THERAPEUTIC EFFECTS OF GROUP COUNSELING WITH VISUALLY-IMPAIRED ELDERLY ADULTS

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

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By

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The purpose of this study was twofold: (a) to determine the therapeutic effectiveness of group counseling with visually-impaired elderly adults, and (b) to provide information concerning the effectiveness of group counseling to practitioners in the field. The study reviewed the literature regarding aging and vision, psychosocial reactions to vision loss, and group counseling with the visually-impaired and the elderly.

Twenty subjects, who were above age 65 and had recently experienced a severe loss of vision, were selected to participate in the study. Ten subjects were assigned to an experimental counseling group and 10 subjects were assigned to a no-treatment control group. The experimental group participated in 1-1/2 hour group sessions once a week for 10 weeks.

Both the experimental group and the control subjects were administered pre- and posttests. The tests measured depression, anxiety, self-esteem, and life satisfaction.
The four hypotheses in this study were tested with a univariate analysis of covariance. Significance in differences between means was tested at the .05 level of significance. All four hypotheses were supported. The experimental group showed significant decreases in depression and anxiety and significant increases in self-esteem and life satisfaction.

It was concluded that the findings of this study strongly suggest that group counseling with visually-impaired elderly adults is effective in facilitating psychological adjustment after a severe loss of vision. The study also demonstrates that group counseling can be used effectively in a clinic or rehabilitation setting.
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CHAPTER I

INTRODUCTION

It is commonly acknowledged that the "graying of America" is a reality of our times. The U.S. Special Committee on Aging (1985) reports that the elderly population, those persons 65 years and older, has increased far more rapidly than the rest of the population for most of this century and that the 85 and older population is the fastest growing age group in America. Demographic experts forecast that within the next 30 years one in five Americans will count themselves among the ranks of the elderly. The aging of the American population is considered one of the most significant demographic facts ever to affect our society (U. S. Census Bureau, 1983).

Although the U.S. Census Bureau uses age 65 and over to define the older population, there is increasing agreement that it is unwise to describe this growing population group by one chronological age measure (Bader, 1986). There is no typical older individual, and large individual differences are observed in the older population. At least three sub-populations within the older age group can be identified: (a) the young-old, (b) the middle old, and (c) the old-old.
Bader (1986) describes the three groups from a socio-economic viewpoint. The young-old (60% of the population 65 years and older) are generally 65 to 74 years of age. They are often newly retired and healthy. Many are newly widowed women unprepared for their sudden change in marital status.

The middle-old (31% of the population 65 years and older) are 75 to 84 years of age, a majority of whom are women. They experience reduced incomes and begin to require extensive aid from family, friends, and social agencies.

The old-old (9% of the population 65 years old and older) are often called the frail elderly or chronically disabled. They are generally 85 years of age or older. They are often institutionalized and impaired. Most are women who may have outlived their children (Bader, 1986).

Demographic studies consistently show that age is the best predictor of blindness and vision impairment (Padula, 1982). Over two-thirds of legally blind individuals are over 65 and national statistics suggest that the numbers of visually-impaired elderly, already substantial at approximately 1.4 million, will increase by another 25% in 10 years (Feldman, 1987).

A significant loss of vision can be a devastating experience for the individual who experiences it at any time in life. Bauman and Yoder (1966) assert that loss of sight is the greatest misfortune that can befall an individual
next to loss of life itself. For the elderly, the loss of vision may be another in a pattern of losses which frequently forms the fabric of the older person's life experience. The other losses may include the loss of family and friends, the loss of income and employment, the loss of satisfying activities, and the loss of mobility. While blindness may be one of these losses, in some ways it aggravates the others, such as the loss of mobility and the loss of satisfying activities. It also tends to accentuate the individual's alienation and lack of meaningful contacts with others in social situations (Welsh, 1978).

Although there is no single or simple theory of adjustment attributed to the loss of vision, most practitioners have identified at least three stages of psychosocial adjustment to vision loss that patients go through: shock, reactive depression, and readjustment (Emerson, 1981). Schulz (1977) adds anxiety and hostility to these sequential but overlapping stages. A blow to self-esteem and reduced feelings of self-worth permeate these stages.

It would appear important to offer counseling, group counseling in particular, for visually-impaired older persons in order to alleviate these reactions and to counteract some of the associated losses. Yet, the elderly are not commonly served by mental health or rehabilitation
agencies, and when they are, the help offered is in the area of learning new coping skills and adaptive behaviors. Learning new life skills can be extremely discouraging, especially for those whose patterns of behavior have become rather rigid and inflexible (Tuttle, 1984).

Practitioners in the field have strongly suggested that the psychosocial problems of older visually-impaired persons can be addressed most effectively through group counseling (Emerson, 1981; Routh, 1970). However, very few outcome studies have been reported which measure the effectiveness of group counseling with this emerging population. Welsh (1978) has put out the call by stating that the first priority in research with the visually impaired should be to test whether group strategies are effective and achieve their intended results. This study answers that call and will help determine the role of group counseling in the rehabilitation process.

Related Literature

A survey of the related literature involved the review of aging and vision, psychosocial reactions to vision loss, and group counseling with the visually impaired and the elderly. This review is organized and divided into the following areas: (a) aging and vision loss, (b) psychosocial reactions to vision loss, (c) group
counseling with the visually impaired, and (d) group counseling with the elderly.

Aging and Visual Loss

There is a profound association between vision loss and the aging process. The anatomical and physiological changes which occur with age bring about declines in visual acuity, glare tolerance, and dark adaptation. Reduction of pupil size, opacities in the lens, and lens rigidity all reduce the quality or intensity of light reaching the retina (Kleen & Schieber, 1985). Loss of accommodation (focusing ability), diminished depth of focus, and reduced contrast are all normal in the aging eye (DiStephano & Aston, 1986).

The normal deteriorations in vision the older person faces may cause difficulties in the performance of activities of daily living, such as reading newspaper print, mail, oven dials, the face of a clock, and street signs. Safe independent travel may be impeded because of glare and shadows which reduce the elderly persons' ability to see obstacles in their path. The reduction in contrast and depth perception often makes stairs difficult, if not dangerous, to climb (DiStefano & Aston, 1986).

The risk of actual blindness or severe visual impairment also increases with age. All of the major diseases of the eye--diabetes, glaucoma, macular degeneration, and cataracts--are more likely to occur in
older people (Goodman, 1985). Greenberg and Branch (1982) reviewed the incidence and prevalence of visual deterioration with age and reported that the risk of having any one of these visual impairments is increased six to eight times as a function of aging.

Padula (1982) notes that elderly people generally experience greater frustration and failure from vision impairment than younger persons. The frustration may also lead to depression, irritability, disorientation, memory loss, and ultimately can result in a loss of independence.

