Factors Affecting Readiness for Low Vision Interventions in Older Adults

Amanda Jean Mohler, Peggy Neufeld, Monica S. Perlmutter

OBJECTIVE. We sought to identify factors that facilitate and inhibit readiness for low vision interventions in people with vision loss, conceptualized as readiness for change in the way they perform daily activities.

METHOD. We conducted 10 semistructured interviews with older adults with low vision and analyzed the results using grounded theory concepts.

RESULTS. Themes involving factors that facilitated change included desire to maintain or regain independence, positive attitude, and presence of formal social support. Themes related to barriers to change included limited knowledge of options and activity not a priority. Themes that acted as both barriers and facilitators were informal social support and community resources.

CONCLUSION. This study provides insight into readiness to make changes in behavior and environment in older adults with vision loss. Study findings can help occupational therapy practitioners practice client-centered care more effectively and promote safe and satisfying daily living activity performance in this population.


Low vision is defined as a bilateral visual impairment that cannot be altered with corrective lenses, medication, or surgery (Weisser-Pike & Kaldenberg, 2010). The Centers for Disease Control and Prevention (2009) listed vision impairment as one of the top 10 disabilities in people older than age 18; 17% of people older than age 65 have reported some form of vision loss. Common causes of low vision include age-related macular degeneration, glaucoma, and diabetic retinopathy (National Eye Institute, 2004).

Low vision can result in decreased participation in activities of daily living and health and increased falls, morbidity, and institutionalization (Alma et al., 2011; Crews & Campbell, 2004; Lamoureux et al., 2010). Crews and Campbell (2004) found that participants with low vision were 3 times as likely to report difficulty with getting in and out of a bed or chair, managing medication, and preparing meals. Alma and colleagues (2011) determined that 94% of participants with low vision reported restrictions in one or more participation categories, and Lamoureux and colleagues (2010) found that 40% of participants had fallen within the past 12 mo.

In working with people with low vision to preserve their independence, occupational therapy practitioners assess residual vision and function and promote occupational performance by providing training in adaptive strategies, modifying the home environment, and restoring performance skills (Markowitz, 2006). To achieve successful outcomes of occupational therapy intervention, clients must be receptive and willing to make changes in the ways they perform valued activities (Zimmer & Chappell, 1999). Therefore, for practitioners working with older adults with low vision, identifying factors that may clarify a client’s willingness to accept or not accept low vision interventions provides essential information for intervention planning.
A potential guide for understanding readiness for low vision interventions in people with low vision is the Transtheoretical Model (TTM; Prochaska & Norcross, 2001). The TTM addresses *readiness for change*, defined as a person’s desire, receptivity, and willingness to make changes. The TTM is a comprehensive model that describes change as a process occurring through a continuum of six stages. The first three stages of change are pre-contemplation, contemplation, and preparation to make changes. In the fourth stage, action, the person successfully makes behavior change; whereas the first three stages may take years, Stage 4 typically lasts less than 6 months. Stage 5 is maintenance of successful behavior changes, and the sixth stage, termination, is consolidation of the changes made and lowered risk of reversal. The TTM includes 10 processes of change that foster readiness for change; these processes are most effective when interventions are matched to the stages of change (Prochaska, Norcross, & DiClemente, 1994). For example, consciousness raising and environmental reevaluation are processes of change that fit with the early stages of readiness for change, and helping relationships and contingency management are processes best used in later stages.

