranges a neutral forum where parties can share their viewpoints and discuss their differences in order to reach an acceptable compromise for all. The mediator role is three-fold: **to keep the peace; to make peace; and to build peace**. The mediator must be unbiased and perceived as fair by both parties in order for the mediation to be successful. Conflict is sometimes inevitable when resolving a dispute, however, it does not have to be destructive. By utilising problem-solving techniques, conflict can be resolved constructively (Garvin and Seabury; 1997:320; Potgieter, 1998: 170).

(b) Role of advocate

According to the New Social Work Dictionary (1995:2) the advocate role of the social worker is to **defend** the **rights** of their clients. This role has been duplicated from the law profession, and is an active directive role in social work (Zastrow, 1999: 14). Compton and Galaway (1994: 434) indicate that the social worker acting as advocate must learn to argue, debate, bargain, negotiate and manipulate the environment in favour of the older person.

Problems frequently originate from within organisations or the social network. Organisational problems may occur due to the organisation's various structures, functions or policies (Johnson & Yanca, 2004:265). When the mediator role does not accomplish the required change, then the advocate role needs to be employed in order to influencing the organisation to be more responsive. The following **skills** help execute this function: pressure, coercion, or appeals to third party intervention. Appeals to third party intervening can include use of media, mobilisation of community processes, and involvement of the legislative, economic, or regulatory agencies in the organisation's environment (Germain & Gitterman, 1980:196-198).

Sheafor et al. (2000:57) are of the opinion that advocacy is at the heart of social work. However, advocacy must be balanced with **client self-determination** and **client participation** in the change process. The ideal would be to empower older persons to become their own advocates. This role is not always well-liked and it often encounters resistance, but it is very crucial in social work, none the less. Functions associated with this role are: **client or case advocacy and class advocacy**. In client or case advocacy the social worker aims to advocate for an individual client, class advocacy on the other hand serves to advocate for groups of clients or a section of the population e.g. older persons (Sheafor et al., 2000:57).

The social worker utilises the role of advocate when challenging an institution or agency that refuses to provide necessary services to a older persons. To utilise this role effectively, the social worker must have a good understanding of the other organisation's service policies. The aim of this role is to obtain the necessary services or resources for the older persons by coercing an external agency or influencing political processes. The social worker acts as spokesperson for the older persons. This role must undoubtedly be applied in a **diplomatic** manner (Miley et al., 2004:18; Potgieter, 1998:166-167).

When older persons have no social network or wants to break from a present social network and establish a new social network, the social worker can introduce the individual to existing networks or to potential sources for creating new networks like church groups or self-help groups. In order to accomplish this, the social worker uses the skills of enabler, facilitator, mediator, and advocate.

(c) Role of organiser

However, when there are no social networks or network substitutes in the older persons's life space, the social worker can employ the role of organiser to **organise an informal social network.** For example, the social worker can help older persons with similar interests or concerns to form or a more structured self-help group like a telephone network among older persons with visual impairments (Germain & Gitterman, 1980:196-198).

The **skills** involved in organising include (Germain & Gitterman, 1980:196-198):

- Assessing of needs through survey techniques, such as canvassing all the neighbours on a block or in a high-rise building;
- Mobilising motivation and interests;
- Identifying and supporting natural leaders;
- Locating and securing resource persons, and providing of physical arrangements;
- Using media and other public relations techniques to publicise the programme and to engage the interest of local churches, shopkeepers, and other local business people in serving as sponsors, and providing supplies.

These skills can be successfully employed in order to organise the necessary support structure for older persons with visual impairments.

The organiser uses knowledge and skill to improve **communication, co-operation** and **co-ordination** among different service providers to facilitate access to resources (Potgieter, 1998:166).

When helping people move through stressful **life transitions** the social worker utilises the roles of enabler teacher and facilitator (Payne, 1997:148). When dealing with problems arising from the **physical environment**, the social worker can use the same roles when the older persons's lack of information, fearfulness, or inability to use or respond to the natural and built worlds is involved. However, when the social worker must influence service systems or significant individuals in the social network, the roles of mediator and advocate are required. Finally, the organiser role is

employed when it is necessary to mobilise community efforts in order to have an impact on the physical environment (Germain & Gitterman, 1980:196-198).

3.2.4.3 Maladaptive patterns of interpersonal relationships and communications

In dealing with maladaptive patterns of interpersonal relationships and communications, the social worker is dealing primarily with families, which organise a network of statuses and roles, and are also the place where basic survival needs are met (such as shelter and food). Families have to develop communication methods internally between each other and externally with the outside world. The nuclear family and the structure and role of families in our lives apply many stresses. Similar issues arise in formed groups, where clients come together in the agency to share work on a life task that they have in common (Payne, 1997:147).

The social worker can utilise the same roles as mentioned in the first section (life transitions):

- **Enabler** (for example, strengthening the communication skills between parents and children);
- **Teacher** (like teaching new communication techniques); and
- **Facilitator** (such as enhancing communication between person and environment regarding available resources).

These role can be employed in order to reduce stress caused by maladaptive patterns of interpersonal relationships and communications.

3.2.5 Welch's Concentric Model

Welch (1987:155-159) is of the opinion that the human ecosystems theory provides an appropriate cognitive framework for social work in the South African context. This model is still relevant today as the synergetic effect of the interaction between the individual and his/her environment still occurs today. The synergetic effect can be compared to throwing a stone in a dam of water and seeing the ripples form outwardly from small to big. The smallest ripple causes a bigger ripple and so on.

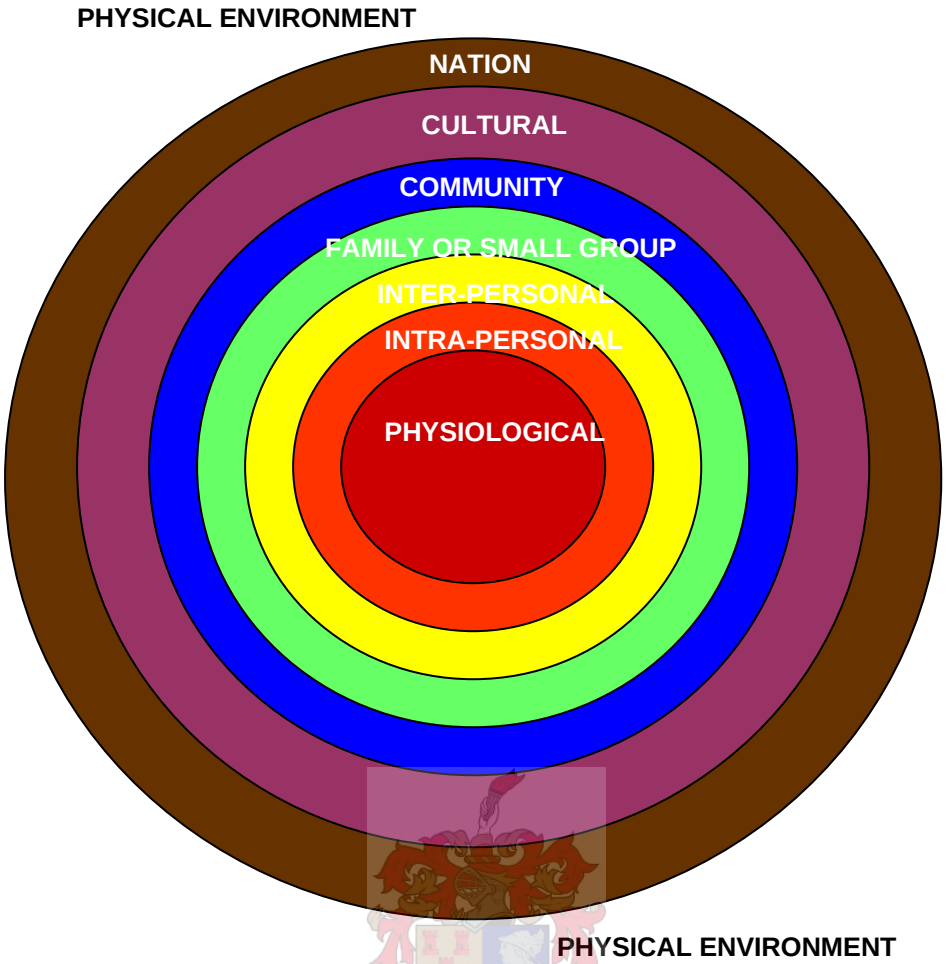


Figure 3.2 The human ecosystem
(Welch 1987:156)

In his concentric model, Welch (1987:156) demonstrates the synergetic effect of the interaction between the individual and his/her environment. Each circle represents a level of functioning within the greater human ecosystem. Even though the lines indicating the different levels are solid lines, the borders of the level are permeable to allow interactions between the different levels of the ecosystem and also the ecosystems and the physical environment. The levels are: intra-personal, inter-personal, family or small groups, community.

In the following section, Welch's model will be used to explore the socio-emotional experience of older persons with visual impairment.

3.3 THE SOCIO-EMOTIONAL EXPERIENCE OF OLDER PERSONS WITH VISUAL IMPAIRMENT

Using Welch's model, the experience of older persons with visual impairments can be discussed by looking at different systems in the person-environment interaction such as the intra-personal, inter-personal, family or small groups, community. In this discussion the socio-emotional experience of older persons affected by visual impairment will be outlined according to the following five levels adapted from Welch's (1987:156) concentric model: person-level, family-level, friends-level, Old Age Home-level, and occupational-level.

3.3.1 Person-level

In this level of social functioning the following aspects will be discussed: personal feelings and fears; finances; travelling; shopping; mobility; modes of communication; general housekeeping; and alcoholism.

3.3.1.1 Personal feelings and fears

This first level of social functioning focuses on the personal experience of older persons related to vision loss. Many older persons experience visual loss for the first time in old age due to conditions associated with aging like cataracts (Rogers & Long, 1991: 155). Vision loss is a dramatic experience for most confronted by it. All individuals tend to be afraid of the unknown, especially when there are so many unpleasant myths and stereotypes associated with illness and disability (Barron, 1978:355).

There are many similarities between the myths regarding old age and those regarding blindness, they describe these individuals as: **helpless, passive, unhappy and dependent**. Some older persons believe these myths and fall into a pattern of learned-helplessness (Jacobs, 1984:154). Older persons with these negative attitudes towards themselves, sometimes experience visual impairment as punishment for past sins (Goodman, 1985:160).

As older persons begin to experience visual impairment, they are inclined to **withdraw** from their former interactions with their family and community and may become very **lonely and isolated** (Hill & Harley, 1984:50). Many **fears** arise as they

wonder how it will affect their health and also their inability to meet their financial obligations. As these feelings and fears increase, they experience a less satisfying family life and limited personal growth. They are faced with the reality of losing their independence and even intellectual abilities. Due to their **increased dependency** on others there is a rapid **decrease in their mobility**. Many prefer to remain inside rather than leaving their safe home environment. Due to the increase dependence on others, many visually impaired older persons experience a **decrease in self-esteem** and in privacy. They may even feel unproductive and unable to perform activities they participated in before. They become strangers in their once comfortable environment. Older persons tend to experience vision loss more negatively in that they already experience many **other losses** in this life-stage (e.g. moving to a care facility or becoming senile) that bring about distressing emotions (Hill & Harley, 1984:50).

As Emerson (1981:42) states, for many older persons the loss of eyesight is psychologically equated with the loss of 'I'. The response to visual impairment usually involves three phases: shock, depression and readjustment. In the **first stage** of shock, individuals often experience denial, isolation, anger and resentment. During this phase, older persons utilise several negative coping strategies like: passing as sighted or isolating themselves from others.

The **second phase**, depression, is often accompanied by feelings of bitterness and apathy. During the **final stage**, individuals experience only minor feelings of depression as they finally move towards readjustment. Older persons who are in this final stage start participating in new hobbies and sometimes even resume old activities. They experience new ways to cope with visual impairment and have renewed hope for the future (Emerson, 1981:43).

Individuals may struggle to readjust due to other factors influencing this process. Some of the **factors** that influence readjustment are: loss of vision accompanied by other losses; a lack of support from family; and very severe impairment (Emerson, 1981:43).

Jacobs (1984:157) states that the effects of visual impairment on older persons lives are influence by: over-all life satisfaction level; extend of life changes; extend of relationship changes; and perception of loss compared to other older persons their age.

3.3.1.2 Finances

In a study conducted by Cherry et al. (1991:110) older persons with visual impairments indicated that they needed assistance with **money identification** and **money management**.

3.3.1.3 Travelling

According to Long, Boyette and Graffin-Shirley (1996:302) one of the essential aspects of everyday life activities is the ability to travel in the community. Travel affects several aspects of a person's life, for example:

- Opportunities to take part in social, cultural, recreational, and religious activities;
- Access to goods and services; and
- Opportunities for employment.

The ability to travel could therefore have a significant influence on someone's overall quality of life.

The **regularity** and **variety** of travel by older persons in the community is determined by a variety of personal abilities interacting with characteristics of the travel environment (Long et al., 1996:302). Personal abilities include:

- Sensory skills (vision, hearing, and touch);
- Gross motor skills (includes the ability to walk outdoors and negotiate changes in terrain and elevation);
- Problem-solving skills; and
- Psychological factors (desire for social contact, tolerance of taking risks, perceived control, perceived vulnerability to crime, and degree of social and family support for travel).

These abilities range from physical to psychological factors.

Furthermore, Long et al., (1996:302) point out that environmental characteristic include:

- Access to various types of public transpiration,
- Availability of sidewalks,
- Legibility of signs,
- Density of pedestrian and vehicular traffic,
- The likelihood of encountering unanticipated hazards, and
- Weather conditions.

These factors interact with each other to determine the regularity and variety of travel by older persons in the community.

Older persons who are visually impaired experience greater difficulty when travelling by public transport. Jackson, Peck and Bentzel (1983:469) point out that individuals who are visually impaired and utilise public transport may experience unnecessary delays, embarrassment, injury, and/or disorientation. They may also become dependant on sighted persons for assistance.

Cherry et al. (1991: 118) reported that older persons with visual impairment rely mostly upon sighted guides to aid in travel. These older persons indicated that they were unable to travel to all the places they needed and wanted to go to. Although they had access to public transport, this form of transportation was often inadequate. Older persons were also less likely to have access to private transport.

3.3.1.4 Shopping

When **shopping for clothes**, it is especially difficult for visually impaired individuals, as they have to rely on others to help them. Their own personal preferences are often subject to those of others helping them to buy clothes (Marcias & Rucker, 1979:400).