Fozard, Wolf, Bell, McFarland, and Podolsky (1977) report that nearly 75% of those over age 75 who experience vision changes are neither adequately assessed nor generally amenable to treatment. Hiatt (1986) notes that visually-impaired older people needlessly give up interests and curtail routines because they (a) do not understand their vision needs, (b) have no information on what can be done to compensate for vision loss, or (c) presume that these losses are to be expected with old age.

**Psychosocial Reactions to Vision Loss**

Practitioners who work with the visually impaired agree that there is no "psychology of blindness." Rusalem (1972) emphasizes the idea that emotional reactions to a visual loss are highly individualized. The individual's personality established prior to the loss of vision is
considered one of the most significant predictors of the outcome of the adjusting process (Blank, 1957).

In a study designed to determine whether individuals who adapted well or poorly to the loss of their vision could be differentiated, Greenough, Keegan, and Ash (1978) administered the Cattell 16 Personality Factor Inventory to 114 recently-blinded subjects between the ages of 17 and 70. The researchers also administered the depression scale of the MMPI and Gunszberg's Social Function Scale to measure social functioning. The results indicated that individuals who displayed the least amount of psychological depression after the loss of vision were those who scored high on factors of assertiveness, independence, stubbornness, free-thinking, and social boldness. The individuals who became seriously depressed could be characterized as humble, mild, shy, restrained, and conservative.

Hicks (1979) presents a unique model of adjustment which begins prior to the actual onset of vision loss. Hicks labels the first stage "preloss;" it involves the individual's previous personality, previous capacity for stress management, and previous overall adjustment. The succeeding stages follow the normative loss model.

Much of the literature describes reactions to vision loss as proceeding through the following sequential stages: shock and denial, anger, bargaining, depression, and
acceptance. It is no coincidence that these stages are identical to Kubler-Ross' well-known research on the stages of death and dying. Kubler-Ross' original research was based on her work with the blind in Chicago (Kubler-Ross, 1974).

Cholden, a psychiatrist who pioneered psychological treatment with the blind, described the stages of shock and depression. During the period of shock or psychological immobility, Cholden asserts, the newly-blinded individual finds himself unable to think or feel. This period may last from a few days to a few weeks and is, Cholden writes, "... a period of protective emotional anaesthesia which is available to the human organism under such stress" (Cholden, 1958, p. 24). Cholden (1958) counsels against psychological intervention during this stage, as it is the individual's time to marshal his forces and reorganize his inner strengths to meet the new challenges before him.

Cholden holds an interesting view of the role of depression in the adjustment process; he describes it as the recognition of the loss of vision and the beginning of a period of mourning for the "dead" eyes. Depression is further viewed as an important and necessary phase in the adjustment process, for "the patient must die as a sighted person in order to be reborn as a blind man" (Cholden, 1958, p. 18). Others disagree with this extreme posture and hold
that the basic nature of the "self" can be preserved even with the loss of sight (Tuttle, 1984).

Schulz (1980) also describes the stages of loss and states that the degree to which the emotions appear is related to the degree of vision loss. For the individual experiencing a partial loss of sight, anxiety also manifests itself concerning the possibility of further losses. Counseling, Schulz writes, can benefit the individual in a depressive and anxious stage as he or she can begin to work through the feelings of loss and become more aware of adaptive ability (Schulz, 1980).

The process of adjustment or reorganization, as Schulz calls it, begins sometime during the period of depression. The individual begins to recognize his coping skills and learns to perform simple tasks. Through counseling or psychotherapy, Schulz maintains, it is possible to maximize the achievement or functioning ability of a newly blinded person as the individual resolves feelings about the loss and begins to deal effectively with friends and family. Effective use can also be made of whatever training the individual receives (Schulz, 1980).

In one of the only systematic studies on the subject, Fitzgerald (1970) investigated the reactions to loss of sight in a group of newly blinded adults of working age. Sixty-six subjects (35 men and 31 women with a median age
of 55) were interviewed. Twelve percent of the subjects reported a major depressive reaction to loss of sight, although all experienced the stages of loss which unfolded in a dynamic manner, ranging from disbelief and protest to depression to recovery. These phases, Fitzgerald reports, were usually overlapping. Since adjusting with blindness is adjusting to life's internal and external demands, it is dynamic and continuous rather than static and fixed (Giarratana-Oehler, 1976). Every time a blind person meets a new trauma or a new psychological situation, the person is vulnerable to cycling back through some or all of the adjusting phases.

A dominant aspect of the adjustment process is self-esteem, yet it is one which has been largely ignored in the literature (Delafield, 1976). The few studies which exist concerning self-esteem and blindness have concentrated on the differences between blind children and sighted children (Jervis, 1959; Meighan, 1971; Zunich & Ludwith, 1965). Wright (1960) discussed the effect of disability on self-esteem, stating that a disability can threaten self-esteem to the extent that the individual is unable to contain the "spread effect"; that is, the feeling that he is totally incapacitated even though only one aspect of his functioning is in fact affected.
Tuttle (1984) has suggested that how the visually-impaired person feels about himself, how he feels about blindness, and how he feels about the attitudes of others toward him are all important determiners of his self-esteem, as are the adaptive behaviors and coping skills he acquires through rehabilitation. Tuttle asserts that the acceptance of blindness and its implications is a prerequisite to self acceptance and self-esteem.

Tuttle (1987) has delineated four problems with which visually-impaired persons must contend. First, in order to feel competent and adequate, they must develop good coping skills and adaptive behaviors. Second, they deal with the task of maintaining a sense of high self-esteem in the face of predominantly negative attitudes. The third problem centers on the visually-impaired person's abilities to maintain control of situations and to make personal decisions. The fourth problem has to do with the negative impact on self-esteem that results from the necessary dependence on others to accomplish some daily tasks. As a result, the visually-impaired person does not appear to exercise an internal locus of control.

Roessler and Boone (1979) examined the relationship between locus of control and self-esteem in a sample of visually-impaired subjects at a rehabilitation center. Thirty-four students with a mean age of 34 were administered
Rotter's Scale of Beliefs, Rosenberg's Self-Esteem Scale, and Cantril's Self-Anchoring Scale. Fifty-three percent of the subjects in the sample studied were congenitally blind. Results indicated that locus of control was significantly related to self-esteem and that visually-impaired subjects with an external-control outlook reported lower self-esteem. This finding is not surprising and seems to agree with the findings of the Greenough et al. (1978) study.

Group Counseling with the Visually Impaired

In his comprehensive review of the literature on group strategies with the visually impaired, Welsh (1977) describes several specific approaches which have been used with this population. Early studies reported the use of groups in rehabilitation centers for the blind. A controversy which arose some 30 years ago had to do with the depth that group work should attempt to reach in working with blind people. Routh (1957) believed that group therapy in rehabilitation settings should deal with superficial topics which would not raise the anxiety level of clients.

