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ADJUSTMENT TO BLINDNESS: A STUDY OF THE PSYCHO-SOCIAL
EFFECTS OF VISUAL LOSS IN ADULTHOOD

Rosemarie Newell

Thesis Presented to the
University of Surrey
for the Degree of
Master of Philosophy

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September, 1983
The aim of the present study was to examine the psycho-social effects of blindness on a sample of individuals who were registered as blind in adulthood. In particular, it considered what influence societal reaction had on those studied. Four main areas of the blindness career were studied: 1) the early period of blindness; 2) the rehabilitation process and agency involvement; 3) occupational mobility and employment outcomes; and 4) what it is like to be a blind person.

A symbolic interactionist approach was taken, using the concepts of career, status passage, social role, self-concept, deviance and stigma. The study drew largely on the work of Scott (1969) who proposed that there is a specific "blind role", which public attitudes and blindness agencies impose on those who lose their sight.

The sample consisted of males and females between the ages 22-60, living in Southern England, and who had differing degrees of sightedness. The method employed was that of in-depth interviewing. In addition, various rehabilitation and employment personnel were interviewed.

The findings indicate that the majority of respondents did not permanently adopt the blind role, that is, become helpless and dependent, but held a variety of roles. The work role was highly valued; those who were employed put little emphasis on the effects
of blindness, whereas those who were involuntarily unemployed generally regarded their condition as disabling. It was evident that the direct influence of agencies was not as great as Scott found in the United States. The major problem people face is in dealing with the public stereotypes held about them, and being assigned deviant status. Although it was felt by most of those studied that the physical implications of blindness could be surmounted, societal reaction was seen as being responsible for many of the difficulties they encountered.
ACKNOWLEDGEMENTS

I would like to express my appreciation to all those who took part in this study, particularly the respondents who so patiently gave up their time to be interviewed. My thanks go to the Royal National Institute for the Blind, the Manpower Services Commission, the various social services departments who provided the names of respondents, and the many other people who contributed to this study.

My appreciation also goes to Dr. Nigel Gilbert and Mr. Keith Macdonald for their excellent guidance and constructive criticisms of this project.

I would also like to thank Paul Friend for his encouragement and his valuable assistance in helping me overcome the idiosyncrasies of the word processor.

One final word of thanks must go to the S.S.R.C., whose funding allowed me to carry out this project.
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How do people cope with a loss of sight in adulthood and what influences their adjustment to this loss? Do they follow a well-defined rehabilitation pathway? Does their occupational status change as a result of becoming blind? Are their social roles and self-concepts affected by it? What attitudes do they have towards their blindness? This study sets out to answer these questions by examining the experiences of a sample of people who have lost their sight in adulthood. It is concerned with four main areas of the blindness career: 1) the early period of blindness and the psychological implications of loss; 2) the rehabilitation process and agency involvement; 3) employment outcomes and occupational mobility; and 4) what it is like being blind in terms of social interaction.

There are over 100,000 people registered as blind in England at present, and over 24,000 are of working age. Every year approximately 12,000 people are entered onto the blind register, with 2,000 of these in the working age category. The majority of these will come into contact with both statutory and voluntary agencies dealing with blindness. Provision for the blind has, for various historical reasons, grown separately from that dealing with general disabilities. Throughout the disablement literature, and the rehabilitation and employment services, reference is continually made to the blind forming a separate group from those with other disabilities. For example, there is a League whose title
declares that it provides services for the disabled and, as a separate group, the blind. The development of blind welfare increased after the Second World War when there were large numbers of war blinded. The blind had their own Acts of Parliament: the Blind Persons' Acts of 1919, 1920 and 1938. In addition, special provision was made under the National Assistance Act of 1948, and the Ministry of Social Security Act of 1976.

Assistance for those blinded in adulthood is mainly provided by local authority social services departments and the major charities dealing with the blind. The largest of these is the Royal National Institute for the Blind. Employment services are also provided by this Institute, and by the Manpower Services Commission, via Job Centres.

Although this research is primarily concerned with blindness, reference will frequently be made to general disability, particularly in terms of rehabilitation. Blindness is a disablement, and those who become blind are likely to share similar experiences to those who are severely impaired in some other way. In addition, as there is little research and literature dealing specifically with blindness, it has been necessary (and valuable) to draw on the works of those writing more generally on disability and rehabilitation.

What is Disability?

One of the most confusing aspects of studying any physical impairment is the contradictory usage of definitions. Social
workers, rehabilitation staff, medical personnel, social psychologists, medical sociologists, and other writers do not use a universal definition of the terms 'disablement' and 'handicap'. The terms impairment, disability, and handicap are frequently used interchangeably. Carver and Rodda (1978) describe disability as being a "very murky concept" in medicine, psychology and sociology. A brief discussion of some of the most pertinent definitions will follow.

Harris (1971) made an attempt to distinguish between the terms impairment, disability and handicap. She states that: impairment refers to a physical defect and the loss of normal mechanical functioning; disability is used to describe a loss or reduction of ability to carry out certain activities, that is, the loss of functional ability; and handicap is the disadvantage caused by the disability.

Other writers also describe disability as being a limitation on activities (Sussman, 1965; Safilios-Rothschild, 1970; Haber, 1971). Sussman sees disability as any limitation which occurs to an individual compared with other individuals, similarly matched for age, sex and culture (1965).

Both Safilios-Rothschild and Sussman emphasise the importance of putting disability within a social context. That is, although the individual has to deal with the physical impairment, there will also be consequences determined by social norms.
Nagi (1965), suggests that disability is a pattern of behaviour which arises when an impairment is long-term and involves functional limitations. He uses the term in the way that Harris uses handicap, that is, the limitations may not be solely clinically determined, but may be the result of psycho-social influences.

In order to encompass all aspects of physical impairment, Townsend (1967) established five broad meanings of disability:

1) Anatomical, physiological or psychological abnormality or loss.
2) Chronic clinical conditions altering or interrupting normal physiological or psychological processes, for example, tuberculosis or diabetes. 3) The functional limitation of original activity. 4) A pattern of behaviour which has particular elements of a socially deviant kind. 5) Disability as disadvantage.

Disability can certainly be seen in the terms outlined by Townsend, but it should be said that not everyone who becomes physically impaired will necessarily experience all these aspects of disability. Indeed, it would be difficult to produce an overall definition by which all those who experience physical malfunctioning could be judged. For example, how could functional limitation be measured for everyone, taking account of previous roles, their motivation, age, and their varying degrees of impairment?

Townsend also refers to deviance; this raises the problem of who can be defined as 'normal' and who 'deviant'. Would 'normal'
criterion imply that to be non-disabled there would have to be a complete absence of illness or impairment? The final point made by Townsend, that disability is disadvantage could also be questioned for two reasons: 1) someone who becomes disabled may not necessarily experience any disadvantage, and 2) it is not possible to talk only of the disabled being disadvantaged. There are several groups in society who could fall into this category, for example, the homeless, or the illiterate.

Rawls (1957) suggests that cultural and social factors play a large part in definitions of disability. He states:

"Most disabilities would not be recognized by the individual if they were not culturally defined as such and were not so interpreted to the individual by the people with whom he associates." (p. 231)

Thus, how the disabled are defined will largely depend on who is doing the defining. Blaxter (1974) proposes four ways in which disability is defined. 1) Legally, or administratively, by professional bodies (such as charitable organisations) dealing with those who are physically impaired. 2) Medically, which involves the actual clinical condition and treatment. 3) Publicly, by the disabled being designated as deviant. 4) Self-definitions, involving the individual's own view of his or her condition. According to Blaxter there is a "continuum between sickness and health" and that whether people regard themselves, or are regarded, as disabled will depend on societal norms, the attitudes of the individuals concerned, and the attitudes of their families, in addition to clinical diagnosis.
In official terms, the Disabled Persons' Employment Act of 1944 defined disabled people as those:

"... who on account of injury, disease or congenital deformity, are substantially handicapped in attaining or keeping employment of a kind suited to their age, experience or qualifications".

This seems to be an inadequate definition as the term "substantially handicapped" is open to interpretation. There are severely disabled who are able to obtain full-time employment appropriate to "their age, qualifications and experience". The National Insurance Act of 1946 placed emphasis on rehabilitation which returned the impaired person to employment and therefore official definitions are seen in terms of levels of employability.

Because of these official definitions of disability, many people may feel that the extent of their disability is determined by their ability to obtain employment. Thus, if an individual is unable to find employment, they may view their impairment as seriously disabling. Conversely, someone retaining employment may see their impairment as of minor importance and may not consider themselves disabled.

What is Blindness?

The four definitions of disability, proposed by Blaxter, can also apply to blindness.

1) Like the legal definitions of disability, the legal definition of blindness is based on the ability to work. The 1948 National
Assistance Act states that: "... a person should be so blind as to be unable to perform any work for which eyesight is essential".

2) The medical definition suggests that to qualify as blind, a person may only be able to read at three metres that which a normally sighted person can read at sixty metres. There are varying degrees of sightedness that come under the umbrella of blindness, for example, 'tunnel', 'peripheral', or 'fragmented' vision. According to Sorsby (1966), a total loss of visual perception is comparatively rare. He estimates approximately three per cent of the blind population have no sight; ten per cent have perception of light; over half have "useful vision", and twenty-seven per cent have adequate reading ability. In a recent survey carried out at the Royal National Institute for the Blind's rehabilitation centre, of five hundred people who received training, over two hundred were able to read with the aid of low vision equipment, and eighty-nine people could actually read the telephone directory. 3) As Blaxter suggests of those who have a general disability, the public are likely to assign those who are blind to a deviant role, and have specific expectations of their behaviour. 4) Self-definitions of blindness are also important, even though an individual is designated as blind by both medical and legal definitions, he or she may not see the blindness as ultimately disabling. How it is viewed will depend on the personality, attitudes of the individual and family, and the life events which occur after loss. How other members of society perceive and interact with the individual is also likely to influence his or her view of blindness.

Definitions of blindness then, like those of general disability,
are determined by "environmental circumstances, and personality factors" (Topliss, 1975). It is certainly difficult to define disability in terms of the limitations on activities, or even in terms of employment. How blindness is defined, and its influence on the adjustment to blindness of the adventitiously blinded is considered in more depth in this thesis.

Previous Research on Blindness

The present study is concerned with how people adjust to blindness and the psycho-social effects of visual loss. There is a dearth of research on the subject of adjustment to blindness. Certainly in Britain, no previous study has explored the long-term effects of blindness. Most previous research has been carried out in the United States; these works are concerned mainly with public attitudes towards blindness, and are generally based on limited empirical evidence (Barnett, 1951; Braverman, 1951; Cutsforth, 1951; Gellman, 1959; and Monbeck, 1973). Several of these authors suggest that it is societal reaction to blindness which produces 'blindness behaviour'. However, they do not attempt to examine the behaviour of blind people, nor their interaction with the sighted, to establish the ways in which this might occur.

Lukoff and Whiteman (1963) did investigate the effects that public attitudes had on blind people and concluded that societal response did indeed play a significant part in influencing behaviour. Chevigny and Braverman (1950) carried out a study of adjustment to blindness, but they did not provide any detailed account of the stages likely to be encountered when blindness is experienced.
Gowman (1957) also examined the factors which affected the adjustment of the war blinded, and the perception that these individuals had of themselves. Other studies in the United States have centred solely on the psychological implications of visual loss (for example, Villey, 1930; and Lowenfeld, 1949). Of considerable importance to the present research is the study carried out by Scott (1969). He examined the various explanations of blindness behaviour; that is, the "commonsense explanation", the "stereotype explanation", and the "psychological explanation". The first explanation suggests that there are commonly-held views about blindness behaviour, frequently involving a negative evaluation of blindness, and the second explanation suggests that these views are self-actualised by the blind. The third explanation proposes that those who become blind in adulthood must pass through specific stages in order to adjust to blindness. Scott studied both a sample of those adventitiously blinded, and blindness agencies dealing with rehabilitation, and concluded that: "...blind men are made". That is, they are socialised into the "blind role" by both agencies, and those with whom the blind interact.

In Britain, the most valuable contribution to the study of blindness was provided by Abel (1976), who studied a sample of adults who had become blind, but who had not yet registered as blind. This study examined the "personal, social and occupational effects" of increasing impairment, contacts with health and welfare services, and views of the sample on registration. Abel's is the only study of this type, and it gives valuable insights into the psycho-social implications of visual deterioration and attitudes.
towards anticipated blindness. Fitzgerald (1970) also examined early reactions to blindness, mainly concentrating on the psychological implications of loss. He suggested that there were specific stages which had to be encountered by all adventitiously blinded people before they could adjust to their blindness. Fitzgerald proposed that every blind person would go through the stages of: disbelief, protest, depression, and recovery. Two other British studies, carried out by Hilbourne (1972), also examined blindness in adulthood. The first of these related the likelihood of recruitment of newly blind adult males into a residential rehabilitation centre, with their social class. Although Hilbourne found that social class was important in the selection procedure, he found no differences in terms of performance. The second study considered a sample of female patients being treated for eye disease, examining their referral, socioeconomic status, mobility, and family structure.

The Present Study

Although the above studies provided insights into reactions to blindness, and described some of the psycho-social effects of blindness, they all concentrated on the early period of blindness. Adjusting to blindness, however, can be a long-term process and a more adequate treatment is to study those who have been blind for a number of years in order to fully examine their blindness careers.