Inana (1980:329) points out that **grocery shopping** can prove to be a great challenge for visually impaired individuals. A study by Cherry et al. (1991:110) identified that older persons with visual impairments expressed a need for assistance with grocery shopping. However, Inana (1980:329) explains that it is difficult for

someone who is used to buying the food to hand over this task to someone else that may not have the same consideration for the individual's budget or preference of food as the individual would.

3.3.1.5 Mobility

Research (Cherry et al., 1991:101) indicates that some of the older persons with visual impairments used **support canes** in order to enhance their mobility. However, older persons with visual impairments who used walkers and crutches experienced greater difficulty in mobility. Older persons further indicated that they had not received any mobility training.

3.3.1.6 Modes of communication

In a study conducted by Cherry et al. (1991:110) few older persons with visual impairments indicated that they communicated in written form. Those that did use a written form of communication either wrote without seeing, used **large print** or typed.

3.3.1.7 General housekeeping

As outlined by Cherry et al. (1991:110) older persons with visual impairments indicated that they require assistance with **housekeeping** and **cooking**.

3.3.1.8 Alcoholism

In the past, **alcohol problems** have been noted among physically disabled individuals. Sometimes this unseen disability needs to be addressed before the overt disability can be rehabilitated. Social workers should conduct a thorough assessment with clients in order to establish whether the visually impaired client is an alcoholic or not, and if he/she is an alcoholic they should be referred for treatment (Peterson & Nelipovich, 1983:345).

3.3.2 Family-level

The second level of social functioning focuses on the experience of older persons with visual impairment in relation to their family. This section will focus on family relationships.

3.3.2.1 Family relationships

According to Parry and Young (1978:56) interactions among family members are often disrupted due to the onset of disability in one family member. Disruption in **family patterns** occurs and **role reversals, economic strain, marital stress,** and **social isolation** results (Parry and Young, 1978:56).

With the onset of visual impairment in older persons, misunderstandings among family members seem to occur as a result of the changes in the older persons and his/her feelings regarding the situation (Jacobs, 1984:155). Family members who have internalised **myths** about aging have a negative stereotype regarding older persons with visual impairment. The dynamics within a family are very complex - if one experiences a problem it affects everyone. It is essential that family members gain insight into the situation in order to enhance family unity and encourage the older person experiencing visual impairment to maintain independence (Jacobs, 1984:155).

According to Ponchillia (1984:97) visually impaired persons seem to experience more marriage-related problems than sighted persons. Both the marriage and divorce rates are affected by the presence of visual impairment. The **main problems** experienced by couples are: overprotection of the visually impaired partner, financial problems associated with the loss of employment, role changes caused by the impairment, reactions to dependence, and rejection of the visually impaired spouse (Ponchillia, 1984:97). Asch and Sacks (1983:244) relating the experiences of several visually impaired adults, emphasise these challenges in marriage when one spouse becomes visually impaired.

3.3.3 Friends-level

The next level of social functioning points out the experience of older persons with visual impairment with regards to their interactions with their friends.

3.3.3.1 Friends

As mentioned in chapter two, to many older persons, the most significant phenomenon in life is their relationships with friends and family. Several authors (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al.,

1998:642) clarify this statement by explaining that relationships keep older persons connected to those around them. Often by the time a person reaches late life, he or she has certain friends they have known many years. These **friendships** are often **more significant** than relationships with younger family members because friends fulfil the role of confidant and act as a source of support in a way that younger family members cannot.

As individuals become visually impaired, they fear that they may become **detached** from significant people in their lives. They are concerned about how their visual impairment will influence their relationships and worry about maintaining interpersonal relationships (Asch & Sacks, 1983:243).

3.3.4 Old Age Home-level

In this level, the experience of older persons with visual impairment is discussed within the context of an Old-Age Home.

3.3.4.1 Old-Age Homes

Older persons who are visually impaired and living in Old-Age Homes may have more negative experiences than those still living at home, especially those that experienced the onset of visual impairment while in the old-age home (Hill & Harley, 1984:50).

As Vaughan and Hobson (1990:370) state, older persons feel **bitter** and **angry** about their loss of vision and may even blame the personnel for their loss. Staff members in these institutions often hold the assumption that older persons with visual impairments are dependent on others for assistance and this influences the way they treat and interact with these older persons (Vaughan & Hobson, 1990:370).

Authors (Hill & Harley, 1984:50; Yeadon, 1991:190) report that older persons with visual impairment are mostly left in their rooms where they do not have to move around a lot. They do not participate in previous activities like playing cards, and watching television. They spend most of their time sleeping and sitting alone. This causes them to become **isolated** and bored, feeling increasingly **angry, afraid**, and

depressed. By learning a few skills, they could enhance their mobility and become more independent (Hill & Harley, 1984:50; Yeadon, 1991:190).

3.3.5 Occupational-level

The last level of social functioning, the occupational-level, looks at the experiences of older persons with visual impairment from an occupational view.

3.3.5.1 Volunteerism

Acting as a volunteer can play a significant role in the experience of older persons with visual impairment. The Braille Institute's Community Outreach Program developed in America provides visually impaired older adults with the opportunity to **volunteer** in the community. Older persons who took part in this programme were found to have an increased self-confidence and satisfaction in their ability to serve others. In this way, older persons with visual impairments have been made aware of their capabilities despite their visual limitations (Berkman, 1984:10-12).

Ludwig and Schneider (1991:30) affirm this by suggesting that older persons with visual impairments could play a valuable role as volunteers in the community.

Individuals may experience visual impairment in differing ways as it affects their lives differently. However, from the above, it is clear that effects of visual impairment can be detected in all spheres of older persons' lives: person-level, family-level, friends-level, Old Age Home-level, and occupational-level.

3.4 CONCLUSION

The chapter firstly outlined the ecological perspective as practice framework in social work by discussing the adaptation between person-and-environment and the intervention phase in social work (from an ecological perspective). The intervention phase specifically focussed on the two main areas that cause stress in the relationship between person-and-environment and the social work roles that can be utilised during intervention in these areas:

- life transitions (enabler, teacher, facilitator)
- environmental problems and needs (mediator, advocate, organiser)

This first section of the chapter concluded with an overview of Welch's Concentric Model that can be applied when identifying the socio-emotional experience of older persons with visual impairment.

The second part of the chapter discussed the socio-emotional experience of older persons affected by visual impairment according to the following five levels adapted from Welch's (1987:156) concentric model: person-level (personal feelings and fears; finances; travelling; shopping; mobility; modes of communication; general housekeeping; and alcoholism), family-level (family relationships), friends-level (friends), Old Age Home-level (Old Age Home), and occupational-level (Volunteerism).

In the following chapter social work intervention for older persons with visual impairments will be described from an ecological perspective.

CHAPTER 4

SOCIAL WORK INTERVENTION FOR OLDER PERSONS WITH VISUAL IMPAIRMENTS FROM AN ECOLOGICAL PERSPECTIVE

4.1 INTRODUCTION

From the previous chapter it is clear that visual impairment can have a negative impact on the daily living of older persons. Therefore, social work intervention is required in order to assist older persons in adjusting to visual impairment. The third aim of the study is to describe social work intervention for older persons with visual impairments from an ecological perspective. In order to meet this aim, the chapter will firstly give an overview of Welch's (1987:156) concentric model and the different levels in the person-environment interaction such as the intra-personal, inter-personal, family or small groups, community. Then the chapter will describe social work intervention for older persons with visual impairments according to the five levels adapted from Welch's (1987:156) concentric model: person-level, family-level, friends-level, Old Age Home-level, and occupational-level.

4.2 OVERVIEW OF WELSCH'S CONCENTRIC MODEL

As mentioned in chapter three, Welch's (1987:155-159) concentric model demonstrates the synergetic effect of the interaction between the individual and his/her environment. Each circle represents a level of functioning within the greater human ecosystem. Even though the lines indicating the different levels are solid lines, the borders of the level are permeable to allow interactions between the different levels of the ecosystem and also the ecosystems and the physical environment. The levels are: intra-personal, inter-personal, family or small groups, community.

4.3 SOCIAL WORK INTERVENTION

In this section, social work intervention for older persons with visual impairments will be discussed by looking at the different systems in the person-environment interaction as adapted from Welch's (1987:156) concentric model: person-level, and community-level. At person-level the following interventions will be mentioned:

addressing older persons' needs; self-limiting beliefs about visual impairment; focus on strengths; orientation and mobility training; rehabilitation services; self-help groups; telephone counselling; low vision services; and utilising all strategies.
Community-level will address the following: training workers; focus on grassroots level; rehabilitation centres; distribution of information; multi-disciplinary teams; and evaluating outcomes.

4.3.1 Interventions at person-level

Older persons with visual impairments are in need of both **formal** and **informal** support systems such as medical services and family support services in order to adjust to their changing circumstances (Ludwig & Schneider, 1991:30). Jacobs (1984:154) mentions the following ways in which adjustment to visual impairment can be attained:

- Teaching and counselling
- Group work or peer counselling

These could be both formal and informal support systems, depending on the context.

In this section the following interventions will be mentioned: addressing older persons' needs; self-limiting beliefs about visual impairment; focus on strengths; orientation and mobility training; rehabilitation services; self-help groups; telephone counselling; low vision services; and utilising all strategies.

4.3.1.1 Addressing older persons' needs

The first intervention is addressing older persons' needs. Foremost, it is important to recognise that the **needs** of older persons with visual impairments differ from those of younger persons with visual impairments in at least two ways. Firstly, older persons are more prone to having **multiple health problems** besides their visual impairment. Social workers need to be aware of the health problems other than visual impairment that may impair daily functioning and how to address all of these challenges. Secondly, older persons with visual impairments differ from younger persons with visual impairment in that they are not interested in occupational training, but they are rather interested in services geared at advancing **independent living** and enhancing greater life satisfaction (Cherry et al., 1991:120).

It is furthermore important to recognise that work with any older persons must be sensitive to their experience of aging (Toseland, 1995:153). In order to **increase sensitivity** towards the experience of aging, social workers could:

- Awareness regarding the feelings and attitudes of older persons;
- Awareness regarding the influence of membership in a particular age cohort;
- Awareness regarding the effect of gender and/or ethnicity minority status on the aging experience;
- Awareness regarding individuality among older persons; and
- Awareness regarding the developmental life-stage of older persons.

From the above it is clear that the most important aspect of working with older persons is being sensitive to their experience of aging and avoiding negative stereotypes that exist regarding this age group.

4.3.1.2 Self-limiting beliefs about visual impairment

The second intervention is eradicating self-limiting beliefs about visual impairment. According to Needham and Ehmer (1980:58) one of the reasons some people do not adjust to their disability is due to the fact that they harbour irrational, **self-limiting beliefs** about visual impairment. These beliefs can be summarised into four general groups:

- Visually impaired people differ in self-worth and value compared to sighted people;
- Visually impaired people have a unique psychological constitution;
- Visually impaired people have a special relationship with others in general;
- Visually impaired people are subject to magical circumstances.

These self-limiting beliefs could stand in the way of older persons adjusting to visual impairment.

4.3.1.3 Focus on strengths

The third intervention is focussing on strengths. The social worker working with older persons with visual impairment should aim to permit them to adjust to the loss as a reality, but also to acknowledge their remaining strengths as realistically as they

see their deficiencies (Hill & Harley, 1984:50). The focus should be on identifying and enhancing their strength's.

4.3.1.4 Orientation and mobility training

The fourth intervention is orientation and mobility training. Specialised services for older persons with visual impairment include orientation and mobility training. This kind of training is aimed at helping the client to **travel** and move about more independently in the community. Older persons are taught how to use their remaining senses optimally to compensate for the loss of vision. Furthermore, clients learn decision-making skills, interaction strategies and methods to safely avoid obstacles when travelling. The use of optical aids like canes and guide dogs are also encouraged where needed. Each client receives individualised training for his/her specific needs (Weiner, 1991:69).

Long et al. (1996:311) suggest that orientation and mobility training could be provided in community-based day programmes or in older persons' homes. Travel-related support services in the community may be required for many older persons with visual impairments as they may be unable to fulfil all their needs involving independent travel outside their homes. Some **requirements** for effective training are:

- Training should be easily accessible to users;
- Training should focus on short-term access for specific problems and specific routes; and
- Re-training should be promptly available when/if required.

From the above, it is clear that accessibility and availability of training is an important requirement for effective training. These requirements need to be met in order to provide effective training for older persons with visual impairments.

At certain points in an older visually impaired person's life, service providers need to intervene, for example, when a spouse dies or when travel-related support decreases. A direct benefit of improved travel skills for older visually impaired persons is an increased sense of psychological well-being resulting from a greater sense of competence and control over their circumstances (Long et al., 1996:311.)

Furthermore, Long et al. (1996:311) are of the opinion that caregivers should also receive training in sighted guide techniques in order to assist older visually impaired persons effectively and without risk of injury to either party. Training for **caregivers** may include the following topics:

- Environmental alterations to improve orientation and mobility;
- The psychosocial implications of visual impairment;
- The functional implications of various types and degrees of visual impairment; and
- Access to related services.

Caregivers need training regarding how the physical, emotional and social aspects of visual impairments influence older persons' lives and how these can be manipulated in order to improve their independent functioning.

4.3.1.5 Rehabilitation services

The fifth intervention is rehabilitation services. In order to gain a better understanding of rehabilitation services, this section has been divided into the following subsections: goal of rehabilitation; nature of rehabilitation services; preventative rehabilitation work; challenges of rehabilitative work (including: problems in attitudes, problems in characteristics, financial considerations; and involvement and training of staff); rehabilitation outcomes; and rehabilitation teachers.

(a) Goal of rehabilitation

According to Rosenbloom (1982:210) the **goal of rehabilitation** is to restore the older person's potential to enjoy life i.e. to lead a useful life. This is obtained by empowering the individual to be self-sufficient, emotionally independent and able to maintain satisfying social relationships.

Goodman (1985:162) explains that the goal of rehabilitation includes providing the client with the skills to manage ordinary activities independently and safely. Hill and Hill (1991:405) define these activities as grocery shopping, going to church or visiting friends in their homes.

However, as Goodman (1985:162) points out, goals are highly individualised and vary from client to client. Therefore, Hill and Hill (1991:406) suggest that clients be encouraged to formulate their own goals, based on their realistic potential and these goals should be attended to through a dynamic approach that takes into account both short-term and long-term needs.