Wilson (1970, 1972) described the use of therapeutic groups in the rehabilitation program of the New York Association for the Blind. Therapeutic sessions were used in addition to the use of groups for vocational counseling and for discussion as a part of the diagnostic phases of the rehabilitation program. Wilson (1970) indicated that group
therapy was useful in helping clients cope with the following behavioral reactions to blindness: (a) feeling inadequate to the stress of undergoing rehabilitation, (b) handling the meaning of their loss, (c) learning to accept reality in a flexible manner, (d) learning to cope with frustration and conflict, (e) coming to terms with guilt feelings, (f) handling shock and the period of mourning, and (g) learning to accept one's altered body image.

Even with all of the aforementioned benefits, Wilson stressed that the rehabilitation agency is not a mental hygiene clinic, and that the psychotherapy program should be secondary to the primary goals of the rehabilitation program which are the development of physical and expressive adequacy, social adequacy, and vocational readiness.

Other group strategies used with the visually impaired have included "encounter microlabs." Goldman (1970) described this approach with young adults in which he attempted to help congenitally blind persons to come into direct contact with the meanings of concepts often unfamiliar to blind people. He used action techniques, such as relaxation training, trust building exercises, and guided fantasy, to help his clients increase their self-awareness and assertiveness.
Moreno (1961) utilized psychodrama with blind clients, assigning an auxiliary ego to each one. The function of the auxiliary ego was to give the imagination of the blind "physically and mentally full rein." The auxiliary ego would hold the hand of the blind client and move with him through space during the acting out of the tasks of the psychodrama.

More recently, Emerson and Long (1978) reported on the use of short-term group therapy (every other week for six months) to treat the psychosocial problems of two groups of elderly and one group of young adults. Eight people were assigned to each group. The authors state that members in each group showed movement in three phases: (a) shock, (b) reactive depression, and (c) readjustment. Emerson and Long concluded that those members who did not readjust shared three characteristics: (a) loss of vision was accompanied by other losses, (b) there was a lack of support from family, and (c) the impairment was severe. Age, however, was not a factor and the authors maintain that the psychosocial problems of the visually-impaired elderly can be addressed most effectively through a therapeutic group.

Another report of group counseling with the elderly was related by Harshbarger (1980) who described her observations following a one-year period during which she provided group therapy for clients of an agency serving a primarily aged
blind population. She limited the group to eight members because the average age of members was 65 and several members had hearing difficulties, as well as a visual disability. Harshbarger described the differences from traditional group therapy which she found necessary, including outside socialization of members, "free visits" without obligation to remain a member, superficial discussions of a topical nature, and occasional visits from family members. She allowed these adaptations because there is such a strong resistance to using mental-health services by the elderly. The main emotions discussed by the group were (a) anger at their forced dependency, (b) feelings of inferiority and lowered self-esteem, and (c) guilt. Overall, the group members learned that they were not alone and that it was permissible to ask for help. They received encouragement to become active again.

Oehler-Giarratana and Fitzgerald (1980) reported success with a small group that they led. The group members were adult diabetics who were going blind. There were seven consecutive weekly 2-hour group sessions, and the leaders recorded the sessions and ranked the frequency of topics which arose. The central issues of concern to this group were their diabetes, fear of death, loss of vision, and mobility problems. The authors concluded that group therapy
is an important initial step in the rehabilitation of the patient with deteriorating vision.

Social isolation and inactivity are other main areas of difficulty for the blind. In order to alleviate these conditions, Evans, Werkhoven, and Fox (1982) attempted a unique form of group counseling with elderly visually-impaired men. Group therapy by telephone, using a conference call mechanism, was provided to a sample of 42 elderly blind veterans. A weekly series of eight 1-hour conference calls with three clients and a facilitator was conducted. One week prior to and one week after the study the Wakefield Depression Inventory was administered, also by telephone. The U.C.L.A. Loneliness Scale was also given to the subjects. Pretesting indicated that less than six percent of the subjects were clinically depressed although the sample exhibited a full range of depressive symptoms. Loneliness scores were high for the entire sample and were considered a reflection of social isolation.

Results of the study indicated a positive change in social routine for the subjects, and posttesting revealed increased scores for social involvement. The authors recommended group telephone intervention for clients who are extremely resistant to coming into a helping agency.
Group Counseling with the Elderly

Group work with the elderly has become increasingly popular since World War II (Burnside, 1984). However, reports of group counseling with the elderly are still rather scarce. To be sure, there are very real problems inherent in attempting to establish and maintain groups for this population. For example, transportation difficulties, weather preclusion, and ill health can combine to make group attendance difficult, if not impossible. For these reasons, most of the literature that has been reported on group counseling with the elderly has occurred in institutional settings.

The neglect of the older population in terms of psychological intervention has been well documented (Levy et al., 1980). Reasons for this neglect appear to be twofold: the hesitance of older people to seek psychological help, and the reluctance of some therapists to work with this age group (Ingersoll & Silverman, 1978).

When psychological intervention can take place, the group approach appears to be very beneficial. Barrett (1978) compared the effects of self-help, consciousness raising, confidence support, and control groups in a study involving community-dwelling widows ranging in age from 32 to 74. The consciousness-raising form of intervention was reported to be the most effective, with women in the group
reporting improvement in health and self-esteem, while becoming less "other" oriented. Another study, reported by Keller and Croale (1975), compared rational-emotive group therapy with a control condition and reported a significant decrease in irrational thinking and anxiety in the experimental group.

Ingersoll and Silverman (1978) also compared two approaches to group psychotherapy: a "here and now" model which focused on present concerns using relaxation and self-awareness exercises, and a "there and then" model which emphasized the past using a life-review orientation. The groups had nine and eight members, respectively, with a mean age of 69.8 and 69.5 years. All participants were functioning independently in the community, and each person was experiencing anxiety or depression resulting from age-related losses. Data were gathered by means of pretests and posttests, consisting of Rosenberg's Self-Esteem Scale and unidentified anxiety and somatic behavior questions. Results indicated that a greater percentage of the "there and then" group showed improvement on the anxiety and the somatic behavior measures, but the authors conclude that either model may benefit certain individuals. Limitations of the study included the small sample size, no control group, and only one statistically significant result.
The use of a group which integrates elements from both approaches was suggested by the authors.

Tutaj (1975) attempted to determine the extent to which group counseling would reduce the degree of depression among a group of institutionalized aged individuals. Experimental and control groups were chosen, and the Self-Rating Depression Scale and the Depression Adjective Check Lists were administered in the pretests and posttests. The results were tested through the use of one-way analysis of covariance (.05 level of significance) and were not significant between the two groups. It was also concluded that long-term group sessions with the aged are less effective than short-term sessions.

