JVIB

April 2005 • Volume 99 • Number 4

The Greatest Generation Meets Its Greatest Challenge: Vision Loss and Depression in Older Adults

Colleen O'Donnell

Abstract: Having lived through the Great Depression and World War II, older adults now face the challenge of vision loss in record numbers. Depression is closely associated with functional loss and social isolation in late-life vision loss. The principles of assisting those who are aging will also benefit those who are aging with a visual impairment. They include recognizing depression, addressing multiple health concerns, promoting well-being, using a client-centered approach, and working collaboratively with the medical community and aging network.

When today's older adults were children, more than 15 million people were out of work during the greatest economic depression the world had ever known. When they became young adults, their youthful plans were put on hold, and they marched off to war. President Franklin D. Roosevelt said of those who were growing up between the Great Depression and World War II: "This generation of Americans has a rendezvous with destiny" (Brokaw, 1998, p. 3). This generation shared the values of faith, honor, country, duty, personal responsibility, and a common sense of purpose. In describing his own childhood experiences, Brokaw said, "Whatever else was happening in our family or neighborhood, there was something greater connecting all of us, in large ways and small" (Brokaw, 1998, p. 11). Having lived through poverty and war, those young people learned the true value of life and how to overcome adversity by working hard

and working together.

These adults are now in their golden years and have a different challenge—the challenge of vision loss—and it is occurring in record numbers. According to the Lighthouse National Survey on Vision Loss, conducted in 1994, one-fourth of adults over age 75 reported a functional visual impairment (that is, a visual impairment that interfered with their ability to perform activities of daily living) (Horowitz, Reinhardt, & Cantor, 1995). Visual impairment is already one of the leading causes of the loss of independence among people aged 65 and older (Alliance for Aging Research, 1999).

Considerable research has focused on the quality of life and well-being of this generation of older adults. When working with older adults who are visually impaired, it is important to remember, first, that they are older adults and, second, that they are older adults who have lost their vision later in life. The principles of assisting those who are facing the challenges of aging would also benefit those who are aging with a visual impairment. They include identifying depression, addressing multiple conditions, promoting well-being, and using a client-centered approach.

Vision loss in later life

Vision loss in older adults is invisible and confusing. For example, Ron cannot understand why Bernice, his wife of 52 years, can pick up a piece of paper off the floor but cannot write a check. People at church see that she walks in the door without a problem but does not acknowledge a friend approaching her and no longer sings all the hymns like she used to. At the supermarket, Bernice does not stumble, bump into displays, or need help to go to the bathroom; why, then, is she so slow to count her money at the checkout line?

When these adults were faced with problems in the past, they rolled up their sleeves and went to work. They want to act. They want to have their eyes back. They find it hard to understand that their ophthalmologist or optometrist can do nothing to restore their vision. How is it that medicine can fix a blockage in the heart overnight but cannot give you new eyeglasses so you can see? In the past, new eyeglasses were the answer.

What have we learned from older people about the experience of vision loss? “First, loss of vision in old age is no small thing. It permeates all aspects of life. And it hurts a lot: anxiety, frustration, aggravation, caution, and depression are frequent accompaniments” (Burack-Weiss, 1991, p. 23). According to Carroll (1961), a pioneer in blindness rehabilitation, the losses associated with sensory impairment include losses in psychological security, basic skills, communication, appreciation, occupation, and financial status, as well as a sense of wholeness. “I feel like someone cut off my right arm,” Bernice said when she was told that she could no longer drive because of her vision loss (B. Myers, personal communication, June 12, 2003).

The loss is isolating and lonely. Their families do not understand, the community is not aware, and the physicians cannot “fix” their vision. Depression frequently results.

Late-life depression

According to the psychosocial model of mental health, late-life depression can result from “the loss of self-esteem (helplessness, powerlessness, alienation), loss of meaningful roles (work productivity), loss of significant others, declining social contacts owing to health limitations, reduced functional status, dwindling financial resources, and a decreasing range of coping options” (Reker, 1997, p. 709). The symptoms of depression in older adults can be expressed in a variety of ways, some of which

are not as commonly seen in younger people:

- hypersomnia or insomnia
- of inadequacy (loss of self-esteem or expressions of self-depreciation)
- tiredness or a low energy level
- decreased ability or an inability to concentrate or attend to activities or events, as well as a decreased ability to think clearly
- loss of interest in or enjoyment of pleasurable activities
- effectiveness in attending to personal affairs (such as personal care and housework)
- or excessive anger
- inability to respond with pleasure to rewards or praise
- of being slowed down (including motor activity and conversational activity)
- or crying
- pessimistic attitude toward the future, brooding over past events, or feeling sorry for oneself (including regressive and self-punitive wishes)
- withdrawal
- thoughts of death or suicide
- feeling apathetic or unmotivated
- feeling agitated, empty, or numb

- losing or gaining more than 5% of one's body weight in a month (Lewis, 1989; Mogk & Mogk, 2004)

A diagnosis of major depression includes five or more of the following symptoms: depressed mood, loss of interest or pleasure in all or almost all usual activities, a change in weight, a sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating, or suicidal ideation. To meet the criteria, all the symptoms must be present for most of the day for two weeks or longer (American Psychiatric Association, 1994).

Older adults have been identified as a high-risk group for suicide (Mireault & DeMan, 1996). In 1992, older adults made up about 13% of the U.S. population but accounted for 20% of the country's suicides (Miller, Segal, & Coolidge, 2001). From 1980 to 1990, the number of suicides among older adults showed an increase of .5%, rather than the steady decrease that researchers had seen since 1940 (Suicide Awareness Voices for Education, 2004).

Vision loss and depression

Older adults with visual impairments may face the same losses and declines in health or finances as their peers without visual impairments. In addition, they have the special challenges of declining vision and are at a particular risk for depression. Studies have shown that older adults who are visually impaired show more symptoms of depression than do those who are sighted. Almost one-quarter of those who have difficulty seeing, compared to only one-tenth without vision loss, have reported feeling hopeless all or some of the time in the past month (Center on an Aging Society, 2002).

Two studies found similar results with regard to vision loss and

depression. In 2000, Mogk, Riddering, Dahl, Bruce, and Brafford, at the Henry Ford Health Systems Visual Rehabilitation and Research Center, administered the Geriatric Depression Scale (GDS) to 98 clients during their initial visit to the low vision clinic and found a 29.6% prevalence of depression (GDS score > 10) and a 39.8% prevalence of probable depression (GDS scores between 5 and 10). Brody et al. (2001) interviewed 151 community volunteers with age-related macular degeneration in 1998–1999 at the University of California–San Diego using portions of the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Axis 1, Fourth (IV) Edition, Research Version (SCID-IV), as well as the Geriatric Depression Scale. They found a 32.5% depression rate—a rate that is approximately twice as high as that reported in the general population of community-dwelling older adults (Koenig & Blazer, 1996).

Horowitz's (2003) findings suggest that the initial experience of vision loss can be a trigger for depression and that higher levels of depression have been associated with the recent onset of a visual impairment. Horowitz and Reinhardt (2000) proposed two possible explanations for the strong associations: Even a moderate degree of vision loss can have a dramatic affect on an older person's ability to manage activities of daily living, and vision loss evokes an intense fear of dependence.

In a comparison study involving 28 visually impaired, legally blind older adults and 26 sighted older adults, Heyl and Wahl (2001) found that, over a six-year period, competence in activities of daily living remained constant in both groups. The use of outdoor resources and leisure activities remained relatively high for the sighted group, but the participation of those who were legally blind declined significantly. Both groups experienced a loss in general life satisfaction, which is an indicator of emotional adaptation. However, a future orientation, another indicator of

emotional adaptation, declined in the visually impaired group but remained stable in the sighted group. Heyl and Wahl concluded that "in the long run, the challenge of visual impairment seems to have limited the capacity for psychological resilience" (p. 746). Psychological resilience is the ability to preserve a sense of well-being despite physical and social losses and is an attribute that is seen in many older adults.

It is therefore critical to provide both rehabilitation and psychosocial interventions early in the process of vision loss to preserve a sense of well-being and prevent depression and dependence. In addition, since most age-related visual impairments are progressive, it is equally important to maintain a therapeutic relationship with an older visually impaired person over time. As the individual's vision declines further, so may his or her ability to cope with its loss.