In order to investigate the experiences of the adventitiously blinded, a sample of blind people, living in Southern England, was obtained. All the respondents were of working age (between 22–60
The respondents in the sample range from those who have been registered for less than a year to those who have been designated as blind for over thirty years. These respondents were subject to in-depth interviewing. By describing the stages, life events, and their attitudes towards their blindness they give some idea of what it is like to be blind.

The main theoretical framework for this study has drawn largely on symbolic interactionism, utilising the concepts of career, status passage, role, self-concepts, deviance and stigma. The study examines the psycho-social effects of blindness, in particular the rehabilitation process, the effect on occupational status, and how blindness affected attitudes, self-concepts, and social interaction.

Outline of Thesis

This study covers many different aspects of disablement; for the sake of clarity the theories, concepts, and previous research works are discussed in detail in the appropriate chapters when the findings are presented.

Chapter 2 discusses theoretical considerations, and introduces some of the concepts which are utilised. It examines two main approaches to disablement: 1) societal reaction theory, which proposes that those who are visibly impaired are designated a deviant role and
that rehabilitation agencies encourage this deviance; and 2) rehabilitation theory, put forward mainly by practitioners, which argues that far from encouraging deviance, rehabilitees are encouraged to achieve maximal functioning, and thus successful reintegration into society. This chapter goes on to discuss the "blind role" (Scott, 1969), the 'career model' which is utilised in this research, and puts forward the main hypotheses.

Chapter 3 considers the social origins of blindness behaviour and elaborates on some of the topics raised in the preceding chapter. This chapter outlines three explanations of blindness behaviour. The first suggests that there are common conceptions of blindness; the second suggests that these beliefs about behaviour significantly influence the blind; the third explanation concerns those who are adventitiously blinded, and proposes that they will follow various stages before achieving adjustment to their loss.

Chapter 4 discusses the blind and partially sighted population and the development of services in Britain. Scott (1969) emphasised the importance of agencies in influencing those who become blind. In Britain a considerable amount of assistance is provided by voluntary agencies, that is, on a charitable basis; thus it is important to consider the ways in which this may influence the blind directly and indirectly, by the public image of blindness that it helps perpetuate. This chapter thus provides the background to the issues which are raised in later chapters.

Chapter 5 discusses research design and methodology, outlining the
method employed; ie. in-depth interviewing, the sample, and data analysis.

The following four chapters (6-9) deal with the presentation of the data.

Chapter 6 covers the early part of the blindness career, that is, becoming blind. It shows the status passages that the newly blinded person encounters and the various properties of these passages. In particular, it examines the degree of scheduling, that is, whether there was slow deterioration or sudden loss; the crisis period; multiple status passages; registration as a change of status; early reactions to loss; and the psychological implications of blindness.

The next period of the blindness career, the rehabilitation passage, is covered in Chapter 7. This chapter deals mainly with rehabilitation which has agency involvement; it describes the formal definitions of rehabilitation, rehabilitation services and agencies' goals. It also examines the stages of a rehabilitation passage, and the views and experiences of rehabilitation of both passagees and agents. It also discusses assistance provided by self-help groups, and familial support.

Central to this study is the examination of employment outcomes of those who become blind. Chapter 8 deals with the employment passage; it examines the occupational mobility of those studied, and employment in terms of four outcomes: 1) the ability to retain the previously-held occupation; 2) the gaining of 'non-traditional'
employment, that is, work generally open to the able-bodied; 3) 'traditional' employment, that is, a range of occupations which have become 'appropriate' for blind people; and 4) unemployment. This chapter also examines the functions of work; the reasons for difficulty in gaining employment; and the effects of unemployment.

Chapter 9 describes what it is like to be blind. In particular, dealing with the publicly-held conceptions of blindness. It considers whether blindness constitutes a form of deviance; whether it is regarded as a stigmatising condition; and the attitudes towards blindness of those studied. It examines whether social roles, self-concepts and self-esteem are affected by blindness. The difficulties of social interaction between the sighted and non-sighted, and the problems of reciprocity in relationships, are also considered.

The final chapter summarises the findings; discusses two theoretical approaches to the study of disablement; examines whether those who become blind inevitably take on the blind role (Scott, 1969); gives recommendations about rehabilitation services; assesses the objectives of the study; and gives suggestions for future research.
CHAPTER 2

THEORETICAL CONSIDERATIONS

The aim of this research was to investigate various aspects of the blindness career. By examining the early period of blindness, the rehabilitation process, employment outcomes, and the social consequences of blindness, a complete picture of blindness is presented.

Although relevant theories, concepts, and previous research works are discussed more fully in later chapters, the approach which was taken in the present study is briefly described here.

Previous research on disability has taken various theoretical stances, including those considering the political, economic, behavioural, and motivational consequences of disablement. However, the two approaches which are considered (though not exclusively) in this study are those proposed by societal reaction theorists, and rehabilitation theorists. The former approach has been postulated mainly by sociologists, whereas the latter, by practitioners.

The societal reaction theory, or labelling approach, has frequently been used in the study of criminal behaviour, but it has also found favour with a number of researchers dealing with disability and rehabilitation (Freidson, 1965; Scott, 1969; and Safilios-Rothschild, 1970). According to these researchers, those
who are disabled are designated as being deviant from the rest of society. Primary deviance occurs when behaviour is labelled as being deviant, and yet does not necessarily affect the attitudes, self-concepts, and social roles of the individual. Secondary deviance, on the other hand, occurs when behaviour is produced because the individual has been labelled as deviant. That is, the individual's social roles and attitudes change in response to primary deviance (Becker, 1963; Erikson, 1964; and Lemert, 1967). Deviance is frequently seen in terms of the deviant being a willing accomplice in the labelling process; thus can the disabled really be said to belong to a deviant group, as they are likely to be unwilling members? According to Scott (1969), blind people do become part of a deviant group and its members are likely to change their attitudes and behaviour as a result of the labelling process.

The fundamental means of deviance occurring is by an audience designating behaviour as being a violation of social norms. According to Becker (1963) an audience is needed to define deviancy, and sanctions ensure that the deviant is confined to that status. The person who has been stigmatised and labelled as being a deviant will behave according to specific expectations and thus continue to be responded to as a deviant. The status of deviant overrides all others, and the deviancy becomes the master status (Becker, 1963).

It could be argued that those who are disabled can fit the criteria
of primary deviancy: their appearance, lack of wholeness, and behaviour may lead to them being stigmatised and assigned the role of deviant. According to Davis (1961), Goffman (1963), and Hilbourne (1973), the disabled will inevitably be stigmatised and their interaction with the non-disabled subject to strain and ambiguity. (See Chapters 3 and 9). Furthermore, because they are likely to be socialised into the role of deviant, secondary deviance can occur when they internalise the expectations held about their behaviour.

According to some writers, this deviancy is reinforced by agencies dealing with disability and rehabilitation (Scott, 1969; Safilios-Rothschild, 1970; and Gove, 1976). Gove argues that:

"... the concept of disability has been institutionalized into our social structure, and persons are processed by various government and private agencies and found to be either disabled or not disabled" (p. 60)

Gove states that individuals are encouraged by these agencies to accept being disabled and to adopt behaviour appropriate to that status. Scott (1969) certainly criticises agencies dealing with the blind. He concludes from his study of blindness that there is a specific 'blind role' which rehabilitation agencies persuade their clients to adopt.

Scott says that the blind role is one of helplessness and dependency; this role has to be learnt and those who commence rehabilitation believing themselves to have defective sight finish with a changed self-concept and become "blind men". Scott (1969)
argues:

"The disability of blindness is a learned social role. The various attitudes and patterns of behaviour that characterize people who are blind are not inherent in their condition, but rather are acquired through ordinary processes of social learning. Thus, there is nothing inherent in the condition of blindness that requires a person to be docile, dependent, melancholy, or helpless; nor is there anything about it that should lead him to become independent or assertive." (p. 14)

Scott, then, sees the rehabilitation process as a form of adult socialisation, whereby a person with seriously impaired vision is encouraged to adopt the blind role. He implies that this role is adopted to the exclusion of all others. Most members of society hold a number of social roles. The concept of role links social structure with personality, and role represents the dynamic aspect of status (Linton, 1936). Holding a particular role will mean that others will have a set of expectations of anticipated behaviour which will comply with norms attributed to that role. Role learning is a crucial part of the socialisation process; those who conform to the role imputed by significant others, will be reinforced positively. Conversely, sanctions will be applied to those deviating from the imputed social role. As will be shown (in Chapter 3), there are commonly-held views of what constitutes appropriate blindness behaviour. Those who interact with the blind may try to attribute them with characteristics which may have no basis in fact, and this may present the blind person with a dilemma. That is, should they comply with the expectations which have been circumscribed by society?
Scott states that the blind role will be learnt in three ways:

1) The congenitally blind person will learn the role of the blind at a primary stage, that is, familial contacts will produce the behaviour and attitudes deemed appropriate.

2) At the second stage of socialisation, the blind person may adopt the role conveyed to him or her by other members of society.

3) The adventitiously blinded will be socialised into the blind role by agencies. According to Scott, the concept of 'self' developed by the blind individual is likely to be that of "helpless, docile, dependent, or incapacitated". Although the blind person may try to combat the attitudes and stereotyped assumptions, continuous pressure to 'play out' the blind role may prove seductive. Scott suggests that even if the blind role is initially rejected it may "become a reality".

In contrast to societal reaction theorists, many rehabilitation theorists and practitioners argue that far from encouraging those who are disabled to become deviants and thus become separate from society, they assist these individuals to achieve 'physical, social and economic usefulness' (World Health Organisation, 1958; Litman, 1962; Tunbridge Committee, 1972). As will be shown (Chapter 7), definitions of rehabilitation are generally concerned with encouraging the individual to achieve maximal functioning within the limitations of their impairment, and in re-integrating the disabled person into society. However, Gove (1976) suggests that rehabilitation theorists, are generally concerned with persuading
the disabled person to mix with similarly disabled people, believing this to be of value in restoring social relationships. While societal reaction theorists and rehabilitation theorists both recognise that relationships are important in producing disability behaviour, the former see rehabilitation theorists as reinforcing the deviant role. On the other hand, those involved in rehabilitation argue that they give rehabilitees the assistance to "lead a normal life" (Gove, 1976).

Gove (1976) criticises both theorists. One of the most pertinent criticisms is that societal reaction theorists tend to concentrate on the negative aspects of labelling. He suggests that there is a positive side, in that special provision in terms of aids and training can provide considerable benefits to the disabled individual. However, Gove goes on to say that rehabilitation theorists can be criticised for stripping the individual of his or her identity, segregating the disabled person from the community, and being authoritarian in procedures. He also states that they frequently ignore the subject of stigma.

The present research is considering both these theoretical perspectives. Because much of the literature on blindness is concerned with attitudes towards blindness, this is considered in more depth in the following chapter (and in Chapter 9). The subject of approaches to rehabilitation is also returned to in the following chapter, but is discussed extensively later in the thesis.
It has already been stated that the present study draws largely on symbolic interactionist perspectives. In particular, a career model is employed. Several levels of analysis are used in this study and a career perspective allows for this to be carried out. Like Blaxter (1976), the present author sees a career as a continuous process, and thus it is not satisfactory to simply examine specific outcomes. Rather, a blindness career is a process involving the individual encountering various status passages, social roles and life events. The concept of career allows for an examination of "the personal and the public", that is, of self-concepts and positions in society (Goffman, 1963; Blaxter, 1976).

In this study, the term career is not used in a restrictive sense, in that it denotes occupational progress, but in the way Goffman describes it, as a "social strand" through the course of a person's life. Career is defined more explicitly by Roth (1963) as:

"... a series of related and definable stages or phases of a given sphere of activity that a person goes through on the way to a more or less definite and recognisable end-point or goal ..." (p. 18)

Farber (1962), who carried out a study of types of family organisation found that there were varying degrees of orientation towards role or career, describes career as:

"... the organization of an individual's activities in an institution such as the family at any particular time. A career is regarded as a progression by an individual through a series of roles." (p. 288)
Becker (1963) defines career more restrictively than Goffman, Farber or Roth, referring to it as the movement of an individual from:

"... one position to another in an occupational system made by any individual who works in that system. Furthermore, it includes the notion of 'career contingency', those factors on which mobility from one position to another depends. Career contingencies include both objective facts of social structure and change in the perspectives, motivations and desires of the individuals" (p. 24).

The individual will make movements through a social structure, for example, the job market, educational environments, or marriage. Becker points out that a career involves subjective and objective elements. The subjective aspect, the self, and its relationship to the wider social structure, will influence the individual's move from one "identity-giving status" (Strauss, 1962) to another. The objective view of career, recognises that the individual assumes a number of social roles and follows a variety of status passages. This latter view of career implies that social structure will, in part, determine behaviour, and that alterations in objective career can lead to changes in identity.

Career, then, represents the concept of a dynamic individual with a self-concept which is likely to change over time, particularly as significant others change their attitudes towards the individual, or as there is a change of reference group.

The concept of a career in disability has been utilised by a number of writers (Goffman, 1963; Lemert, 1969; Safilios-Rothschild, 1970;
and Blaxter, 1976). Blaxter does not see disability as necessarily being a permanent condition. She describes a disability career as referring to the course a disabled person will follow insofar as handicapping conditions occur which relate specifically to impairment. This would suggest that a career in disability will end when the individual no longer encounters impairment related problems.