The overall goal of rehabilitation then aims to enable each older person, given his or her level of impairment, needs, and preferences, to function as independently and productively as possible and so increase the level of satisfaction with his or her life (Hill & Hill, 1991:406).

(b) Nature of rehabilitation services

Vaughan and Hobson (1990:370) point out that the need to provide rehabilitation and prevention services for older persons with visual impairments have gained increasingly more attention. Gross (1978:51) suggests that older persons who are visually impaired require a **number of services**: health care; income maintenance; employment opportunities; socialisation; self-care; supportive services and mobility. More specifically, older persons who are visually impaired identified their **need** for help with: housekeeping chores; cooking; travelling to shops, social appointments or medical appointments; library services; socialisation opportunities; and financial aid.

According to Farish and Wen (1994:526) **independent living services** for older persons with visual impairments aim to increase older persons' functioning in activities of daily living (ADLs). These services may include:

- Services to help correct visual impairment like visual screening and surgical treatment;
- Provision of visual aids and training in communication like large print, cassette recorders, and readers;
- Provision of equipment to increase mobility and self-sufficiency in familiar and unfamiliar environments, like a cane;
- In-home training to perform ADLs like cooking, telling time, and selecting clothing;

- Guide and/or transportation services; and
- Supportive services like family and peer counselling.

The above-mentioned services could considerably improve the daily functioning of older persons.

De l'Aune, Welsh and Williams (2000:286) identify four types of rehabilitation service programmes for older persons with visual impairments:

- *Centre-based personal-adjustment training:* an inclusive combination of skill-training and counselling services delivered to more than one person at a time in a centre.

- *Community-based personal-adjustment training:* skill training and counselling services delivered in a community setting other than a rehabilitation centre, usually in a participant's home.

- *Low vision services:* outpatient services typically provided by an interdisciplinary team consisting of low vision eye care provider (an optometrist or ophthalmologist) and one or more of the following: low vision specialist, orientation and mobility specialist, rehabilitation teacher, social worker or counsellor.

- *Vocational services:* a range of services designed to lead ultimately to a participant's employment or to evaluate whether employment is feasible.

These four types of rehabilitation services could occur either individually or collectively and be provided either by an individual professional or a team of professionals.

Some basic principles for improving the quality of life of older persons with visual impairments are (Yeadon, 1991:182): to maximise individuals unique abilities; to stimulate the emotional support and involvement of family and care-givers; to link clients and community resources; to develop and distribute self-help information; and to maximise the use of all relevant resources. These principles focus on the older person's emotional and physical needs.

(c) Preventative rehabilitation work

According to Vaughan and Hobson (1990:370), the early detection of visual impairment is crucial in prevention of increased dependency. Oehler-Giarratana (1978: 360) suggested that **preventative rehabilitation work** should be done on a continuous basis with individuals having a degenerative visual prognosis in order to help the individual to adjust to the loss of vision with as little difficulty as possible. Some of the types of preventative rehabilitation are: counselling regarding the anatomy and physiology of the eye; individual/group therapy; occupational guidance; and basic rehabilitation information regarding aspects like mobility. Yeadon (1991:186) affirms that preventative approaches should be developed that could reach people in rural areas that have limited access to services.

A programme aimed at reducing late-life dependence resulting from declining visual acuity was conducted in Missouri (Vaughan and Hobson, 1990:370). The aim of this programme was to locate older persons experiencing visual impairment; to diagnose the cause there-of; and to provide low vision devices to enhance visual functioning where needed. This programme successfully managed to decrease older persons' dependence on others. The older persons who benefited from this programme noted that due to the help they received they could function more independently in everyday tasks like reading their mail, writing checks, threading needles, and reading large print. Quality of life for older persons with visual impairments can be enhanced and their dependence reduced through relatively low-cost projects like this one (Vaughan and Hobson, 1990:370-372).

(d) Challenges of rehabilitative work

Rogers et al. (2000:338) emphasise that the growing number of older persons with visual impairments, limited funding and the lack of trained personnel has an increasing effect on service delivery by social workers.

Despite the increase in older persons with visual impairments, the greater majority of older persons with visual impairments have not received needed support and rehabilitative services from social workers and other helping professionals. Some factors that have been associated with the **lack of support services** include (Hill &

Hill, 1991:402-403): problems in attitudes, characteristics, financial considerations, and in-service training. These will now be discussed in more detail.

i) Problems in attitudes

Negative attitudes and stereotypes regarding blindness and aging like dependency, helplessness and inadequacy limit the extent of service demand by older persons and provision to this vulnerable group (Hill & Hill, 1991:402-403).

ii) Problems in characteristics

Older persons are often viewed as more cautious and passive than younger persons. Other problems like memory loss, arthritis, and poor physical fitness also limit their readiness for orientation and mobility training. Overprotection from friends and family members may perpetuate dependence and lessen willingness to become more independent (Hill & Hill, 1991:402-403).

iii) Financial considerations

According to Hill and Hill (1991: 402-403) there is limited funding for support and rehabilitation services to older persons with visual impairments from government and private sponsors. This results in a lack of available support services for this vulnerable group.

iv) Involvement and training of staff

Furthermore, Hill and Hill (1991:402-403) report that there is limited training for staff working with older persons that also have visual impairments in the USA. Staff in old-age homes could teach basic adaptive techniques to older persons with visual impairments and implement verbal reinforcement strategies. They are also in the best position to recognise behavioural indicators of increasing visual impairment and refer individuals for needed services. Volunteers could also be trained to provide intervention for older persons with visual impairments (Hill & Hill, 1991:402-403).

According to Hill and Hill (1991:402-403) these four factors add to the lack of available services for older persons with visual impairments.

(e) Rehabilitation outcomes

An important outcome of rehabilitation service is the **adjustment** of older persons to visual impairment. In chapter one, adjustment to visual impairment is defined as the attainment, by a visually impaired older person, of an *environment* in which they are optimally constructive and minimally incapacitated by their visual impairment (Cambert et al., 1981:193).

According to Cambert et al. (1981:193) the *environment* consists of physical, social, psychological, behavioural, and relational elements, and an individual is adjusted to blindness if the *environment* in which he/she lives accords him/her status and roles that is beneficially rewarding despite his/her visual impairment.

Goodman (1985:160) clearly states that visual impairment is a highly individualised experience. Older persons with visual impairment experience it in different ways. For some, loss of vision is 'living death'. The ability to adapt to visual impairment depends on the interaction between different factors: environmental circumstances, personal characteristics, and the general impact of aging (Goodman, 1985:160).

In a study among older persons with visual impairments in Nebraska, it was determined that older persons who had adjusted best to visual impairment had several similarities (Jacobs, 1984:156):

- They all seemed to cope well with general changes in life and used these same coping skills to adjust to visual impairment;
- They expressed and over-all positive perspective on life;
- They had good communication skills;
- They were part of a well-established support system;
- The maintained family interactions;
- They were encouraged to be independent and do things for themselves;
- They knew people with visual impairment before they became visually impaired;
- Their main strategy to cope with visual impairment was: keeping busy.

From the above, older persons who have a general positive outlook in life seem to adjust best to visual impairment.

According to Jacobs (1984:154) there are two factors in the process of successful adjustment to visual impairment: accepting that visual impairment is not a devastating change, and learning alternative non-visual ways to cope.

According to Rogers et al. (2000:338) several variables that influence rehabilitation outcomes have been identified in rehabilitation services. These include:

- Individual's level of vision loss,
- Response to vision loss,
- Age,
- Sense of control over his or her life,
- Level of self-esteem,
- Gender,
- Education
- Mental status,
- The presence and severity of other disabilities,
- Family and community support systems,
- Living situation, and
- Type of intervention.

These diverse variables could either negatively or positively influence rehabilitation outcomes of individuals. It depends on the combination of these variables. Each individual's unique characteristics need to be taken into account in order to determine whether or not rehabilitation outcomes will be successful.

(f) Rehabilitation teachers

According to Weiner (1991:71) **rehabilitation teachers** help older persons cope with activities of daily living like: communication (e.g. Braille, computers, handwriting, listening, recording, low vision techniques, mathematical calculations, and type writer.); food preparation; personal management; home management; home mechanics; leisure and recreational activities; indoor orientation and movement. This service focuses on individualised needs and usually takes place in the client's

home. Sometimes the rehabilitation teachers also fulfil the role of counsellor as the client learns to know and trust him/her more (Weiner, 1991:71). In South Africa, volunteers in welfare organisations can be trained as rehabilitation teachers.

4.3.1.6 Self-help groups

Kalafat and Dehmer (1993:112) propose that **self-help groups** are particularly appropriate to address the need for services for older persons with visual impairments because of these provide help for chronic difficulties and emphasise mutual support and the importance of personal experience and strength, instead of dependence and pathology. Several findings (Kalafat & Dehmer, 1993:112) suggest that active membership in groups is associated with enhanced satisfaction and coping. However, most groups are started by agencies and unlike 'true' self-help groups, few of the groups operate without professional or trained peer leaders, and the main obstacle to the formation and maintenance of groups is lack of transportation.

Strategies suggested by Kalafat and Dehmer (1993:114) to encourage the independence of self-help groups include: training group leaders, collecting funds for transportation, and encouraging groups to network with each other to enhance resources and models for success.

Several formal self-help groups for blind people have been established, but very few exist for older persons with visual impairment. **Peer counselling** can play an effective role in assisting older persons with visual impairments to cope with this challenge and also other aspects of aging that add to the increased complexity of losing one's vision. In a study conducted by Byers-Lang (1984:196) older persons who participated in these kinds of groups seem to handle frustration associated to their visual impairment better; have an increased self-esteem; and greater ability to function independently.

Galler (1981:173-176) promotes long-term support groups for older persons with visual impairments. Older persons benefited from participation in this kind of support group by acquiring basic skills for daily living. However, the social support gained from this kind of group was the most significant advantage.

A study conducted by Harshbarger (1980:221-224) pointed out that group work with older persons who are visually impaired is effective in facilitating the process of psychological adjustment to the loss of vision. Furthermore it was established that adjustment to visual impairment is best attained by approaching the rehabilitative process as one that influences all areas of a person's life: social, psychological and physical. Some issues that could be discussed in a group context are:

- Adjustment to living alone;
- Physical, emotional and environmental changes resulting from visual impairment;
- Tendency of family members to be either over solicitous or to withdraw from persons with disability;
- Feelings of depression and hopelessness; and
- Changes in personality.

All relevant aspects of the individual's life – physical, social, and emotional need to be addressed.

According to Ludwig and Schneider (1991:31) participation in support groups could provide the necessary foundation for integrating older persons with visual impairments into mainstream senior centre activities.

4.3.1.7 Telephone counselling

A study conducted by Jaureguy and Evans (1983:150-157) showed that group telephone counselling had a positive effect on the physical and social behaviour of visually impaired older persons. Older persons who received this kind of counselling showed a distinct increase in activities of daily living.

4.3.1.8 Low vision services

Low vision services (Seymour & Marston, 1984: 537) assist older persons with visual impaired by optimising the use of whatever visual ability remains. The social worker conducts a **preliminary interview** in which he/she takes a social history, including information about how the impairment came about, coping strategies, and what the patient would like to do to end the visual impairment. The social worker talks with

patients to give them a realistic idea of what to expect from the services offered. **Objectives** and **tasks** are formulated in order to reach the desired goal. The social worker can discuss **unrealistic expectations**. The social worker then plans **follow-up meetings** to ensure the patient executes tasks and utilises low vision aids. The social worker can also offer therapy and support when a serious impairment is diagnosed or after surgery. The social worker therefore aims to help the patient understand, obtain and utilise treatment or rehabilitation programme that will improve functioning or reduce the impact of vision loss (Seymour & Marston, 1984: 537).

4.3.1.9 Utilising all strategies

It seems obvious that the most common strategy for enhancing the quality of life and independence of older persons with visual impairments is the utilisation of care and **support from family**, neighbours and friends. However, Yeadon (1991:184) points out that it is one of the strategies that has been documented the least.

4.3.2 Interventions at community level

In this section, the following will be outlined: training social workers; focus on grassroots level; rehabilitation centres; distribution of information; multi-disciplinary teams; and evaluating outcomes.

4.3.2.1 Training of social workers

Social workers interested in working with older persons with visual impairments **need in-depth training** regarding how to work with this specific group of clients. Some agencies that are delivering services need to re-evaluate their services, and maybe even modify these services. Services may need to be more individualised as each client experiences unique challenges and may require differing degrees of self-care and daily living skills (Cherry et al., 1991:120).

Service providers need to recognise and understand their own feelings and views regarding visual impairment. They need to overcome their own negatives attitudes they may have toward visually impaired older persons (Hill & Harley, 1984:49).

Stuen (1991:167) points out that agencies rendering services to older persons do not need to be specialists in dealing with visual impairment, but they need to have a

general awareness of the normal age-related vision changes and the implications for independent functioning. Agencies should be aware of existing rehabilitation services in order to refer clients to appropriate resources. However, there is a need to train some rehabilitation specialists that can provide the necessary information to service providers, clients and communities and initiate self-help groups in the community.

4.3.2.2 Focus on grassroots level

Yeadon (1991:188) suggests that a greater emphasis in service delivery for older persons with visual impairment should be placed on **grassroots level** due to the fact that very few people in the world have access to services, especially those living in rural areas.

As Ludwig and Schneider (1991:30) point out, in certain rehabilitation programmes young people are trained as volunteers to assist older persons with daily tasks like reading their mail, shopping or running errands. They also play an important role in providing companionship to these older persons who tend to become increasingly isolated as a result of their visual impairment.

4.3.2.3 Rehabilitation centres

Yeadon (1991:191) points out that rehabilitation centres are in urban areas. This author (Yeadon, 1991:191) goes on to explain that **rehabilitation centres** offer a range of activities like: individual counselling, orientation and mobility training, training in skills for daily living, communication skills, and recreational activities. There are both advantages and disadvantages to rehabilitation centres. The advantages include: exposure to specialised personnel; gaining practical hints; and gaining emotional support from peers. Some of the disadvantages, however, are: difficulty in transferring skills learnt to home environments; exclusion of the family in the rehabilitation process; and a under utilisation of local resources (Yeadon, 1991:191).