Studies have reported the effective use of the TTM in managing a variety of health behaviors relevant to occupational therapy practice, but no study specifically relates to low vision and occupational therapy. Studies have focused on home modifications (Cumming et al., 2001; McNulty, Johnson, Poole, & Winkle, 2004), driving cessation (Windsor & Anstey, 2006), physical activity and exercise (Kirk, Mutrie, MacIntyre, & Fisher, 2004; Marcus, Eaton, Rossi, & Harlow, 1994), and pain management (Jensen, Nielson, Romano, Hill, & Turner, 2000; Kerns, Rosenberg, Jamison, Caudill, & Haythornthwaite, 1997). Although the TTM was used to guide these studies, the authors did not address factors influencing readiness for change. For example, Cumming and colleagues (2001) studied adherence to occupational therapists’ recommendations for home modifications to prevent falls and posited that lack of adherence was attributable to clients’ lack of belief that home modifications would lower their risk of a fall. However, this perspective did not recognize other factors that could be making change difficult. In another study referring to the TTM, McNulty and colleagues (2004) used stages of change as predictors for adoption and maintenance of equipment use. Both studies had participants who did not comply with occupational therapy intervention plans and could have benefited from an examination of factors affecting their readiness for change.

Several studies that applied the TTM to older adults with low vision were conducted by non–occupational therapy practitioners. These studies examined health educators’ programming on driving self-regulation (Stalvey & Owsley, 2003), physician–patient communication regarding glaucoma medication adherence (Hahn, 2009; Schwartz, Plake, & Mychaskiw, 2009), and use of self-help groups facilitated by vision rehabilitation teachers (Moisey & Golembiewski, 2002).

The current study is the first to focus on the low vision population when applying readiness for change concepts from the TTM to the occupational therapy intervention process and client-centered care. Focusing on readiness for change in this population has the potential to increase the client-centeredness of occupational therapy for older adults with low vision and promote the success of interventions. The purpose of this qualitative study was to better understand the readiness of people with low vision to modify the way they performed daily activities. The research question for this study was, *What factors facilitate or inhibit changes in the way older adults with low vision perform valued activities?*

**Method**

**Study Design**

A qualitative approach using grounded theory (Pandit, 1996; Strauss & Corbin, 2008) and semistructured interviews was used to identify and describe factors that facilitate or inhibit changes in the way people with low vision perform valued activities. We used a purposive sampling method, and for convenience, we recruited participants from the Low Vision Community Practice database (n = 2) and a low vision support group (n = 8), resulting in a total of 10 people willing to participate. We conducted a brief telephone screening to determine eligibility using the following inclusion criteria: age 55–90, visual acuity ranging from 20/70 to 20/500, and low vision diagnosis that affects daily activities. Exclusion criteria included congenital vision loss, residence in a nursing home or assisted care facility, and refusal to provide written consent. Following approval from the institutional review board, we initially obtained assent during the phone screening and then obtained written consent on meeting with the participants for their interview. We collected demographic information using a questionnaire during the phone screening.

Participants took part in 1-hr, face-to-face interviews that occurred in the participant’s home (n = 7) or in the community (n = 3). The first author (Mohler) conducted all interviews and recorded them for data analysis by the study team. Interview question design was informed by the...
TTM (Prochaska & Norcross, 2001) and the Person–Environment–Occupation Model (Baum & Christiansen, 2005) for the purpose of eliciting information about occupational changes made by participants with low vision, their readiness to make changes, and factors that influenced their readiness to modify the way they performed activities (Figure 1). The semistructured interview questions related to various aspects of the change process. The questions focused on how participants gained awareness of changes in their vision; the impact of those changes on daily activities; the changes participants had made in the past and the benefits of those changes; and the roles others had played when participants were contemplating, preparing for, or taking action toward making a change. Consistent with a semistructured interview process (Lysack, Luborsky, & Dillaway, 2006), additional probing questions facilitated further elaboration.

Data Analysis

We analyzed the data using a grounded theory approach and constant comparative analysis to identify themes (Strauss & Corbin, 2008). Three research team members (including authors Mohler and Perlmutter) compared, contrasted, and analyzed the interview transcripts using open, axial, and selective coding (Pandit, 1996). Open coding, the process of conceptualizing, labeling, and categorizing the phenomena, identifies key patterns, phrases, and words related to participants’ readiness for change. Coders made memo notes to facilitate reflection on participants’ narratives and identify emerging categories. Axial coding identifies similarities and differences in the data to develop categories and eventually reveal emerging themes (Pandit, 1996; Turner, Ownsworth, Cornwell, & Fleming, 2009). The coders constructed a taxonomy to formally categorize the data and provide a basis for coding (Bradley, Curry, & Devers, 2007); our taxonomy is presented in Table 1. As themes emerged, we elected to focus on the facilitators and barriers to change; the remaining themes in the taxonomy provided a useful context for analysis and discussion.