The blindness career will involve the individual negotiating a number of status passages which occur as a result of becoming blind (see Chapter 6). These passages include the blindness passage itself, from being sighted to becoming blind; the rehabilitation passage; and the employment passage. It has, however, already been suggested that the number of social roles open to those who become blind are limited, and indeed, that they are likely to be encouraged to adopt the blind role.

An important part of the present study is to examine whether those who become blind are able to take up a variety of roles, for example, the work role, or whether they do have to adopt the blind role. As a result of carrying out a pilot study on both the adventitiously and the congenitally blinded, the present research began with a number of hypotheses:

1) That the blind role, as described by Scott, will not be permanently adopted by those studied. That is, the blind role is not necessarily stable, but may develop or change over the course
2) That there will be a wide range of reactions to blindness. While some will regard blindness as incapacitating, others may consider themselves as little disabled by their blindness.

3) That occupational changes will result from blindness, and that the blind will experience difficulties in regaining employment. In particular, retaining previous occupational status may not be possible.

4) The retention of employment will be the key contributory factor in aiding adjustment.

5) That although there are stereotyped assumptions made about the blind, that these may not necessarily significantly influence behaviour, but will present problems for the blind.

6) That the physical implications of loss will play a less significant part than both the psychological and social implications.

Although Scott's work provides a valuable starting point for the present study, it is felt to be inadequate in a number of ways. Firstly, it concentrates on the effects of agencies on the blind, whereas the present study is interested in the effects of blindness on both those who have contact with agencies, and those who do not. Scott assumes that most newly blinded people automatically become involved with blindness agencies. Secondly, he proposes that only the exceptional will escape the blind role. Thirdly, he implies that the newly blinded individual is malleable and begins a
blindness career with no knowledge and experience of other roles. That is, Scott proposes an "oversocialized conception of man" (Wrong, 1961). Fourthly, he does not provide an analysis of the stages of adjustment which occur after blindness.

The present study sets out to examine adjustment to visual loss, the status passages negotiated, the social roles attained by the blind, in particular the work role, and the self-concepts and attitudes held by the blind. The career model facilitates the analysis of the subjective and the objective, that is, the psycho-social effects of blindness.
CHAPTER 3
THE SOCIAL ORIGINS OF BLINDNESS BEHAVIOUR

This study examines the careers of the adventitiously blind and the factors which affect adjustment to blindness. It has been suggested in the previous chapter that one of the most important factors influencing those who become blind is societal reaction to their condition. Several researchers argue that the sighted's response to blindness plays an important part in influencing the self-concepts, attitudes, behaviour, and opportunities of those who are blind (including Gowman, 1957; Lukoff and Whiteman, 1961; and Scott, 1969). This also applies to those with other disabilities (Safilios-Rothschild, 1970). Some writers also suggest that those who are disabled are treated as a deviant group and are stigmatised (including Goffman, 1963; Hilbourne, 1973; and Blaxter, 1976).

This chapter provides the background to many of the subjects which are dealt with in more detail in Chapters 6 to 9. It sets out some of the views of blindness held by the sighted, which have been gathered and assessed by a number of researchers (Chevigny and Braverman, 1950; Gowman, 1957; and Lukoff and Whiteman, 1961). The view, put forward by these writers, that the beliefs about blindness will influence the blindness careers of individuals who lose their sight, is considered.

One of the most significant works on blindness was provided by
Scott (1969) and has, as previously stated, formed the basis for the present study. Scott carried out a study in the United States of both blindness organisations and their blind clients. From this, he concluded that "blind men are made", that is, they are socialised into a 'blind role'. He began by exploring some of the possible causes of 'blindness behaviour', by assessing the ways the blind were viewed by society. Special qualities are often attributed by the sighted to those who are blind, and, according to Scott (1969), three alternative "explanations" are commonly offered by the sighted to account for the blind's possession of these special qualities. These explanations will be outlined, incorporating the contributions of other researchers in the field. These are: 1) the commonsense view, which proposes that the blind are 'different' from the rest of the population; 2) the stereotype view, which implies that expectations of specific blindness behaviour influences the self-concepts and behaviour of the blind; and 3) the psychological view, which suggests that, although the blind are an heterogeneous group, the adventitiously blind follow a common pattern of experiences before 'adjusting' to blindness. Scott suggests the approaches taken in rehabilitation programmes will be influenced either by the commonsense explanation, or by the psychological explanation of blindness behaviour.

The Commonsense Explanation

The commonsense view of blindness behaviour suggests that the blind possess a common set of personality characteristics which lead them all to behave in essentially similar ways. This view proposes that people who are blind have different personalities from the 'normal'
population, for example they are said to exhibit a "spirituality, purity and innocence of mind" (Scott, 1969). Furthermore Scott says that it is assumed by the sighted that those who are blind share similar feelings about their blindness, for example, experiencing frustration, and suffering from permanent melancholia.

Other authors concur with Scott's belief that society imputes certain qualities to the blind, however, the various views of blindness are often conflicting. Monbeck (1973) found from a study of attitudes towards blindness that some sighted people believe the blind to be miserable and unhappy, and yet others describe them as being friendly and cheerful. Hines (1950) found that a common view was that all blind people had a "smiling disposition" and had an appreciation of all help from the sighted. Another view held by the sighted is that the blind have special skills, for example, Hines found that it was a common belief that blind people had a gift for music. Lemert (1951) states that ancient folklore surrounds the subject of blindness and that it is believed by the sighted that those without vision develop "mystical abilities", "supernatural powers", a highly developed sense of touch, hearing and smell, and a good memory.

The most prevalent view of blindness is that it leads to helplessness and dependency, often forcing the blind person to become a blind beggar (Hines, 1950). Monbeck (1973) suggests that blind people are viewed as "paralyzed and incapacitated". Other authors also state that helplessness is seen by the sighted as a typical characteristic held by the blind (Chevigny, 1947;
At its most extreme it may be believed that the blind individual cannot hold 'normal' responsibilities, nor take on the work role. Chevigny and Braverman (1950) found that sighted people they interviewed associated helplessness with loss of vision and therefore those studied believed that society should give aid to the blind person. They state that it is commonly believed that the duty of the sighted is to assist the blind. Chevigny (who is himself blind) describes the situation:

"Toward the blind the world presents a face it turns to no other group on earth. Everyone else must struggle for his survival. The blind, however, need not want. Society, profoundly convinced of the utter helplessness of the man who has lost his sight, stands ever ready to help him ..." (1950, p.77)

These views of blindness are embedded in myths and cultural norms. Langsworthy (1930) analysed the way blindness was depicted in fiction. She, like the authors cited above, also found that the views of blindness were contradictory and inconsistent, but almost all suggested that there were specific characteristics which were held by blind people, and that generally these had a negative evaluation.

Other writers on general disablement also suggest that disability is viewed negatively. Furthermore, this often involves an evaluation of worth of the individual (Hilbourne, 1972).
Societal expectations of behaviour relate less to the nature of the impairment, and more to preconceived ideas about those with a "spoiled identity" (Goffman, 1963). That is, although there are commonly-held beliefs about blindness, these may have little basis in fact. Gowman (1957) studied both the war blind, and public attitudes towards the blind, in America. He found that there were a large number of differing views held about the blind, however, he could find no evidence that specific attributes were inevitably part of blindness. Scott (1969) also stated that the accomplishments of individual blind people, and the clinical experiences of blindness workers:

"... provide ample evidence that behaviour, attitudes, and patterns of adaptation among the blind are not invariant but quite diverse" (p.5).

However, despite the misconceptions, and negative evaluations, the blind are likely to find the public sympathetic towards them. Whatever views the sighted hold, inevitably they involve a measure of pity, possibly produced by a generally-held fear of blindness. Monbeck (1973) quotes statements on blindness indicating this fear, for example, "it would be worse than being dead". Several other authors also cite fear of blindness as being a likely cause of public sympathy (Braverman, 1951; Ritter, 1958; Barshay, 1964 and Siller, et al, 1967). It is suggested by some writers that blindness produces more sympathy than other disabilities. For example, Gowman (1957) asked 104 high school students to rate amputations, blindness, deafness and burns. Blindness was chosen as the worst fate that can occur to an individual.
The beliefs held about blindness can cause considerable problems for those who become blind. Some researchers (Chevigny and Braverman, 1950; Lukoff and Whiteman, 1961) argue that these beliefs can be worse than the physical condition. Farrell (1956) in a study of how blind people viewed their blindness, found that the actual impairment was not the main problem, but difficulties were caused by the sighted viewing it as a "terrible affliction". Farrell suggests that there are three main attitudes towards the blind: 1) non-acceptance of the blind, leading to the blind being isolated; 2) the assumption that the blind cannot be independent; and 3) the conviction that the sighted have a duty to help the "poor blind". Helen Keller (1950), who was both blind and deaf, also stated that it was not the blindness, but rather the misconceptions the sighted hold which was the most difficult "burden to bear".

Scott (1969) argues that, not only do the sighted's beliefs cause direct problems for the blind, but commonly-held views influence rehabilitation programmes. Several authors have stated that the blind are seen as an homogeneous population (Townsend, 1949; Twersky, 1955; and Gowman, 1957), despite contradictions in the views held by the sighted. This identification of the blind as separate and distinct from the general population, means that the goal of integrating the blind may not be held by blind educational establishments and rehabilitation agencies. In a study of the education system in America, Villey (1930) assessed the significance of generally-held attitudes in influencing blindness workers' approaches to training. He found that a common belief
among workers was that the blind were dull and stupid and concluded that these "misconceptions" were largely responsible for the blind being discouraged from being independent.

Scott (1969) states that there are two possible approaches towards rehabilitation: the "custodial or accommodative" approach, which is influenced by the commonsense explanation of blindness, and the "restorative" approach which is influenced by the psychological explanation (this will be discussed later). The custodial approach aims to create a protected environment which is specifically concerned with disability, and Scott says that it assists the blind in their "helplessness". He says that the institutional environment is especially adapted to their needs, and that the blind are "cossetted". Moreover, Scott states that:

"Clients are rewarded for trivial things and praised for performing tasks in a mediocre fashion." (1969, p. 85)

The custodial approach also encourages clients to build their lives around blindness agencies. Prior to Scott's study, Chevigny and Braverman (1950) had carried out a study of agencies serving the blind in the United States and also found that these agencies tended to manoeuvre the blind person into a pattern of adjustment which would comply with the sighted world's view of appropriate behaviour. Scott (1969) argues that in turn the agency will affect the blind person's conception of self.

The foregoing has indicated that the blind are regarded as being different from the general population. Scott argues, however, that
these commonsense views are "wrong", and that the only two restrictions blind people suffer are: 1) that blindness prevents a person from "relating directly to his distant physical environment" (1969, p. 5). This means that the blind cannot be mobile in an unfamiliar environment unless they obtain some sighted assistance. 2) Those who are severely visually impaired cannot have direct access to the printed word.

The Stereotype Explanation

Scott (1969) suggests that a further explanation for blindness behaviour is the "stereotype theory of blindness", put forward by various researchers (including Chevigny and Braverman, 1950; Cutsforth, 1951; and Himes, 1960). These researchers argue that although the views of blindness held by the sighted may be erroneous, stereotyping the blind will influence their behaviour.

Stereotyping involves the identification of a category of persons, and consensus in attributing certain traits to those persons, even though the traits may not match actual characteristics. It is likely that the stereotype has been "acquired secondhand" and those who hold it will have had little experience of those it is representing (Lippman, 1922). In assessment of others, a typology of stereotypes is used as a guide in interaction. These "well-patterned ideas" (Lukoff, 1960; and Schutz, 1964) apply to groups as well as individuals, and often arise due to lack of contact with the groups or individuals concerned. The blind are a relatively small group and therefore contact for most sighted members of society is rare.
As suggested earlier, beliefs about blindness may have arisen from folklore and cultural norms. This also applies to other disabilities. The stereotyped assumptions are likely to result in the disabled facing prejudice and discrimination. Gellman (1959) argues that prejudice exists towards all disabled people in the United States at "all socioeconomic levels and in all regions of our country" (p. 215). He states that there are four roots of this prejudice:

"1) social customs and norms; 2) child-rearing practices stressing normalcy and health; 3) the recrudescence of neurotic childhood fears in frustrating or anxiety-provoking situations; and 4) discrimination-provoking behaviour by the disabled - prejudice by invitation." (p. 216)

Meyerson (1948) states that the able-bodied "place a highly negative value" on variation in physique. That is, there are negative values attached to impairment and consequently this may lead to those who are disabled devaluing themselves. Newly disabled people may also continue to hold the same devaluing orientations they held prior to impairment. In talking specifically about blindness, Hilbourne (1973) says that:

"... the stereotypes which the layman has of specific disabilities bear little resemblance to the disadvantages that are inherent in them. For example, the blind frequently complain of being treated as deaf, dumb, stupid or lame and, like children, lacking in the ability to take responsibility for themselves." (p.497)

The blind person's self-concept is derived through the process of socialisation and through everyday interaction with the sighted. They may be encouraged to conform with the stereotype that they are
helpless and socially dependent (Cutsforth, 1951; and Lukoff, 1960). These are effective and "inevitable" (Scott, 1969) in part because blindness is generally a visible impairment (Gowman, 1957). However, the individual with severely impaired vision may find he or she is confused by others' expectations of their actions and their own conception of self.