4.3.2.4 Distribution of information

Many older persons with visual impairments do not have the knowledge or skills concerning their condition. Social workers could **distribute information** by means

of mass public education in newspapers, magazines, video's, instructional audio tapes, radio and television interviews, and public speaking at community meetings in order to inform older persons regarding visual impairment, the availability of services and self-help strategies (Yeadon, 1991:189-191).

In a study conducted by Cherry et al., (1991:109) more than half of the participants were unaware of available rehabilitation services, and older persons were less likely to have received any rehabilitation services.

Public awareness can be raised by means of forums, seminars or newsletters distributed in the community (Ludwig & Schneider, 1991:332-33).

4.3.2.5 Multi-disciplinary teams

Several agencies and service delivery systems need to go about collaborative endeavours in order to design appropriate services. For example, various agencies working with older persons and blind rehabilitation services can combine ideas to form a comprehensive programme directed at the specific needs of older persons with visual impairments (Cherry et al., 1991:121).

Authors (Du Pre, 1982:366; Ludwig & Schneider, 1991:29) agree that successful rehabilitation services cannot be provided by a single professional, rather a **team** is needed to address the realities of older persons suffering from visual impairment and other conditions associated with old age.

The multi-disciplinary team consists of many different professionals, including: social workers, rehabilitation counsellors, psychologists, audiologists, speech pathologists, and teachers. Services can either be specialised or general in nature (Weiner, 1991:69).

4.3.2.6 Evaluating outcomes

One of the most important aspects of service delivery is **evaluating** whether or not services are effective or not. Agencies need to have a built in evaluation programme to ensure that services remain appropriate and effective. In this way services that

are ineffective can be modified timeously in order to optimally benefit the clients (Gillman, Gordon & Simon, 1978: 385-387).

Table 4.1 Interventions from an ecological perspective

Level of Human Ecosystem	Examples of possible social work interventions
Person-level	• orientation and mobility training; • rehabilitation services; • self-help groups; • telephone counselling; • low vision services; and
Commmunity- level	• training workers; • rehabilitation centres; • distribution of information; and • multi-disciplinary teams;

Table 4.1 summarises possible social work interventions that could be employed when working with older person with visual impairments on person and community levels from an ecological perspective. At person-level orientation and mobility training, rehabilitation services, self-help groups, telephone counselling and low vision services can be employed. At community-level possible interventions include: training workers, establishing rehabilitation centres, distributing information, and organising multi-disciplinary teams.

However, there are always challenges to successful service delivery that need to be noted. Rogers and Long (1991:157) identify the following **challenges** to successful service delivery have been identified:

- Inadequate transportation for clients to rehabilitation centres;
- Lack of accessible services for clients;
- Negative attitudes of staff members regarding the aged and the visually impaired;
- Lack of trained personnel and lack of financial resources for rehabilitation centres; and

- Negative attitudes of clients regarding utilising of such services.

Service delivery is faced with many challenges mostly related to accessibility and availability of services and service providers. These challenges need to be addressed in order to provide appropriate services.

4.5 CONCLUSION

The chapter gave an overview of Welch's (1987:156) concentric model and the different levels in the person-environment interaction such as the intra-personal, inter-personal, family or small groups, community. Then the chapter described social work intervention for older persons with visual impairments according to the five levels adapted from Welch's (1987:156) concentric model: person-level, family-level, friends-level, Old Age Home-level, and occupational-level. These interventions included: orientation and mobility training, rehabilitation services, self-help groups, telephone counselling, low vision services, training workers, establishing rehabilitation centres, distributing information, and organising multi-disciplinary teams. Finally challenges to successful service delivery were identified.

According to the above discussion, it can be concluded that a variety of rehabilitation services exists that could be utilised in order to meet clients' needs. However, rehabilitation services should be individualised in order to address the specific needs of the clients, as not all older persons experience visual impairment in the same way, and may not benefit from the same rehabilitation services.

The following chapter explores the socio-emotional experience of older persons with visual impairments and outlines the results of the study.

CHAPTER 5

EXPLORATION OF THE SOCIO-EMOTIONAL EXPERIENCE OF OLDER PERSONS WITH VISUAL IMPAIRMENTS

5.1 INTRODUCTION

Despite the fact that literature (Cherry et al., 1991:100; Crews, 1991:138; Branch et al., 1989: 359; Goodman, 1985:155; Rogers & Long, 1991:154;) confirms the increase in the number of older persons and validate that the risk of severe visual impairment increases with age, there is a noteworthy lack of recent research (Branch et al., 1989:360; Yeadon, 1991:185) related to the socio-emotional experience of older persons with visual impairments.

Furthermore, researchers (Branch et al., 1989: 359; Lupsakko et al., 2003:573-574; Stuen, 1991:166; Vaughan & Hobson, 1990:370) are of the opinion that visual impairment, especially after a lifetime of normal vision, has an intense effect on the quality of life for many older persons contributing to an increase dependency on others. Orr and Rogers (2001:670) point out, there is an increased awareness of the growing need and demand for services for older persons who are visually impaired.

Visual impairment does not only affect the individual but also those who care for and about the older person. This is not an isolated event, but one that concerns family, support systems and social structures (Crews, 1991:138). With the detection of visual impairment the individual and family members experience changes in family life, relationships, work, recreation and finances. In order to facilitate the adjustment process to these changes, Asch (1995: 2461- 2467) notes that there is a need for social workers to render multi-dimensional services to older persons and their families in order to ensure optimal social functioning.

The exploration of the socio-emotional experience of older persons with visual impairments was based on the above. The results of the study will subsequently be discussed.

5.2 DELIMINATION OF THE INVESTIGATION

Following a literature review and an interview with the Head of the Ophthalmology Department at Tygerberg Hospital, the need for updated research in this field was identified and permission to conduct this study was granted. Due to the difficulty of identifying participants, the researcher limited the investigation to older persons attending the Eye Clinic at Tygerberg Hospital. The researcher is convinced that the experience of other older persons with visual impairment attending Tygerberg Hospital and within the service area of the Hospital corresponds with those in the study.

The population for the study consisted of all the patients, 65 years and older, from the Ophthalmology Outpatients Department at Tygerberg Hospital. The sample consisted of ten participants selected by means of a purposive sampling method (De Vos et al., 2002:334) that experienced visual impairment, and visited the Department during the month of August 2005.

5.3 GATHERING AND ANALYSING DATA

Data was collected by means of a semi-structured interview with the aid of an interview guide. All the interviews were conducted in the home-language of the participant (either English or Afrikaans) and audiotape with the consent of the participants (De Vos et al., 2002: 302-303).

The researcher began the process of data collection by making contact with the potential participants while they awaited treatment. During this contact, the researcher introduced herself to the potential participants and explained the purpose and procedures of the research study. The researcher then established their readiness to participate in the research study. Permission was obtained from willing participants to tape-record the interview. Participants were informed about the confidential nature of the tape recordings and transcripts of the interview. The researcher then explained that if they decided to voluntarily participate in the study, they would be requested to sign a consent form. Where participants were indeed willing to take part, the researcher proceeded with the interview.

Participants had the opportunity at the end of the interview to ask questions regarding any uncertainties or express any feelings caused by the interview. As a registered social worker, the researcher was able to offer debriefing were necessary.

When the data collection process reached the point of data saturation (Tutty et al., 1996: 92), the process of data analysis began. First the tape-recoded interviews were transcribed. The data was then analysed in the following way: first the transcriptions was organised in computer files, then the researcher read the transcriptions and sorted the data according to categories and themes.

In the rest of the chapter, the data will be presented and interpreted by comparing it to existing data from the literature review. Where relevant, the data will be presented in narrative, tabular or figure form. It is important to note that due to the qualitative nature of the study, not all the participants answered all the questions as the researcher merely guided the discussion. The researcher did however try to incorporate all aspects of the research in the interview, but in some cases the flow of the interview did not allow for it.

5.4 RESULTS OF THE INVESTIGATION

5.4.1 Identifying details of participants

Table 5.1 summarises the identifying details of the ten participants that took part in the study. The details will be discussed in the following section.

Table 5.1 Identifying details of participants

Participant	Age	Marital Status	Race	Gender	Monthly Income
1	65	Widow	Coloured	Female	R500-R999
2	80	Widow	White	Female	R500-R999
3	78	Widow	Coloured	Female	R500-R999
4	73	Widow	Coloured	Female	R500-R999
5	70	Married	White	Male	R1500-R1999
6	69	Married	White	Male	R1000-R1499
7	74	Married	White	Male	R500-R999
8	75	Married	White	Male	R1500-R1999
9	77	Married	Coloured	Male	R500-R999
10	66	Never married	Coloured	Female	R500-R999

5.4.1.1 Age

Firstly the age of the participant had to be determined in order to ensure that the participant qualified to take part in the study, as the study focuses on older persons over the age of 65 years. All ten (100%) participants were over the age of 65 years and therefore qualified for the study. As shown in figure 5.1, the participants' ages ranged between 65 years and 88 years. Most of the participants (60%) were in their 70's. Three (30%) of the participants were in their 60's, and only one participant (10%) was older than 80 years.

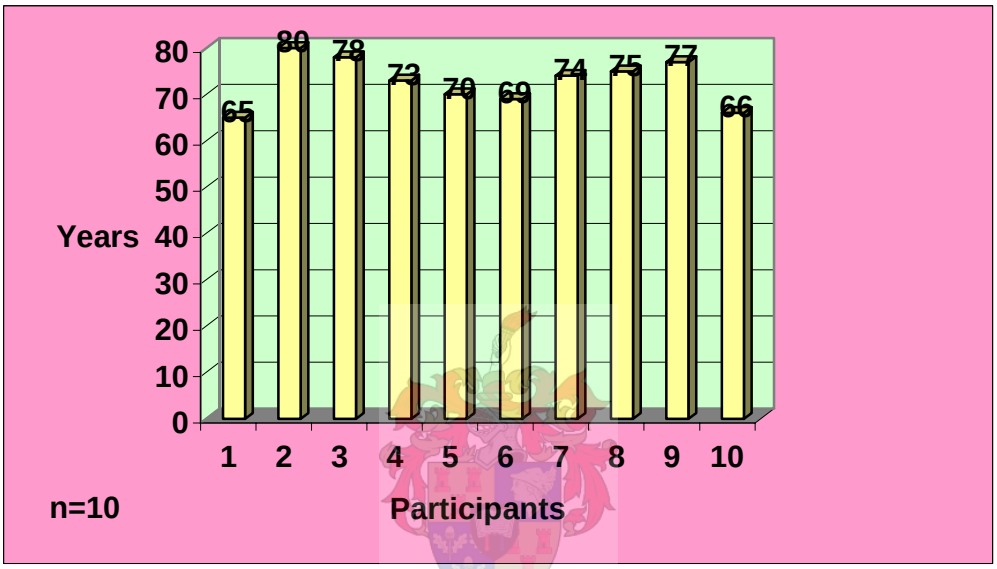


Figure 5.1: Age of participants

5.4.1.2 Marital status

In the study, half (50%) of the participants were married as shown in figure 5.2.

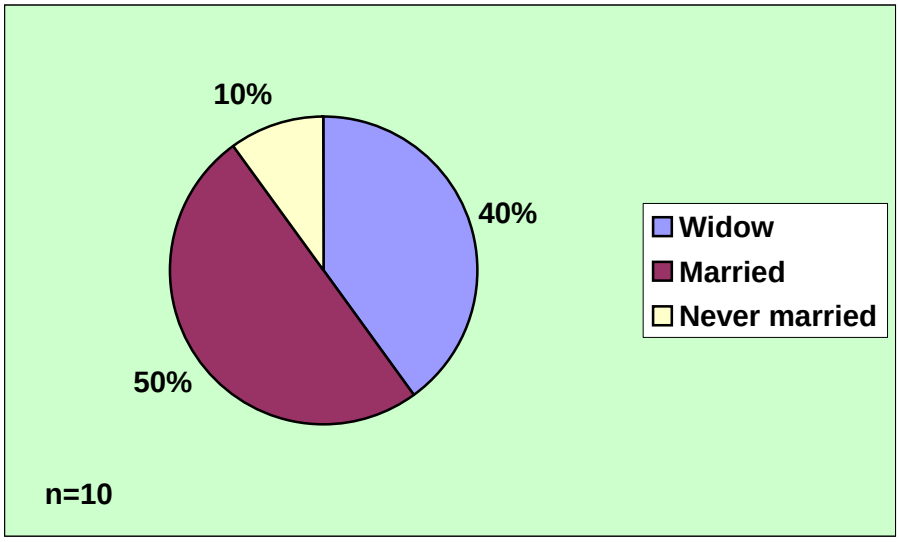


Figure 5.2: Marital status of participants

According to Raubenheimer et al. (1998: 631-636) older persons who are married tend to be physically and psychologically more healthy and appear to live longer than their unmarried counterparts, due to spouses providing each other with both physical and emotional support during times of illness or difficulties. Only one (10%) participant had never been married.

Four (40%) of the participants were widows. Several authors (Kail & Cavanaugh, 2000:552-553; Perlmutter & Hall, 1992:329-330) point out that women have a longer life expectancy than men, and therefore the average wife can expect to live more than ten years as a widow. Raubenheimer et al. (1998:634) further states that older persons who are widowed are physically and psychologically more prone to problems after the loss of a spouse.

5.4.1.3 Race

According to the Census of 2001 (http://www.statssa.gov.za/census01), the majority of older persons in South Africa are Black (68,9%). The second largest group are White (21.5%). The third largest group (7,2%) are Coloured older persons in South Africa. The smallest proportion (2.3%) of older persons in South Africa is Indian or Asian.

Only Coloured (50%) and White (50%) participants took part in the study. These results are portrayed in figure 5.3. The results cannot be generalised to all South Africans, as the majority of older persons in South Africa are Black. The results can however be useful in working with Coloured and White communities.