Vision loss and functional loss

Vision loss presents serious functional problems to older adults. Crews and Campbell (2001) analyzed information from the 1994 Second Supplement on Aging (SSA) to compare functional problems encountered by older sighted and visually impaired people. The people who reported vision problems were twice as likely as those who did not to have difficulty walking (45.0% versus 20.5%) and difficulty getting in or out of a chair or bed (23.2% versus 9.4%). The visually impaired older adults were close to three times as likely to report difficulty getting outside (29.7% versus 10.7%), getting to outside places (35.6% versus 12.3%), preparing meals (20.1% versus 6.7%), shopping for groceries (32.6% versus 11.3%), managing money (15.0% versus 4.2%), and managing medications (12.8% versus 4.4%) (p. 460).

Activities that are especially valued, such as reading and driving, are directly affected by vision loss. Reading for information is

needed to perform many activities of daily living safely and connects the individual to his or her social community and to the larger society. Driving is more than a way to get around; it is closely related to a person's sense of autonomy and independence and is one of the most feared losses associated with visual impairment (Horowitz, 2003).

In addition to the GDS, Mogk et al. (2000) administered the Instrumental Activities of Daily Living Scale (IADL) (used to measure function in terms of everyday activities) to the same clients. The GDS and IADL scores correlated directly and were statistically significant; the greater the functional loss, the greater the depression. The depression scores did not correlate with visual acuity, sex, age, marital status, or living situation. Other studies have found significant associations with visual impairments, decreased functioning, and depression. These comparisons exceed those of other common debilitating conditions, such as hypertension, diabetes, and a history of myocardial infarction (Casten, Rovner, & Edmonds, 2002; Horowitz, 2003; Lee, Spritzer, & Hays, 1997).

Older adults with visual impairments may also lose interest in activities. Everyday tasks take longer and require more effort with vision loss. The older person may experience reduced concentration and visual endurance. Gradually, activities that are frustrating are given up or handed to someone else to do. The downward spiral of vision loss, functional loss, and depression-dependence starts to spin.

Vision loss and social interactions

Crews and Campbell (2001, p. 461) found additional differences between visually impaired and sighted older adults with regard to activities involving social participation. People with visual impairments were less likely than were sighted people to get

together with friends and neighbors (64.5% versus 72.0%) and slightly less likely to talk on the telephone with friends and neighbors (75.0% versus 80.5%). Greater differences were evident in community participation. People who reported vision problems were less likely than were sighted people to go to church or temple (41.4% versus 51.5%), to attend movies (19.5% versus 28.1%), and to have eaten in a restaurant in the previous two weeks (53.7% versus 64.55), and 31.5% of those with vision problems compared to 22.9% of those who were sighted said that they would like to engage in more social activities (Crews & Campbell, 2001, p. 461). This generation pulled together during the toughest times. Now they have difficulty even getting together socially.

Barriers to social participation may extend even to families and affect their relationships. In Israel, a program was established to work with grandparents who lost their vision later in life and were fearful about interacting with their grandchildren. These grandparents participated in group therapy that emphasized adjustment to vision loss, especially in relation to the grandparent role. Through imagery, role playing, and free association of childhood memories, the members connected with the "child within them." They used their own childhood experiences, family photographs, traditions, and play activities to strengthen the grandparent-grandchild bond. Through participation in this directed program, the visually impaired grandparents were able to resume and expand their relationships with their grandchildren (Gutman & Jaffe, 2002).

What can professionals do?

Older people who are visually impaired are at a high risk for depression because of the effects of the aging process itself, the fear of dependence, and the functional problems and isolation that frequently accompany vision loss. What can vision rehabilitation

professionals (rehabilitation teachers and counselors, orientation and mobility instructors, certified low vision therapists, or occupational therapists) do to help them?

Identifying depression

Even early signs of depression can affect an older person's ability to participate in a rehabilitation program. Depression may affect a person's learning capacity or ability to retain information; it may also result in a disturbance in thought processes and difficulty making decisions or remaining oriented toward achieving goals. Rather than a major depression requiring medication or with suicidal ideations, a vision rehabilitation professional who works with an older visually impaired adult may observe behaviors that range from sadness and anger to withdrawal, self-consciousness, fear, denial, anxiety, grief, a refusal to participate, a lack of motivation, hopelessness, and helplessness (Kannenberg & Greene, 2003).

Depression in older people who are visually impaired is highly underdiagnosed. This generation of older people views itself as healthy and may not recognize the signs of depression or may ignore them. Depression is considered a private problem, one that is a personal responsibility or a sign of weakness—or worse, of impending insanity. They are survivors and do not easily seek help. In Mogk et al.'s (2000) study, only one participant with a high GDS score of 22 out of 30 had previously been diagnosed as depressed.