A variety of groups and group methods may be used in working with the elderly. The most prominent are reality orientation, remotivation therapy, reminiscing therapy, and psychotherapy.

Reality orientation (RO) groups are designed for confused, disoriented elderly. The purpose of this kind of group is to help alleviate memory deterioration through continual stimulation and repetitive orienting activities. The use of props such as bulletin boards, clocks, calendars, and name tags are common and this approach usually occurs in institutional settings (Donahue, 1984).
Remotivation therapy is designed to focus on the simple, objective aspects of day-to-day living. This treatment was developed in a state hospital for use with mental patients. Generally, patients in remotivation groups are helped toward resocialization, and the group's meetings take place in a very structural classroom setting with props. The leader tries to get the patients to discuss their experiences in regard to a specific topic.

Reminiscing therapy (RT) or life-review is designed to explore memories with a group of six to eight elderly persons and can meet in an institutional or noninstitutional setting. The group leader encourages the sharing of memories and gives the elderly an opportunity to examine their "whole life," to reexamine or restructure their identity, to accept the inevitability of death, and to develop a "lively capacity" to live in the present (Lewis & Butler, 1974).

Psychotherapy groups are designed for the purpose of expressing, eliciting, accepting, and working through various aspects of the individual's functioning and developing the person's healthier and more satisfying potentials. Finkel (1982) writes:
In my experience, group therapy is the treatment of choice for the nonpsychotic elderly who are experiencing difficulty in adjusting to loss(es). Groups offer a number of advantages for the older person: they decrease the sense of isolation, facilitate the development of new roles or the reestablishment of familiar roles, provide information on a variety of topics from other group members, and afford group support for effecting change or enhancing self-esteem. (p. 167)

Finkel (1982) lists the following ways in which group therapy for the elderly differs from group therapy for younger groups:

1. Therapists share more personal information.
2. There is more physical contact—hugging, touching, kissing.
3. There is more tolerance of silent group members.
4. There is usually a predominance of female members.
5. Common themes are loss (physical, social, or economic), interpersonal conflicts, and struggle to adapt.
6. There is a greater emphasis on reminiscence and life review.

Summary

Aging contributes to visual impairment through both normal deterioration of eye tissues and increased incidence of eye pathology. Ocular changes, such as opacities in the lens, loss of focusing ability, pupil constriction, and diminished visual acuity are normal in the aging eye. The major diseases of the eye—diabetes, glaucoma, macular
degeneration, and cataracts--greatly increase in incidence and prevalence among the aging population.

A significant loss of vision causes difficulties in the performance of activities of daily living. Reading, independent travel, and cooking may be impeded. Psychologically, visually-impaired elderly people generally experience frustration which may lead to depression, memory loss, and disorientation and ultimately can result in the loss of independence.

While individual response to vision loss will vary, typical stages of emotional reaction include shock, denial, anger, and depression. These stages are considered normal and, with psychological intervention, lead to a state of readjustment.

Theorists also have discussed increased anxiety and decreased self-esteem as consequences of vision loss. Anxiety levels appear to be higher for individuals who have experienced only a partial loss of sight, since the fear of losing more sight or going completely blind is evident.

The visually-impaired person's self-esteem may be injured as a result of the loss of independence one experiences when unable to perform common tasks easily. Other factors which determine self-esteem are feelings about self, blindness, and the attitudes of other people toward the visually-impaired person.
While there are few outcome studies available, the consensus of researchers seems to be that group counseling is a helpful and positive intervention in working with both visually-impaired and elderly populations. Increases in self-esteem and improved coping mechanisms have been reported, as well as decreases in anxiety and depression.

The literature describes some adaptations and unique methods in conducting group counseling with the elderly and visually-impaired populations. Among the group methods used with the elderly are reality orientation, remotivation therapy, and reminiscing therapy, as well as traditional group psychotherapy. Adaptations which have been reported are the outside socialization of group members, visits to the group from family members, discussions of a topical nature, and the use of physical contact—hugging, touching, and kissing.

The elderly visually-impaired population is a particularly neglected one in terms of the delivery of social services and psychological intervention. Older people are hesitant to seek help, and some therapists are reluctant to work with this age group. Many elderly people with vision impairments needlessly accept their condition by presuming there is nothing that can be done to help them.
CHAPTER II

PROCEDURES

This chapter presents the purposes, hypotheses, and definitions of this study. It also describes the instruments, subjects, delimitations, experimental group, and procedures for the collection and analysis of data.

Purpose of the Study

The purpose of this study was twofold: (a) to determine the therapeutic effectiveness of group counseling with visually-impaired elderly adults, and (b) to provide information concerning the effectiveness of group counseling to practitioners in the field.

Hypotheses

The following hypotheses were generated for this study.

1. Subjects who participate in group counseling will exhibit a greater decrease in depression than the control group.

2. Subjects who participate in group counseling will exhibit a greater decrease in anxiety than the control group.
3. Subjects who participate in group counseling will exhibit a greater increase in self-esteem than the control group.

4. Subjects who participate in group counseling will exhibit a greater increase in life satisfaction than the control group.

Definitions

For the purpose of this study, certain key terms have restricted meaning. They are defined as follows.

**Group counseling** refers to the process defined by Gazda,

Group counseling is a dynamic interpersonal process focusing on conscious thought and behavior and involving the therapy functions of permissiveness, orientation to reality, catharsis, and mutual trust, caring, understanding, acceptance, and support. The therapy functions are created and nurtured in a small group through the sharing of personal concerns with one's peers and the counselor. The group counselees are basically normal individuals with various concerns which are not debilitating to the extent requiring extensive personality change. The group counselees may utilize the group interaction to increase understanding and acceptance of values and goals to learn and/or unlearn certain attitudes and behaviors. (Gazda, Duncan, and Meadows, 1967, p. 350, cited in Gazda, 1975)

**Visually-impaired** is operationally defined as bilateral subnormal visual acuity or abnormal visual field resulting from a disorder in the visual system. Visual acuity cannot be corrected to normal performance levels with conventional spectacles, intraocular, or contact lens refraction (Faye,
The visually-impaired person is a person with an eye disorder whose visual performance is decreased as the consequence of reduced acuity, abnormal visual field, reduced contrast sensitivity, or other ocular dysfunctions that prevent performance to full capacity compared to a normal person of the same age and sex.

Elderly refers to persons 65 years and older, as designated by the U.S. Census Bureau. It is noted that at least three subpopulations exist: (a) the young-old, generally 65 to 74 years of age; (b) the middle-old, those 75 to 84 years of age; and (c) the old-old, who are 85 years of age and older. There is increasing agreement that chronological age is not sufficient for most gerontological purposes; however, for the purpose of this study, the elderly population includes all three sub-groups.

Depression is operationally defined as the level of depression indicated by the score received on the Beck Depression Inventory.

