Incorporating Social and Leisure Participation into the Clinical Setting

Karla Sternberg, MOT, OTR, SCLV, CLVT

Social isolation and loss of participation in meaningful social and leisure occupations is common in the general older adult population and has been well documented for those older adults with varying levels of vision impairment. Two significant factors that limit social and leisure participation include vision and depression. Perlmuter\(^1\) reported that mild vision impairments (20/40) have been found to reduce participation and increase symptoms of depression. A visual acuity of 20/40 is not an acuity that places an individual into the "low vision" category; however, this visual impairment is significant enough to limit a person’s participation and engagement in social and leisure activities. Depression has been found to be two to five times greater in older adults with low vision than in sighted individuals of the same age.\(^2\) Vision loss can result in a perceived loss of control, loss of meaningful connections, and loss of social roles, which exacerbate symptoms of depression.\(^3\) Visual functioning, co-morbidities, and coping strategies are a greater predictor of depression than degree of vision loss\(^4\); therefore, a person with 20/40 visual acuity may have additional co-morbidities and poor coping strategies for their visual changes and is predicted to experience greater symptoms of depression.

Social participation is defined as “organized patterns of behavior that are characteristic and expected of an individual or a given position within a social system”\(^5\) including peer/friend relationships, family roles, and community interactions. Social participation is a significant...
Incorporating Social and Leisure Participation into the Clinical Setting
Karla Sternberg, MOT, OTR, SCLV, CLVT

Severe Brain Injury, Vision Loss and Promising Employment Models
BJ LeJeune, M.Ed, CRC, CVRT

Vision Impairment: The Impact on Social Cognition and Social Ability
Carolyn D. Palmer, PhD

Envision Conference 2012

Qualitative Outcomes

- “I sort of got disinterested in life, which is not normal for me and stopped being around my friends. This group has been good for me to get out.”
- “I like these guys. We are all dealing with the same stuff.”
- “Getting here is hard, I have to catch the bus at 6:30 am and then don’t get home until late, but I like the chance to get out of my house.”
- “It’s nice to know there are other people out here worried about similar stuff, like protecting ourselves. It’s scary out there.”
- “I went to the multi-service group on Thursday to have lunch. There were 40 people there, all vision impaired.”

TABLE 1

Environment, Occupation frame of reference. This frame of reference describes occupational performance as “an outcome that is created among people, occupations, and their environment.” This frame of reference suggests that the person is engaged in ever-changing roles that evolve over time and context. The environment includes the many contexts in which the person engages and can include cultural, social, environmental, physical or organizational. The occupation includes the leisure pursuits in which the person engages. The result is occupational performance where a dynamic experience is created.

The formation of this social/leisure activity group required the use of group building blocks to include participation, communication, problem-solving and leadership.

Participation was essential for group development and required that participants have concern for the task and willingness to contribute to the goals of the group, either indirectly or directly. Multiple factors affected participation, including the content of the group, physical atmosphere, psychological atmosphere, personal preoccupations, level of interactions, and familiarity with others in the group.

Selecting participants played a significant role in the level of participation expected from the group. The social/leisure group’s participants were selected based on results of standardized assessments including the NEI VFQ-25 and Geriatric Depression Scale (GDS). The NEI VFQ-25 measured visual disability and visual symptoms using generic health and task-specific domains. At the time of discharge from basic low vision training, the selected participants demonstrated no improvement in domains specific to social engagement, role performance, dependency and mental health. Levels of depression were determined using the GDS, which is a 15-question non-visual interview that helps to identify symptoms of depression in the geriatric population. The selected participants demonstrated GDS scores at the same level following basic low vision training. Initially, participants were selected based on their scores using the NEI VFQ-25 and the GDS. Five male participants were selected between the ages of 50 and 61 with eye diseases including exudative age-related macular degeneration, advanced glaucoma, post cerebrovascular accident with left homonymous hemianopsia, and bilateral retinal detachments with corneal irregularities.