A further problem that the blind can experience is that the sighted are unwilling to form relationships with them. As both Handel (1960) and Himes (1960) found in studies of attitudes towards the blind, there was substantial evidence of stereotyping, and an aversion to social closeness was apparent. Gowman (1957) also suggests that the stereotype acts as a "potent factor" in preventing reciprocal relations between the sighted and the non-sighted and that this leads to a distortion of the blind person's conception of self.

"For these fixed beliefs imply a lag in society's conception of the range of capacity left to a blinded individual and grossly underestimates his social worth." (p. 24)

It is not only social interaction which will be influenced, but also the programme of services, legislation, education, and employment opportunities. That is, stereotyping affects the 'life chances' of blind individuals' attempts to gain independence. As was suggested earlier, it is not the visual loss which presents the greatest problem, as Lukoff and Whiteman (1970) found:

"Many people who are blind or acquainted with blindness have asserted that the disadvantages associated with being blind stem less from the visual deficit than from
Although many writers suggest that public stereotypes do affect the self-concepts, attitudes and behaviour of the blind, there are few studies which examine these effects. Cutsforth (1951) carried out a study to examine how stereotyped views influenced the personality of the individual blind person. He found that there were three broad types: 1) Those who internalise the stereotypes, accept them and behave in ways consistent with the views of them held by the sighted. 2) Those who withdraw from the sighted world because of the stereotypes held about them and restrict their contacts to family or specialised institutions. 3) Those who defiantly resist the expectations held about them by the sighted and do not conform. Lukoff (1960) also tried to categorise the blind population, examining the degree of conformity to stereotyped expectations, and the primary reference groups of the blind. He identified four groups of blind people: 1) the 'traditional' blind, 2) the withdrawn, 3) the innovators, and 4) the rebels.

Scott (1969) stated that the aim of the stereotype explanation was to "show how misguided commonsense assumptions that laymen make about the blind affect the blind" (p. 9). He argues, from evidence obtained in his own study, that continual treatment of a blind person as being helpless will eventually be self-actualised. However, the stereotype explanation does not adequately explain blindness behaviour. It proposes an 'over-socialised conception' of blindness behaviour, leaving no room for the blind to create their
own roles. It does not explain why some people do not conform to the traditional role and are able to lead independent lives. Scott (1969) himself discusses those who carried out occupations and held responsibilities normally held by the sighted. As both Cutsforth (1951) and Lukoff (1960) found, there were those who accepted and complied with the sighted's expectations, and those who rejected them.

The Psychological Explanation

The third explanation of blindness behaviour which Scott discusses is concerned specifically with the adventitiously blind, that is, it concerns adjustment to blindness. It begins with two assumptions: firstly, that the patterns of behaviour exhibited by the blind are "diverse rather than monolithic" (Scott, 1969). Secondly, that this diversity of behaviour is preceded by a common behaviour pattern during the initial stages of blindness. For example, Fitzgerald (1970) states that the loss of sight is a dynamically unfolding process following four stages: firstly, there is a period of disbelief; secondly, there is protest at visual loss; thirdly, depression follows, and finally, "recovery" will occur. The psychological approach proposes that only when both acceptance and adjustment to blindness takes place can the blind person become independent and learn new skills.

The psychological approach incorporates the idea that loss of sight is a form of bereavement, and that before gaining independence the individual must almost sink to "rock bottom" (Carroll, 1967).
Carroll refers to there being six types of loss: 1) losses of psychological security, confidence in remaining senses, reality and contact with the environment, visual background, and light security; 2) losses of skills of mobility and 'daily living' techniques; 3) communication losses, that is, written information about daily events in the world; 4) losses of appreciation: visual perception of the "pleasurable and the beautiful"; 5) losses of occupational and financial status: security, career, vocational goals, opportunities; and 6) resulting losses to whole personality, including loss of personal independence, social adequacy, self-esteem, and total personality organisation.

The psychological view is the basis for the restorative approach in rehabilitation. Rehabilitation agencies who follow this approach see specific stages as applying to all adventitiously impaired blind people. They regard the newly blinded individual as being in need of help to gain 'insight' into their problem, and once this is achieved, new skills can be developed in order to deal with their blindness and their social environment.

Rehabilitation agencies who take this approach have to help restore all the losses brought about by blindness (Carroll, 1967). Their major objective is to re-integrate the blind person into society. This approach proposes that those who accept their blindness will adjust and become independent. Those who do not, have failed to accept their blindness and remain 'helpless', because they have not come to terms with their loss (Carroll, 1967). This means that any failure is attributed to the unsuccessful individual, rather than
to the rehabilitation agencies.

The psychological explanation is inadequate in several ways. Firstly, it suggests that the impaired individual must accept the impairment, in order to adjust successfully. Josephson (1969), however, contradicts this assertion. In a study of the blind in America, he found people with a severe visual impairment who refused to admit that they were blind, and yet they were independent, carrying out normal activities, and did not appear to exhibit any form of depression. Thus, those studied had succeeded in gaining independence without apparently passing through the adjustment phase. Secondly, the psychological explanation does not sufficiently explain why some individuals do adjust successfully, while others do not. Thirdly, the explanation does not consider societal response to the blind.

Although the commonsense, stereotype, and psychological explanations put forward by Scott do not fully account for blindness behaviour, each explanation is worth considering in a study of adjustment to blindness. The first explanation proposes that the blind exhibit specific characteristics, but that these attributes are often contradictory. They are rarely neutral, but attribute either positive or negative traits to the person without sight. The most commonly-held view appears to be that the blind are helpless. The second explanation, the stereotype view, implies that the stereotypical beliefs held by the public towards the
non-sighted are self-actualised. That is, the self-concepts, attitudes and behaviour of the blind are developed through the socialisation process. The third explanation suggests that blindness is a form of bereavement. It recognises that those who are blinded do not form an homogeneous group, however, it proposes that there are specific stages that the adventitiously blinded person goes through before adjustment is achieved. Each of these explanations will be considered in the light of the findings from the present study (Chapters 6 - 9).
Several services which are available to the registered blind are referred to throughout this thesis. This chapter describes the development and present provision of these services. It begins, however, by giving details of the blind and partially sighted population. The partially sighted are discussed because many of those who eventually register as blind are firstly entered on the partially sighted register.

The Registered Blind and Partially Sighted

There are two registers held by the Department of Health and Social Security concerning those with severe visual impairment: 1) the Blind Register and 2) the Partially Sighted Register. The definition of blindness has already been given in Chapter 1. As stated there, it concerns the ability of a person to perform work for which "eyesight is essential". It was also stated that it is possible for people who are registered as blind to be able to read. The definition of partial sight is that a person should be "substantially and permanently handicapped by congenitally defective vision of a substantial and permanently handicapping character", or have suffered from an illness or injury that has caused "defective vision of a substantial or permanently handicapping character". To qualify for registration as partially sighted it is necessary to be unable to read a test card at a distance of between three and six feet, or have a severely limited
field of vision.

Table 1 shows the main causes of blindness in England and Wales. As can be seen from this table, the main cause of blindness in males is through congenital defects. For females, the main cause is diabetic retinopathy; this normally occurs suddenly by a haemorrhage taking place in one, or both eyes. An additional problem for those who lose their sight through this disease is that the diabetic's sense of touch may be poor and it may not be possible for Braille to be learned. Several of the other diseases responsible for impairing vision are slowly degenerative.

### Table 1

| Main causes of blindness. Clinical classification: diseases and defects resulting in more than 0.5 per cent of cases: 1962-68* |
|---|---|---|
| Male | Female | Total |
| %age | %age | %age |
| Congenital defects | 15.5 | 12.8 | 14.2 |
| Myopic atrophy/detachment | 11.9 | 16.0 | 14.0 |
| Diabetic retinopathy | 13.1 | 18.2 | 15.7 |
| Optic atrophy | 14.2 | 10.7 | 12.6 |
| Retinitis pigmentosa | 8.4 | 5.7 | 7.0 |
| Macular dystrophy | 0.9 | 1.3 | 1.1 |
| Glaucoma | 7.7 | 6.7 | 7.2 |
| Cataract | 5.7 | 7.4 | 6.6 |
| Uveitis | 2.8 | 3.5 | 3.1 |
| Retinal detachment | 1.9 | 1.5 | 1.7 |
| Macular degeneration | 2.7 | 3.1 | 2.9 |
| Vascular retinopathy | 2.2 | 1.7 | 2.0 |
| Congenital syphilis | 0.9 | 1.4 | 1.6 |
| Cerebro-vascular affections | 1.7 | 0.7 | 1.0 |
| Other causes | 10.0 | 10.0 | 10.0 |

Registration is voluntary for all visually impaired people, but it is usually encouraged by an ophthalmologist, who completes a registration form (B.D.8) and passes it to the appropriate local authority. A register is kept by every local authority. It is only by registering that the visually impaired person can gain access to all the services and training available, although some societies do provide advice and aids to those who have not registered. The figures which will be presented have been obtained from the Department of Health and Social Security (D.H.S.S.). Each local authority submits their individual figures to the D.H.S.S. headquarters and they provide a compilation of these figures. However, the most recently obtainable figures are those for 1980. Furthermore, these figures do not include a breakdown of the total population into males and females, nor do they give details of employment; therefore figures for 1977 are also quoted. As this study is concerned with a sample taken from Southern England, figures will only be presented for the blind and partially sighted population of England.

As Table 2 shows, the total blind population of England in 1980 was estimated to be 107,765. This shows that the highest percentage of those registered were over 65 years of age, that is, 75 per cent. There were 24,630 people between the ages 16-64 years, that is, 23 per cent. (It is this group which is of most interest in this study.) In the Southern area of England there were 2,900 registered blind persons.
Table 2: Number of blind persons registered at 31st March 1980; and percentages by age group

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Total</th>
<th>0-4</th>
<th>5-15</th>
<th>16-64</th>
<th>65-74</th>
<th>75+</th>
<th>0-4</th>
<th>5-15</th>
<th>16-64</th>
<th>65-74</th>
<th>75+</th>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<td>115</td>
<td>1772</td>
<td>1349</td>
<td>2996</td>
<td>..</td>
<td>2</td>
<td>28</td>
<td>22</td>
<td>48</td>
</tr>
<tr>
<td>Yorks/Humberside</td>
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<td>209</td>
<td>2742</td>
<td>2213</td>
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<td>..</td>
<td>2</td>
<td>24</td>
<td>19</td>
<td>55</td>
</tr>
<tr>
<td>North Western*</td>
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<td>38</td>
<td>289</td>
<td>4048</td>
<td>3035</td>
<td>9032</td>
<td>..</td>
<td>2</td>
<td>25</td>
<td>18</td>
<td>55</td>
</tr>
<tr>
<td>West Midlands</td>
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<td>12</td>
<td>202</td>
<td>2768</td>
<td>1996</td>
<td>5689</td>
<td>..</td>
<td>2</td>
<td>26</td>
<td>19</td>
<td>53</td>
</tr>
<tr>
<td>East Midlands</td>
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<td>21</td>
<td>177</td>
<td>2027</td>
<td>1642</td>
<td>4946</td>
<td>..</td>
<td>2</td>
<td>23</td>
<td>19</td>
<td>56</td>
</tr>
<tr>
<td>London North*</td>
<td>12979</td>
<td>39</td>
<td>201</td>
<td>2831</td>
<td>2137</td>
<td>7771</td>
<td>..</td>
<td>2</td>
<td>22</td>
<td>16</td>
<td>60</td>
</tr>
<tr>
<td>London*</td>
<td>16779</td>
<td>49</td>
<td>274</td>
<td>3951</td>
<td>3045</td>
<td>9460</td>
<td>..</td>
<td>2</td>
<td>24</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Southern*</td>
<td>16532</td>
<td>29</td>
<td>211</td>
<td>2900</td>
<td>2683</td>
<td>10709</td>
<td>..</td>
<td>1</td>
<td>18</td>
<td>16</td>
<td>65</td>
</tr>
<tr>
<td>South Western</td>
<td>7756</td>
<td>15</td>
<td>103</td>
<td>1591</td>
<td>1399</td>
<td>4648</td>
<td>..</td>
<td>1</td>
<td>21</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>England Total*</td>
<td>107765</td>
<td>254</td>
<td>1781</td>
<td>24630</td>
<td>19499</td>
<td>61601</td>
<td>..</td>
<td>2</td>
<td>23</td>
<td>18</td>
<td>57</td>
</tr>
</tbody>
</table>

*Estimated, includes 1979 figures for 9 authorities who could not supply the information required.

.. less than .5 per cent.

