

PSYCHOLOGICAL FACTORS IN CASEWORK WITH BLIND OLDER PERSONS

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SOcial agencies concerned with the needs of older persons are likely to encounter problems related to blindness, just as specialized agencies for the blind increasingly find themselves concerned with older persons. These agencies are faced with problems presented by individuals frequently over 45, more often over 60, who have become blind during the course of adult life. In the country generally, over 40 per cent of those who become blind are in the two decades 50-59 and 60-68 years of age. In 1953 it was estimated that the blind population of our country was approximately 316,000 with an additional 25,000 persons likely to become blind each following year.¹ Glaucoma and cataracts, specific diseases of the eye which may cause blindness, occur with greater frequency after the age of 45. They are recognized as the cause of about one-fourth of known blindness. In addition, experience shows that despite laws for mandatory reporting, blindness among persons over 65 is frequently not reported to State Commissions for the Blind.

For some of the older persons, the

onset of blindness is fairly sudden following a specific injury, an operation, or retinal detachment. For others, vision dwindles over a period of time ranging from months to years; for still others, blindness results when vision is lost in the "good eye," after vision in one eye has already been absent. In many cases the individuals are likely to have other illnesses or disabling health conditions, such as diabetes, arthritis, cardiovascular disease, which have a high incidence among those over 65.

The cases reviewed for this paper included men and women aged 59 to 92 years of age, known to the Social Service Department of the New York Guild for the Jewish Blind. The group included individuals residing in their own homes or those of close relatives, in boarding homes, in nursing homes as well as residents of the Guild Home for the Aged Blind in Yonkers, N. Y. None were blind since birth or early childhood. The visual loss in some cases was the result of sudden trauma. In other cases gradual loss of vision covered periods ranging from two months up to 12 years. In the greatest number of these cases, blindness occurred after the sixtieth birthday.

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Reactions to Blindness

Ability to cope with the handicap of blindness, as well as to adapt to other changes in the life situation during the older years, is in each case a product of many facets of personal adjustment, prevalent social attitudes, and available community resources. To offset the limitations imposed by blindness, a variety of services may be useful. Among these are such concrete services as: guiding, talking book machine, vocational training, recreation, living arrangements, and orientation. The last is perhaps the most basic, as it refers to the re-education of the individual to enable him to function through utilization of other senses and aids. It may include a wide range of subjects and activities from ways of performing the diverse tasks of daily living, such as bathing, pouring liquids, shaving, cooking, threading needles, care of personal belongings and traveling alone, to Braille reading, writing and typing.

Casework counseling and other services directed toward resolving problems of personal adjustment and strains in interpersonal relationships are equally essential. The blind individual, as well as other family members, requires psychological help and emotional support to enable the blind person to acknowledge the need to live with his blindness, achieve emotional readiness and mobilize effort to utilize the special services mentioned earlier.² In many cases, this help is needed also to enable the blind person to regain satisfying avenues of social participation. An older person who becomes blind, whether he is residing in his own home or in an institution, needs consideration as an individual, consideration for the relationship between his blindness, aging, other disabilities or illnesses and his social and emotional problems.

The way the individual reacts to his blindness, as well as the reaction of others to him, is conditioned by the prevalent attitudes to older persons as well as to blindness. Community practices and institutions generally do not reflect the growing knowledge about the possibilities for change, growth, and learning in the older years. It is still characteristic that "little place is found in a mobile aggressive society, except fortuitously for individuals in the post reproductive phase of life."³ Under-estimation of the varied rehabilitative potentials for emotional and social adjustment for older persons is probably one of the reasons that blindness among persons over 65 is frequently not reported.

Analysis of the requests at application in our cases shows that the largest number of requests were for institutional placement, because both lay and professional persons considered it the only resort for older persons who became blind. In many of the cases no consideration was given to securing any service to help with the adaptation to blindness. For example, among those whose blindness resulted from diabetic retinopathy, we found often that they had received the most careful instruction in relation to the diabetes, but in no way were prepared for blindness. Moreover, in many instances, relatives, friends, and even physicians tended to protect these older individuals from the impact of acknowledging their blindness to the point where they were discouraged from any constructive effort at personal adjustment, and problems in daily living were intensified to an extreme. These facts suggest that the combination of blindness and aging holds out special threats not only to the blind individual, but also to the sighted.