Communication included spoken and unspoken language and required two-way communication from each member. Being able to offer and receive feedback was critical to group development and cohesiveness. Communication within the social/leisure participation group was initiated through the use of a semi-structured interview that was utilized during a focus group. This provided an opportunity for group members to meet one another while providing feedback in regards to individual needs, wants and expectations from this group. The group responses were recorded and transcribed.

Problem-solving was initiated through the use of the focus group in which three significant problems were noted as themes from group transcriptions. These problems included:

- **Loss of engagement:** “The last time I got a book was last year, and I couldn’t see the print and got discouraged and quit my book club.”
- **Transportation:** “I stay home all the time. I stopped going to my art classes, book club, and spending time with my gardening friends. I feel so different from them now, and I have to find someone to take me.”
- **Acceptance of disease and disease process:** “I have realized that I need to accept my impairment and reach out and ask for help. That was a big thing for me: asking people to help and accept me as I am.”

This focus group, as well as subsequent groups, allowed the members to determine commonalities with one another, normalize their problems and feelings regarding vision loss, develop understanding of the causes behind their problems, and generate ideas for one another to help address the problems that were verbalized.

Leadership required focusing the participants toward a common goal while maintaining knowledge of interactions, commitment levels, and expectations of the group, as well as providing activity-based interventions. Through fostering the leadership role, informal roles within the group began to develop. Soon an informal leader, a task manager, a social butterfly and a wallflower emerged. The activity-based interventions provided an outlet for participants to engage safely and independently. These activities included:

- Attending community activities including art exhibits at the local art history museum
- Introduction to other community groups for people with visual impairment
- Education sessions from local sheriff’s department
- Movies
- Gardening
- Mentorship through group membership
- Over the months, as the group continued to develop and become more cohesive, an additional focus group was conducted to determine qualitative outcomes. Statements obtained during this focus group have been included in Table 1. Positive results were noted with each participant expressing their enjoyment of one another, an opportunity to leave the house, realization that they are not alone with their vision impairment, and suggestions of additional community group opportunities. In addition, the NEI VFQ-25 domains specific to social engagement, role performance, dependency and mental health were completed to determine qualitative outcomes that offered positive results.
been displayed in Table 2. This group has demonstrated many successes and many challenges. Commonalities beyond vision impairment were identified and, for the most part, disclosing personal needs, asking others for assistance, and supporting one another physically and emotionally. Each participant developed a level of personal responsibility for the group and demonstrated a strong commitment to one another. Each participant demonstrated improved social interactions, improved quality of life, measurements, and improved social/leisure activity engagement outside of the group. Professionally, the formation of this group has been incredibly rewarding. Staff and participants have been receptive and willing to participate without hesitation. Creating a group that fit multiple participants’ needs, while providing individual support, proved to be a challenge. Acknowledging trans- lation of personal needs, social conflicts and expenses required for community engagement continues to be an ongoing challenge. The selection of receptive group participants and establishing group norms provided a guide to the group formation and has helped to reduce the significance of these challenges. The group continues to grow and expand. Opportunities to engage in multiple groups, both through the rehabilitation program as well as in the community, are provided and participants are encouraged to attend and engage in as many as they wish. Overall, participation in leisure and social activities is important to quality of life for people with vision impairments. A rehabilitation program that includes social and leisure participation programming is crucial in holistically addressing patients’ needs while providing a transition into the community.