To determine interrater reliability, each of the three research team members independently coded one transcript using the taxonomy and defined codes. Overall consensus and percent agreement were determined using proportional agreement among reviewers. Initially, interrater reliability was 66%. Team members discussed differences in interpretations and revised the category definitions. They coded the same transcript again using the revised definitions and achieved interrater reliability of 81%.

Selective coding consists of identifying the relationship between each category and then integrating categories to develop themes that explain the phenomena (Pandit, 1996). Interview statements supporting each category were placed in an Excel spreadsheet to allow for in-depth reflection, comparison, and generation of ideas about the study participants’ readiness for low vision interventions. Overarching themes emerged from this analysis. Data saturation was determined through a constant comparison process during theme analysis (Tuckett, 2004), with quoted content fitting well into the identified main categories. Once themes emerged, member checking was achieved through telephone follow-up; participants agreed that the themes captured the perspectives they shared in the interviews.

Study Trustworthiness

Rigor was achieved by promoting trustworthiness, a process of ensuring accuracy and believability of qualitative data (Krefting, 1991), using three strategies. First, transcripts were typed verbatim and checked for accuracy. Second, interrater reliability was established during axial coding of qualitative data to ensure that categories accurately represented participants’ perspectives. Third, triangulation (Knafl & Breitmayer, 1989) was achieved through a multimethod approach of using a research team to generate multiple perspectives and holding interviews at different times and settings to prevent environmental influences on responses.

Results

Participants

Descriptive demographic information was compiled for the 8 women and 2 men; 9 were White, and 1 was African-American; age ranged from 55 to 87 yr. Six participants were
married and lived with their spouse, and 4 were widowed or single and lived alone. No participants were employed at the time of the interviews. All participants lived in the St. Louis, Missouri, area. Diagnoses included macular degeneration (n = 5), glaucoma (n = 2), myopathy of the optic nerve (n = 1), retinitis pigmentosa (n = 1), Usher’s syndrome (n = 1), macular edema (n = 1), diabetic retinopathy (n = 1), and intraocular cataract lens implants following cataract removal (n = 4). Half of the participants had multiple low vision diagnoses.

Identification of Themes

Coders identified 122 codes that explained participants’ readiness for low vision interventions and factors facilitating or inhibiting behavior or environmental changes. The following themes emerged:

- Desire to maintain or regain independence
- Positive attitude
- Presence of formal social support
- Limited knowledge of options
- Activity not a priority
- Informal social support
- Community resources.

These themes are categorized as facilitating, inhibiting, or both facilitating and inhibiting a participant’s readiness for change and are described in the sections that follow.

Factors Facilitating Readiness for Change

Three themes were related to facilitators of change: (1) desire to maintain or regain independence, (2) positive attitude, and (3) presence of formal social support.

Desire to Maintain or Regain Independence. The desire to maintain or regain independence and rely less on friends and family was the most commonly mentioned factor that facilitated change. Despite being married and living with her husband, 1 participant saw independence as important: “I didn’t want to rely on other people. I wanted to keep my independence as much as I can.” Another participant reported, “I do not want anybody feeling sorry for me. I am too independent. I can do things.”