Vision plays an important part in the learning process, in reality testing, and

in orienting oneself. Loss of vision at any age is a severe blow resulting in the interruptions of accustomed ways of learning, knowing, making choices, moving from place to place, and communicating with others. Loss of such powers and the consequent need to find substitute means and different ways of daily living are a threatening shock to the whole being.

The reaction to such a shock, like that to other shocks, is reflected in changes in behavior. The lowered self-esteem, and threats involved in increased dependency, may show up as sadness, inertia, querulousness, hostility, increased anxiety, forgetfulness, overdependence, or attempts to perform beyond capacity. The difficulties presented may be closely related to the blindness. Very often they are also due to the interaction of the shock of blindness with the impact of other changes in the life situation.

In the older years, blindness may occur when the person is endeavoring to adapt to other shocks and changes, such as those that accompany marriage of adult children, birth of grandchildren, illness of a husband or wife, death of a spouse, loss of employment, declining physical vigor, or other handicaps. The older person encounters blindness at a time when opportunities for emotional satisfaction may be dwindling, those for social participation diminishing; there seems less to look forward to, and questions arise about being useful and being wanted. When the person has experienced gradual loss of vision over a long period of time, without apparent reaction, a delayed or intensified reaction may appear when the individual is faced with one of these changes. In situations where an individual has worked out a satisfactory mode of living with his blindness, the shock may be reactivated when he is threatened by one of these changes. Determining the di-

rection of help requires assessing the degree to which the loss of vision, and the extent to which the emotional impact of other trauma and conflicts are creating his present problem.

Psychoanalytic data about the symbolic significance of the eye helps us to understand other features of the shocking impact that blindness may have.^{4,5} The close association of the eye with sexuality, and eye injury with castration, exists to some degree in persons who are not in the least faced with the loss of vision, and conditions behavior toward the blind individual. The reactions of the blind person to blindness are influenced by intensity and extent of such feelings prior to blindness. In older persons, reactions to blindness may be complicated by additional anxiety and questions about self-worth related to diminished sexual powers or lack of outlet for sexual need.⁶

In addition to sub-conscious questions, cultural patterns, such as those which make "blind" synonymous with "beggar" or "outcast" may contribute to false and primitive fears about blindness. These may add to the anxiety and depression of the older person or his family. Subjective reactions on the part of caseworkers may also interfere with full realistic consideration of the needs and potentials of the older blind client.⁷ The impact on the worker of the depression, the apparent helplessness and anxiety of the client and his family may obscure the hopeful rehabilitative possibilities. Unconscious fears and personal conflicts, such as those related to blindness, aging and illness may also influence the worker's reaction. The tendency on the part of some caseworkers to take at face value problems as initially presented in cases of older blind persons results from a lack of awareness of such subjective reactions.

Diagnosis and Treatment

Our experiences pointed up that comprehensive consideration of the varied interacting factors influencing psycho-social balance in each case, and differential diagnosis were basic to helping older blind persons and their families deal with their current reality. Where the older person showed highly neurotic symptoms, withdrawal from reality, delusions or depression, psychiatric consultation was sought in clarifying achievable goals. Medical consultation was sought when organic involvement was suspected. Social planning could not be related alone to the blindness or age of the individual, but took into account the hopes and fears, the achievements and frustrations, capacities and interest, environmental and economic situation, interpersonal relations and physical health condition.

Understanding the connection between the blind older individual's past and his present was significant in diagnosis and setting of treatment goals. Like other adults, such persons were found to have unresolved conflicts, to have experienced hurt and anxiety in the past which were reawakened by the new trauma of blindness. The expectations of self before blindness and the expectation of others influenced reactions to blindness. Stress on physical perfection in the past, attitudes towards blind persons before loss of sight also determined the way one saw and used oneself as a blind person. Opportunity for the older person to express these and to separate his fantasies and misconceptions from his present situation made learning and planning in the present more possible. Knowledge of the connection between the individual's past and present also provided clues about strengths and possible sources of satisfaction.