Table 3: Number of partially sighted persons registered at 31st March 1980; and percentages by age group.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Total</th>
<th>0-4</th>
<th>5-15</th>
<th>16-64</th>
<th>65-74</th>
<th>75+</th>
<th>0-4</th>
<th>5-15</th>
<th>16-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern*</td>
<td>2941</td>
<td>9</td>
<td>121</td>
<td>916</td>
<td>529</td>
<td>1366</td>
<td>..</td>
<td>4</td>
<td>31</td>
<td>18</td>
<td>46</td>
</tr>
<tr>
<td>Yorks/Humberside</td>
<td>7754</td>
<td>36</td>
<td>365</td>
<td>1796</td>
<td>1397</td>
<td>4160</td>
<td>..</td>
<td>5</td>
<td>23</td>
<td>18</td>
<td>54</td>
</tr>
<tr>
<td>North Western*</td>
<td>8648</td>
<td>24</td>
<td>308</td>
<td>2163</td>
<td>1578</td>
<td>4575</td>
<td>..</td>
<td>4</td>
<td>25</td>
<td>18</td>
<td>53</td>
</tr>
<tr>
<td>West Midlands</td>
<td>4033</td>
<td>10</td>
<td>375</td>
<td>1407</td>
<td>554</td>
<td>1687</td>
<td>..</td>
<td>9</td>
<td>35</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>East Midlands</td>
<td>3636</td>
<td>12</td>
<td>177</td>
<td>1061</td>
<td>626</td>
<td>1760</td>
<td>..</td>
<td>5</td>
<td>29</td>
<td>17</td>
<td>48</td>
</tr>
<tr>
<td>London North*</td>
<td>6670</td>
<td>20</td>
<td>230</td>
<td>1673</td>
<td>1047</td>
<td>3700</td>
<td>..</td>
<td>3</td>
<td>25</td>
<td>16</td>
<td>55</td>
</tr>
<tr>
<td>London*</td>
<td>8153</td>
<td>30</td>
<td>298</td>
<td>2013</td>
<td>1292</td>
<td>4520</td>
<td>..</td>
<td>4</td>
<td>25</td>
<td>16</td>
<td>55</td>
</tr>
<tr>
<td>Southern*</td>
<td>6498</td>
<td>10</td>
<td>232</td>
<td>1411</td>
<td>956</td>
<td>3889</td>
<td>..</td>
<td>4</td>
<td>22</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>South Western</td>
<td>3093</td>
<td>6</td>
<td>120</td>
<td>696</td>
<td>515</td>
<td>1756</td>
<td>..</td>
<td>4</td>
<td>23</td>
<td>17</td>
<td>57</td>
</tr>
<tr>
<td>England Total*</td>
<td>51426</td>
<td>157</td>
<td>2226</td>
<td>13136</td>
<td>8494</td>
<td>27413</td>
<td>..</td>
<td>4</td>
<td>26</td>
<td>17</td>
<td>53</td>
</tr>
</tbody>
</table>

*Estimated, includes 1979 figures for 9 authorities who could not supply the information required.
.. less than .5 per cent.

Table 3 shows that there were a total of 51,426 partially sighted people registered in 1980. Once again, the highest percentage were those over 65 years of age, that is, 70 per cent. Those in the working age category, 16-64 amounted to 13,136, that is, 26 per cent.

In order to give some idea of the numbers of males and females registered, the following table, Table 4, gives these details provided by the figures produced in 1977.

<table>
<thead>
<tr>
<th>Age</th>
<th>Blind Persons Registered at 31 March 1977</th>
<th>Blind Persons Registered as New Cases during the period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Under 2</td>
<td>26</td>
<td>56</td>
</tr>
<tr>
<td>2 - 4</td>
<td>145</td>
<td>120</td>
</tr>
<tr>
<td>5 - 15</td>
<td>1019</td>
<td>830</td>
</tr>
<tr>
<td>16 - 20</td>
<td>518</td>
<td>433</td>
</tr>
<tr>
<td>21 - 39</td>
<td>3120</td>
<td>2312</td>
</tr>
<tr>
<td>40 - 49</td>
<td>2469</td>
<td>1786</td>
</tr>
<tr>
<td>50 - 59</td>
<td>4313</td>
<td>3740</td>
</tr>
<tr>
<td>60 - 64</td>
<td>3113</td>
<td>3066</td>
</tr>
<tr>
<td>65 - 74</td>
<td>8299</td>
<td>11031</td>
</tr>
<tr>
<td>75+</td>
<td>16127</td>
<td>39928</td>
</tr>
<tr>
<td>Age unknown</td>
<td>104</td>
<td>230</td>
</tr>
</tbody>
</table>

Total 39253 63532 102785 4521 7758 12279

From Great Britain, D.H.S.S., Local Authority Statistics, 1977

As can be seen by this table, the total female blind population who are registered is 61.8 per cent of the total blind population. This is explained by the longevity of the female life span compared with
the male; at the 60-64 age level, numbers are almost equal, but they increase thereafter. As Table 4 shows, in 1977 there were 24,870 blind of working age (240 more than in 1980); 13,533 males and 11,337 females (D.H.S.S. include females up to 64 in this category).

Table 5 shows that there were 12,086 (1,050 less than in 1980) partially sighted people of working age; 6,729 males and 5,357 females.

<table>
<thead>
<tr>
<th>Age</th>
<th>Partially Sighted Persons Registered at 31 March 1977</th>
<th>Partially Sighted Persons Registered as New Cases during the period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Under 2</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 - 4</td>
<td>83</td>
<td>70</td>
</tr>
<tr>
<td>5 - 15</td>
<td>1518</td>
<td>937</td>
</tr>
<tr>
<td>16 - 20</td>
<td>881</td>
<td>482</td>
</tr>
<tr>
<td>21 - 39</td>
<td>2451</td>
<td>1686</td>
</tr>
<tr>
<td>40 - 49</td>
<td>931</td>
<td>729</td>
</tr>
<tr>
<td>50 - 59</td>
<td>1468</td>
<td>1255</td>
</tr>
<tr>
<td>60 - 64</td>
<td>998</td>
<td>1205</td>
</tr>
<tr>
<td>65 - 74</td>
<td>2935</td>
<td>5016</td>
</tr>
<tr>
<td>75+</td>
<td>5503</td>
<td>17169</td>
</tr>
<tr>
<td>Age unknown</td>
<td>28</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>16808</td>
<td>28626</td>
</tr>
</tbody>
</table>


Table 6 shows the employment figures for the blind in 1977. As the total shows, there were 7,521 blind people in employment, which represent 30 per cent of the blind population of working age. It shows that there were 19.1 per cent in sheltered workshop
employment; 6.9 per cent in home worker (or home industries) schemes; and 74.1 per cent in open employment. Of those in sheltered employment, 82.7 per cent were males (if the female retirement age of 60 years is taken into account). In home worker schemes, 72.8 per cent were males; and 76.8 per cent of those in open employment are males.

Table 6
Registered Blind Persons aged 16 or over at 31 March 1977 in Employment

<table>
<thead>
<tr>
<th>Age</th>
<th>Special Workshops</th>
<th>Home Workers</th>
<th>Employed in ordinary conditions</th>
<th>Total Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>T*</td>
<td>M</td>
</tr>
<tr>
<td>16-20</td>
<td>11</td>
<td>8</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>21-39</td>
<td>222</td>
<td>65</td>
<td>287</td>
<td>52</td>
</tr>
<tr>
<td>40-49</td>
<td>234</td>
<td>49</td>
<td>283</td>
<td>67</td>
</tr>
<tr>
<td>50-59</td>
<td>424</td>
<td>115</td>
<td>539</td>
<td>99</td>
</tr>
<tr>
<td>60-64</td>
<td>243</td>
<td>30</td>
<td>273</td>
<td>70</td>
</tr>
<tr>
<td>65+</td>
<td>30</td>
<td>4</td>
<td>34</td>
<td>66</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1164</td>
<td>271</td>
<td>1435</td>
<td>355</td>
</tr>
</tbody>
</table>

* M = Male; F = Female; T = Total.


In 1977 there were 15,096 blind persons unemployed. Table 7 shows that there were 5,860 males and females (females up to 60 years) who were registered as being not capable of work. The D.H.S.S. does not define who constitutes this group. They are likely to be those people who are sick, or who are impaired in other ways which prevents them being employed (there are 5,710 blind people registered as having additional handicaps). It can be seen from Table 7 that at 31st March 1977 there were 226 people undergoing training for both sheltered employment and open employment, plus those undergoing professional or university training (82), and
those remaining at school (111). This represents 2.8 per cent of those registered as unemployed. Therefore the D.H.S.S. figures show that there are 7,647 males and females (again, D.H.S.S. include those over 60 years) who are regarded as being capable of work; however, they state that 6,177 of these are capable but "not available for, nor actively seeking work".

Table 7
Registered Blind Persons undergoing Training

<table>
<thead>
<tr>
<th>M</th>
<th>F</th>
<th>T</th>
<th>%age*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergoing training</td>
<td>a. for sheltered emp.</td>
<td>62</td>
<td>17</td>
</tr>
<tr>
<td>b. for open emp.</td>
<td>101</td>
<td>46</td>
<td>147</td>
</tr>
<tr>
<td>c. prof.or univ.</td>
<td>56</td>
<td>26</td>
<td>82</td>
</tr>
<tr>
<td>d. remaining at school</td>
<td>60</td>
<td>43</td>
<td>111</td>
</tr>
</tbody>
</table>

Capable - actively seeking:
1. trained for:
   a. sheltered emp. | 100 | 37 | 137 | 0.91 |
   b. open emp. | 321 | 102 | 423 | 2.80 |
2. subject to being trained for:
   a. sheltered emp. | 88 | 23 | 111 | 0.74 |
   b. open emp. | 252 | 74 | 326 | 2.16 |
3. without training in:
   a. sheltered emp. | 57 | 32 | 89 | 0.59 |
   b. open emp. | 288 | 96 | 384 | 2.54 |
Capable of, but not available for, nor actively seeking work:
   a. aged 16 - 59 | 1190 | 2936 | 4126 | 27.33 |
   b. aged 60 - 64 | 643 | 1408 | 2051 | 13.59 |
Not capable of work:
   a. aged 16 - 59 | 2489 | 2267 | 4756 | 31.51 |
   b. aged 60 - 64 | 1104 | 1170 | 2274 | 15.06 |
TOTAL: | 6819 | 8277 | 15096 | 100.00 |

* M = Male; F = Female; T = Total; %age = percentage.
From D.H.S.S., Local Authority Statistics, 1977

Table 8 shows the numbers of those who are partially sighted and who would be capable of obtaining full-time employment, that is, 24 per cent of the partially sighted population. It appears from the information available that a smaller percentage of the partially-
sighted population is employed than in the blind population (30 per cent). However, it is difficult to compare these figures accurately because the D.H.S.S. figures do not specify a maximum age limit.

<table>
<thead>
<tr>
<th>Employed</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1276</td>
<td>531</td>
<td>1807</td>
</tr>
<tr>
<td>Undergoing training</td>
<td>105</td>
<td>57</td>
<td>162</td>
</tr>
<tr>
<td>Not employed but:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Actively seeking work</td>
<td>319</td>
<td>157</td>
<td>476</td>
</tr>
<tr>
<td>2. Others</td>
<td>1615</td>
<td>3265</td>
<td>4880</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>3315</td>
<td>4010</td>
<td>7325</td>
</tr>
</tbody>
</table>


It can be seen from the tables supplied by the D.H.S.S., that there is a problem in analysing and interpreting their figures. They, as already stated, include females up to 65 years in the working age category. In addition, the D.H.S.S. give no full explanation as to the causes of unemployment.

Every year, approximately 12,000 people go onto the blind register. The majority of these will be over 65 years, while around 2,000 are of working age. Whether they are of employable age or elderly, they are likely to need some assistance to adjust and may turn to agencies dealing with blindness.

**Provision for the Blind**

This section describes the development of provision for the blind.
This has been included to act as a basis for understanding the way in which blindness agencies deal with their clients.

The three major organisations dealing with the blind are the Royal National Institute for the Blind, the National Federation of the Blind, and the National League of the Blind and Disabled of Great Britain. The first of these deals mainly with providing services for the blind, for example, education, or technical aids, while the others act as supportive organisations and actively campaign for the rights of blind people. There are many voluntary organisations, including the London Association for the Blind, the British Association for Sporting and Recreational Activities of the Blind, the Mobility of the Blind Association, the Guide Dogs for the Blind Association, as well as numerous specialist societies, for example, for telephonists, physiotherapists, computer programmers, and so on. Statutory assistance is provided by both local authorities and the Manpower Services Commission. The following will describe the historical roots of social, educational and occupational services.

The development of present day services began in a diverse way, with establishments for education, training and welfare being formed by a handful of unconnected people, in various parts of Britain. Prior to the 19th century most disabled people were treated as outcasts and forced into begging. The blind, however, by virtue of their lack of visual sense, tended to be more dependent than most on sighted assistance. Blindness was seen as a stigmatising condition, sometimes regarded as being a punishment from God (blindness due to syphilis was prevalent at the time) and
thus the blind tended to be seen as 'sinners'. Restrictions on drinking alcohol were also enforced on those who could be so supervised, and marriage between the blind was prohibited. In the early part of the 19th century the only help given to the blind was of a 'spiritual' nature, that is, they were given religious ministration in order for them to gain knowledge of biblical teachings and to become 'worthy' of any charity given to them.

The first society to deal specifically with the blind was established in 1834. Founded by Lord Shaftesbury and Lord Ebury and entitled the Indigent Blind Visiting Society (I.B.V.S.), the purpose of the society was to organise visits to the blind, "relieving them and ministering to them the consolations of sympathy and religion" (quoted in Rose, 1970, p. 15). The I.B.V.S. was simply a benevolent society designed to alleviate the spiritual and physical problems of the blind, and it did not set out to discourage the dependence of the blind.