Vision rehabilitation professionals need to educate themselves about depression and learn how to recognize it, how to discuss it, and how to assist the client or family to get help. A variety of depression-screening instruments, such as the GDS, can be administered in an ophthalmologist's or optometrist's office or as part of a vision rehabilitation evaluation-interview. While

working with the client or talking to the family, the vision rehabilitation professional should watch for signs of depression. Once depression is recognized, Crews and Campbell (2001, pp. 463–464) admonished, it "should be addressed as a legitimate concern, rather than dismissed as an expected dimension of aging."

Addressing multiple health conditions

Growing older may involve changes in many areas of health simultaneously. These other conditions contribute to functional visual problems and/or depression and further challenge the older person who has low vision. In their analysis of the 1994 SSA findings, Crews and Campbell (2001) compared the presence of other health conditions among visually impaired and sighted older people. They found that the following conditions were higher among those who were visually impaired than among those who were sighted: hypertension (53.4% versus 42.5%), heart disease (30.8% versus 19.5%), and arthritis (68.0% versus 54.7%). Diabetes was also more common (17.2% versus 10.6%) among those who were visually impaired, especially in the 70–74 age group, who experienced the condition twice as often (23.9% versus 11.4%) (p. 459).

Other sensory or physical changes that may have an impact on an older visually impaired person's ability to manage daily activities safely include hearing loss; neuropathies and tactile sensory loss; breathing difficulties; decreased physical endurance, joint mobility, and muscle strength; balance or walking problems; and memory impairments or cognitive difficulties (Riddering, 2002). In Crews and Campbell's (2001, p. 459) 1994 analysis of the SSA data, 31.5% of the visually impaired older people had fallen compared to 19.2% who were sighted.

Issues of instructional methods, energy conservation, ergonomics,

adaptive tools and techniques, types of assistive or optical devices, and support by caregivers or family members need to be addressed in a holistic approach to working with older people to achieve the goals of vision rehabilitation. In addition, a reasonable rhythm of activity and rest is necessary; it is important to recognize signs of physical, visual, or mental fatigue in setting the pace of a rehabilitation session (Rosenfield, 1997).

Although most older people prefer to “age in place” in their own homes and in the community, many need to move. Visually impaired older people may be found in a number of environments: senior apartments, living with family members, assisted living situations, or nursing homes. Each environment presents its own physical challenges, especially if it is a new one for a person who has recently lost his or her vision.

Promoting well-being

It is instructive to consider what generally promotes well-being in older adults. Those who view life with personal meaning, who have a clear sense of choice, responsibility, and a positive outlook, are less likely to become depressed (Reker, 1997). The University of Southern California’s Well Elderly Study found that older adults who were able to choose and participate in meaningful activities (occupations) that were tailored for them achieved a healthy and personally satisfying daily routine. The participants were 361 low-income, ethnically diverse, women and men aged 60 years or older who resided in Los Angeles. For nine months, one-third received occupational therapy services, one-third engaged in a socially controlled activity program, and one-third were not treated. The group who received occupational therapy was involved in a program called Lifestyle Redesign. At the beginning of the study and directly after the program ended, all the participants were assessed using a number of self-administered questionnaires that were designed to measure

physical and social and emotional function: the Functional Status Questionnaire, Life Satisfaction Index-Z, Center for Epidemiological Studies Depression Scale, Medical Outcomes Study Short Form General Health Survey, and RAND 36-Item Health Status Survey. The participants in the Lifestyle Redesign program showed significant improvements in the following self-rated outcome variables: life satisfaction, quality of social interaction, perception of overall health, physical functioning, vitality, health-related role functioning, social functioning, emotion-related role functioning, mental health, and reduced bodily pain. However, the two control groups did not (Clark et al. 1997; Clark, Carlson, Jackson, & Mandel, 2003).