The desire to continue participating in important activities was a related facilitator for changes that promoted independence. Participants who lived alone described activities they were now able to do independently because of changes they had made: “I can’t read anymore, which I used to do a lot of, but a wonderful part of that is using the Wolfner Library, which I use all the time, and

Table 1. Taxonomy and Definitions Used for Coding Transcripts

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected occupations</td>
<td>Activities affected by low vision, such as activities of daily living, instrumental activities of daily living, leisure, work, community mobility, and social participation</td>
<td>- Occupations done less often, changed in the way they are completed, completed with difficulty or less enjoyment, or dropped</td>
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<tr>
<td></td>
<td></td>
<td>- Driving</td>
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<td></td>
<td></td>
<td>- Reading</td>
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<tr>
<td></td>
<td></td>
<td>- Computer use</td>
</tr>
<tr>
<td>Occupational changes</td>
<td>Identified changes made in the ways occupations are performed</td>
<td>- Labeling appliances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Moving laundry upstairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Using public transportation</td>
</tr>
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<td></td>
<td></td>
<td>- Asking a family member to drive</td>
</tr>
<tr>
<td>Important occupations</td>
<td>Occupations that are highly valued, as indicated by specific phrasing, level of enthusiasm or passion (determined by word choice), or frequent mention by the participant</td>
<td>- Repeated mention of a valued activity, such as driving or reading, at multiple points in the conversation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- “Reading my Bible is very important.”</td>
</tr>
<tr>
<td>Less important occupations</td>
<td>Occupations that are less valued, as indicated by specific phrasing, lack of enthusiasm or passion (determined by word choice), or limited discussion by the participant</td>
<td>- “TV . . . is not a high priority. I don’t watch much television, period.”</td>
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<tr>
<td></td>
<td></td>
<td>- “I am not as interested in using the computer.”</td>
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<td></td>
<td></td>
<td>- Brief mention of a prior interest in playing poker</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Factors that promote changes or make changes easier</td>
<td>- Social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Positive outlook</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Desire for independence</td>
</tr>
<tr>
<td>Barriers</td>
<td>Factors that prevent changes or make changes difficult</td>
<td>- Lack of someone available to help make the change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Limited knowledge</td>
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<td></td>
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<td>- Activity not a priority</td>
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</table>
listen to books on tape.” Moreover, participants indicated they were most receptive to change when they knew the change would make everyday tasks easier: “I purchased TV glasses. . . . They [TV glasses] help out a whole lot. They just bring in things a whole lot clearer.”

A feature of the desire for independence was necessity. Participants were more likely to make changes when they believed the changes they made were necessary to continue to live independently. One participant noted, “If I want to continue to live by myself, I am going to have to do what I have done [make changes]. . . . I see it as necessary.” Another reported, “It [making changes] was the need. It was like, ‘Are you going to go on living, or are you going to hibernate?’”

Positive Attitude. Possession of a positive attitude, characterized by expressions of optimism, emerged as an important influence for change, and participants most commonly expressed a positive attitude in the form of determination and willingness to accept their situation. One participant described what it was like living with low vision and the positive outlook needed to make changes: “Things get real dark during the daylight hours. . . . You’re sitting around in a dark house all the time and got to accept to make changes. You have to try to make things better.”

Some participants reported that their positive attitude emerged once they acknowledged their vision loss and experienced a grieving process. One noted,

It was about 9–10 years ago that I hit a certain point in my life and I just said, “You know, the heck with this ‘oh, me’ stuff. Look at all the other people with challenges much worse than yours.” So, I think from that, once I acknowledged my vision loss, and once I got through the grieving process, things were easier.

Presence of Formal Social Support. Social support is defined as “the experience of being cared for and loved, valued, esteemed, and able to count on others should the need arise” (McColl, 1997, p. 412). Social support consists of informal supports (e.g., friends, family, spouse) and formal supports (e.g., groups, organizations, institutions, professionals; McColl, 1997). Participants reported the need to change the way they completed instrumental activities of daily living, such as shopping, by using formal social supports from local markets and businesses. Two participants described the formal shopping assistance they received:

In the meat department, I can’t see, and there is a wonderful gal there. I like certain $5 chicken breasts. . . . She’ll pick those out for me.

I have someone with me at all times [shopping], but if I didn’t, I would go up to the service desk and get a helper. You know, [in] a lot of your stores, you can do that—go up and ask for assistance.