Anxiety is operationally defined as anxiety level indicated by the score received on the Anxiety Scale for the Blind.

Self-esteem is operationally defined as the level of self-esteem indicated by the score received on the Rosenberg Self Esteem Scale.
Life satisfaction is defined as the level of life satisfaction indicated by the score received on the Life Satisfaction in the Elderly Scale.

Instruments

The instruments selected for this study were chosen because each has been used with either a visually-impaired or elderly population. Another consideration in selection was ease of administration and scoring. It should be noted that because of vision loss, the instruments were administered orally to each individual in this study. As Scholl and Schnur (1976) state, almost any verbal measure may be simply read to the client.

The Anxiety Scale for the Blind (ASB) consists of 78 true-false items and is designed to provide a measure of manifest anxiety among blind persons (both totally blind and partially sighted) (Hardy, 1968). Reliability of the ASB has been evaluated through split-half and test-retest procedures. A split-half reliability check yielded a correlation coefficient of .798. The retest consistency of the ASB was checked by measuring the joint variation of two testings over a 3-week period, and the procedure yielded a value of .746 (Hardy, 1968).

Empirical validity of the scale is indicated by a correlation of 0.742 with the Taylor Manifest Anxiety Scale (Hardy, 1968). This correlation held over a 3-week period.
Content validity has been established through item evaluations by psychologists (Hardy, 1968).

While the ASB was standardized on a high-school-aged population, the author states that the instrument may be reproduced and modified according to individual research and evaluative needs. For the purpose of this proposed research study, two statements were changed in order to adapt it to the elderly. Item number 25, "I often worry about making a living," was changed to "I often worry about my ability to take care of myself," and item number 31, "I would not date a sighted person," was changed to "I feel uncomfortable associating with a sighted person." These changes were consistent with those previously made in another study utilizing the ASB with the elderly (Hensley, 1987). Because two items were modified, a reliability check on the ASB was done for the present study. A split-half procedure, using odd- and even-numbered items, was conducted. The split-half reliability check yielded a correlation coefficient of .89 at the .001 level of significance. This value indicates that the ASB maintained its strong internal consistency. High scores on the ASB indicate high levels of anxiety.

The Rosenberg Self-Esteem Scale was originally developed for use with high school students, but it has been used substantially in gerontological research as well (Breytsprook & George, 1979). It is a Likert-type scale
consisting of 10 items. Silber and Tippett (1965) reported a 2-week test-retest reliability coefficient of .85 (N = 28).

In a study involving the investigation of the impact of age identification upon older people, Ward (1977) used the Self-Esteem Scale with 323 persons ranging in age from 60 to 92 and reported an interitem reliability coefficient of .74.

Convergent validity for the Self-Esteem Scale has been reported by Silber and Tippett (1965) who found that the scale correlated from .56 to .83 with several similar measures and clinical assessments. Crandall (1973) found the scale correlated .59 with Coopersmith's Self-Esteem Inventory. Scores range from 10 to 40, with high scores representing high self-esteem and low scores representing low self-esteem. In his study with 323 older persons, Ward (1977) reported a mean of 29.4 and a standard deviation of 3.07 on the SES.

The Beck Depression Inventory (BDI) is a widely used 21-item self-report measure of the presence and degree of depression in adolescents and adults (Gallagher, Mies, & Thompson, 1982). In prior studies with younger patients, split-half reliability estimates have ranged from .53 (Weckowicz, Muir, & Cropely, 1967) to .93 (Beck et al., 1961). Test-retest reliability using normal undergraduates was reported to be .74 after three months (Miller &
Seligman, 1973, cited in Gallagher et al., 1982) and .75 after one month (Rehm, 1976, cited in Gallagher et al., 1982).

In a study designed to assess the reliability of the BDI in two older adult groups: (a) a patient sample (N=77), and (b) a comparable non-clinical group of community volunteers (N=82), Gallagher et al. (1982) reported three reliability coefficients: test-retest (.90), split-half (.84), and coefficient alpha (.91). These results, the authors state, suggest two conclusions:

1. The BDI has respectable internal consistency and stability for use with older adults in research, and
2. The BDI appears relatively adequate as a clinical screening instrument for use with the elderly.

Validity for the BDI was originally established by comparing scores to clinical estimates of depth of depression made by psychiatrists. The biserial coefficients obtained were found to be highly significant (.65 and .67 at the .01 level) (Beck et al., 1961). Numerous studies by other investigators have confirmed the relatively high concurrent validity of the BDI (Beck, Rial, & Rickels, 1974).

Beck and Beck (1972) designed a shortened version (13 items) of the BDI which yielded a correlation coefficient of .996 with the original 21-item total BDI score. Beck, Rial, and Rickels (1974) administered the short form of the BDI to
a variety of patient samples with a total of 431 subjects. Depending on the sample, the correlations of the short form with clinical ratings ranged from .55 to .67.

The reliability, validity, and factor structure of the standard 21-item and short 13-item forms of the BDI were investigated by Reynolds and Gould (1981). Internal consistency reliability procedures yielded a coefficient of .85 for the standard and .83 for the short form. The correlation between the standard and short forms was found to be .93. The authors support the use of the short form for research purposes as an accepted measure of depression.

Furthermore, potentially embarrassing and inappropriate items concerning weight loss and libido levels are omitted from the short form. For this reason, and in order to decrease testing time for the subjects, the short form of the BDI was selected for use in the present study.

Beck and Beck (1972) estimate the degree of depression according to the BDI short form in this manner:

<table>
<thead>
<tr>
<th>Range of Scores</th>
<th>Degree of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None or minimal</td>
</tr>
<tr>
<td>5-7</td>
<td>Mild</td>
</tr>
<tr>
<td>8-15</td>
<td>Moderate</td>
</tr>
<tr>
<td>16+</td>
<td>Severe</td>
</tr>
</tbody>
</table>

The Salamon-Conte Life Satisfaction Scale (LSBS) was designed to measure life satisfaction among the aged in a
variety of settings (Salamon & Conte, 1984). The scale consists of eight categories: (a) daily activities—taking pleasure in daily activities; (b) meaning—regarding life as meaningful; (c) goals—goodness of fit between desired and achieved goals; (d) mood—positive mood tone; (e) self-concept—positive self-concept; (f) health—perceived health; (g) finances—financial security; and (h) social contacts—perceived satisfaction with the number and quality of social contacts which are characteristic of the respondent's usual routine.

The scale consists of 40 items and uses a Likert format. It was designed for ease of administration with the elderly.

Reliability was measured in two studies by Cronbach's coefficient alpha procedure to provide an estimate of internal consistency. In a study of 408 individuals, aged 55 to 90, a reliability coefficient of .93 for the LSES total score was reported. The reliability coefficients for each of the eight subscales ranged from .60 to .79. A retest of 120 of these subjects 6 months later yielded a test-retest reliability of .67.