References:

Severe Brain Injury, Vision Loss and Promising Employment Models

B.J. LeJeune, MEd, CRC, CVRT

In January 2007, my husband, who has a congenital vision loss, was involved in a severe brain injury. We moved out of our home in Tennessee and tripped over a rock in the snow, pitching himself headfirst down the side of a mountain. His downhill journey was stopped by a large tree which probably saved his life, but which also caused considerable damage. Most notably, he suffered a traumatic brain injury known as a subdural hematoma. He was airift to the University of Tennessee Medical Center in Knoxville where he had a craniotomy and suffered a stroke. I have been a vision rehabilitation therapist and vocational rehabilitation counselor for years, so I felt as though I had at least some idea of what we were facing. Unfortunately, I found myself in very new territory. During the rehabilitation process, I often felt we were going three steps forward and two steps back. We had wonderful resources throughout the acute and rehabilitation process, but when he was released for us to go home to rural Mississippi, we were on our own. I began the process of reading and educating myself on traumatic brain injury and vision loss. According to a recently revised definition of traumatic brain injury (TBI) by the Brain Injury Association of America, traumatic brain injury is defined as an alteration in brain function or other evidence of brain pathology, caused by an external force.

One of the major challenges in working with someone with a brain injury is that each individual is dramatically different. These differences are due to the type of brain injury (i.e. concussion, diffuse axonal, shaken baby syndrome, etc.), the severity of the brain injury (mild, moderate or severe), the age at which it occurs, the rehabilitation resources available, the overall health and intellect of the individual involved, and the type of support system that is available to assist the person in coping with their injury. The additional complications of a related visual impairment caused by brain injury rather than ocular issues makes rehabilitation even more complicated. For someone with a pre-existing visual impairment, it is even more complex.

The typical types of visual impairments related to a brain injury include hemianopsia (a loss of half of the field of vision), visual neglect (seeing but not acknowledging areas, usually on the left), visual spatial disorders (causing difficulties with depth perception, localization and personal space boundaries), impaired eye movements (nystagmus, saccadic or difficulty tracking), visual memory loss, reading impairments similar to dyslexia, low light sensitivity, and visual hallucinations (Charles Bonnet Syndrome).1,2 Visual impairments in some, particularly children, may also include Post Traumatic Vision Syndrome (PTVS) which includes strabismus, ocular motor dysfunction, blurred and double vision and the onset of some blindness-specific mannerisms such as rocking.

Keep in mind that damage to the brain as a result of a traumatic brain injury may also have characteristics of Cortical Vision Impairments (CVI); it is good to assess these areas as well. The classic CVI characteristics according to Christine Roman-Lansky1 include 1) difficulty with novelty (inability to recognize new things), 2) difficulty with visual complexity, 3) distinct color preferences (red and yellow), 4) non-purposeful gaze, 5) visual latency, 6) atypical motor behaviors (looking away when reaching), 7) absent or atypical reflex responses.

My husband has congenital glaucoma and is aphakic. Neither my husband nor I had any training in working with someone with a brain injury. I began the process of reading and educating myself on traumatic brain injury and vision loss. According to a recently revised definition of traumatic brain injury (TBI) by the Brain Injury Association of America, traumatic brain injury is defined as an alteration in brain function or other evidence of brain pathology, caused by an external force.

One of the major challenges in working with someone with a brain injury is that each individual is dramatically different. These differences are due to the type of brain injury (i.e. concussion, diffuse axonal, shaken baby syndrome, etc.), the severity of the brain injury (mild, moderate or severe), the age at which it occurs, the rehabilitation resources available, the overall health and intellect of the individual involved, and the type of support system that is available to assist the person in coping with their injury. The additional complications of a related visual impairment caused by brain injury rather than ocular issues makes rehabilitation even more complicated. For someone with a pre-existing visual impairment, it is even more complex.

The typical types of visual impairments related to a brain injury include hemianopsia (a loss of half of the field of vision), visual neglect (seeing but not acknowledging areas, usually on the left), visual spatial disorders (causing difficulties with depth perception, localization and personal space boundaries), impaired eye movements (nystagmus, saccadic or difficulty tracking), visual memory loss, reading impairments similar to dyslexia, low light sensitivity, and visual hallucinations (Charles Bonnet Syndrome).1,2 Visual impairments in some, particularly children, may also include Post Traumatic Vision Syndrome (PTVS) which includes strabismus, ocular motor dysfunction, blurred and double vision and the onset of some blindness-specific mannerisms such as rocking.