Formal social support not only enabled participants to maintain their daily activities related to home management but also fostered participation in community-based activities. Two participants commented on how use of formal social support fostered changes that enabled them to attend church and maintain volunteer and work-related roles:

It was pretty abrupt when I couldn’t drive. . . . I had volunteers from friends and church members that drove me to and from work.

I am on the planning committee. The chairman of the committee gives me a ride.

All types of formal support systems reported by participants acted as facilitators to change, enabling continued participation in important activities.

Factors Inhibiting Readiness for Change

Participants identified two themes related to barriers to change: (1) limited knowledge of options and (2) activity not a priority.

Limited Knowledge of Options. Participants who were unfamiliar with a process or product or not aware of what changes to make were less likely to be ready for change. This theme was relevant to use of adaptive equipment, optical devices, computers, environmental modifications, and community resources. Two participants in their 80s described their lack of readiness to use a computer and a community resource because of limited knowledge of their options:

I don’t use the computer. I have never learned. I could learn that, and I may because I would like to be able to.

It just seems like a big step to take.

When we first came here, I did not know that the society [low vision support group] existed.

Another barrier to change related to limited knowledge of options included unfamiliarity with adaptive strategies. As 1 participant noted in relation to the strategy of labeling items, “Socks are difficult. I didn’t realize that
when I bought them, they are the wrong kind. . . . They are not marked. It is hard to mark socks.”

**Activity Not a Priority.** Some participants were less likely to make changes when the activity affected by the changes was not a priority. Priority was determined by a variety of factors: In some cases, the activity had become less important or was not of interest to the participant; in other cases, maintaining style preferences was more important than potentially improving function by making a change; and in still others, decreased awareness of vision contributed to a view of recommended changes as not being important. Examples of changes participants reported not making because the activity became less important included labeling items, using public transportation, and purchasing electronics:

I decided not to mark my keyboard because I am not very interested in using the computer anymore.

I have not learned to use a bus or public transportation, and I really do not have much interest in public transportation.

Some participants chose maintaining style preferences over making changes with the potential to improve quality of life. Examples of changes dismissed to preserve style preferences included installing shower grab bars and railings, adding light fixtures, and using adaptive strategies to participate in leisure activities:

He [her husband] found these ugly metal things [handrails], and I said, “Get those off of there. I don’t want those. . . . I don’t want those ugly things.”

My aesthetic side—I did not like those [contrasting door handles].

Some participants did not fully recognize their declining vision and thus did not view recommended changes as important:

I functioned pretty much thinking I had a perfect body that operated perfectly.

I was raising four kids and working and so forth, and I don’t think I thought of what was wrong.

**Factors Both Facilitating and Inhibiting Readiness for Change**

Informal social support and community resources acted as both facilitators and barriers to change, depending on the quality and quantity of each factor.  

**Informal Social Support.** Unlike formal supports, informal support systems acted as both barriers and facilitators. Informal support systems most commonly were mentioned in the form of family. All participants reported receiving informal social support that facilitated change, including informational support, practical support, and emotional support. Some participants received informational support from family or friends who informed them about options and encouraged them to make changes. One participant who walked to work alone on a daily basis recalled, “The reason I got the dog is because my husband did not feel comfortable with me out [by myself]. . . . He is the one that got that going.”

Practical support included providing transportation or putting on makeup. A participant reported, “He [her husband] does my makeup. He will do my lids [eyelids], my blush, and use the eyebrow pencil. He has been doing that for a long time.”

Emotional support came from family members who provided encouragement and reinforcement when participants made changes. One participant stated, “I don’t think it was ever difficult to make any kind of change regarding my vision loss because of the support [from her husband].”

Informal social support also acted as a barrier. Some participants with more and better quality social support were less likely to make changes because they relied on their social support for everyday tasks and saw no need for change. One participant who had been married for many years stated, “I get lazy at times, and I depend on him [her husband] for things I am sure I could do myself. You know, I ask him to read the recipe instead of using my CCTV.” Informal social support also acted as a barrier when family members associated changes with a negative stigma:

I went to San Diego and visited my mother in the adult retirement facility. . . . She looked at me when I got out of my sister’s car and said, “Put that thing [white cane] away. You do not need it here.”

