The effect of counselling and emotional support on the mental health of low vision patients

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Introduction

The link between visual impairment (VI) and reduced psychological wellbeing is well- established. It is especially apparent for older people, where the prevalence of depressive symptoms may be as high as 50% compared with less than 20% in people with no visual impairment (Burnell et al., 2002). A recent review similarly demonstrated a link between visual impairment and reduced psychological wellbeing in working-age adults, although the link between VI and visual impairment was weaker in this age group (Ryan et al., 2010). Several studies have also identified an increased risk of suicide in people with visual impairment (De Leo et al., 1995; Mitchell & Bradley, 2006; Lam et al., 2006). It remains unclear what effective interventions are available to address the negative psychosocial impact of visual impairment. We report here the results of an evaluation of an emotional support and counselling (ESaC) service integrated within the provision of other services to low vision patients.

Methods

The ESaC Service: This service was set up as a pilot project by the Royal National Institute of Blind People (RNIB) in two integrated Low Vision Services (RNIB in London and Sight Service in Gateshead). Low Vision Service clients were provided with information about the ESaC Service and could refer or be referred by LVIS Optometrists, rehabilitation workers or the Service Coordinator. At initial assessment, a counsellor invited clients to explore their psychological support needs and, if appropriate, offered time-limited individual or group counselling and emotional support. Counselling provided clients an opportunity to explore their thoughts and feelings about the impact of VI on their everyday lives and sense of self. Those with VI often express a need for someone to talk to outside family and friends, but not all feel ready to engage in counselling. Therefore emotional support was offered, in which the counsellor worked at less depth in a less formalised approach using their skills, offering clients the opportunity to talk and be listened to within a confidential setting. Three counsellors were involved in the project; one was a Member of the British Association for Counselling and Psychotherapy, Senior Accredited, two were Chartered Counselling Psychologists (British Psychological Society and Health Professions Council registered).

Measurements: The CORE Outcome Measure (CORE-Om) was used at baseline and post- intervention to assess the impact of the ESaC service on psychological wellbeing and social functioning (Evans et al., 2002). It taps into a ‘core’ of clients’ distress, including subjective wellbeing, commonly experienced problems or symptoms, and social functioning (34 items: four domains: wellbeing/problems/symptoms, life functioning and risk). All items are scored on a five-point scale, higher overall scores reflect greater psychological distress. Total score ranges from 0 to 156; responses were summed across items and total mean score is calculated (total score/number of completed items). The mean total score can be used as a global index of distress. Mean item scores can also be compared with reference values.

At baseline and post-intervention, a ‘Needs and Expectations Questionnaire’ (NEQ) was administered. Prompted by a series of open response questions, service users articulated what they perceived their needs as being, what they expected the ESaC service and, at post-intervention, whether and in what ways they felt the service had met their needs and expectations. The completed questionnaires were coded anonymously, identifying common themes for each question and grouping the responses under these themes.

Results

Of Full CORE Sample of 35 individuals (see Table 2), 76% received counselling and 24% emotional support. Clients receiving emotional support remained in the services for a significantly shorter duration than those receiving counselling (6 vs 13.38 weeks respectively). The main number of counselling sessions were 8.54±3.70. Table 3 details some of the characteristics of the sample. Table 3 (second Table) shows that at T2, mean scores were significantly reduced, compared to T1 (Figure 1). The average total mean score (providing an overall measure of distress) Figure 2 was statistically significantly reduced at T2. Within each domain there were statistically significant improvements in mean scores (Figure 3).

The NEQs provided the clients’ own commentary on their experience. In particular, it appeared that whilst at the outset many clients felt that they simply needed a sympathetic ear, post-intervention they were aware that they actually had needed something beyond this.

Discussion

Our CORE-Om results suggested that at the outset, the group of clients referred to the ESaC service formed a ‘clinical’ population in addition to their visual disability, they had unmet psychosocial needs. However, their CORE-Om scores were significantly improved by a relatively straightforward, time-limited counselling intervention. Note that this was delivered integrated within a low vision care setting. However, labelling this intervention ‘counselling’ may well act as a barrier to some clients entering an ESaC-type service. ‘Emotional Support’ may be a less intimidating option at the outset, but the NEQ responses post-intervention imply that something more than a listening ear may be required to observe the benefits we have observed.

References


Acknowledgements

We are grateful to the clients and colleagues who were involved in the ESaC service for their cooperation with this research project, and the RNIB for their support.

Table 1: Number of clients providing various levels of data to CORE (full pre- and post-intervention CORE was completed).

Table 2: Each item in the ‘Full’ CORE sample of 35 was assigned a visual acuity score based on its location in the reading. The median visual levels for this group were Level 2.

Table 3: The characteristics of the Full core sample on which the following analyses is based.

Figure 1: Mean scores for each of the four domains in the CORE-Om, comparing pre-intervention (T1: baseline) score with post-intervention (T2) score.

Figure 2: Points are the individual subject total mean scores, comparing pre-intervention (Pre) and post (Post) intervention scores. This shows the significant improvement in scores (a parametric paired t- test). The results are also significant with a non-parametric Mann-Whitney U test (p<0.001). The three regions shown from mean 152 to mean 125 is a normal young population.

Figure 3: Mean scores for each of the four domains. In each case the post-intervention scores were statistically significantly reduced compared to the pre-intervention scores (paired t-test, all p<0.001 except Risk, p=0.0059). Plotting conventions as for Figure 2.

Figure 4: The histogram shows the distribution of total scores on the last two time points. Note the shift to the left, post-intervention.