Keep in mind that damage to the brain as a result of a traumatic brain injury may also have characteristics of Cortical Vision Impairments (CVI); it is good to assess these areas as well. The classic CVI characteristics according to Christine Roman-Lansky1 include 1) difficulty with novelty (inability to recognize new things), 2) difficulty with visual complexity, 3) distinct color preferences (red and yellow), 4) non-purposeful gaze, 5) visual latency, 6) atypical motor behaviors (looking away when reaching), 7) absent or atypical reflex responses.
He also seems to need more light because he has trouble seeing in a darkened environment. It is unlikely that this group will ever meet, so there needs to be one or two professionals who can coordinate and facilitate the process of sharing information.

In terms of facilitating employment outcomes, there are three models. One would like to suggest be investigated for our purposes. No single model will suit all persons as everyone with a brain injury is different. However, these may hold ideas that will facilitate our use. We do know that participation in vocational rehabilitation is a predictor of employment outcomes.5,6

Research by Ben-Yishay, Silve, Piasetsy and Ratok7 confirms that early vocational rehabilitation services, a supportive work environment, cognitive skills training and assistive technology were all moderately supportive in returning people to work after brain injury. Three models were investigated by a systematic literature review by Fadyl and McPherson8 who were looking at brain injury rehabilitation in a structured environment with guided work trials outside the center. Job placement with transitional job support was available. According to Fadyl and McPherson8, this model was found to show weak evidence that individuals had better vocational outcomes after completing the program. There was also weak evidence that individuals in this type of program were more likely to gain competitive employment, more work hours and receive higher wages. About half of those placed in competitive employment services retained employment for more than a year. The advantage of this type of program is that for those individuals who need restructuring of neural pathways, repetition and structure is necessary. This type of program is comprised of a full array of specialists with individualized strategies that may enhance employability and independence by retraining the brain to think and act differently.

Since my husband began his journey, I have heard physicians say that no one with a severe brain injury will ever be able to return to full-time employment. I have heard others state that with proper interventions and support, employment is a viable option for the same group. My personal observation is that there are a lot of “ifs.” If the person is motivated and able to self-regulate behaviors, if they have the necessary support system, and if they have an active in-place team of persons working to that end, perhaps employment is a viable option. However, I have talked with many VR counselors within the field of blindness and low vision who are trying to facilitate job placement without either access to successful models or any of the “ifs” in place. My husband is past retirement age so for him, job placement was not a goal. However, since the majority of those with brain injuries are between the ages of 18 and 35, for them, and their families, it is critical that we find ways to facilitate the job development process.

References:
Vision Impairment: The Impact on Social Cognition and Social Ability

Carolyn D. Palmer, PhD

Vision plays a role in the development of early skills for social cognition which involve perspective-taking and joint-attention behaviors. The impact of vision loss on the development of social cognition and social ability affects a child’s proficiency in perceiving and interpreting the ideas and sensitivities that underlie what people say and do. Decreased visual acuity restricts understanding of the context of social interaction and the ability to choose appropriate initiations or responses. It may also affect competence in processing how peers interact with each other and how they act upon other information such as verbalizations.

This study reports on an aspect of the findings of a much larger study that aimed to investigate the effects of severe vision impairment on children’s social competence, social ability and their involvement in peer relationships. The major focus of the larger study was on children and youth with Albinism. The aim was to investigate whether or not there is a relationship between their vision loss, social information processing, and patterns of social behavior. The major study also involved a parallel investigation of students with vision impairment and those with no vision loss in order to establish similarities and differences in the social competence of the three groups.

THE NATURE OF SOCIAL COGNITION AND SOCIAL ABILITY

Social cognition is a significant aspect of social ability and a mediator in the socialization process. It underpins how individuals process social cues, operate appropriately in various situations and show appropriate feelings. It is concerned with the capacity to conceptualize others, understand social relationships, understand the thoughts, emotions, intentions, and viewpoints of others in social situations, and the ability to relate to others. Social cognition is influenced by children’s intelligence, experience and culture.