Last, many participants were willing to make changes but relied on unwilling informal supports to assist them with making the changes. In several instances, participants’ families put off making a change or did not understand the importance of the change. Common changes participants wanted to make but their informal support prevented included installing ceiling lights, rearranging furniture, and purchasing food:

I wanted to get a better light in the stairwell going to the basement, and my husband says, “We are going to, we are going to,” but he doesn’t.

My daughter takes me shopping. I will say, “I want Cracker Barrel extra sharp cheese,” and she will . . . buy
some other brand that was cheaper. I don’t get the groceries that I used to.

Community Resources. Access to community resources was influential in facilitating change. The most common community resources used by participants included a community low vision agency, public transportation, and occupational therapy. A community low vision agency most commonly facilitated changes that involved adaptive technology (e.g., magnifiers, CCTVs) and social participation (e.g., computer classes, book clubs). Two participants stated, “A lot was told to me at the [community low vision agency] about those machines [CCTVs]. I think it was through the [agency] that I realized that was available and how helpful it was.

They [community low vision agency] are great. We play games. . . We had crafts. . . We have a book club. It is a way of getting out and being with people instead of being home all the time.

Public transportation was important to many participants because it allowed them to rely less on family and friends. Common forms of public transportation participants reported using included cabs, paratransit, and community transportation agencies. One participant noted, “They [community transportation agency] have volunteer drivers who will take you to doctor appointments or maybe grocery shopping, so they have been very good for me.”

Changes participants made as a result of occupational therapy most commonly included adaptive strategies. One participant said, “Thanks to [the occupational therapist], I can read the dials on the washing machine, the directions on the microwave. . . . She put pins on my shirt.”

Community resources were described as facilitating change, and lack of these resources was likewise described as inhibiting change. Transportation services offered at limited times and locations prevented some participants from making changes. A participant who lived outside a metropolitan area stated, “You have to live in [a suburb]. It [public transportation] will only take you in the county. It will not take you in the city.” A second participant stated, “I am limited to where I can go sometimes because maybe [paratransit services] does not go somewhere or at a certain time.”

Discussion
In this study, we used a grounded theory approach to better understand readiness to modify the way daily activities are performed by people living with low vision. Our literature review revealed evidence from prior studies of the effectiveness of interventions promoting change using the TTM (Cumming et al., 2001, McNulty et al., 2004), but a gap existed; we found no studies involving people with vision loss and occupational therapy intervention. In addition, existing TTM studies focused on placing participants in one of the model’s six stages of change to predict the effectiveness of interventions rather than examining factors influencing participants’ readiness for change.

In this study, we used the TTM to inform the design of our qualitative interview questions to enable us to gather descriptive information and closely examine the factors preceding changes people with low vision made in the way they performed daily activities. This approach led us to identify themes in participants’ responses surrounding the factors that facilitated and inhibited their readiness for change. Themes related to facilitators of change included the desire to maintain or regain independence, positive attitude, and presence of formal social support. Themes related to barriers to change included limited knowledge of options and activity no longer a priority. In addition, two factors functioned as both facilitators and barriers depending on the participant’s situation: informal social support and community resources.

As we looked across our themes related to the factors influencing readiness for change in people with low vision, a multilayered complexity of this construct became apparent involving person, environment, and occupation aspects. Many factors influenced participants’ readiness for change, and much variability existed in their contexts, both important considerations for occupational therapy practitioners. Use of the TTM approach to simply classify a client into a single stage of readiness for change glosses over factors that could potentially be instrumental in planning occupational therapy intervention. The typical TTM practice of placing someone in a particular stage of readiness for change does not reflect the reality that people may be at different stages depending on the specific activity under consideration and their contexts and environments.