When a London physician, Dr. Thomas Rhodes Armitage began losing his own sight, and developed an interest in blindness, he saw the existing system of 'help' as being unsatisfactory. In the mid-19th century most blind people were housed in asylums or workhouses, segregated from the sighted. When they were seen by the sighted it was usually in their role of beggary, as lace or match sellers, or operators of barrel organs. Armitage disliked this segregation, and the lack of education given to blind people, and argued that the philanthropists who were giving them assistance, and who themselves had not experienced the disability, did not understand the real
needs of blind people. He outlined his main objective as attempting to make the blind self-supporting, and thought this required attention to blind people's education, training and employment. The main obstacle he encountered at that time was the lack of written teaching materials which would enable successful instruction. Although raised print was available (mainly in religious texts) it was inadequate as a reading tool. In 1868, Armitage, with four other blind men, founded the British and Foreign Society for Improving the Embossed Literature of the Blind. This formed the foundation for what became the Royal National Institute of the Blind. The committee tried to find the most adequate reading system. (At this time, only a handful of people in Britain were aware of the Braille system.) The system of organised raised dots had been invented by a blind professor at the National Institute for the Young Blind in Paris. Dismissed at first by the French, it was not officially adopted until 1854, two years after Braille's death. The advantage of Braille is that it can be fast to read, and may also be used for musical notation. In 1870 the Society adopted the Braille method, together with the Moon system, which consists of embossed shapes, and they encouraged other institutions to employ these systems. For the next twenty years the Society produced books, music, embossed maps, arithmetic and writing frames, games and other apparatus for the blind. In addition, they pressed for the blind to be educated, and encouraged training for various trades.

The Armitage group's society continued to grow, and in 1871, Dr. Campbell, a blind teacher of music from the Perkins Institute for
the Blind in Boston, introduced the idea of musical training for
the blind to the Armitage Committee. As a result, the Royal Normal
College and Academy of Music was founded for the Blind, and taught
various subjects, including music, gymnastics, military drill,
running, and skating.

This was not the first attempt at providing education for the
blind; a system for educating the congenitally blind had in fact
begun in 1791. The first school for the blind was founded in
Liverpool by Edward Rushton, a sailor and poet who himself became
blind on a cargo ship while looking after a cargo of negro slaves
with malignant ophthalmia. He organised the school, beginning with a
handful of pupils, and eventually twenty towns in Britain ran small
schools; but their teaching consisted mainly of biblical works, and
of crafts such as wickerwork. This was not an attempt to provide
wide skills or to integrate the non-sighted with the rest of
society. A more ambitious project was undertaken in 1866 by the
Rev. R.H. Blair who founded a school for the sons of wealthy
parents, which eventually became the Worcester College for Blind
Boys, a grammar school with an emphasis on academic achievement.

A similar college for girls was founded in 1920 by the National
Institute for the Blind. The Chorley Wood College for Girls with
Little or No Sight had the same aims as Worcester College, that is,
to prepare the pupils to become independent, with emphasis on
academic subjects. Gradually other schools were established at both
primary and secondary levels, but it was not until the Education
Act of 1944 that statutory changes took place, and education with
an academic bias became generally available to pupils by way of scholarship examination entrance.

The first establishment designed to train adolescents for open industry was set up in Reigate in 1956, and called Hethersett. The Principal of Hethersett described it as an "institution to deinstitutionalise" (Rose, 1970, p. 46). The main emphasis is on providing industrial skills, that is, light engineering, and on commercial skills such as typing and telephony. Manual dexterity is also encouraged by means of various crafts. The establishment is co-educational and the stated aim is to try to integrate the residents with the local community as much as possible. A similar centre was set up in 1964 in Birmingham, based at The Queen Alexandra Technical College; the students are mainly trained in light engineering.

Industrial training for adults had been developing along separate lines. In 1889 a Royal Commission on the condition of the blind recommended that a workshop be established in every large town in order to teach trades to the blind. In 1899 the National League of the Blind was founded. This body is a trade union and argued then, as today, that the State should provide all necessary facilities for the blind to enable them to become financially independent. Its members disliked the voluntary groups and felt that charitable organisations increased the stigma of blindness. They also felt that these organisations were complacent and not doing enough to alleviate the problems of the blind; at the end of the last century, two out of every seven of the blind population were
classed as paupers. The blind became more vociferous and were beginning to agitate for state intervention and greater provision of services for themselves. In 1914, the then Government formed a department committee on the welfare of the blind, and again special workshops were recommended. The unemployment rate among blind people was high, and in 1920, 250 blind people from various parts of the country marched to London to put their demands to Government. As a result of this, the Blind Persons Act was introduced later in that year. This was one of the most important measures for blind people, as it placed a great deal of responsibility for welfare on local authorities. This involved each authority keeping a register of the blind and providing the necessary services. At the same time, the number of workshops was increasing and by 1939 sixty workshops employed 4,500 people. However, these were the 'traditional' blind occupations, carried out in workhouse surroundings.

The need for more effective blind welfare and training programmes increased during the First World War when the problem of the adult blinded grew considerably. The National Institute for the Blind, founded in 1914, had begun growing and became established as the main organisation dealing with the blind, when Sir Arthur Pearson (a newspaperman blinded in adulthood) secured funds to establish the Institute's headquarters in Great Portland Street. He felt that there should be aftercare and rehabilitation provided for those suddenly losing their sight, particularly the war blinded, and therefore also founded the Blinded Soldiers and Sailors Hostel (St. Dunstan's) in 1915, assisted by the British Red Cross and the Order
of St. John. He felt it was beneficial to separate the newly blind from the rest of society, temporarily, in order for them to learn to be blind. The war-blinded veterans were taught crafts, poultry-keeping and market gardening. In the 1920s, St. Dunstan's began placing blind people in open employment, a totally new development which was further advanced by the need for a labour force during the Second World War. St. Dunstan's still continues to deal solely with those blinded in service. The National Institute for the Blind became the Royal National Institute for the Blind (R.N.I.B.) in 1953. The R.N.I.B. established a rehabilitation centre, America Lodge, in Torquay in 1941. This was designed to give both occupational and 'social' training to the newly blind.

Some local authorities provided Home Teachers to enable blind people to remain in their own homes. This training was limited to mobility training and Braille. However, staff dealing specifically with assisting the blind are now no longer available. Under the National Assistance Act of 1948 and Local Government Act of 1972, local authority services provide a number of arrangements for the blind. These include providing social work advice and support, facilities for rehabilitation, and occupational, social and recreational activities. They may also provide free or subsidised travel, and may give assistance in obtaining accommodation. Under the Chronically Sick and Disabled Persons Act of 1970, local authorities may help with the following if they deem the handicap severe enough: adaptations to homes, providing radio and television, providing educational facilities, holidays, meals at home, and a telephone.
Employment for the blind is dealt with both by the Manpower Services Commission (M.S.C.) and the R.N.I.B. In 1950, the then Ministry of Labour was given responsibility for training and seeking employment for the blind. Its duties were handed on to the M.S.C. who primarily had to deal with unskilled and semi-skilled manual jobs, such as assembly work, or capstan lathe operation. The M.S.C. employs 500 Disablement Resettlement Officers, and 35 Blind Persons' Resettlement Officers. The R.N.I.B. also has a number of employment officers; they are mainly concerned with seeking professional and clerical positions for blind people.

It can be seen that those agencies based on voluntary contributions are those dealing mainly with caring for, and providing educational facilities for the blind. Although the main organisation for the blind, the R.N.I.B., does provide basic occupational training, most of the training offered is provided by statutory services. The charitable basis of the institutions may influence the way clients are viewed by agency personnel. This, and the possible effects on their clients, is explored in subsequent chapters.
This chapter discusses the background to the research, the sample, the main methodology employed, and the method of data analysis.

The present study arose as the result of an earlier one (by the author) on the occupational rehabilitation of adventitiously blinded people. The main aim of that research was to study, by in-depth interviewing, a sample of fifteen adventitiously blind people in order to compare their occupational status prior to blind registration with that gained subsequently. In addition, the study examined the process of becoming blind and the various factors which affected adjustment. The main concepts under consideration were career, social role, labelling and stigma. A sample of nine congenitally blind respondents was also included for comparison. The results of this study showed that similar status occupations to those previously held were retained by most of the adventitiously blind, and that these were professional and high grade technical occupations. All but one of the congenitally impaired respondents were employed in 'traditional' blind occupations. Although this was a small study, the findings are of interest as they contradict those of a study of 500 registered blind individuals in the United States, carried out by Lukoff and Whiteman (1970). They found that the congenitally blind were more independent and less likely to be in 'traditional' blind occupations.

The respondents in the pilot study, however, all suggested that
employment prospects were limited by blindness, although this limitation was not necessarily a direct result of the condition itself. The study showed that employment was regarded by the respondents as being important to self-esteem. It also showed that the attitudes and behaviour of the sighted were important in determining how the non-sighted regarded their physical impairment.

The present study looked at a sample of adventitiously blinded people and obtained accounts of the personal, social and occupational effects of severe visual impairment, and in particular, what factors affected adjustment after registration as a blind person. A comparison of occupational status prior to registration and present occupational status was made, noting whether there had been changes.

The Sample
Although a blind register exists, it was not possible to gain access to this to enable a satisfactory random sample to be drawn. Therefore the respondents were identified using a number of sources. Thirty-two social services departments in Surrey, Sussex, Hampshire and Berkshire were applied to in order to obtain respondents. Of these, fifteen replied, but only seven could provide suitable candidates. (The geographical area chosen was to reduce travel costs.) The Royal National Institute for the Blind, Manpower Services Commission Job Centres, and some of the respondents themselves, also provided names. Because several of the respondents interviewed were involved (by their own admission) in the 'blind world', that is, they belonged to clubs and associations
specifically for the blind, they were treated as informants.

The main selection criteria put forward to the above agencies were that the candidates should have been registered as blind in adulthood, that they should have been registered for at least three years, and should have no additional handicaps. This allowed time for their adjustment, retraining and establishment in some employment. The study began by interviewing fifty-four candidates; these were males and females between the ages of 22 and 60. However, twelve of the candidates were, on interview, found to be unsuitable for this study (although information they provided was useful). These candidates were found to have additional handicaps, for example, a serious heart condition, an amputee, or they had been registered in early childhood or during teenage years. It had been expected that the majority of the sample would have suffered a slow deterioration of vision, with respondents having experienced visual problems in childhood, or puberty; however, the final sample selected consisted of forty-two individuals who had registered as blind in adulthood.

The characteristics of the sample are listed below.
### Characteristics of the Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<tr>
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<td>Females</td>
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<td><strong>Age range</strong></td>
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<tr>
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<td></td>
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<tr>
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<tr>
<td>Light &amp; dark perception</td>
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<tr>
<td>Reading ability</td>
<td>15</td>
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<tr>
<td><strong>Cause of blindness</strong></td>
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<tr>
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<tr>
<td>Optic atrophy</td>
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<td>Divorced</td>
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<tr>
<td>Housewives</td>
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</table>

In deciding whether forty-two respondents was an adequate number for the type of study envisaged, a search of research methodology was carried out. There did not seem to be any guide to the suitable number for a qualitative study, unlike the sampling theory appropriate to quantitative studies. It was felt, however, it would only be possible, within the time and limited resources available, to interview in-depth, the above number.
In addition to the main sample, twenty-seven interviews (of one to three hours) were conducted, at the outset, with blindness agency personnel, including rehabilitation workers, employment services personnel and training officers, social workers, and personnel organising self-help groups. There were sixteen follow-up interviews. The R.N.I.B. was visited on several occasions; the Torquay rehabilitation centre, the home industries for the blind, a sheltered workshop, a general rehabilitation centre for the disabled, job centres, and self-help groups were also visited. This, along with the data obtained during the pilot study, provided considerable information on blindness.

An important consideration was how representative would the sample prove to be, and would those respondents put forward by the various agencies constitute a biased sample. It was feared that perhaps the 'cream' of the blind population would be suggested, that is, those who had been successfully rehabilitated, and who perhaps looked favourably on those agencies. However, both the pilot study and the present study showed this not to be the case, in that the respondents had a cross-section of occupations, status and social class, and furthermore, most of the respondents were open in their comments, and sometimes criticisms, regarding the agencies. Some respondents who refused to go through the traditional blindness system, rejecting assistance from the agencies, were, nevertheless, still proposed as members of the sample. There are, however, two areas, which show the sample not to be truly representative of the blind population of working age: 1) in the sample, almost a quarter are unemployed, whereas for the whole blind population, two-thirds
are unemployed; 2) almost a third are totally blind, whereas only three per cent of the blind population are totally blind. There seems to be no explanation for this.

**Interviewing**

This section discusses the research method employed in this study, that of in-depth interviewing, and outlines the interview schedule.

The aim of the interviews was to provide information on the respondents' careers, their experiences of blindness agencies, their perspectives on blindness, and how they perceive the sighted's view of the blind.

The interview itself was semi-structured; a standardised interview schedule was not felt to be suitable for this type of study. A focussed interview where certain information is required from each respondent but the ordering of the questions and the manner in which they were asked varies with each respondent, was chosen as likely to be the most effective strategy. By keeping the interview open to the possibility of a wide range of subjects being raised, important issues arise which may not have been considered initially (most of the categories were, however, derived during the pilot study). The interviews were informal and friendly in order to develop some rapport between respondent and interviewer.