Social ability is about how individuals make social decisions and how they solve social problems. It involves social understanding, showing appropriate feelings, and the ability to process social cues in various situations, and knowing how and when to say and do appropriate things. It represents the integration of socio-cultural knowledge, cognitive, developmental and behavioral experiences.

IMPACT OF SEVERE VISION LOSS

The literature indicates that social cognition and social information processing is disrupted by severe vision impairment and that children and youth with vision impairment have limited social understanding. Their social behavior indicates impairments in social cognition that result in significant impediments to successful peer and other relationships. They often have limited social understanding. This limitation is due to their difficulty in interpreting social cues and body language, monitoring and responding to the interests of peers, monitoring their own behavior in social situations and being aware of how others respond to certain behaviors. The majority of children with vision impairment do not have enough sight to learn about the social nuances being enacted around them.

To gain a picture of the social cognition and social ability of children and youth with vision impairment, the following research questions were posed:

Do children and youth with vision impairment:
1. Say things that fit inappropriately with what others say?
2. Do things that fit inappropriately with what others do?
3. Show inappropriate feelings?

METHOD

Data were collected using the Social-Emotional Dimension Scale (SEDS) which relied on informant reports from teachers. Three aspects of the SEDS questionnaire from the section on inappropriate behaviors were examined. These focused on: student says things that fit inappropriately with what others are saying; student does things that fit inappropriately with what others are doing; student shows inappropriate feelings (e.g. looks or acts happy when should be sad). Class teachers rated each of the items according to whether the behavior had been observed never or rarely, occasionally or frequently.

INSTRUMENTS

The Social-Emotional Dimension Scale (SEDS), which teachers were asked to complete in relation to each participant, is described as a highly structured, norm-referenced rating scale. For the purpose of this study, the SEDS instrument was used as an informant report to judge the behavior of children with vision impairment in their educational setting.

THE PARTICIPANTS

Three groups of students participated in the study: 10 young learners with albinism, six with vision impairment and nine students with no vision problems. The students with albinism were divided into three groups: Those with oculocutaneous albinism: tyrosinase negative (OCA1); oculocutaneous albinism: tyrosinase positive (OCA2); and ocular albinism (OA). The student participants were aged between 8 and 16. The nature of the instruments used in the study were not appropriate for students younger than 8, and students over the age of 16 were either engaged in their final years of study, or were likely to leave school during the collection of data. Table 1 shows the gender, age and visual acuity of the participants with vision impairment.

The reason for differentiating between the three albinism groups was to gauge whether the physical appearance of these children had physical appearance (very pale, non-pigmented skin and white hair). The inclusion of children and youth with albinism enabled the researcher to establish whether the additional factors inherent in this condition resulted in significant differences in the social cognition and social ability of these students compared with peers with vision impairment (not albinism) and those with no vision loss.

Why children with albinism were included in the group

Children and youth with albinism differ from other young people with vision impairment because of their