In the case of Mrs. A, age 65, her feelings in earlier life that the least physical blemish

was reason to ridicule a person, interfered with her current ability to function. She felt that others must now react the same way to her. To defend herself from such reactions she tried unsuccessfully to simulate a sighted person in all her activities. Consequently she did not make the progress in orientation that might have been expected of someone who was so alert and in such relative good health. She blamed the attitudes of various members of her family and their shame at her blindness for her difficulties in adapting to her handicap. When she was able to come to grapple with her own feelings of fear and shame, however, she was able to benefit more from orientation instruction.

Blindness itself has unique significance for each person. The relative importance of specific environmental and emotional factors in the psycho-social balance were clarified only as the worker came to grips with specifics rather than generalities. It was important to know whether the individual perceived difference between light and dark, or could distinguish objects, or could perceive nothing at all. It was significant if there was disparity between the functional vision and the visual acuity as measured by the ophthalmologist. When an older man was concerned with inability to care for his personal needs, it was necessary to learn whether his problem was with feeding himself, dressing, shaving, bathing, toilet needs. If it was with shaving, it was helpful to know that the problem was not that he cut himself but rather that shaving required so much more time since he became blind. When a woman stressed difficulty in cooking, did she have trouble before she became blind? Was an electric broiler or hot plate available to reduce the hazard of using a gas stove? If such equipment was available, unwillingness to use it was often a clue to other pressures. If loneliness was a complaint, understanding of how the individual spent his time previously, as well as current opportunities for companionship,

provided a basis for clarifying the kind of help needed.

The feelings of blind older persons, like those of other persons, also could not be taken for granted. It was only in dealing with the specific meaning of manifested behavior that the worker gained a fresh understanding of the meaning of blindness and its relation to the total problem in each case. In some cases this resulted in re-emphasizing that the older blind persons had the same right to self-determination as others, that on a positive basis they might choose to endure risks in order to maintain self-reliance.

Mr. and Mrs. B, age 67 and 69 respectively, were referred to us by the social service department of a hospital with the request that we place Mr. B in one of our supervised boarding homes. The hospital physician had recommended that separation of Mr. B from Mrs. B was advisable, as tension between them appeared to be a contributing factor in several cardiac episodes which required Mr. B's hospitalization. Mr. B had become blind in an accident at the age of 30. Until two years ago he worked and earned enough to support himself and his family. Since he stopped working he was spending much more time at home, with the result that the strife and friction which had characterized the 40 years of Mr. and Mrs. B's marriage were intensified. It could not, however, be concluded that separation of husband and wife would reduce tensions without knowing from each of them what the marriage meant, what they saw as good, what they saw as bad, how they felt about the suggested separation. Their satisfactions in the marriage, the sources of current tension and their desire to remain together despite them, came out more clearly as the worker commented on the ambivalence that each displayed, on the one hand going through the motions of looking at boarding homes for Mr. B and on the other hand delaying decision. Recognition of the angry tone that Mr. B used in telling how "this time" he was going to a boarding home, brought out his feeling that his wife wished to put him away because of his blindness. He was angry and upset and saw the separation as a way of "showing" his wife, but he really wanted her to stop the separation. His wife

too, when given the opportunity, showed that despite some conflict and the risk, the preponderance of her feeling was for remaining with her husband.

In each situation the worker was concerned with understanding the nature and role of the psychological defenses. Like all people, older blind persons use defenses to maintain self esteem, or to cope with their wishes for dependence on others, in dealing with their unsolved conflicts, unmet needs, and forbidden desires. Depending on the degree to which these defenses do or do not interfere with the requirements of reality, they serve more or less well. When they are so geared as to conflict with requirements of practicality, difficulties in functioning and interpersonal relationship increase. Many of the applications were made only at the point when denial of blindness on the part of the individual or his family, with continued effort to do things exactly as if the individual could see, became threats to the safety of the blind person or that of others, or a strain on the conscience or peace of mind of those around him.

Among the older blind individuals, there are also those who attempted to "act out" hostilities through their requests. Thus, even apparently logical and clear cut placement requests by older people were found, on exploration, to be attempts to punish oneself or adult children. A number of cases could be cited where the older persons requested placement because of feeling that they have failed themselves and their children by becoming blind and deserved such "punishment." In other cases the desire was to punish an adult child. Often the parent intensified pressure for placement, in the hope that the adult child would not allow placement. Before deciding whether behavior was healthy and appropriate, or was a sign of mental ill-

ness, its meaning and motivation were clarified.