An interview schedule was used as a guide, outlining the questions which, in general, required factual answers (see Appendix). The first section was about the medical background of the respondent.
It was necessary to know whether the impairment had arisen because of a slow deterioration or a sudden loss of sight, and whether the first visual defects occurred in childhood, in order to assess the following: 1) whether the respondent was prepared for his or her subsequent blindness; 2) whether, if sudden loss occurred, trauma was attached to the event and possibly a major re-adjustment was necessary, and 3) whether the eye condition was static. It was also important to know whether periods of hospitalisation occurred, as these may have affected employment opportunities.

It has been suggested by previous research (Blaxter, 1976; Abel, 1976), and by rehabilitation and employment personnel, that in many cases, the visually impaired person is reluctant to register as blind, or partially sighted, and this question was discussed. The interviews held during the pilot study suggested that the respondent's reluctance largely arose from a fear of the possible stigmatising effects of registration and a feeling that the disadvantages of being labelled as a 'blind' person might not be outweighed by the 'advantages' resulting from registration. This was explored further.

A question as to the degree of sightedness was also asked, as the amount and quality of vision of a respondent may influence adjustment and mobility and thus their degree of independence. The pilot study showed that there was a wide range of sightedness amongst respondents registered as blind, from those who had limited visual acuity and yet were able to read with the assistance of aids, to those who were totally blind. For the purposes of this
research, the respondents were grouped into three categories, those with: 1 = Total Loss; 2 = Light and Dark Perception; and 3 = Reading Ability.

The second section of the interview schedule asked brief questions on family history. This had two purposes: firstly, to establish whether the visual defect was hereditary; and secondly, whether the respondents were familiar with a visual disorder. It was observed from the pilot study that when there had been a member of the family with a visual impairment, respondents appeared to be more independent than those whose families had been unfamiliar with blindness. This was investigated further. Questions regarding the respondent's familiarity with blindness prior to impairment were also asked at this point; this was to seek out information on the respondent's attitude, while sighted, towards blindness, and also to establish whether there had been any contact with a blind role model.

The third section included questions regarding help and advice which may have been given in the early stages of impairment. Ophthalmologists are responsible for registering the blind; the registration form is then passed to the appropriate local authority. As a result of this, a visit from a social worker is usually made, and advice given as to contacts and available assistance. It was also important to establish what contacts were made with the Royal National Institute for the Blind (R.N.I.B.) and the Manpower Services Commission (M.S.C.) Job Centres, as these are the main agencies dealing with occupational rehabilitation.
Section four dealt with training. Training of some kind is offered to all newly blinded individuals, whether it is to gain mobility, communication skills such as Braille or typing, or occupational re-training. The latter was the training given most consideration; from the pilot study and early interviews in the present research, it was found that many respondents believed that the type of training they had been given was inappropriate and below what they regarded as their capabilities. Therefore, the respondent's evaluation of training, and in particular, on how the respondent perceived assessment decisions, needed to be considered.

Sections five to nine included questions on previous employment, on employment since registration, how they found this employment, and on unemployment. These questions were asked in order to compare previous occupational status with present occupational status to examine whether there had been any social mobility; to what extent 'traditional' occupations for the blind were held; and attitudes to unemployment.

The pilot study suggested that the majority of respondents regarded re-instatement or re-employment after impairment of paramount importance in order to "regain confidence" and aid their adjustment. Because so much emphasis was put on the desire for employment by those respondents in the pilot study, this was discussed fully. These respondents had indicated that this was a major influence on their self-concepts, self-esteem and what respondents described as their "dignity". Much discussion centred
around this subject, and the role of the agencies in the occupational rehabilitation process.

Questions regarding previous employment also centred around the events connected with loss or deterioration of vision. Many respondents suggested that the individual with deteriorating vision will try to hide their visual defects: this involves them developing a number of strategies in order to conceal their condition. It was also important to establish whether the respondent's employer tried to accommodate the newly impaired employee, either by retaining him or her in their previous job, or by offering alternative employment. Employment Officers state that they try to encourage employers to retain the employee and that the blind person can be given various aids and training to help him or her carry out his occupation 'satisfactorily'.

The interview guide also included questions which required information on employment history, in order to follow the occupational progress of the respondent. Present employment was discussed: this centred mainly on employment problems, the degree of contact with sighted colleagues, and the amount and type of assistance required to carry out their jobs.

Questions regarding the domestic details of the respondents were asked, for example, marital status, whether they lived alone, or shared with others.

The questions outlined acted merely as a guide to the type of
information which it was hoped could be obtained from the respondents. In practice, the interview began with an informal discussion (for as long as was necessary) to relax the respondent and gain their confidence. Some of the above questions were then asked. However, most respondents tended to go through their disablement history in their own way. No attempt was made to adhere rigidly to any particular ordering of the questions. Nevertheless, care was taken that all the questions were covered in some way. It was important to obtain each respondent's personal view of the disability process, thus the strategy of holding back on already known information was adopted by the author. When necessary, reinforcement was given, and only if a certain important point had not been raised tended to say "Others I have interviewed experienced ... did you have a similar experience?" Finally, there was always a general discussion on blindness, how the respondent felt the sighted viewed it, how the respondents themselves have viewed it prior to loss, how it affected their self-esteem, and how it had changed their lives, and problems of social interaction.

The four main aims of the interview were to: 1) gain insight into the process of becoming blind; 2) examine the rehabilitation process and the role of agencies; 3) analyse occupational mobility and outcomes; and 4) gain an idea of the respondents' attitudes towards blindness, whether it had affected their self-concepts, and whether they regarded blindness as a stigmatising condition.

The interview is an 'interactional situation'; what Kahn (1957)
describes as:

"... a specialized pattern of verbal interaction - initiated for a specific purpose, and focused on some specific content area, with consequent elimination of extraneous material. Moreover, the interview is a pattern of interaction in which the role relationship of interviewer and respondent is highly specialized, its specific characteristics depending somewhat on the purpose and character of the interview." (p. 16)

The interview "talk" Silverman (1973) says is a "report on the world" and although the report may not always be accurate, it still applies to a reality which needs to be interpreted. Both Kahn and Silverman are saying that the interview involves extraction of information, selection of what is relevant, and interpretation. There may be inherent difficulties in interpreting the talk, and making inferences, in particular if those in discussion speak a different 'language' and do not share the same frame of reference. The problem of 'language' is overcome to some extent in the present study because the respondents were not presented with formal questions which may be misinterpreted, but were allowed to present their own accounts. To try to ensure that the author's interpretation of the report given was correct, the main points were re-stated at the conclusion of the interview. The data gained was also matched with knowledge from research literature and previous interviews. When a statement was made which seemed to conflict with data already gained, this was explored in greater depth.

Denzin (1971) states that the interview is an encounter which incorporates the rules of etiquette and yet must elicit "intimate
and private perspectives". A problem with any interview is that it is likely to be one-sided, with one individual controlling the nature of the "talk" in a way which may constrain the other. In 'normal' verbal interaction there is usually more equality between the conversationalists, but in the research interview, two strangers meet in order to obtain one person's view of reality. Acquiring that view requires skill and sensitivity on the part of the interviewer. This was especially important in situations where the respondents regarded their loss of sight as being particularly traumatic.

One consideration when commencing this study, was how would the respondents view the interviewer. Although all were informed that the research being conducted was an independent study, about six respondents identified the author as being associated with agencies, and insisted on giving criticisms which they hoped would be passed on to these agencies. In at least four cases, the author was designated a counsellor role, and 'an authority on blindness', and thus asked for advice about a number of issues. In these situations it is difficult for a researcher to remain detached.

**Data Analysis**

Each interview produced a number of categories; their analysis was an on-going process which involved continually searching out underlying patterns. During the pilot study, the number of categories grew with each interview and linkages between different properties were made. These categories were further developed in this study.
The interviews, which lasted between two and four hours, were tape-recorded. At the time the tapes were replayed, the data was dealt with in three ways: 1) the factual details, eg. medical details, employment record, and so on, were entered onto an interview schedule. 2) Each time a particular issue was raised it was entered onto an existing card, or if previously unpresented, a new card was raised. The cards covered a variety of topics, and were headed, for example, 'loss of independence', 'interaction between the sighted and non-sighted', 'blindness as a stigmatising condition' and so on. The entry on to the cards usually took the form of direct quotes, sometimes with an additional comment if relevant. This card system simplified data organisation and subsequent categorisation. 3) A synopsis of the interview, with comments on the respondent's situation noting for example, whether they regarded themselves as being "well-adjusted" to their loss, or whether they felt their "life was shattered", was created. This synopsis was a useful reminder of the respondent and interview content, as it usually took the form of perhaps a page of commentary.

The respondents have been given pseudonyms to ensure confidentiality.
CHAPTER 6
BECOMING BLIND

Every person who registers as blind will alter his or her status. The adventitiously blinded person will no longer be simply Mr. A. who holds a number of roles, who has a particular occupational status and a variety of interests, but he will become blind Mr. A. Even if Mr. A. continues with most of his previous activities, everything he does will now be judged within this context of blindness.

In this study, a career model has been adopted to look at the way blindness has affected a group of people blinded in adulthood. Every career involves an individual negotiating a number of status passages and adopting a variety of roles. This in turn affects the identity and self-concepts of the individual. By examining the blindness career it is possible to examine the objective and subjective elements of disablement.

This chapter discusses the early stages of a blindness career, and the passage from sighted to blind status. Status passages have a number of properties, for example, a passage may be scheduled, desirable, reversible, followed with other passagees, and controlled by agencies. These, and other properties, are considered in the light of the findings of this study. In addition, reaction to loss and the psychological implications of blindness are considered.
The notion of career involves the negotiation of status passages, but what does the term status mean? It has two distinct, though related meanings. Firstly, it can be a socially determined classification in the stratification of a society, involving collective judgements, and may confer some measure of social standing or honour on a given position. In common usage, people are referred to as "having status", that is, they have some sort of prestige. It can, of course, be used to refer to a low or poor standing in society. Secondly, Linton (1936) describes status as a collection of rights which are associated with social position. Thus status can be seen as the location of a person in society, and social role is the pattern of behaviour that a person occupying a particular status exhibits to others. Weber (1922) says that status can be socially distributed in a patterned way, and exist outside of a particular individual. The discussion here centres on the move from one status to another, that is, status passage.

Glaser and Strauss (1971) argue that status passages are an enduring feature of societies:

"Insofar as every social structure requires manpower, men are recruited by agents to move along through social positions or statuses. Status is a resting place for individuals." (p. 2)

Every individual experiences a number of status passages throughout his or her life, for example, employment or marriage. Strauss (1959) describes status passage as an inevitable part of belonging to any social group, within which the individual can hold a number
of roles. These status passages may be marked by some form of ceremony, described by Van Gennep (1908) as "rites de passage", for example, the Barmitzvah of the young Jewish male to mark the transition to manhood. Other passages may result from occupational career progression through institutional ranks, perhaps beginning with a formal apprenticeship and ending at retirement with the 'ceremony of the gold watch'. When disablement occurs there is not a formal ceremony, but the act of registration as disabled is an event which marks a change in status.

All passages have what Glaser and Strauss describe as a "temporal dimension". When examining any status passage, they suggest that an analysis of its rate, length, and direction should be made. In addition, the stages of the passage, whether it is scheduled or unscheduled, and who is in control of the passage is also worth considering.

Glaser and Strauss imply that there is a great deal of movement between statuses, and that once attained, a particular status is not necessarily held forever. For example, some status passages, such as pregnancy, illness, or imprisonment may be quite short, whereas the status of disablement is usually permanent (although a return to able-bodied status is sometimes possible).

As well as temporality, status passages have a number of other properties. Some passages are scheduled, and others unscheduled: when scheduling occurs, it may sought by the passagee, for example, following a defined occupational passage. Some passages are entered
willingly, others unwillingly, for example, while pregnancy may be a sought passage, it is unlikely that imprisonment or disablement would be regarded as desirable by the passagee.

Glaser and Strauss suggest that passages vary according to whether they are inevitable, reversible and repeatable. Furthermore, the way an individual responds to a particular passage will be influenced by their knowledge of its properties. Passages can be controlled by the passagee, or by others, as, when illness occurs, health agencies can exert control over the patient's passage. Passages can be carried out alone, collectively, or in an aggregate, possibly involving the awareness of others following the same passage and in communication with these fellow passagees. Some passages may be clear, others may be disguised.

To illustrate the variable properties of a passage, Glaser and Strauss give the example of dying. The rate of the passage will vary depending on the cause of death. The passage, once begun, is likely to be inevitable, although, occasionally, the passage may be temporarily reversed. The signs of death may be clear or disguised to the various participants, that is, the dying person, relatives, and medical personnel. The dying person may be following this passage in parallel with other patients (perhaps in a hospice), which may lead to communication and shared awareness of their plight. There may be varying degrees of control that the patient has over the passage, and medical personnel may have control in terms of treatment and medication given to the patient. The actual death has to be certified by a recognised agency.
Glaser and Strauss state that multiple status passages are possible, and in most cases, it is not adequate to concentrate simply on one aspect of a status passage. They cite Roth (1963) who studied the rate of recovery of tubercular patients, the ambiguity of the signs of recovery, and the way patients manipulated physicians in order to have their condition defined as they wished. Davis (1963) also dwelt on recovery and the ambiguity of signs. However, Glaser and Strauss feel that any analysis is incomplete if the researcher focusses on only a small number of properties.