Table 1: Profile of students with vision impairment in terms of gender, age, eye condition, date of birth.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Gender</th>
<th>Age</th>
<th>Eye Condition</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>10</td>
<td>Oculocutaneous Albinism Tyrosinase negative (OCA1)</td>
<td>9 years</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>11</td>
<td>Oculocutaneous Albinism Tyrosinase negative (OCA1)</td>
<td>11 years</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>11</td>
<td>Oculocutaneous Albinism Tyrosinase negative (OCA1)</td>
<td>11 years</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>14</td>
<td>Oculocutaneous Albinism Tyrosinase positive (OCA2)</td>
<td>14 years</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>9</td>
<td>Oculocutaneous Albinism Tyrosinase positive (OCA2)</td>
<td>9 years</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>13</td>
<td>Oculocutaneous Albinism Tyrosinase positive (OCA2)</td>
<td>13 years</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>13</td>
<td>Oculocutaneous Albinism Tyrosinase positive (OCA2)</td>
<td>13 years</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>11</td>
<td>Ocular Albinism (OA)</td>
<td>11 years</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>8</td>
<td>Ocular Albinism (OA)</td>
<td>8 years</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>16</td>
<td>Ocular Albinism (OA)</td>
<td>16 years</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>13</td>
<td>Microphthalmia progressive degenerative retinal dystrophy</td>
<td>13 years</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>11</td>
<td>Calotina</td>
<td>11 years</td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>13</td>
<td>Retinitis Pigmentosa</td>
<td>13 years</td>
</tr>
<tr>
<td>14</td>
<td>F</td>
<td>13</td>
<td>Encephalitis, vision impairment</td>
<td>13 years</td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>12</td>
<td>Congenital nystagmus</td>
<td>12 years</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>12</td>
<td>Bilateral retinal impact, Congenital cataracts, micro cornea, astigmatism</td>
<td>12 years</td>
</tr>
<tr>
<td>17</td>
<td>M</td>
<td>No vision loss</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>M</td>
<td>No vision loss</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>No vision loss</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>No vision loss</td>
<td>8 years</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>M</td>
<td>No vision loss</td>
<td>8 years</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>M</td>
<td>No vision loss</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>M</td>
<td>No vision loss</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>F</td>
<td>No vision loss</td>
<td>12 years</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>M</td>
<td>No vision loss</td>
<td>9 years</td>
<td></td>
</tr>
</tbody>
</table>
an impact on their social ability and social understanding. Although all of the participants had what is considered to be severe vision impairment, their physical characteristics differed, ranging from those in the most severe form of albinism (OCA1) with white hair and skin, to those with the mildest form (OA), whose skin and hair was not affected.

LIMITATIONS AND DELIMITATIONS

This study was limited by the size and nature of the group of students with vision loss under investigation. Vision impairment is a low incidence disability, and albinism is a rare condition. The subjects studied were limited to the children and youth (both vision impaired and sighted) who lived in the metropolitan area in a city in Australia and attended a regular primary or secondary school. The age of the participants was limited to students between the ages of 8 and 16. The sensitivity of the area and the unwillingness of some parents to participate in the study, further limited access to subjects. Because of the low numbers of participants available for the study, findings must be interpreted with care.

RESULTS

Three subjects (20%) with albinism (OCA1, 1; OCA2, 1) did so frequently. In other words, six (60%) of the group of students with albinism, as shown in Figure 2, exhibited this inappropriate behavior either occasionally or frequently, with students with OCA2 being the most likely group within the albinism group to do so, and students with OA being the least likely.

Students do inappropriate things

Two students (20%) with albinism (OCA1, 1; OCA2, 1) were reported by their teachers to do things frequently that fitted inappropriately with what others were doing, three (30%) were reported to do this occasionally (OCA2, 3), and five (50%) never (OCA1, 2; OA, 3). Figure 3 shows that when the findings on students with albinism were examined in relation to those on students with vision impairment (not albinism) and students with no vision loss, students with albinism had a lower incidence of behaviors that fitted inappropriately with what others were doing than students with vision impairment (not albinism) and students with no vision loss. Within the group of children with albinism, students with OA were less likely to behave inappropriately in relation to what others were doing compared with children with OCA1 and those with OCA2. The findings are shown in Figure 3.

Students show inappropriate feelings

Only one student (10%) with albinism (OCA2) was reported to show inappropriate feelings frequently, four (OCA1, 1; OCA2, 3) were said to show these feelings occasionally (40%) and five (50%) never (OCA1, 2; OA, 3). When these findings were examined in relation to the teachers’ assessment of the behavior of students with vision impairment (not albinism) and no vision loss, it was found that six students with vision impairment (not albinism) never or rarely showed inappropriate feelings (100%). In addition, seven sighted students (78%) rarely or never showed inappropriate feelings and two (22%) showed them occasionally. These findings are represented in Figure 4.