The LSES was validated through the use of several approaches, including a principal components analysis and a comparison of scores to psychological interview results and physical assessments.
The LSES scores produce diagnostically significant information which is sensitive enough to aid in establishing treatment plans and in monitoring client progress (Salamon & Conte, 1984). Eight subscale scores and a total score are tabulated.

Salamon and Conte (1984) established normative data for the LSES based on scores of over 600 individuals, ranging in age from 55 to 98. Scores ranged from a low of 63 to a high of 192, with a mean of 135.33. High scores indicate high levels of life satisfaction.

Delimitations

This study was limited to a sample of visually-impaired elderly adults from a low vision clinic in the North Texas area. Experimental and control group members were volunteers. All participants in the study were women.

Selection of Subjects

The subjects consisted of 20 volunteers who responded to a letter of invitation (Appendix A) to participate in a counseling group for visually impaired persons 65 years of age and older. Sixty letters were mailed to persons who had received or were seeking services from a low-vision clinic in the North Texas area. The letters were typed in large print and recipients were invited to use the telephone
number listed if interested in participating or to seek further information.

Fourteen people responded by telephone to express interest in participating in the group. Follow-up phone calls were made by the researcher to increase the number of participants needed for the study.

Individuals who were currently in individual or group counseling or who had received counseling within the past year were eliminated from the study. Individuals who had experienced their vision loss for longer than two years were also eliminated from the study. Twenty adults, all of whom were women, who met the requirements of the study were selected to participate.

Assignment to Group

Ten subjects were assigned to the experimental counseling group, and 10 other subjects were assigned to the no-treatment control group. Subjects assigned to the experimental group were chosen on the basis of their stated intention to participate in all 10 sessions and their capability to arrange transportation to and from the group sessions. Subjects were assigned to the no-treatment control group if they knew in advance that they could not attend all group meetings (vacations, other business, etc.) and/or had transportation problems. Control-group subjects
were told that they could participate in group counseling at the conclusion of the 10-week study.

Ideally, random selection would be applied in a study of this nature; however, deviation from randomization was necessary in the assignment of subjects to the groups. Analysis of covariance was used to provide statistical control because it was not possible to randomize.

The experimental group consisted of 10 females with an age range of 75-86. The average age of this group was 80.3. The no-treatment control group consisted of 10 females with an age range of 70-87. The average age of this group was 79.2. More detailed information on the experimental group subjects is provided in Appendix B, as well as information about the control group subjects.

Of the 10 experimental group subjects, 7 may be considered legally blind (20/200 visual acuity or less in the better eye). Nine of the subjects had the diagnosis of macular degeneration, a retinal disorder which causes loss of vision in the central field.

Of the 10 subjects in the control group, 7 may be considered legally blind. Nine of the subjects in the control group had macular degeneration, the most common eye disease among the elderly.
The Experimental Group

The experimental group followed an unstructured group counseling format. The group experience was divided into 10 one and one-half hour sessions occurring once a week.

Special attention was directed toward comfort of seating, proper room illumination, and freedom from audible distractions. Care was taken to have the room temperature at a comfortable setting prior to the beginning of each session. Coffee was available before and after the sessions.

The group leader followed a client-centered approach in which he communicated the attitudes of caring, nonjudgmental understanding, and respect for the uniqueness of each member (Meador, 1975). He attempted to establish the goal of creating a safe climate in which the group members could feel free to share fully their fears and hopes, and thus help release the potential within them.

The experimental group was conducted by the experimenter. He was a doctoral candidate in counseling at North Texas State University. He had completed three group counseling courses, including beginning group counseling, a doctoral level group counseling seminar, and a doctoral level practicum in group counseling. He had several years of experience in conducting groups of all ages, including the elderly.
Collection of Data

All subjects were administered the pretest battery during a 2-week period prior to the first group session. Tests were administered orally and individually to each participant. The posttest battery was administered to the treatment group and control group subjects during a 2-week period at the conclusion of the 10-week group counseling interval. The instruments were again administered orally and individually.

Procedure for Data Analysis

The researcher used a pretest-posttest control group design to reveal treatment effects. Analysis of covariance was used to test the data. Analysis of covariance reduces the effects of initial group differences statistically by making compensating adjustments of the final means on the dependent variable (Borg & Gall, 1971). In each analysis of covariance, the pretest score was the covariate. Differences between means were tested for significance at the .05 level.
CHAPTER III

DATA ANALYSIS AND FINDINGS

This chapter presents the results of the data analysis and includes a discussion of the findings and recommendations based on the findings.

Analysis of Data

A univariate analysis of covariance was performed for each of the dependent variables with its respective covariate. In each analysis of covariance, the pretest score was the covariate. There were two reasons for using the analysis of covariance. First, it is a powerful statistical test, which means that it is very sensitive to differences among groups. Second, the analysis of covariance adjusts the comparison group means to account for differences between the groups. This means it statistically controls any initial differences in the groups that might have been present (Ferguson, 1976).

Hypothesis 1

Hypothesis 1 was stated as follows: Subjects who participate in group counseling will exhibit a greater decrease in depression than the control group.
The Beck Depression Inventory, Short Form was used as a measure of general depression. The mean scores and the standard deviations obtained from the short form of the Beck Depression Inventory are presented in Table 1. The experimental group had a greater overall decrease in depression scores than did the control group, which had a general increase in depression scores.

Table 1
Means and Standard Deviations for The Beck Depression Inventory

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Adjusted</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp.</td>
<td>6.50</td>
<td>5.00</td>
<td>4.95</td>
<td>4.52</td>
<td>3.19</td>
</tr>
<tr>
<td>Control</td>
<td>6.40</td>
<td>6.90</td>
<td>6.94</td>
<td>3.86</td>
<td>3.98</td>
</tr>
</tbody>
</table>

The results of the analysis of the mean scores for the Beck Depression Inventory are presented in Table 2. The obtained F-value was significant at the .0002 level of significance. Hypothesis 1 was supported because a significant difference was found between the experimental group and the control group with respect to scores for the Beck Depression Inventory.
Table 2

Analysis of Covariance Data for the Comparison of Scores for the Beck Depression Inventory

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within cells</td>
<td>15.68</td>
<td>17</td>
<td>.922</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>19.65</td>
<td>1</td>
<td>19.65</td>
<td>21.30</td>
<td>.0002</td>
</tr>
</tbody>
</table>

Hypothesis 2

Hypothesis 2 was stated as follows: Subjects who participate in group counseling will exhibit a greater decrease in anxiety than the control group.