Thus 80-year-old Mrs. C did not know the date, the day of the week, or the time when she came for the medical examination, required of applicants to the Home for the Aged. In casework contacts we learned that she had been alert, aggressive, and accustomed to much social and community activity prior to her entering a nursing home. She told of how she accepted the plan of her children for entering the Home because she saw no other possibility for receiving needed care. In the nursing home, life was so constricted that she had little reason to keep track of the days. It made no difference whether "it was day or night because both were alike." A program of orientation instruction which she undertook timidly was encouraged by the caseworker. Heartened by her achievement in this, Mrs. C and her family were able to successfully consider the plan of Mrs. C's living in a boarding arrangement and traveling twice weekly to the agency to participate in a recreation program.

The causes for behavior of the older blind individual could be understood, and achievable casework goals set, only when the balance of forces in the family were weighed, and all members of the family were considered. When an adult child or a spouse emphasized that an older person was the chief problem, manipulation of the older blind individual was for the benefit of others without consideration of his own needs, wishes, and potentials could not be considered. Nor could the reverse occur without destructive impact on all involved.

In many cases the older blind person could make decisions about orientation, social outlets, daily activities and living arrangements only after considerable work with other significant persons in the familial balance—e.g. spouse or adult children. Instruction of other family members in correct ways of guiding the older individual and education about what was realistically achievable created a more encouraging atmosphere for the older person's efforts at learning and

constructive adjustment. Frequently these family members needed help in recognizing the older blind persons as separate individuals, subject to the same positive and negative feelings common to all people. They also needed help in dealing with their own fears and fantasies about blindness. In some cases only after an adult child was enabled to cope with dissatisfactions in his life situation could he free the parent of function according to the latter's own interests, drives and wishes.

In the recovery from trauma, shock or depression, due to loss and change, time itself has been recognized as a factor. Time is also important in dealing with the reactions following loss of vision—or the final realization that it has occurred. Long range plans made under the pressure of this period are likely to be unsatisfactory and often indeed intensify feelings of worthlessness and depression. This is particularly true of plans for placement. When the shock reaction was still strong, time was used most effectively by offering a supportive casework relationship to the older person, as well as extending help to other members of the family. They used casework help in bearing with the depression of the blind person, and in coping with their reactions to blindness, as well as in arranging for financial, homemaker, or other concrete help, until the older person could take more responsibility for his own planning.

Applicants for admission to our Home for the Aged Blind are required to visit the Home and participate in its routines and activities as part of the application process. The reaction of individuals to these visits provided useful guides as to what such a setting might involve for them. For example, only the experience of being in this setting where all the residents were blind brought out the overwhelming threat that this was to some

blind individuals. Well timed trial use of a homemaker or housekeeper, participation in a recreation program, orientation instruction, as well as other structured experiences, also helps the older person partialize his problem and find answers to what he really wanted.

Conclusions

This paper grows out of experiences in a multiple service, multiple function, specialized agency for the blind, including casework counseling, recreation, orientation instruction and vocational services in its program. While this offers a unique opportunity to become familiar with the problem and needs of blind older persons, our experiences point up the importance of individualization as well as the applicability of generic casework principles. In many communities the cooperation of a number of agencies, such as The Family Agency, Local Office of the State Commission, The Vocational Agency, The Golden Age Program, may be required to provide the varied services needed in any case.

In all social programs, deepened understanding of individual requirements has guided workers and agencies in improving services and finding ways to help people who could not be helped before. Too often still, the possibilities for useful and satisfactory living in the community for the older person who becomes blind are regarded in a hopeless light. Lack of information about the wide range of possibilities for help result in delaying the use of available services, thereby impeding realization of the fullest benefit. Re-emphasis of the common and individual needs of older blind persons reveals the considerable potential for encouraging

social functioning through personal counseling and social planning, including use of specialized services for the blind, as well as those services available to the community as a whole. The need for improving the effectiveness and range of integrated services for blind older persons is a challenge not only to agencies for the blind but also to other social agencies serving older people.

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