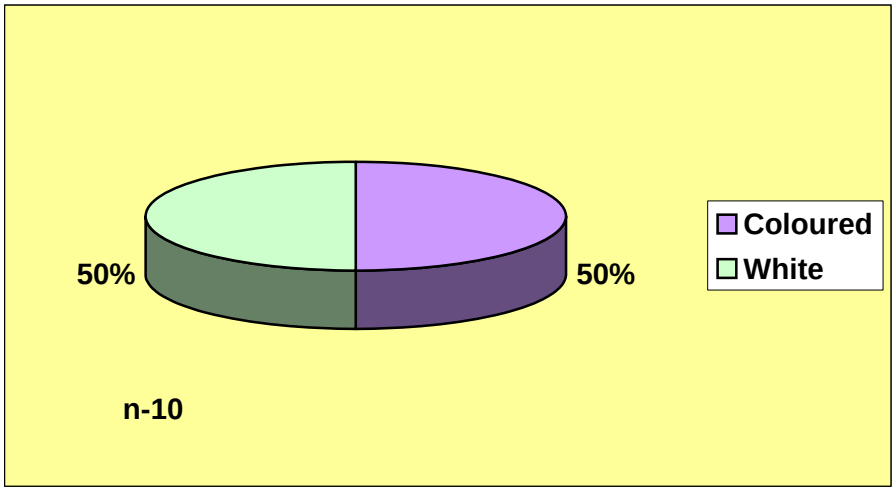


Figure 5. 3: Race of participants

5.4.1.4 Gender

According to Dunkle and Norgard (1995:143), older persons form a demographically heterogeneous group. An equal number of males (50%) and females (50%) took part in the study, as represented in table 5.1. Race does not play a role in visual impairment in older persons.

Table 5.2: Gender of participants

Male	**5**
Female	**5**
TOTAL	**10**

n=10

5.4.1.5 Monthly income

Figure 5.4 summarises the monthly income of participants. More than half (70%) of participants have a monthly income of between R500 and R999. Two (20%) participants have a monthly income of between R1000 and R1500. Only one participant (10%) had a monthly income of between R1500 and R1999. Several authors (Kail & Cavanaugh, 2000:552-553; Perlmutter & Hall, 1992:329-330) indicate that widowhood is often accompanied by poverty. All four widows that participated in the study had a monthly income of between R500-R999. Most of these older persons are dependent an Old Age Pensions and cannot afford private services. Especially the female participants, of whom the majority (40%) was widowed, were dependent on an Old Age Pension. They can therefore be identified as vulnerable as they are old, female, poor, and visually impaired.

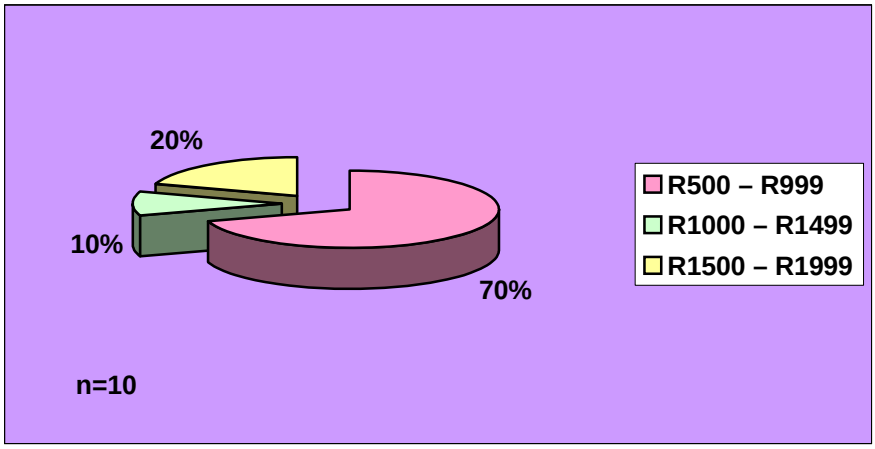


Figure 5.4: Monthly income of participants

5.4.2 Overall health

Cherry et al. (1991:100) and Du Pre (1982:365) explain that in addition to visual impairment, older persons often struggle from other physical deficits like deafness, arthritis, and other infirmities associated with old age.

The participants were requested to describe their overall health. More than half (60%) of the participants described their overall health as good. Their responses included the following:

- *My gesondheid is goed.* (My health is good.)
- *Die gesondheid is ouraait.* (The health is 'okay'.)
- *Algeheel kan ek nie sê ek is sieklik nie*. (Overall I cannot say that I'm sickly.)
- *Algemene gesondheid is puik…* (Overall health is excellent.)
- *Nee, dis goed…* (No, it is good.)
- *My gesondheid is baie goed...* (My health is very good.)

The other four (40%) participants had other health problems not related to their eyesight. One of the four participants had several complaints:

> *Ek het maar baie probleme. My voete is so seer. En ek… die heup moes al geopereer geraak het, maar ek het dan mos nou nie die geld nie. En ek het 'n spastiese dikderm en my mond het swamme, en my hart is nie lekker nie… Ja, nou nog die oë en my ore.* (I have lots of problems. My feet are very sore. I need a hip operation but I do not have the money. I have a spastic colon and my mouth is filled with sores. My heart is not well. On top of it all still the eyes and the ears).

The other three participant had the following illnesses respectively: chronic lymphatic leukaemia and diabetes; pneumonia; and emphysema. These participants with visual impairments also had other very serious health problems. Visual impairment therefore adds to their daily life stress as they need to cope with several health conditions. This confirms the statements by Cherry et al. (1991:100) and Du Pre

(1982:365) that suggest that older persons with visual impairments often have to cope with other illnesses (and the impact of these illnesses) too.

5.4.3 Visual ability and impairment

Participants were required to respond to three questions regarding their visual ability and impairment:

- When did you first experience vision loss?
- How did you feel when your vision became impaired?
- How would you describe your vision at present?

These questions will now be answered.

5.4.3.1 First experience of vision loss

In response to the first question, half (50%) of the participants experienced vision loss within the past 2-4 years. One participant experienced vision loss in the last six months. Of the remaining participants, two (20%) participants experienced vision loss within the past 10-12 years, and two (20%) participants suffered from vision loss since childhood, but it had worsened in the last few months. For these older persons, loss of vision was a progressive process over a number of years.

5.4.3.2 Feelings related to vision loss

The participants described their feelings towards their visual impairment in the following ways:

- *Ek het **nie lekker gevoel** nie, want ek kan mos nou nie sien nie.* (I did not feel well, because I cannot see.)
- *Ek het baie **hartseer** gevoel. Dis nie lekker om blind te word nie.* (I was very sad. It is not pleasant to become blind.)
- *Ek was **vies**, ja. My oë was dan nou so goed, en hoekom kom al die probleme dan nou na my toe nou dat ek so oud is.* (I was upset, yes. My eyes have always been good, why do I have all these problems now that I'm old.)
- *Dis so… **ongemaklik**, ek voel so hulpeloos. Jy kan niks vir jouself doen nie.* (It is so… uncomfortable, I feel so helpless. You cannot do anything for yourself.)

- *En toe voel ek nou, so… '**down'** kan jy maar sê.* (I felt so down.)

In this study, older persons expressed varying degrees of grief (sad, upset, uncomfortable, helpless, and down) with the onset of visual impairment. These were mostly unpleasant feelings.

This corresponds with literature according to Du Pre (1982:365) that describes this as a very emotional event for individuals who lived a previously normal life, especially as very few older persons ever expect to become visually impaired. Vaughan and Hobson (1990:370) agree that visual impairment, particularly after a lifetime of normal vision, has a profound effect on the quality of life for many older persons contributing to an increase dependency on others.

Research (Cherry et al., 1991:100) indicates that visual impairment has consequences in all aspects of older persons' lives: social, emotional, mental and physical. For example, on psychological level, older persons who experience loss of vision have a poorer self-image than those who can see. Older persons who suffer loss of vision tend to feel gradually more tense, anxious, and lacking in energy when compared to those that can see, even though their overall self-image may be positive (Fagerström 1994: 458-461). Furthermore, Rosenbloom (1982:210) describes that older persons may experience intense feelings of grief accompanied by confusion, self-pity, doubt and decreased self-confidence with the onset of visual impairments.

Other participants indicated the need to adjust to this new experience:

> *Nee wat ek kan nie sê ek was kwaad nie, ek het net gevoel ek sal moet iets daaraan doen.* (I cannot say that I was angry, I just felt that I needed to do something about it.)

Cherry et al. (1991:100) agrees that for many older persons visual impairment is a new experience that they need to learn how to cope with in addition to the normal challenges of aging.

5.4.3.3 Visual functioning at present

Thirdly, the participants were required to describe their visual ability at present. The participants described their vision as poor.

- *Ja, ek kan ver sien. Maar ek kan **nie lees nie**. Ek kan nie… as dit groot woorde soos daai kan ek sien, maar as dit klein is kan ek dit nie lees nie.* (Yes, I can see far, but I cannot read. If the letters are small I cannot read them.)
- *Met die oog kan ek glad niks sien nie. As ek die oog toe maak kan ek **jou nie sien nie***. (With this eye I cannot see anything. If I close this eye, I cannot see you.)
- *I **cannot read** telephone pages.*
- ***Nie goed nie**.* (Not good.)
- *Soos ek nou sien, kan ek sien as ek daar kyk, maar **ek kan jou nie sien nie**.* (I can see if I look far away, but I cannot see you.)
- *As ek **TV kyk** sien ek dis 'n bietjie vaal dan is dit eintlik kleur.* (When I watch television I think it is dull, but actually it is colourful.)

These participants described their vision as poor in accordance with Moenstam and Wachtmeister's (2002:1087) description of visual impairment as the "…visual inability to read, to watch television or to orientate one-self in unfamiliar surroundings…".

This implies that older persons cannot enjoy the activities they once took part in, like reading or watching television. For some it is even more severe, they cannot recognise individual faces. Older persons spend several hours a day indoors, if they cannot read or watch television, there is little left for them to do. They can listen to the radio, but other activities like reading or watching television are limited.

5.4.4 Psycho-social implications of vision loss

In order to explore the psychosocial implications of vision loss for older persons, the following implications were investigated: concerns related to visual impairment; influence of visual impairment on relationship with friends and/ or family members; influence on daily activities (like driving, shopping, sport, television, needlework and knitting and reading); and money management.

5.4.4.1 Concerns related to visual impairment

In correspondence with literature some of the participants did express concerns related to their visual impairment. Literature (Hill & Harley, 1984:50) indicates that as older persons begin to experience visual impairment, many fears arise as they wonder how it will affect their health and also their inability to meet their financial obligations.

In the study, one of the participants worried about not being able to continue chores around the house and taking care of her sons. The participant explained her concerns as follows:

> *Ja, dit was nogal 'n* ***bekommernis*** *vir 'n mens gewees. Ek weet nie… Ek doen… Ek 'like' nogal om my werkies self te doen en ek 'like' om my* ***wasgoed*** *self te was en ek het nog twee seuns daar wat ek nog… wat nog in die huis is wat ek na omsien en ek 'like' om self vir hulle te sorg en so aan… Toe was ek nou bietjie bekommerd gewees ja, dat ek dan nou nie kan so of so nie.* (Yes, it was quite a worry for me. I like to do all my own tasks around the house like washing, and I still have two sons at home that I would like to care for. So, I was just a little worried that I would not be able to continue doing that.)

This could have far reaching consequences for an older person's daily functioning as it could lead to increased dependence on other's for assistance in tasks around the house like cooking and cleaning.

Two of the male participants expressed their concerns regarding driving a car. They worried that they would have to stop driving due to their visual impairments:

- *Kyk, ek het maar net besef as dit so gaan, gaan ek oor 'n jaar of twee ophou* ***kar bestuur*** *dis maar al.* (Look, I just realised that in a year or two I would have to stop driving a care, that is all.)

- *But I am worried if it's going to get worse, yes. And I'm worried that I **cannot drive**. And then when I stress my chest closes up from the emphysema.*

This has serious implications in terms of older persons' mobility and independent travel. They could maybe still drive but it is a highly stressful experience and could even be dangerous. For these older persons, their visual impairment could lead to an increased dependence on others for travelling.

However, most (70%) of the participants felt that they had few concerns regarding their visual impairments at present.

Unlike literature (Hill & Harley, 1984:50) suggests, most of the participants did not express any concerns at present regarding their visual impairments. However, this could be due to several reasons:

- Older persons not feeling comfortable sharing their worries with the researcher;
- Older persons not wanting to appear worried;
- Having dealt with their worries in a constructive manner; or
- Really not experiencing any worries.

5.4.4.2 Influence of visual impairment on relationship with friends and/ or family members

As outlined in the literature study, according to Parry and Young (1978:56) interactions among family members are often disrupted due to the onset of disability in one family member. With the onset of visual impairment in older persons, misunderstandings among family members seem to occur regarding the changes in the older persons and his/her feelings regarding the situation (Jacobs, 1984:155). Some of the participants confirmed these suggestions. As the participants note:

- *My familie het nie eintlik **belanggestel nie** en so aan…* (My family was not really interested and so on…)
- *Hulle kon net 'n **bietjie ongemaklik** gewees het oor die oog.* (They were a little uncomfortable with the eye.)

- *Not at the moment. But when I get stressed I'm **short tempered**.*

However, other participants were of the opinion that it did not really influence their relationship with their friends and family negatively, and that their family was very supportive.

- *Nee, hulle's baie **simpatiek** en **meelewend**.* (They were very sympathetic and concerned.)
- *Hulle het my **gerusgestel**.* (They set my mind at ease.)
- *Ja. Hulle **worry**.* (Yes, they worry.)

Authors (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al., 1998:642) point out that to many older persons, the most significant phenomenon in life is their relationships with friends and family. Friends and family members can act as a strong support system for older persons with visual impairments. Older persons tend to depend on family members for support and help. This is a powerful resource/strength that needs to be utilised in coping strategies for older persons. The positive contribution of friends and family members need to be taken into account in formulating support services for older persons.

5.4.4.3 Influence on daily activities

When asked how their visual impairment influenced their daily activities the following categories were mentioned: driving, shopping, sport, television, needlework and knitting and reading

(a) Driving

In the study four of the participants (40%) mentioned that their visual impairment influenced their driving:

- *Ek het gevoel ek moet **versigtiger** bestuur as vroeër. Waar ek by 'n ander voertuig verby gaan moet ek dubbel seker maak die pad is skoon.* (I feel that I have to drive more carefully than before. When I pass another vehicle I have to make double sure the road is clear.)

- *Dis nou so as dat ek kan, as ek nou agter 'n kar ry,* ***nie eers sy registrasie lees nie****.* (It is so bad that when I drive behind a car I cannot read the registration number.)
- *As ek kar bestuur dan moet ek hierdie oog toe maak anders* ***sien ek twee karre*** *aankom, die een is reg voor my en die ander links van my, dan moet ek die een oog toe maak.* (When I drive I have to close my one eye otherwise I see two cars, one in front of me and the other left of me, then I must close my one eye.)
- *…now it is effecting my driving. It is like a* ***haze*** *all the time.*

Older persons that do still drive describe it as a very stressful experience. This increases their anxiety levels. Older persons mobility therefore decreases, as they tend to rather stay at home than drive around under stressful conditions.