The Lifestyle Redesign program taught the older people how to change their approach to shopping, grooming, exercising, and engaging in hobbies, among other things, to maximize their vitality and productivity, giving each a sense of control over his or her aging process. The weekly group intervention was comprehensive in scope and included a wide range of topics, such as health, safety, and transportation. Each participant also met with the therapist once a month to work on specific individual goals (Mandel, Jackson, Zemke, Nelson, & Clark, 1999). In this intervention, the occupational therapists served as coaches. Using a client-centered approach, they encouraged each individual to "tell his or her story," which helped the therapists understand each participant's individual strengths, weaknesses, lifestyle, culture, needs, and goals. The individualized treatment also included assessing the amount of activity, the meaningfulness of these activities, and balance in the daily routine. The therapists used techniques like active listening, building empathy, and marking progress in setting up occupations that would be meaningful, workable, and sustainable (Clark et al., 2003).

Using a client-centered approach

Vision rehabilitation professionals have an opportunity to apply the same principles that were used in the Well Elderly Study when working with older adults who are visually impaired. Taking time to listen to an older person's story will enable a professional to assist the person in choosing what is uniquely meaningful to him or her as everyday occupations. It will engage the older adult from the beginning and will save time and resources that may be lost in pursuing something that does not interest him or her.

What is important today is a compilation of past experiences, strengths, roles, and coping styles. To understand an older person's life, the professional may ask questions, such as, "What is a typical day for you? How is it now versus before? What are you worried about? How do you manage your day? How do you feel about the future?" (Kannenberg & Greene, 2003, p. CE-5). In addition, interviewing skills, such as active listening, probing, reflecting, paraphrasing, clarifying goals, asking open-ended questions, summarizing, and using a sense of humor, are helpful in enabling a person to "tell his or her story." As work progresses with the older person and trust is established, insight may also be gained through spontaneous conversations.

If a client appears to be uncooperative or unmotivated or not to have the potential for rehabilitation, it may be that the professional has chosen the wrong goals, irrelevant tasks, or interventions that are beyond the client's capacity. From the beginning, the climate must be one of respect, interest, support, and acceptance. In working with older visually impaired persons, vision rehabilitation professionals need to take the time to learn about their experiences, personal characteristics, skills, interaction styles, beliefs (especially on aging), attitudes, concerns, needs, and views on change (Li Yeung, 2003; Rosenfield, 1997).

In working with an older person, a client-centered approach

means “having a genuine interest in him/her, participating in his/her experiences and sharing frustrations and successes” (Kannenberg & Greene, 2003, p. CE-5). In developing an interpersonal relationship, the professional learns to use himself or herself to help the person effectively. “In order to think reflectively about your interactions with clients, ask yourself: What do I see happening? Do I understand this perspective? Is my view the same? How are my values different or the same?” (Kannenberg & Greene, 2003, p. CE-5).

When working with optical devices or adaptive tools, the vision rehabilitation professional should introduce them in the context of an activity that is meaningful to the older person. This generation views themselves as healthy, not as potential users of assistive technology, and are afraid that they may appear disabled if they are seen using an assistive device. During interaction, the vision rehabilitation professional should view the older person as the expert, be respectful, and use language with which the person is familiar. Humor and self-disclosure can also be helpful (Li Yeung, 2003).

Collaborative efforts: A new team approach

To minimize the impact of vision loss on function and mental health, vision rehabilitation professionals need to develop a new team approach, especially since they have not traditionally worked with older adults. Orr and Rogers (2001, pp. 671–672) identified three key factors that have had a negative influence on efforts to provide vision rehabilitation services to older adults with age-related vision loss:

1. for vision–related rehabilitation services have always been limited and earmarked mainly for vocational rehabilitation.

2. Only a limited number of professionals in the field have had expertise (or even an interest) in aging.

3. The needs of this population have been less understood and defined than have those of the traditional working-age population.

Funding for much-needed services is opening up. By 1997, Medicare, in some regions, recognized vision loss as a disability and vision rehabilitation as a reimbursable service. National coverage was gained in 2002 for reimbursement of occupational therapy services in any location and the services of all other vision rehabilitation professionals when they are provided in the same location as the referring physician. In 1999, the effort began to reimburse providers of vision rehabilitation services who work at any site, and that effort continues.

In the 1990s, the Administration on Aging began to fund projects that involved the development of coalitions between the aging and vision fields. In addition, the National Aging and Vision Network, initiated by the American Foundation for the Blind, was formed in 1994 (Orr & Rogers, 2001). Its goal is “to increase the availability of responsive, high-quality services for older individuals who are visually impaired through the vision-related rehabilitation system, the aging network, and the health care system” (Orr & Rogers, 2001, p. 682).