Another key contribution of our study is insight into client-centered care for older adults with low vision. Client-centered care, a core tenet of occupational therapy, is dependent on the development of a partnership between the practitioner and client (Baum & Christiansen, 2005). In this partnership, the practitioner evaluates client needs and strengths and offers services in ways that promote client participation and self-efficacy. The process emphasizes client autonomy and decision making (Law, Baptiste, & Mills, 1995) and collaboration between practitioner and client in problem solving and goal setting (Wielandt & Strong, 2000). We propose that evaluating client readiness for change and tailoring occupational therapy
interventions accordingly are also significant in client-centered practice.

Occupational therapy practitioners can use the themes we identified as factors that influence change in people with low vision to guide assessment and intervention. Although desire for independence and positive attitude may be considered inherent personality characteristics, they may be malleable in response to motivational practices. Helping clients identify and gain access to social support systems can foster their confidence and knowledge for building relationships and networks. Identifying clients’ priorities to inform occupational therapy goals may further enhance their readiness for change and promote successful outcomes.

In this study, family and social support played pivotal roles in participants’ readiness for change, either facilitating or inhibiting readiness depending on the situation. Practitioners and clients can ascertain how family and support systems are influencing clients’ receptivity to making changes. A possible intervention approach with family members is to provide education about needed changes, benefits of adaptive strategies and modifications, community resources, and ways to build social support. Intervention with family members can enable clients in the contemplation, preparation, or action stages of readiness for change to be in control as much as possible while family members provide support and assist in acquiring equipment or resources for recommended changes.

This study suggests that receptivity to making changes can be promoted when occupational therapy practitioners ask clients about changes they have made thus far and the degree of benefit they experienced as a result. Raising clients’ awareness about prior success in changing the ways they performed daily activities and modified their environments may pave the way for subsequent changes, thus facilitating movement from precontemplation to subsequent stages. In addition, when using a TTM approach with a client who is reluctant to adopt a potentially effective modification, the practitioner could offer the client several options and ask which is most acceptable or appealing. Alternatively, the practitioner could suggest a trial period with a change with the promise that if the client does not like the change, it will be revised or removed. These strategies could enhance readiness in clients with low vision to modify home lighting, mark appliances, initiate a fitness routine, and participate in many other aspects of intervention and may have application at several TTM stages of change.

Throughout the course of occupational therapy intervention and before discharge, practitioners can prepare their clients for future changes they may need to consider. Given the chronic and often progressive nature of age-related vision conditions, it is important to educate clients about additional strategies to use if their situation changes. Clients can be encouraged to contact their occupational therapy practitioner and other resources if they encounter difficulties in the future. This continued contact will promote continued receptivity and contemplation of future changes that may be necessary if vision loss progresses.

**Limitations and Future Research**

Although rich descriptive data were collected with themes emerging and data appearing to be saturated, the small sample size in this study could be a limitation. Because of the limited diversity in this small sample, results from this study cannot be generalized to the entire older adult population. Participants in this purposive sample were already making changes to compensate for low vision when they contributed to this study. Consequently, this study does not describe the perspectives of those who have not yet pursued changes or services to address low vision. Therefore, future research is recommended with clients who have not yet made changes or sought low vision services. Additional future research efforts could include examination of why people are more receptive to some changes than others, exploration of the role of self-efficacy in making changes to support independence, and evaluation of the effectiveness of TTM strategies to enable occupational therapy practitioners to enhance their clients’ readiness for low vision interventions.

**Implications for Occupational Therapy Practice**

The results of this study have the following implications for occupational therapy practice:

- Occupational therapy practitioners’ attention to factors that facilitate or inhibit a client’s readiness for change can enhance the client’s willingness to modify the way he or she performs valued activities.
- Assessment of drive for independence, positive attitude, formal and informal social support, and access to and availability of community resources can inform occupational therapy intervention goals and methods to facilitate readiness for change in older adults with low vision.
- Effective client-centered occupational therapy requires practitioners to consider clients’ readiness to adopt changes in the way they perform activities and to modify interventions accordingly.

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References


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