This corresponds with literature (Jackson et al., 1983:469) that suggests that older persons who are visually impaired experience greater difficulty when travelling. Literature (Cherry et al., 1991:118) further mentions that older persons may become dependant on sighted persons for assistance. Cherry et al. (1991:118) reports that older persons with visual impairment rely mostly upon sighted guides to aid in travel. Older persons are also less likely to have access to private transport.

(b) Shopping

According to Inana (1980:329) grocery shopping can prove to be a great challenge for visually impaired individuals. Two of the participants confirmed that they experienced difficulty shopping due to their visual impairments:

- *Uh, dit het sleg gegaan. My* ***dogter*** *het toe laterhand inkopies gedoen.* (O, it was very bad. My daughter eventually had to shop for me.)
- *My* ***seun*** *kom altyd my help en dan neem hy my winkel toe.* (My son always comes to help, and then he takes met to the shop.)

Clearly older persons rely heavily on the support of their family members in order to cope with daily activities. Family members need to be encouraged to act as

resources for older persons with visual impairments and help older persons maintain as much independence as possible.

Several categories not mentioned in the literature review came up during the study:

(c) Sport

One (10%) participant explained that visual impairment influenced the ability to take part in sport: *Dit is 'n bietjie moeilik, want kyk, hulle het vir my gesit… dis 'n amper soos 'n* ***netbal ring*** *dan moet jy die ball daar ingooi, en nou kan ek nie lekker sien om die ball in te skiet in die net nie.* (It is a little difficult, because I have to through the ball in a ring, sort of like a netball ring, and I could not see to through the ball in.)

For this respondent, visual impairment limits his/her participation in social activities, and has a negatively influences his/her daily functioning. In chapter two, it was clear that exercise is important in preventing many diseases in old age (Raubenheimer et al., 1998: 595-596), therefore, not being able to participate in sport activities could in turn have a diverse effect on older persons overall health.

(d) Television

Two (20%) participants explained that visual impairment influenced their ability to watch and enjoy television:

- *As ek TV kyk sien ek dis 'n bietjie* ***vaal*** *dan is dit eintlik kleur.* (When I watch television I think it is dull, but actually it is colourful.)
- *As ek die weerberig kyk, en daar staan 10 dan lees ek 110. Of hy* ***vloei so oor mekaar*** *dat ek dit nie kan lees nie.* (When I watch the weather report, than it says 10 but I read 110. Or the letters seem to flow into each other so that I cannot read them.)

During their free time, many older persons enjoy watching television. However, visual impairments negatively impact on their ability to watch television, limiting their ability to enjoy this activity. Furthermore, for many older persons television acts as a source of information like the participant mentioned above that could not watch the weather report anymore. This could lead older persons to become uninterested in

the world around them as they cannot gain the needed information as easily as before (Corn, 1983: 373-376).

(e) Needlework and knitting

One of the activities that many older women partake in, in old age, is needlework and knitting. For many, it is a hobby that they enjoy.

- *Ek is mal oor naaldwerk doen. Ek later nie meer kan sien op die masjien nie. Om die **naald in te steek** of so nie, die kleinseun moet dit vir my doen. Toe beginne ek nou **nie meer lus voel** vir naaldwerk nie, en dit was mos my **plesier** gewees.* (I love doing needlework. But eventually I could not see to thread the needle, and my grandson had to help me. Then I did not feel like doing needlework anymore, and it used to be my pleasure in life.)

However, with the onset of visual impairment their ability to do needlework or knit becomes limited and they cannot partake in it as easily as before. Several (30%) of the participants expressed that visual impairment influenced their ability to do needlework and knitting.

The participants describe their love for needlework and knitting and how it is limited by visual impairment as follows:

- *Ek is ene wat **lief** is vir brei nou wil ek brei en ek kan nie sien wat daar **geskryf** is nie, elke keer laat die kinders moet kom sê gou vir my wat staan daar op.* (I love knitting, but I could not see what was written on the paper, then I had to call one of the children to tell me.)
- *As ons nou naaldwerk doen, dan **kan ek nie** saam met hulle doen nie.* (When they do needlework I cannot join in.)

These older persons eventually stop doing needlework and knitting due to the frustration they experience of being dependent on others to help them complete this task. Two of the participants mentioned that they required the help of a family

member in order to do needlework or knit. Throughout this chapter, it has become evident that family is an important support system for older persons with visual impairments (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al., 1998:642).

(f) Reading

Half (50%) or the participants indicated that visual impairment negatively influenced their ability to read.

- *Dit het baie swaar gegaan want ek kan toe mos nou nie sien nie, en ek **kan ook nie lees nie**. Ek is **baie lief vir lees**.* (It was really hard when I realised I cannot read. I love reading.)
- *EK het darem die laaste maand of twee het ek nou begin **moeilik lees**.* (The last month or so I started having trouble reading.)

For older persons, reading is often linked to other social activities like going to church. One of the participants still attended church but could not read in her Bible or hymnal.

- *Want ek sit Sondag in die kerk dan sit ek met die **boek onderstebo**, of ek is by 'n **verkeerde gesang***. (Because on a Sunday when I am in the church, then I sit with the book upside down, or I am at the wrong hymn.)

Reading also forms an important part of older persons spiritual life as reading the Bible helps older persons grow and develop spiritually. However, some older persons cannot read their Bible anymore and this negatively influences their spiritual development.

- *Nee ek **lees nie meer** Bybel nie.* (No, I do not read Bible anymore.)

Another participant could not read telephone pages anymore.

- *…but I **cannot read telephone pages**.*

This not only influences the individual personally, but also socially as he/she cannot interact with his/her social environment as easily as before (Corn, 1983: 373-376). .

(g) Summary

All of these aspects, accumulatively, severely limit the range of activities older persons with visual impairments can take part in. Activities that they previously used to engage in during their free time are now limited to activities that do not require sight or seeing. This could leave older persons bored and frustrated as they cannot partake in the activities they previously enjoyed. It also impacts on their social interactions with other e.g. playing sport or participating in church. Older persons may become less socially active and connected. Finally, it leads to an increase dependence on family members for help and support with daily activities that negatively influences the self-concept of older persons.

5.4.4.4 Money management

Literature (Cherry et al., 1991:110) indicated that older persons with visual impairments specified that they needed assistance with money identification and money management. In the study none of the participants indicated that they specifically needed assistance in this regard, they did however mention that their family members assisted them with shopping, which includes money management.

5.4.5 Accessing support and help

Next, participants described their knowledge and experience regarding utilisation of services for their visual impairment.

5.4.5.1 Awareness of services

Only one (10%) participant vaguely knew about services, other than the hospital, that are available for individuals with visual impairments: *Nee ek weet nie van organisasies nie… Hier is mos hier in Bellville in die wat hulle sê.. die blinde skool. Waar die mense is… en dan in Grassypark, is ook ene maar daai is nou weer grootmense wat al werk wat daar is, want my dogter is een keer daar gewerk, wat sy matron gewees het daarso. En dan in Soutrivier is mos nou weer ene wat hulle werk.* (No, I do not know any organisations… Here in Bellville is the school for the

blind. In Grassypark there is a place for adults, my daughter used to be the matron there. And in Saltriver there is one where the people work.)

Most of the participants were only aware of medical services available at Tygerberg hospital in order to address their visual impairment.

From an ecological perspective (Germain & Gitterman, 1980), there is an imbalance between the older persons needs and their awareness of environmental resources. This negatively influences older persons goodness-of-fit with their environment (Payne, 1997: 145), as they are unaware of potential resources in the environment that could fulfill their needs.

5.4.5.2 Services utilised for visual impairment

The only services participants received for their vision loss were those they received at the hospital:

- *Ja, jy gaan dokter toe.* (Yes, you go to the doctor.)
- *Dit was maar hier by die hospitaal, ja.* (It was here at the hospital, yes.)

Again, older person's lack of knowledge regarding available services for visual impairments, limit their ability to access the resources in the environment that can possibly help address their needs (Payne, 1997: 145).

Furthermore, it is important to note the importance of the hospital for older persons with visual impairments, as it is the only resource that they are aware of. The hospital therefore plays a significant part in their experience of visual impairment.

5.4.5.3 Service delivery

Ninety percent (90%) of the participants expressed a positive attitude regarding the services they received for their visual impairment. It is significant to note that their responses were mainly based on assessing the attitude (friendliness) of the staff members in the hospital. They were concerned with the help and explanations they

received from the staff, and not so much with the medical intervention for their visual impairment.

- *Ja, hulle het my **mooi gehelp** ja.* (Yes, they helped me.)
- *Hulle het my **verduidelik** wat gaan aan.* (They explained to me what was going on.)
- *Ek is **tevrede**. (I am satisfied.)*
- *Ja, nee. Hulle is baie **vriendelik**. Almal hier is baie vriendelik en 'n mens maak gou vriende*. (Yes. They are very friendly. Everyone here is very friendly and one can quickly make friends.)
- *Ja, ek moet sê die mense was baie **gaaf** hier gewees, ek kan nie kla van hulle nie.* (Yes, I must say the people are very kind, I cannot complain.)
- ***Baie positief**.* (Very positive.)
- *Ja, dankie, **baie beter!*** (Yes, thank-you, much better.)
- *Nee **goed!** Ek kan nie dingesse nie, complain nie. Ek het nie 'n problem met daar nie.* (No, good! I cannot complain. I do not have a problem with it.)
- *Ja hulle is baie **gaaf** met ons daar, ek het geen klagtes nie.* (Yes, they are very kind, I do not have any complaints.)

Only one (10%) respondent felt negative about the services: *You've got to wait, you have to have patience.*

This response was also not related to his/her physical condition, but to the time spent waiting for medical treatment. From the above it is clear that older persons are more concerned with the nature of interactions with their service providers and not so much the nature of the treatment received for their physical impairment (Kail & Cavanaugh, 2000:548; Perlmutter & Hall, 1992:343; Raubenheimer et al., 1998:642).

5.4.6 Social work intervention

According to Germain and Gitterman (1980:28-30) the **purpose of social work** is to enhance adaptive capacities of individuals and groups (older persons), and to

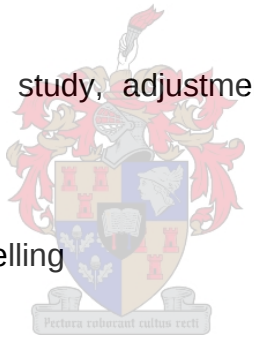
manipulate environments so that transactions will encourage growth and development. In the following section, participants expressed their opinions regarding social work intervention.

It must however, be noted that during this part of the discussion the interviewer noticed a change in the participants willingness to respond. They often only responded with a yes or a no answer and when asked to elaborate did not know what to say. The interviewer is of the opinion that it could be that these older persons were afraid that they would have to participate in further intervention or that they had not given the topic much thought. The interviewer perceived that the participants did not want to appear as uniformed regarding possible interventions, even though they did not really understand how these interventions could assist them (Toseland, 1995:153).

5.4.6.1 Counselling

As pointed out in the literature study, adjustment to visual impairment can be attained by (Jacobs, 1984:154):

- Teaching and counselling
- Group work or peer counselling



A study conducted by Jaureguy and Evans (1983:150-157) showed that group telephone counselling had a positive effect on the physical and social behaviour of visually impaired older persons. Older persons who received this kind of counselling showed a distinct increase in activities of daily living.

In accordance with this, some of the participants (40%) did think talking to someone would help:

- *Ja. Mens kan probeer om met hulle te **praat** ja.* (Yes, someone could try to talk to them, yes.)
- *Ja, natuurlik sal dit vir **party mense** help.* (Yes, obviously it would help some people.
- *Ek dink so **ja**.* (I think so, yes.)

- ***Gehelp het*** *en… kyk al wat hulle baie keer as hulle op moedverlore se vlakte sit, dan soek hulle net 'n bietjie morele ondersteuning dan voel hulle nie so alleen nie.* (It would help… look… all that they sometimes need when they have lost hope is some moral support then they do not feel so alone.)
- ***Ja****.* (Yes.)

Even though these responses were affirmative, the older persons were somewhat uncertain in their responses.

Three (30%) of the participants outrightly disagreed and did not think talking to someone would help:

- *Nee dit sou* ***nie gehelp het nie****. Om te praat met iemand nie. Want die iemand kan my nie help nie.* (No, it would not help to talk to someone, because nobody could help me.)
- ***Ag nee wat****! Ek aanvaar dit, nee wat ek het niemand se hulp nodig nie, jy weet en dan kom sit die man hier met slim stories by my… Dan weet ek nou praat jy nonsense want jy weet nie waar oor dit gaan nie. Ja, so ek het geen behoefte daaraan nie.* (No, I do not accept it, I do not need anyone's help, you know, and then someone comes with clever stories…. Then I know he is talking nonsense because he does not know what it is about. Yes, so I do not have a need for that.)
- *No, I do not know.* ***Not for me****, maybe for others.*

In contrast to the affirmative responses, the older persons who disagreed were very certain of their responses. They were convinced that it would not help to talk to someone about their visual impairment (Hill & Harley, 1984:50). The interviewer sensed that the participants feared that they might be asked to talk to someone and they clearly did not want to.

5.4.6.2 Access to information

Yeadon, (1991:189-191) points out that many older persons with visual impairments do not have the knowledge or skills concerning their condition. In the study, eight

(80%) of the participants indicated that having more information regarding the condition would make a difference in the experience of vision loss, however, once again, most of the responses were not very convincing or explanative:

- *Ja.* ***Bewusmaking*** *soos daar by die klub sou help.* (Yes. Awareness like there at the club would help.)
- ***Ek glo so****.* (I believe so.)
- ***Yes****, that would help us.*
- ***Ja****, dit sal help.* (Yes, that would help.)
- ***Ja****.* (Yes.)
- ***Ja****.* (Yes.)
- ***Ja.*** (Yes.)

Only one respondent was very certain that having more information regarding the condition would make a difference in the experience of vision loss

- *Ja. Maar dit is mos nou so seker as wat die son opkom in die ooste en sak in die weste. Dit spreek vanself. (Yes. But that is as sure as the sun rises in the east and sets in the west. It speaks for itself.)*

The interviewer perceived that the older persons were uncertain of how more information regarding the condition would make a difference in the experience of vision loss, but did not feel comfortable discussing it as they might come across as uninformed (Toseland, 1995:153).