The Anxiety Scale for the Blind was used as a measure of manifest anxiety. The mean scores and the standard deviations obtained from the Anxiety Scale for the Blind are presented in Table 3. The experimental group had a greater overall decrease in anxiety mean scores than did the control group.
Table 3

Means and Standard Deviations for The Anxiety Scale for the Blind

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Adjusted</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp.</td>
<td>19.40</td>
<td>15.70</td>
<td>15.49</td>
<td>10.77</td>
<td>6.75</td>
</tr>
<tr>
<td>Control</td>
<td>18.80</td>
<td>18.70</td>
<td>18.90</td>
<td>6.47</td>
<td>6.66</td>
</tr>
</tbody>
</table>

The results of the analysis of the mean scores for the Anxiety Scale for the Blind are presented in Table 4.

Table 4

Analysis of Covariance Data for the Comparison of Scores for the Anxiety Scale for the Blind

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within cells</td>
<td>132.60</td>
<td>17</td>
<td>7.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>58.20</td>
<td>1</td>
<td>58.20</td>
<td>7.46</td>
<td>.014</td>
</tr>
</tbody>
</table>

The obtained F-value was significant at the .014 level of significance. Hypothesis 2 was supported because a significant difference was found between the experimental
group and the control group with respect to scores for the Anxiety Scale for the Blind.

**Hypothesis 3**

Hypothesis 3 was stated as follows: Subjects who participate in group counseling will exhibit a greater increase in self-esteem than the control group.

The Rosenberg Self-Esteem Scale was used as a measure of self-esteem. The mean scores and the standard deviations obtained from the Self-Esteem Scale are presented in Table 5. The experimental group had a greater increase in self-esteem mean scores than did the control group.

Table 5

**Means and Standard Deviations for the Self-Esteem Scale**

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Adjusted</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp.</td>
<td>27.90</td>
<td>29.10</td>
<td>29.03</td>
<td>4.33</td>
<td>3.31</td>
</tr>
<tr>
<td>Control</td>
<td>27.70</td>
<td>27.20</td>
<td>27.27</td>
<td>2.83</td>
<td>2.70</td>
</tr>
</tbody>
</table>

The results of the analysis of the mean scores for the Self-Esteem Scale are presented in Table 6. The obtained F-value was significant at the .029 level of significance. Hypothesis 3 was supported because a significant difference
was found between the experimental group and the control group with respect to the scores for the Self-Esteem Scale.

Table 6

Analysis of Covariance Data for the Comparison of Scores for the Self-Esteem Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within cells</td>
<td>46.41</td>
<td>17</td>
<td>2.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>15.47</td>
<td>1</td>
<td>15.47</td>
<td>5.67</td>
<td>.029</td>
</tr>
</tbody>
</table>

Hypothesis 4

Hypothesis 4 was stated as follows: Subjects who participate in group counseling will exhibit a greater increase in life satisfaction than the control group.

The Life Satisfaction in the Elderly Scale was used as a measure of life satisfaction. The mean scores and the standard deviations obtained from the Life Satisfaction in the Elderly Scale are presented in Table 7. The experimental group had a greater increase in mean scores for life satisfaction than did the control group.
Table 7

Means and Standard Deviations for the Life Satisfaction in the Elderly Scale

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Adjusted</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp.</td>
<td>137.20</td>
<td>140.70</td>
<td>137.59</td>
<td>19.24</td>
<td>16.71</td>
</tr>
<tr>
<td>Control</td>
<td>130.30</td>
<td>130.40</td>
<td>133.50</td>
<td>19.07</td>
<td>18.27</td>
</tr>
</tbody>
</table>

The results of the analysis of the mean scores for the Life Satisfaction in the Elderly Scale are presented in Table 8. The obtained F-value was significant at the .008 level of significance. Hypothesis 4 was supported because a significant difference was found between the experimental group and the control group with respect to scores for the Life Satisfaction in the Elderly Scale.
Table 8

Analysis of Covariance Data for the Comparison of Scores for the Life Satisfaction in the Elderly Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within cells</td>
<td>154.63</td>
<td>17</td>
<td>9.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>80.45</td>
<td>1</td>
<td>80.45</td>
<td>8.85</td>
<td>.008</td>
</tr>
</tbody>
</table>

Summary of Results

In summary, all four hypotheses were supported. The experimental counseling group showed a decrease in mean depression scores, while the control group showed a slight increase in mean depression scores. The experimental counseling group exhibited a significantly greater decrease in mean anxiety scores than did the control group. The experimental group showed a significantly greater increase in mean self-esteem scores than did the control group which exhibited a slight decrease in mean self-esteem scores. The experimental group showed a significantly greater increase in mean life satisfaction scores than did the control group.

Discussion

A severe loss of vision in the later years of life can be a devastating experience. Depression, loss of self-esteem, increased anxiety, and a decrease in the quality and
satisfaction of life are common reactions that visually-impaired people recently face.

Group counseling is a commonly recommended treatment for people experiencing a vision loss (Emerson, 1981; Oehler-Giaratana & Fitzgerald, 1980; Welsh, 1977). It is believed to be particularly helpful to the older visually-impaired person (Emerson, 1981; Harshbarger, 1980). However, few experimental studies have been reported which support these claims. The present study is one of the first to measure the effects of a counseling group for visually-impaired elderly adults.

The findings of this study supported Hypotheses I, II, III, and IV. Participants in the counseling group exhibited a greater decrease in depression and anxiety than the non-treatment control group, and the participants in the counseling group exhibited a greater increase in self-esteem and life satisfaction than the non-treatment control group.

The instrument used to measure depression was the short form of the Beck Depression Inventory (BDI). Using Beck and Beck's (1972) estimates of the degree of depression with the short form of the BDI, the researcher found four persons in the experimental group whose scores indicated a moderate degree of depression (8-15) upon entering the group (Appendix C). Two of the group members scored within the
mild range of depression (5-7) and four members indicated no or minimal depression (0-4).

The control group had six members who scored within the moderate range of depression and one member who scored within the mild range of depression. The remaining three control group members indicated no or minimal depression on the BDI.

The fact that 13 out of 20 persons scored in the mild to moderate range of depression is not surprising. Depression as a reaction to vision loss has been well documented as a crucial phase of the adjustment process (Cholden, 1958; Schulz, 1977). That no one scored within the severe range of depression indicates that all members of the study were beyond the "shock" stage and were probably more amenable to treatment (Cholden, 1958).

A further examination of the experimental group's posttest scores on the BDI indicated that the individuals who scored within the moderate range of depression on the pretest, although decreasing their scores, still remained within the moderate range of depression. Schulz (1977) claims that readjustment begins while the individual is still in the depressed stage. The decrease in depression scores indicates that all group members showed movement toward readjustment. Perhaps a group of longer duration, such as the 6-month group led by Emerson (1981), would
enable these individuals to continue to reduce their depression and progress further into the readjustment stage.