Ophthalmologists and optometrists are the first professionals whom older people consult when they are beginning to have functional vision problems. As initial concerns with functional loss, especially with reading and driving, become apparent, these eye care professionals and other physicians should refer older people for low vision evaluations and vision rehabilitation. In addition, they should administer a screening tool to identify depression and open a discussion about the impact of vision loss.

Information about declining vision and function and/or signs of depression can then be shared with a patient's internist or family physician.

Collaborative efforts among eye care professionals, vision rehabilitation professionals, medical professionals, and the aging network need to address

- public awareness about age-related vision loss and depression
- identification of older adults with low vision and their access to vision rehabilitation services
- identification of depression among visually impaired older adults and referral for intervention
- of the varied medical and health-related conditions of older people
- provision of holistic services to address the various conditions
- vision rehabilitation services that are designed for older adults

Finally, vision rehabilitation professionals need to work with each other and educate each other about the contributions that each discipline can make to the field for this special group of people (Kern & Miller, 1997).

Conclusion

Crews and Campbell (2001, p. 453) stated, "For rehabilitation professionals, the problems of older people are often so complex that knowing where to begin an intervention may seem difficult." They urged rehabilitation professionals to think more broadly in

responding to the complex needs of older people who are visually impaired. Professionals need to recognize the importance of general physical health, mental health, and the effect of the environment.

As the number of older adults continues to grow and the physical and mental health needs of these older people expand, professionals need to partner with older adults' families, friends, and caregivers. The baby boomers, in particular, have a vested interest in learning how to deal with vision loss. As they observe the struggle of their parents and learn about the familial and genetic patterns of vision loss, they will come to realize that their generation may be the next to face it. They will have more questions and expect more than do their parents.

Each professional needs to help open discussions among older visually impaired adults, their families, physicians, and other professionals and to raise awareness of the problem of depression in the community. Including this awareness in work with older people will be a great benefit to them and will help ensure the success of rehabilitation training.

The greatest generation persevered through this country's greatest economic hardship; heroically fought a world war; and paved the way for growth in economic prosperity, higher education, medical advancements, and social reform. It is the responsibility and privilege of vision rehabilitation professionals to support them in ensuring that their golden years will be as bright as they can be.

References

Alliance for Aging Research. (1999). *Independence for older Americans: An investment for our nation's future*. Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, fourth edition.* Washington, DC: American Psychiatric Association.

Brody, B., Gamst, A., Williams, R., Smith, A., Lau, P., Dolnak, D., Rapaport, M., Kaplan, R., & Brow, S. (2001). Depression, visual acuity, comorbidity, and disability associated with age-related macular degeneration. *Ophthalmology, 108,* 1893–1899.

Brokaw, T. (1998). *The greatest generation.* New York: Random House.

Burack-Weiss, A. (1991). In their own words: Elders' reactions to vision loss. In N. Weber (Ed.), *Vision and aging: Issues in social work practice* (pp. 15–23). Binghamton, NY: Haworth Press.

Carroll, T. (1961*). Blindness: What it is, what it does, and how to live with it.* Boston: Little, Brown.

Casten, R., Rovner, B., & Edmonds, S. (2002). The impact of depression in older adults with age-related macular degeneration. *Journal of Visual Impairment & Blindness, 96,* 399–406.

Center on an Aging Society. (2002). *Visual impairments*: *Data profile No. 3* [Online]. Available: http://ihcrp.georgetown.edu/aging society/pubhtml/visual.html

Clark, F., Azen, S.P., Zemke, R., Jackson, J., Carlson, M., Mandel, D., Hay, J., Josephson, K., Cherry, B., Hessel, C., Palmer, J., & Lipson, L. (1997). Occupational therapy for independent-living older adults: A randomized controlled trial. *Journal of the American Medical Association, 278,* 1321–1326.

Clark, F., Carlson, M., Jackson, J., & Mandel, D. (2003).

Lifestyle redesign. *OT Practice, 8,* 9–13.

Crews, J., & Campbell, V. (2001). Health conditions, activity limitations, and participation restrictions among older people with visual impairments. *Journal of Visual Impairment & Blindness, 95,* 453–467.

Gutman, C., & Jaffe, K. (2002). A group intervention for visually impaired grandparents. *Journal of Visual Impairment & Blindness, 96,* 741–743.