5.4.6.3 Information regarding services

In the study, more than half (60%) of the participants mentioned that it would help to have more information regarding available services:

- *Ja.* (Yes.)
- *Ja. Dit sou help.* (Yes, that would help.)
- *O ja, dit is baie noodsaaklik.* (O, yes, that is very necessary.)
- *Ek sou gegaan het, ja.* (I would have gone, yes.)
- *Yes, that would help us.*

- *Ja, dit sal help.* (Yes, that would help.)

This concurs with literature that portrays a study conducted by Cherry et al., (1991:109) in which more than half of the participants were unaware of available rehabilitation services, and older persons were less likely to have received any rehabilitation services.

However, in this study, the older persons again only responded with a yes, and did not elaborate any further regarding this topic. The interviewer tried to explore this topic in more detail, but the responses remained vague and the participants did not know how it would help.

5.4.6.4 Support groups

The literature study (Kalafat & Dehmer, 1993:112) proposed that self-help groups are particularly appropriate to address the need for services for older persons with visual impairments because of these provide help for chronic difficulties and emphasise mutual support and the importance of personal experience and strength, instead of dependence and pathology. Several findings suggest that active membership in groups is associated with enhanced satisfaction and coping (Kalafat & Dehmer, 1993:112).

Half (50%) of the participants agreed that participation in a group would make a difference in the experience of vision loss:

- *Ja …om met hulle daaroor te praat.* (Yes, to talk with others about it.)
- *Ja. Dit sal help om hulle aan te moedig. Party mense is bang... miskien bang hulle gaan blind raak. Die een wat maklik praat oor die ding wat hom siek maak… nie almal kan nie.* (Yes. That would help to encourage them. Some people are scared. Maybe scared they will go blind. The one that can easily talk about the thing that makes him sick. Not everyone can…)
- *Ja. Ek dink dit sou help. Vir die ondersteuing.* (Yes. I think it would help. For the support.)
- *Ja.* (Yes.)

- *Yes, that would help.*

They felt that it would help by providing an opportunity to talk about mutual concerns and providing mutual support. The participants could not think of other ways in which it could help to be part of a support group. The interviewer could have explored this topic in more detail, but the interviewer perceived a sense of resistance from the participants. As explained previously (Toseland, 1995:153), the interviewer perceived this resistance to be related to:

- Older persons not wanting to partake in any services; and
- Older persons not knowing how such services could assist them but not wanting the interviewer to know this as they may come across as uninformed or uneducated.

Two (20%) participants indicated that they did not think it would help to be part of a support group:

- *Nee, nie eintlik nie.* (No, not really.)
- *Nee wat, ek het tog nie lus om na ander mense se nonsense te sit en luister nie.* (No way, I do not feel like listening to other people's nonsense.)

They were very adamant in their responses and did not want to elaborate any further. There responses were negative and indicated strong disapproval.

5.4.6.5 Coping strategies

Goodman (1985:162) explains that the goal of rehabilitation includes providing the client with the skills to manage ordinary activities independently and safely. Hill and Hill (1991:405) define these activities as grocery shopping, going to church or visiting friends in their homes.

The participants responded positively to this question, indicating that they thought it would help to learn how to cope with daily activities like travelling, cooking, shopping, and reading but they did not know how it would help them. They did not comprehend that it could help improve their quality of daily life.

Lastly, participants were required to explain how they thought social workers could help people to adjust easier to visual impairment. The responses were very vague and general:

- *Jy kan **praat** met die mense.* (You could talk to the people.)
- ***Ek weet nie**. Seker maar om uit te vind wat hulle behoeftes is.* (I do not know. Probably to find out what their needs are.)
- *Ja, ek dink nogal… om ander mense te help as hulle nie kan sien nie. Daar **is seker darem baie metodes** om te doen, om te help, om daai persoon gelukkig te maak.* (Yes, I think… to help others when they ca not see. There are certainly many methods to help those people to be happy.)
- *Ek dink om met hulle te **vra**.* (I think to ask them.)
- *Dit sou help om by die **ouetehuise** om te gaan en te kyk hoe kan jy daar help*. (It would help to go to an Old Age Home and see how you could help there.)

They generally suggested that social workers could talk to older persons and find out what they need. This was a significant response, as the interviewer was talking to them to find out what they need and they could not tell the interviewer.

5.4.7 General comments

The researcher offered participants the opportunity to make any general comments after the interview, but none of the participants expressed any general comments. The researcher further explored whether any participants felt a need for debriefing, but all the participants indicated that they did not feel a need for debriefing. The interviewer briefly summarised the content of the interview and thanked the older persons for their contribution.

5.5. CONCLUSION

The aim of the study was to explore the socio-emotional experience of older persons with visual impairments. This chapter outlined the results of the study.

First a general profile (age, marital status, race, gender, monthly income) of older persons with visual impairments was given. Then older persons' (with visual impairments) overall health was described. Older persons' visual ability and impairment was then outlined by focussing on the following aspects: older persons' first experience of vision loss; feelings related to vision loss; and visual functioning at present.

Then the psycho-social implications of vision loss was debunked: concerns related to visual impairment; influence of visual impairment on relationship with friends and/ or family members; influence on daily activities, and money management. Furthermore, accessing support and help was described with regards to: awareness of services, services utilised for visual impairment, and service delivery.

Finally, older persons knowledge regarding social work interventions (counselling; access to information; information regarding services; support groups; coping strategies) was explored.

The chapter therefore successfully explored the socio-emotional experience of older persons with visual impairments in order to help social workers gain a better understanding of these older persons in order to provide guidelines for social work intervention with these older persons.

In the following chapter conclusions and recommendations regarding social work interventions for older persons with visual impairments will be presented.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This exploration into the socio-emotional experience older persons with visual impairments originated out of an identified need for social work interventions directed at this vulnerable group. The aim of this chapter is to present the conclusions drawn from the study based on the findings of the study to make the appropriate recommendations based on the conclusions. These recommendations will indicate general guidelines regarding social work interventions with older persons suffering from visual impairments, and in so doing meet the final objective in the study: to present guidelines for social work intervention with older persons who have visual impairments.

6.2 CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations are based on the findings from the empirical investigation.

6.2.1 Identifying details

All the participants who took part in the study were older persons over the age of **65 years**. Both **male** and **female** participants took part in the study. The majority of the participants were either **married** or **widowed**. An equal number of **Coloured** and **White** participants took part in the study. No Black participants were identified. This was mainly due to the fact that the service area of Tygerberg Hospital is mainly Coloured and White areas in the Western Cape. More than half of the participants fall into a **low-income group**.

From these findings it can be **concluded** that the general profile of older persons with visual impairments varies between age, gender, marital-status, race and socio-economic status, and that there is not one characteristic that stands out above the others.

Recommendations:

Services aimed at **prevention**:

- Awareness programmes regarding the **impact of visual impairment** in old age should be rendered to all older persons, as visual impairment does not vary between gender, marital-status, race or socio-economic status.
- Awareness programmes regarding **services** for older persons with visual impairments should be rendered to all older persons, as visual impairment does not vary between gender, marital-status, race or socio-economic status.

6.2.2 Overall health

More than half of the participants in the study described their overall health as good. The other participants had other health problems not related to their eyesight: chronic lymphatic leukaemia and diabetes; pneumonia; and emphysema.

The **conclusion** can be made that those older persons who experiencing visual impairment may primarily suffer from other **chronic health problems**, and in addition to these experience difficulties with their eyesight. Visual impairment therefore adds to their daily life stress, as they need to firstly cope with serious chronic conditions and the impact these illnesses have on their daily functioning, and then deal with the challenges brought about by visual impairment.

Recommendations:

Tasks related to the **assessment-phase**:

- The social worker should determine the **overall health** of the older person
- The social worker should determine the **impact of chronic illnesses** on the daily functioning of older persons in conjunction with the impact of visual impairment.

6.2.3 Visual ability and impairment

Most of the participants experienced vision loss within the **last ten years**. For these older persons, loss of vision was a progressive process over a number of years.

The participants expressed their **feelings** associated with the onset of vision loss as follows: sad, upset, uncomfortable, helpless, and down. It can be concluded that the experience of vision loss was associated with a number of negative feelings. It is concluded that vision loss is a very emotional event for individuals who lived a previously normal life, as it contributes to an increase dependency on others. Some participants also expressed the need for adjustment to vision loss in addition to the normal challenges of aging.

In **conclusion**, the participants described their visual functioning at present as **poor** in accordance with Moenstam and Wachtmeister's (2002:1087) description of visual impairment as the "…visual inability to read, to watch television or to orientate one-self in unfamiliar surroundings…". This implies that older persons cannot enjoy the activities they once took part in, like reading or watching television. For some it is even more severe, they cannot recognise individual faces. Older persons spend several hours a day indoors, if they cannot read or watch television, there is little left for them to do. They can listen to the radio, but other activities like reading or watching television are limited.

Recommendations:

Services aimed at **prevention**:

- Awareness promotion by social workers should **begin in adulthood** as several older persons experienced gradual vision loss that began in adulthood.

Tasks related to the **assessment-phase**:

- The **feelings** of older persons with visual impairments must be **identified** by social workers in order to deal with these emotions in a realistic manner.

6.2.4 Psycho-social implications of vision loss

Some of the **concerns** expressed by the participants included: concerns regarding their inability to carry out daily chores, to take care of their children and to drive a car. This could have far reaching consequences for an older person's daily functioning as it could lead to **increased dependence** on others for assistance in

tasks around the house like cooking and cleaning. Furthermore it impacts on older persons' mobility and independent travel. They could maybe still drive but it is a highly stressful experience and could even be dangerous. For these older persons, their visual impairment could lead to an increased dependence on others for travelling.

However, most of the participants felt that they had **few concerns** regarding their visual impairments at present. It could be **concluded** that some older persons do experience concerns related to their visual impairment, while other apparently do not. This apparent lack of concern could however, be ascribed to several reasons:

- Older persons not feeling comfortable sharing their worries with the researcher;
- Older persons not wanting to appear worried;
- Older persons having dealt with their worries in a constructive manner; or
- Older persons really not experiencing any worries.

Some participants noted that their visual impairment had a **negative effect** on their relationship with their **friends and/or family members**. Their family and/or friends were either not interested or uncomfortable in their presence. A participant explained that his visual impairment caused him to be stressed and short tempered at times which had an adverse effect on his relationship with his family and friends. However, other participants were of the opinion that it **did not really influence** their relationship with their friends and family negatively, and that their family was very supportive.

It can be **concluded** that for some older persons visual impairment could have a negative effect on relationships with family and/or friends, however, for others, family and/or friends act as a **supportive network**.

For example, many older persons rely on family members for assistance in daily tasks like shopping. These older persons rely heavily on the support of their family members in order to cope with daily activities. Family members need to be

encouraged to act as resources for older persons with visual impairments and help older persons maintain as much independence as possible.

The **psychosocial implications** of vision loss include the impact of vision loss on daily activities like: driving, shopping, sport, television, needlework/ knitting, and reading.

In the study participants mentioned that their visual impairment influenced their **driving** negatively. Older persons that do still drive describe it as a very stressful experience. Older persons mobility therefore decreases, as they tend to rather stay at home than drive around under stressful conditions. They also become increasingly dependent on others for transportation.

Some of the participants confirmed that they experienced difficulty **shopping** due to their visual impairments and that they relied heavily on the support of their family members in order to cope.

A participant mentioned that visual impairment influenced the ability to take part in **sport**. For this respondent, visual impairment limited his/her participation in social activities, and had a negatively influence on his/her daily functioning. In chapter two, it was clear that exercise is important in preventing many diseases in old age, therefore, not being able to participate in sport activities could in turn have a diverse effect on older persons overall health.

Participants also explained that visual impairment limited their ability to watch and enjoy **television**. During their free time, many older persons enjoy watching television. However, visual impairments negatively impacts on their ability to watch television, limiting their ability to enjoy this activity. Furthermore, for many older persons television acts as a source of information like the participant mentioned above that could not watch the weather report anymore. This could lead older persons to become uninterested in the world around them as they cannot gain the needed information as easily as before.

With the onset of visual impairment older persons' reported that their ability to do **needlework or knit** becomes limited and they cannot partake in it as easily as before. They become dependent on family members to help them complete this task.

Participants reported that visual impairment negatively influenced their ability to **read**. For older persons, reading is often linked to other social activities like going to church. One of the participants still attended church but could not read in her Bible or hymnal. Reading also forms an important part of older persons spiritual life as reading the Bible helps older persons grow and develop spiritually. However, some older persons cannot read their Bible anymore and this negatively influences their spiritual development. Another participant could not read telephone pages anymore. This indicates that visual impairment does not only influences the individual personally, but also socially as he/she cannot interact with his/her social environment as easily as before.

It can be **concluded** that all of these aspects, accumulatively, severely limit the range of activities older persons with visual impairments can take part in. This could leave older persons bored and frustrated as they cannot partake in the activities they previously enjoyed. It also impacts on their social interactions with other e.g. playing sport or participating in church. Older persons may become less socially active and connected. Finally, it leads to an increase dependence on family members for help and support with daily activities that negatively influences the self-concept of older persons.

Recommendations:

Tasks related the **assessment-phase**:

- The social worker should **identify** the **concerns** of older persons regarding their visual impairment in order to provide assistance in addressing these concerns.

- The social worker should **explore** the potential **effects** of visual impairment on the older person's **relationships with friends and/or family** in order to address possible relational concerns.

- The social worker should **recognise** and **develop supportive networks** in order to encourage independence on the part of older persons with visual impairments.

- The social worker should **determine** the **psychosocial implications** of visual impairment for older persons with visual impairments in order to design intervention strategies that can target individual needs.

Aspects related to the **intervention-phase**:

- The social worker must be sensitive towards the **contexts** in which the family functions as well as their **life standard/circumstances**.

- The social worker should **encourage** the **family** to play a part in the adjustment of older persons to visual impairment, as the family forms and important part of the older persons environment.

6.2.5 Accessing support and help

Participants were mostly **unaware of services**, other than the hospital, that are available for individuals with visual impairments. Most of the participants were only aware of medical services available at Tygerberg hospital in order to address their visual impairment. From an ecological perspective, there is an imbalance between the older persons needs and their awareness of environmental resources. This negatively influences older persons goodness-of-fit with their environment, as they are unaware of potential resources in the environment that could fulfill their needs.