The instrument used to measure anxiety was the Anxiety Scale for the Blind (ASB). An examination of the raw scores for the ASB (Appendix C) showed that eight group members decreased their scores on this instrument after completing group counseling. Among the control group members, 5 out of 10 decreased their anxiety scores on the ASB. However, 4 out of 10 members actually increased their scores. Perhaps the sharing of information, thoughts, and feelings communicated by the counseling group members, as well as the successful role-modeling demonstrated by certain individual members, served to decrease the anxiety level of the group as a whole. Additionally, the factual information communicated by the group leader regarding macular degeneration helped allay the fear of going completely blind—a fear a number of the group members held.

The instrument used to measure self-esteem was Rosenberg's Self-Esteem Scale. An examination of the raw scores (Appendix C) shows that 7 of 10 experimental group members increased their scores on this instrument while there were no increased scores among control group members. In fact, four members of the control group decreased their scores, while the remaining members stayed at their pretest level. Without intervention, one may assume that feelings
of self-worth may decrease among the elderly visually-impaired. In contrast, self-esteem actually improves with psychological intervention. These findings support those theorized by Emerson (1981), Schulz (1980), and Tuttle (1984).

The instrument used to measure life satisfaction was the Life Satisfaction in the Elderly Scale (LSES). An examination of the raw scores (Appendix C) shows that seven members of the experimental group increased their scores on this scale after the group counseling experience. Increases were most evident on the daily activities, goals, mood, and self-concept scales of this instrument. Three control group members increased their scores, while four scores decreased from pretest to posttest.

The group counseling format did not follow some of the traditional group counseling guidelines. Instead, the format suggested by Finkel (1982) and Harshbarger (1980) was used. Family members were permitted to visit the group; on three occasions the adult children of group members sat in on the group sessions. When this occurred, discussions usually centered on problems that existed between the children and their visually-impaired parent. One group member shared with the group that it greatly disturbed her whenever her daughter, who was with the group that day, would ask her if she could see certain objects when they
were in public settings. The group helped resolve this problem by pointing out alternative statements the daughter could make in communicating with her mother. The mother also learned to be more direct with her daughter rather than keeping in her feelings.

During the initial group session, members decided that they would like to bring refreshments to the group meetings. Members' self-esteem was enhanced as they received positive feedback for their baking efforts. They also learned that they were still capable of accomplishing successful results in the kitchen and that their efforts were appreciated.

Members were also encouraged to support each other outside of the group, as well as in the group. A roster of group members with addresses and telephone numbers was printed and distributed to the group. Phone calls made to each other between group sessions was not uncommon. Group members were instructed, however, not to discuss other group members or group business during the phone calls.

Members also called the group leader on occasion and were encouraged to share their concerns with the group. As the group progressed, and trust increased, members became more willing to open up to each other and, as a result, they became less dependent on the group leader's individual counsel.
Although traditional group counseling focuses on feelings and subjects of a non-topical nature, much of the group discussion pertained to seemingly superficial topics. Exchanges of information about doctors, housing, and transportation were common. It became apparent to the group leader that the group members had concerns other than blindness and that it was important for them to discuss other aspects of their lives. Yet, the members were encouraged to focus on their feelings whenever possible. Harshbarger (1980) discovered similar patterns of interaction in a group she reported. Like Harshbarger’s group, feelings of helplessness and frustration were evoked concerning the limitations vision loss forces upon the individual.

One topic which was brought up on a regular basis was the search for a "cure" or "magic glasses"--the visual aid which would correct the uncorrectable vision problem. Participants often inquired about special types of lenses that they had heard about. Magnifying aids were shared and passed around the group. Group members offered suggestions to each other as to how they could use the visual aids in different settings.

Greig, West, and Overbury (1986) have suggested that individual or group counseling may be helpful to visually-impaired persons in achieving successful use of vision aids.
Although the present study did not measure successful use of vision aids, the high interest level in such devices was evident.

The objective data gained in this study demonstrated the value of group counseling with the visually-impaired elderly. Subjective data also indicated the worthiness of group counseling, as evidenced by the following quotes from group members:

1. "This group helped me face up to the fact that I have a problem. I feel support from all of you and I appreciate it."

2. "I realize I am not alone with this affliction. You have given me confidence to continue."

3. "The opportunity to share our ideas and feelings is what I enjoy the most."

4. "I feel that I can be myself here and that you all understand me."

5. "This group is the best thing that has ever happened to me."

The benefits expressed by the group members support the claims made by Wilson (1970) and Emerson (1981) concerning group counseling for the visually-impaired. Feeling understood and supported are crucial elements in the readjustment process. The counseling group offered its
members the opportunity to experience these feelings, and to progress toward the stage of readjustment to vision loss.

Conclusions

The findings of this study strongly suggest that group counseling with visually-impaired elderly adults is effective in facilitating psychological adjustment after a severe loss of vision. The study also demonstrates that group counseling can be used effectively as an intervention within a clinic or rehabilitation setting.

Recommendations

The results of this study suggest the following recommendations in the areas of future research and practical application.

1. A similar study should be conducted measuring the therapeutic effects of group counseling for visually-impaired elderly adults, including men, in other clinic and rehabilitation settings. This study should incorporate more controls, such as a comparison treatment group or individual counseling.

2. A new study should be conducted measuring the effectiveness of group counseling for visually-impaired persons and the successful use of visual aids.

3. A new study should be conducted to compare levels of depression, anxiety, self-esteem, and life satisfaction
in visually-impaired and non-visually impaired elderly adults.

4. Group counseling may be made available to the visually-impaired elderly population in clinics and rehabilitation agencies should further research support these findings.

5. Members of the ophthalmology profession who treat the visually-impaired elderly should become aware of the value of group therapy for their patients.

6. The level and effectiveness of rehabilitation and treatment services available to the visually-impaired elderly should be increased nationally.
APPENDIX A

LETTER OF INVITATION
Dear : 

As you know, a significant loss of vision in the later years can be a most traumatic experience. In order to help recently visually impaired people learn to cope with their vision impairment, a Low Vision Counseling Group is being formed for persons 65 years and older.

The group will meet at our Clinic for ten consecutive Mondays from 10:00 a.m. until 11:30 a.m. The first meeting is scheduled to take place on Monday, 

Membership will be limited to twelve individuals. This group is being offered in conjunction with a dissertation research study that I will conduct. I am a licensed professional counselor and have been the Counselor at the Low Vision Clinic since 1984.

There is no charge for this group. Coffee and refreshments are served.

Please call me at 522-8651 if you are interested in participating and for further information. I am looking forward to seeing you.

Sincerely,

Mark Schor
Counselor
Low Vision Clinic

MS:TS
APPENDIX B

DESCRIPTION OF SUBJECTS
Demographic Information and Visual Diagnoses of Experimental Group Subjects

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NLP means no light perception.
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