CONCLUSION

The examination of the social cognition and social ability of children with vision impairment provides new insights into the social competence of this group of children. This paper focuses on factors that have the potential to affect their social development and peer interactions. In an environment where social competence is valued and perceived to be a crucial element in successful interaction with others, children who behave differently and fail to interpret the subtle messages transmitted to them by their peers, are likely to have difficulty establishing relationships with classmates.

Overall, this study concluded that the social ability of students with vision impairment varied from very competent to not very good in much the same way as the social ability of students with no vision problems. Although there is strong evidence in the literature to support the premise that severe vision impairment has a major impact on the development of social skills, the findings from this study show that in terms of social ability, students with vision impairment, while they have some areas of weakness, are not markedly different from other students. If any aspects of social ability...
need to be highlighted as areas of concern, the most obvious ones are social cognition, particularly in respect to students with the most severe form of albinism (OCA1), and the likelihood that children with albinism will show inappropriate feelings. Clearly, the tendency of some children and youth with vision impairment (mainly those with albinism) to say and do inappropriate things, and show inappropriate feelings, increases the likelihood of social rejection and the need for monitoring and intervention. This research was based on theories of social and cognitive development. The importance of social interaction emerges clearly from the theoretical research, and the notion that social competence evolves through a process of interaction with peers, observation, modeling and feedback gives insight into the process of socialization and the critical nature of social cognition and social ability. It is acknowledged that the study of small samples imposes limitations on the generalizability of findings. Despite these limitations, this study generated insights into factors related to the social cognition and social ability of students with vision impairment in ways that had not been investigated previously.

In conclusion, this paper reports on a study that involved a small group of subjects. What was being studied was the student and what the researcher sought to understand was the complex, dynamic system of social cognition and social ability in which vision impairment plays an important role. The major focus of this small study, as reflected in its title, was to investigate the effects of vision impairment on children’s social cognition and social ability. The use of the Social Emotional Dimensional Scale (SEDS) was well-suited to the investigation because this instrument probed the views of teachers who work with the students on a day-to-day basis. Limitations were imposed by the nature of the participants, the groups involved, and the ages of the students. Recruitment was difficult because of the nature and sensitivity of the condition and its low incidence. Finally, when children have albinism or other forms of vision impairment which affects their condition may limit social learning, social ability, social behavior and social emotional reactions. They need to understand that the inability to use vision efficiently in social situations and understand social dynamics makes this group of children vulnerable and at risk of social isolation.

References:
Envision is pleased to announce the launch of Envision University. The mission of Envision University is to provide multi-disciplinary continuing education and research opportunities for low vision rehabilitation professionals, establishing best practices to ensure continued research and clinical care for individuals who are blind or visually impaired. Our promise is to collaborate with vision rehabilitation and research professionals to provide relevant multi-disciplinary continuing education and research opportunities that address practice gaps in current standards of care and research.

Envision University will be comprised of live continuing education events, the annual Envision Conference, Visibility and expanded online education and research opportunities. Stay tuned for more information!

**COMING SOON**

**July 12, 2012**

**July 28, 2012**
**Coping with Chaos: Neuro-Optomteric Rehabilitation Techniques and Their Application in a Clinical and Team Setting.** Wichita, KS. CE – AOTA, COPE

**September 12-15, 2012**
**Envision Conference 2012.** Hilton St. Louis at the Ballpark, St. Louis, MO. CE – ACCME, ACVREP, AOTA, CRCC, COPE

**October 11, 2012**
**Low Vision Grand Rounds** – Research on Contact Lenses. Wichita, KS. CE – ACCME, AOTA, COPE

**November 9, 2012**
**Assistive Technology.** Wichita, KS. CE – ACVREP, AOTA, CRCC, COPE

*For more information, visit the Education and Resources page at [www.envisionus.com](http://www.envisionus.com).*