The only services participants received for their vision loss were those they received at the hospital. These older persons (from a low-income group) were generally **unaware of other services** for individuals suffering from vision loss, and primarily utilise government provided medical services. It can be **concluded** that older

person's lack of knowledge regarding available services for visual impairments, limit their ability to access the resources in the environment that can possibly help address their needs and restore the goodness-of-fit with the environment.

Although participants were only aware of these services and only utilised government provided medical service, almost all of the participants expressed a **positive attitude** towards the **services** they **received** at the hospital. Their attitude, however, was based on their assessment of the attitude (friendliness) of the staff members in the hospital. They were concerned with the help and explanations they received from the staff, and not so much with the medical intervention for their visual impairment. Their responses were therefore unrelated to their physical condition, and it can be **concluded** that these older persons were more concerned with the nature of interactions with their service providers than the nature of the treatment received for their physical impairment.

Recommendations:

Tasks related to the **assessment-phase**:

- Social workers should **identify** older persons **awareness of available service**.

Services aimed at **prevention**:

- Social workers should **encourage** older persons to become aware of different services available for older persons with visual impairments.

6.2.6 Social work intervention

Several **conclusions** can be drawn from this section. **Firstly**, some of the participants noted that **talking to someone** would help. However, even though these responses were affirmative, the older persons were somewhat uncertain in their responses. Other participants outrightly disagreed and did not think talking to someone would help. They were convinced that it would not help to talk to someone about their visual impairment. The interviewer sensed that the participants feared that they might be asked to talk to someone and they clearly did not want to.

Secondly, most of the participants indicated that **having more information** regarding the condition would make a difference in the experience of vision loss, however, once again, most of the responses were not very convincing or explanative. Only one respondent was very certain that having more information regarding the condition would make a difference in the experience of vision loss. The interviewer perceived that the older persons were uncertain of how more information regarding the condition would make a difference in the experience of vision loss, but did not feel comfortable discussing it as they might come across as uninformed.

Thirdly, more than half of the participants mentioned that it would help to have more **information regarding available services**. However, in this study, the older persons again only responded with a yes, and did not elaborate any further regarding this topic. The interviewer tried to explore this topic in more detail, but the responses remained vague and the participants did not know how it would help.

Fourthly, half of the participants agreed that participation in a **support group** would make a difference in the experience of vision loss. They felt that it would help by providing an opportunity to talk about mutual concerns and providing mutual support. The participants could not think of other ways in which it could help to be part of a support group. The interviewer could have explored this topic in more detail, but the interviewer perceived a sense of resistance from the participants. As explained previously, the interviewer perceived this resistance to be related to:

- Older persons not wanting to partake in any services; and
- Older persons not knowing how such services could assist them but not wanting the interviewer to know this as they may come across as uninformed or uneducated.

Some participants indicated that they did not think it would help to be part of a support group. They were very adamant in their responses and did not want to elaborate any further. There responses were negative and indicated strong disapproval.

Fifthly, the participants indicating that they thought it would help to learn how to **cope with daily activities** like travelling, cooking, shopping, and reading but they did not know how it would help them. They did not comprehend that it could help improve their quality of daily life.

Participants generally suggested that **social workers** could talk to older persons and find out what they need. This was an interesting response, as the interviewer was talking to them to find out what they need and they could not tell the interviewer.

Therefore, it can be **concluded** that older persons with visual impairments need the following interventions: talking to someone; information regarding visual impairment; information regarding available services; participating in a support group; and learning to cope with daily activities.

Recommendations:

Aspects related to social work **interventions**:

- The social worker should be **aware of personal feelings** and **experiences** regarding older persons, and address these fully before engaging in intervention with older persons.

- The social worker must be **aware of his/her own knowledge** and **skills** with regards to intervention with older persons.

- The social worker must **possess the needed knowledge** and **skills** regarding basic assessment and intervention skills from an ecological perspective.

- The social worker must conduct a **thorough assessment** in order to determine the current functioning of the older person and identify specific problems or needs.

- Furthermore the social worker should have a basic understanding of the **physiological aspects** of visual impairment in order to give older persons the necessary information that will help prevent unnecessary fears.

- The social worker must possess the needed knowledge regarding **available** and **suitable resources/support groups** in the geographical area of the older person and be able to implement the mediator or advocate role in order to ensure the individual gains access to these resources.

- Society's general lack of knowledge regarding visual impairment in older persons must be addressed by making more **information** regarding this occurrence available to society.

  This can be attained by:

  - Placing information regarding this phenomenon in **reception rooms** at day-hospitals or eye clinics; and
  - Ensuring that **personnel** have the necessary knowledge regarding visual impairment in older persons in order to provide individuals with the necessary information.

- Possible **social work interventions** could include:
  - Individual/family counselling services
  - Informative/teaching services
  - Support groups
  - Learning coping strategies

6.2.7 General comments

Participants did not have any general comments regarding the interview. It can be **concluded** that they had shared everything they could/or were willing to in the interview. The interviewer could have explored certain topics in more detail but the interviewer perceived a certain amount of resistance due to uncertainties on the part of the participants.

FURTHER RESEARCH

In the light of the results of this explorative investigation with regards to older persons with visual impairment, it is suggested that further research focus on the development of social work programmes that increases awareness among social workers regarding older persons with visual impairments and specifically addresses this issues, for example in Old Age Homes. This may decrease negative stereotypes regarding older persons and visual impairment, and may increase the functioning of older persons with visual impairments.

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UNIVERSITY OF STELLENBOSCH/
UNIVERSITEIT VAN STELLENBOSCH

DEPARTMENT OF SOCIAL WORK/
DEPARTEMENT MAATSKAPLIKE WERK

STRUCTURED INTERVIEW SCHEDULE/
GESTRUKTUREERDE ONDERHOUDSKEDULE

The socio-emotional experience of older persons with visual impairments / *Die sosio-emosionele ervaring van ouer persone met beperkte visie.*

All the information recorded in the questionnaire will be regarded as confidential. Individual views or respondents names will not be made known./ Alle inligting wat deur die vraelys ingewin word sal as konfidensieel beskou word. Individuele standpunte of respondente se name sal nie bekend gemaak word nie.

1. IDENTIFYING DETAILS/ *IDENTIFISEERENDE BESONDERHEDE*

1.1 Age/ *Ouderdom*:_____

1.2 Marital status/ *Huwelikstatus*:_____

1.3 Race/ *Bevolkingsgroep*:_____

1.4 Gender/ *Geslag*:_____

1.5 Monthly Income/ *Huishoudelike inkomste*:

R0 – R499	
R500 – R999	
R1000 – R1499	
R1500 – R1999	
R2000 – R2499	
R2499 +	

2. VISUAL IMPAIRMENT/ BEPERKTE VISIE

2.1 How would you describe your overall health at present? / *Hoe sou u, u algehele gesondheid, op die oomblik, beskryf?*

2.2 When did you first experience vision loss? / *Wanneer het u vir die eerste keer verlies van u visie ervaar?*

2.3 How did you feel when your vision became impaired? / *Hoe het u gevoel toe u visie begin verswak?*

2.4 How would you describe your vision at present? / *Hoe sou u, u visie op die oomblik beskryf?*

3. SOCIO-EMOTIONAL IMPLICATIONS OF VISION LOSS/ SOSIO-EMOSIONELE IMLIKASIES VAN GESIGSVERLIES

3.1 What worries you regarding your visual impairment? /W*atter bekommernisse, het u oor u gesigsverlies?*

3.2 What influence does it have on your relationship with your friends and/ or family members? / *Watter invloed het dit op u verhoudings met u vriende en/of familielede?*

3.3 What influence does it have on your daily activities? E.g. Reading, shopping, travelling, sport etc. / *Watter invloed het dit op u daaglikse aktiwiteite? Bv. Lees, inkopies, reis, sport ens.*

3.4 What influence does it have on your finances? / *Watter invloed het dit op u finansies?*

4. ACCESSING SUPPORT AND HELP/ TOEGANG TOT ONDERSTEUNING EN HULP

4.1 Of which different kinds of services available to individuals suffering from vision loss are you aware? / *Van watter verskillende soorte dienste wat beskikbaar is vir mense met gesigsverlies is u bewus?*

4.2 What services do you receive for your vision loss? / *Watter dienste ontvang u vir u gesigsverlies?*

4.3 How do you experience using these services? / *Hoe ervaar u die benutting van hierdie dienste?*

5. SOCIAL WORK INTERVENTION/ MAATSKAPLIKE WERK INTERVENSIE

5.1 Which of the following do you think could make a difference in your experience of vision loss? Please explain. / *Watter van die volgende dink u sou 'n verskil kon maak in u ervaring van gesigsverlies? Verduidelik asseblief.*

5.1.1 Having someone to talk to. / *Iemand om mee te praat*.

5.1.2 Having more information regarding the condition. / *Om meer inligting aangaande die toestand te hê.*

5.1.3 Having more information regarding available services. / *Om meer inligting aangaande beskikbare dienste te hê.*

5.1.4 Being part of a support group. / *Om deel te wees van 'n ondersteuningsgroep.*

5.1.5 Learning how to cope with daily activities like travelling, cooking, shopping, reading etc. / *Om te leer hoe om daaglikse aktiwiteite te hanteer soos reis, kook, inkopies, lees ens.*

5.2 How can social workers help people to adjust easier to gradual visual impairment? / *Hoe kan maatskaplike werkers mense help om makliker aan te pas by verswakende visie?*

5. COMMENTS/ KOMMENTAAR

THANK-YOU VERY MUCH FOR YOUR CO-OPERATION /

BAIE DANKIE VIR U SAMEWERKING

KONSEP INLIGTINGS-EN TOESTEMMING DOKUMENT

Navorsingsprojek: ‘n Maatskaplike perspektief op die sosio-emosionele ervaring van ouer persone met beperkte visie.

Verklaring deur pasiënt

Ek, die ondergetekende, _____
(ID_____) van _____
_____(adres)

A Ek bevestig dat

1. Ek uitgenooi is om deel te neem aan bogemelde navorsingsprojek wat deur die Departement van Maatskaplike Werk van die Universiteit van Stellenbosch, in samewerking met die Departement van Oogheelkunde by Tygerberg Hospitaal, onderneem word.

2. Daar is aan my verduidelik dat:

1.1 2.1 Die doel van die studie is om inligting in te samel aangaande die sosio-emosionele ervaring van ouer persone met beperkte visie ten einde riglyne daar te stel vir maatskaplike werk intervensie.

2.2 Die inligting ingesamel sal word deur middel van ‘n vraelys wat tydens ‘n onderhoud gesamentlik deur my en die navorser voltooi sal word.

2.3 Tien ouer persone betrek gaan word by die studie en dat slegs een onderhoud gevoer gaan word.

3. Ek meegedeel is dat die inligting wat ingewin word vertroulik hanteer sal word, maar wel aangewend sal word vir die doeleinde van ‘n tesis en moontlike verdere publikasie in vaktydskrifte.

4. Ek, na afhandeling van die projek, die navorser kan nader rakende die bevindinge van die projek.

5. Ek meegedeel is dat ek mag weier om deel te neem aan hierdie projek (asook dat ek ten enige tyd deelname daaraan mag staak) en dat sodanige weiering of staking nie op enige manier my toekomstige behandeling by hierdie inrigting sal benadeel nie. Ek verstaan ook dat die navorser my deelname aan die projek mag beëindig indien dit in my belang geag word deur hom/haar.

6. Die inligting wat hierbo weergegee is aan my in Afrikaans verduildelik is en dat ek die taal goed magtig is en dat ek ‘n geleentheid gegee is om vrae te vra en dat al my vrae bevredigend beantwoord is.

7. Daar geen dwang op my geplaas is om in te stem tot my deelname aan hierdie projek nie en dat ek besef dat ek deelname te enige tyd mag staak sonder enige penalisasie.

8. Deelname aan die projek geen addisionele koste vir my inhou nie.

B Ek stem hiermee vrywillig in om deel te neem aan die bogemelde projek.

Geteken/bevestig te_____op _____2005.

_____
Handtekening

VERKLARING DEUR OF NAMENS NAVORSER

Ek, _____, verklaar dat ek:

1. Die inligting vervat in hierdie dokument aan _____ verduidelik het.

2. Hom/haar versoek het om vrae aan my te stel indien daar enige onduidelikhede was.

3. Dat hierdie onderhoud in Afrikaans plaasgevind het.

Geteken/bevestig te_____op _____2005.

_____
Navorser

FORM OF CONSENT

Research project: *A social work perspective on the socio-emotional experience of older persons with visual impairments.*

Statement by patient

I, the undersigned, _____
(ID_____) of_____
_____(address)

A I confirm that:

2. I was invited to take part in the above mentioned research project that is being conducted by the Department of Social Work of the University of Stellenbosch, in co-operation with the Department of Ophthalmology at Tygerberg Hospital.

3. It has been explained to me that:

3.1 The purpose of the study is to collect information regarding the socio-emotional experience of older persons with visual impairments in order to provide guidelines for social work intervention.

3.2 The information will be collected through the completion of a questionnaire by the researcher during an interview conducted with me.

3.3 Ten older persons will be included in the study and that only one interview will be necessary.

4. The collected information will be treated as confidential, but that the findings will be presented in a thesis with the chances of publication in professional journals.

5. I can obtain information from the researcher after the project has been concluded.

6. I have been informed of my right to refuse participation in the study or that participation in the project may be terminated at any time and that this termination will not affect my future treatment at this facility in any way. I also understand that the researcher may cancel my participation in the study if he/she considers it to be in my own interest.

7. The above-mentioned information was explained to me in English and that I am fluent in the language and that I have been presented with the opportunity to ask questions and that the questions were answered to my satisfaction.

8. I was not forced in any way to participate in the study and that my participation may be terminated at any time without me being penalised.

9. No extra cost will be charged for participation in the project.

B I hereby agree voluntarily to participate in the above-mentioned study.

Signed by _____on _____2005.

_____
Signature

STATEMENT BY RESEARCHER

I, _____, declare that I have:

1. Explained the information contained in this document to _____

2. Requested him/her to ask for my explanation if anything was unclear.

3. Conducted this discussion in English.

Signed by _____on _____2005.

_____
Signature