Heyl, V., & Wahl, H. (2001). Psychosocial adaptations to age-related vision loss: A six-year perspective. *Journal of Visual Impairment & Blindness, 95,* 739–748.

Horowitz, A. (2003). Depression and vision and hearing impairments in later life. *Generations: Journal of the American Society on Aging, 27,* 32–38.

Horowitz, A., & Reinhardt, J. P. (2000). Mental health issues in visual impairment: Research in depression, disability, and rehabilitation. In B. M. Silverstone, M. Lang, R. Rosenthal, & E. Faye (Eds.), *The Lighthouse handbook on vision impairment and vision rehabilitation: Vol. 2. Vision rehabilitation* (pp. 655–658). New York: Oxford University Press.

Horowitz, A., Reinhardt, J. P., & Cantor, M. (1995). *The Lighthouse National Survey on Vision Loss*. New York: The Lighthouse.

Kannenberg, K., & Greene, S. (2003). Infusing occupation into practice. *OT Practice, 8,* CE1–CE8.

Kern, T., & Miller, N. (1997). Occupational therapy and collaborative interventions for adults with low vision. In M. Gentile (Ed.), *Functional visual behavior: A therapist's guide to*

evaluation and treatment options (pp. 493–536). Bethesda, MD: American Occupational Therapy Association.

Koenig, H. G., & Blazer, D. G. (1996). Minor depression in late life. *American Journal of Geriatric Psychiatry, 4,* S14–S21.

Lee, P., Spritzer, K., & Hays, R. (1997). The impact of blurred vision on functioning and well-being. *Ophthalmology, 104,* 390–396.

Lewis, S. C. (1989). *Elder care in occupational therapy.* Thorofare, NJ: Slack.

Li Yeung, Y. (2003). Educating older adults in AT. *OT Practice, 8,* 12–15.

Mandel, D., Jackson, J., Zemke, R., Nelson, L., & Clark, F. (1999). *Lifestyle redesign.* Bethesda, MD: American Occupational Therapy Association.

Miller, J., Segal, D., & Coolidge, F. (2001). A comparison of suicidal thinking and reasons for living among younger and older adults. *Death Studies, 25,* 357–365.

Mireault, M., & DeMan, A. (1996). Suicidal ideation among older adults: Personal variables, stress and social support. *Social Behavior and Personality, 24,* 385–392.

Mogk, L. G., & Mogk, M. (2004). *Macular degeneration: The complete guide to saving and maximizing your sight* (2nd ed.). New York: Ballantine Books.

Mogk, L., Riddering, A., Dahl, D., Bruce, C., & Brafford, S. (2000). Depression and function in adults with visual Impairments. In C. Stuen, A. Arditti, A. Horowitz, M. A. Lang, B. Rosenthal, and K. R. Siedman (Eds.) *Vision rehabilitation*

assessment, intervention and outcomes (pp. 663–665). Lisse, The Netherlands: Swets & Zeitlinger.

Orr, A., & Rogers, P. (2001). Development of vision rehabilitation services for older people who are visually impaired: A historical perspective. *Journal of Visual Impairment & Blindness, 95,* 669–689.

Reker, G. (1997). Personal meaning, optimism, and choice: Existential predictors of depression in community and institutional elderly. *The Gerontologist, 37,* 709–716.

Riddering, A. (2002, Spring). A commentary. *AER Division 7 Low Vision Newsletter* (pp. 25–27).

Rosenfield, M. (1997). Ambivalence about aging and health care in America. In M. Rosenfield (Ed.), *Motivational strategies in geriatric rehabilitation* (pp. 9–21). Bethesda, MD: American Occupational Therapy Association.

Suicide Awareness Voices for Education. (2004). *Facts about suicide* [Online]. Available: http://www.save.org

Colleen O'Donnell, M.S.A., OTR, CLVT, *staff occupational therapist, Visual Rehabilitation and Research Center, Henry Ford Health System, 29200 Schoolcraft, Livonia, MI 48150; e-mail: <od300one@yahoo.com>.*

Previous Article | Next Article | Table of Contents

JVIB Home

If you would like to give us feedback, please contact us at jvib@afb.net.

www.afb.org | Change Colors and Text Size | Contact Us | Site Map |

Site Search Go

About AFB | Press Room | Bookstore | Donate | Policy Statement

Please direct your comments and suggestions to afbinfo@afb.net