In order to avoid an inadequate treatment in this study an attempt has been made to examine those properties of status passage suggested by Glaser and Strauss. Those who become blind are likely to follow a number of status passages, in particular the blindness passage, the rehabilitation passage, and for those of working age the employment passage. This chapter considers the blindness passage, its rate, whether it was scheduled or unscheduled, the signs of visual loss, and the multiple status passages which occur as a result of blindness.

Scheduled Passages: Gradual Loss

As Glaser and Strauss point out, some status passages can be scheduled, but can this be said of those that involve disablement? In the case of blindness, in general this does not occur suddenly, but is the result of a gradual deterioration of sight. In this study, thirty-five of the respondents had symptoms which occurred over a long period. There were those who began to have impaired
vision in adolescence, and which slowly declined in adulthood. There were also those who, although the onset of severe symptoms occurred suddenly in their twenties or early thirties, did not register until a number of years after onset (the longest duration was twelve years). In this 'gradual loss' group, nine of the respondents lost the sight in one eye suddenly, and were registered as partially sighted, but none of these regarded themselves as severely impaired until vision declined in the remaining eye.

There were seven respondents who did experience a sudden loss of sight and who became registered within a matter of months after the first symptoms of loss occurred. The rate of status passage, then, can vary considerably, depending on the type of eye condition, and the treatment that is provided.

Although in cases where slow deterioration occurred the status passage between sightedness and blindness could have been regarded as being scheduled, the majority of respondents said that they had not prepared themselves for the final outcome. That is, they had not made any practical preparation for severe visual loss, nor had they prepared themselves for the psycho-social effects of blindness. Of the twenty-seven respondents who had been told that they would eventually have to register as blind (on average, three years prior to registration), five respondents said that they had made specific preparation for blindness. This preparation took the form of learning to use tape-recorders for recording information, learning Braille, finding out about organisations for the blind, in particular, those providing mobility training, and considering
occupational possibilities. These five respondents also said that they prepared themselves "psychologically" for blindness. All of these respondents had a history of blindness in the family and had thus been aware of the practical problems of blindness; in addition, they had considerable forewarning that they might eventually become blind (four were informed of this in their teens).

Of the rest of those in the gradual loss group who had been informed that blindness was a likely outcome, six had a history of blindness in the family. However, they, like the others in this group had not been willing to face up to becoming blind. All of this group said that they had refused to accept the fact of blindness until they had to register. Abel (1976), in her study of "visual handicap", also found a reluctance to face blindness until there were "definite grounds for concern". In the present study, hope for a cure, however remote, was held for a long period of time. Indeed, reluctance to accept the state of blindness initially was common to both the gradual loss and the sudden loss group. This applied to several of those who had experienced severely restricted vision for a number of years prior to blindness.

Treatment, and sometimes numerous operations, held out hopes of, if not a total cure, at least an amelioration of the existing condition. The following two respondents described those early feelings:

"I had suffered with poor sight since I was 16, but it never affected me, or my work - I didn't even tell many people about it - but when they finally went (total loss
of sight) I just couldn't believe it. I put my faith in Mr. S.... the ophthalmic surgeon though, he did everything to try to give me some sight ... it took years to get it into my head that I'd never see." (Mr. Thomas)

"My eyes had been steadily getting worse for years, but, even though they (the surgeons) kept telling me I'd be blind, I wouldn't believe it. It was about 18 months after my last operation that I knew I was permanently blind." (Mrs. Clayton)

Mrs. Bates, who had light and dark perception, had experienced a very slow deterioration of loss.

"I began having problems when I was a teenager, but my vision was corrected with glasses and I didn't really think about them (her eyes) until I was in my last year of nursing ... I knew I was myopic, but I just hoped that I would always be able to see, perhaps with stronger and stronger glasses. In my late twenties I damaged one of my better eyes in a fall ... I couldn't see very well for a couple of years ... After the improvement I was again convinced I'd always be able to see, I never imagined they'd get so bad I'd be registered ... Yes, it was a shock, a big shock, so many people are short-sighted, you don't really think that you could become blind ... but I did have other complications, towards the end."

Although Mrs. Bates encountered visual defects for over twelve years, she did not anticipate blindness, nor did she prepare for it.

Although the initial onset of blindness was frequently described as "a shock" and "traumatic" by the respondents, six felt this initial shock to be a valuable preparation for subsequent blindness. One of these, however, said that he had not made any significant preparation, while the others prepared in both practical and psycho-social terms. The following respondent suggested that being forewarned after the initial loss helped him cope. Mr. Rogers lost the sight of one eye in 1960 when he was 22 years old:
"I was in a state of shock for a while, it was worse because I thought the other can go any day now ... the other didn't go for five years though ... I steeled myself against it; whatever happens to me mustn't be reflected on my family. ... I knew I'd lose the other at some time. I had a social worker teach me Braille and then I went to Torquay (the rehabilitation and assessment centre for the blind) ... I lost the other eye while I was at Letchworth (engineering training) ... It went in the afternoon ... I said to my mate, let's go out for a walk. It hit me two days later, while I was lying in bed ... I was terrified. But I knew that was it, I'd got to get used to being blind."

Sometimes, although the onset of the first symptoms of blindness can be sudden, the condition may be improved by treatment. For example, Mr. Williams experienced a sudden loss of vision in both eyes in 1972, when he was 47 years old. He received treatment which was successful for a time. After two months from onset, most of which had been spent in hospital, he returned to his job as an accounts manager. However, his sight began to slowly deteriorate. At first he was able to continue to read figures with the aid of a magnifying glass, and read written communications by getting his colleagues to write in large letters and with fibre pens. He said that his colleagues were "kept in the picture" about his condition. He then had a major haemorrhage in 1974. He was initially left with light and dark perception, but eventually became totally blind. Mr. Williams did not describe himself as shocked when it occurred:

"Rather, I was concerned. When it first happened I spent most of my time in hospital working out how I could carry on with my job ... I knew I'd coped during the first 'bout'; when it finally happened I was still really concerned about how I would carry on, my job, my responsibility to my family."

Mr. Williams said that he attempted to deal with the practical details of his blindness and how he could overcome it. He said he
being of "any importance". When asked why he did not appear to be unduly perturbed by his blindness, he said that he saw the reason for his loss in terms of "God's will".

"If I didn't have a Christian faith, and a Christian wife, I don't know what I would have done."

Mr. Williams said that he spent a great deal of the early part of his blindness "praying for guidance", and regarded this as being of considerable help in allowing him to "come to terms with it".

Mr. Williams was not typical of the rest of the sample in his reaction to blindness. Although there were others (to be discussed) who quickly came to terms with their blindness, Mr. Williams appeared to be the most accepting of his condition.

It was common amongst the gradual loss group to disguise from themselves, and others, the signs of blindness. There were eight respondents who said that they were so concerned to prevent others from knowing they were having visual problems, that they almost convinced themselves that their condition was not serious. For example, Mr. Elderfield said:

"I had had failing sight for years but I tried to hide it ... I didn't want anyone to know, and I didn't want to face up to it myself. I really began to believe that there was nothing seriously wrong."

He adopted all sorts of strategies to prevent other people knowing that he could not see very well:

"I used to read most of my mail at home - my wife helped - I used low vision aids but only when people couldn't see me."

Mr. Elderfield used delaying tactics if he was presented with some
work he should read, making excuses regarding shortage of time, saying that he had mislaid his spectacles, and so on. (This was a common practice amongst the sample, during the early stages of blindness.)

One of the reasons given for disguising the signs of blindness from others was that the prognosis was uncertain and fluctuating vision was experienced. This made the respondents reluctant to allow others to know that blindness was a possibility. However, 'others' did not include close family, particularly the spouse. In all but two cases of the married group, the spouse was always confided in about the condition, and in most cases, assistance was elicited to cope with the practical problems of visual loss. There were also several respondents who had obtained assistance from work colleagues during the deterioration of sight. Six stated that their colleagues helped them disguise their visual difficulties from their employers. Those who suffered a gradual loss of sight stated that they tried to conceal it for as long as possible from their employers. It was feared that revealing their defective vision would result in loss of employment. However, in most cases, the visual problem was detected by the employer or colleagues before the employee wished to divulge this information.

A blindness passage is not a clear cut passage from full sightedness to total blindness. At first there may be minor symptoms, causing little concern, or severe impairment may occur at the onset, which is then alleviated. Many eye conditions are unpredictable, thus a prognosis as to final outcome may not be
Unscheduled Passages: Sudden Loss

Although most of those who experienced a gradual deterioration of sight felt themselves to be unprepared for the final stage of blindness, they had been used to coping with some visual problems. On the other hand, those who had received a sudden loss saw it as being a "severe shock", "devastating at first", "horrific" and "unbelievable". Although three of the seven said that they had recovered from this early reaction within the first year, all felt that they had been unprepared for blindness. This included two respondents who had a family history of blindness. In all cases, they had been forced into a rapid change of status; registration as blind occurred, for all, within eight months of onset.

The most serious, and the most complicated, loss occurred to Mr. Franklin. He lost the sight in both eyes by having sulphuric acid thrown at him by a "jealous girlfriend". Not only did he become blind, but he was very badly disfigured. In the first three years of his blindness he underwent numerous operations (in thirty years since onset he had undergone over seventy). These early operations involved skin-grafting to rebuild his face; he had lost part of his ears, his eyelids, nose, and mouth, all of which had to be re-formed.

During these early days, Mr. Franklin said he was "depressed and suicidal":

"I was not just concerned about seeing, I couldn't be
fed through my mouth .. my face was burned, disintegrated ... I was in terrible pain ... most of the time I didn't know what was happening to me."

However, Mr. Franklin said that these early feelings of depression did not last for more than six months as his surgeon expressed his belief that some sight could be recovered.

"That was the most important thing to me, at the time; I thought I couldn't face blindness."

Mr. Franklin said that hope of a return to sightedness inspired him to "fight against all the other difficulties" he was facing. Mr. Franklin did regain his sight for two periods during the last thirty years, but was totally blind at time of interview.

Another respondent said he was "overwhelmed" by his blindness during the early stages. This respondent said that he "blamed" himself for his loss of sight. Mr. Downes had suffered from diabetes for over twenty years prior to visual loss. He had been able to cope with his condition (it was kept in check by the use of insulin) and "did not need to keep in touch with the specialists". His visual problem began when he was 36 years old:

"It was all my fault. I left it too late. I should have got some help straight away ... I took the dog out for a walk one evening, when I looked up at the sky, I saw lines before my eyes ... I thought I must have scratched my eyes when I was gardening."

Mr. Downes said that he did not feel unduly worried at this point, he explained it away by trying to find some plausible cause for the symptoms. He said he tried to ignore the symptoms at first, but when the condition worsened a few days later, went to his local hospital. He was then sent for specialist treatment at King's
College Hospital. He was retained in hospital for two weeks, then released as his eye condition had "considerably improved". For ten days he had what he described as "normal vision", then it "suddenly went while I was watching television". He again received treatment and regained his vision for a further three weeks. Mr. Downes then experienced a total loss of sight which had remained static for five years (until time of interview).

Mr. Downes said he had not been prepared for blindness; the period from onset to total blindness was ten weeks. During this time he had experienced two periods of sightedness which encouraged him to believe that he was cured.

He said that he "despaired" when he realised he had lost his sight.

"When you are first told you're blind it's a traumatic experience. This was November, at the time; my first words to him (ophthalmic surgeon) were, thank goodness it's not November 5th. I felt I would have thrown myself on a bonfire ... I went back to the ward - there were four others there - but I cried my eyes out ... I suppose a lot of people who go blind think that the first thing they can do is jump in front of a train, or something like that; I still feel that now, sometimes."

Once someone becomes blind it is usually a permanent condition; however, in the present study, two of the respondents had regained substantial sight during their blindness careers. Mr. Franklin (discussed above) regained his sight twice, for short periods, during the thirty years he had been blind. Although he described himself as being very pleased when he did regain his sight, he had found it "heartbreaking" when he lost it again. He was therefore unwilling to undergo more operations and go through the "trauma of expectation". He said that he could accept his blindness and had
learned to cope "extremely well" with his loss.

Another respondent, Mr. Jones, stated that fluctuating sight was a problem for those who experienced it, not only because of the practical problems it posed, but also because the status of these individuals was rather undefined. Mr. Jones said:

"I don't know whether I use my residual vision to maximum capacity, but I am fortunate in that, whatever happens, I can usually read. However, sometimes, when the condition is particularly bad, I think of myself as a blind man, and when it's good I think I'm 'normal'."

Mr. Jones was experienced as a social worker for the blind and suggested that many of those whose sight was not static did not take measures to prepare for periods when there was severe loss:

"They don't face up to their blindness - they're often very confused."

Although, as has been suggested above, an amelioration of impairment can be produced by continued treatment, generally, once a visually impaired individual begins the blindness passage there is rarely a chance of permanent restoration of sight. Those in the sudden loss group all described the early period of blindness as being "very traumatic". Like the gradual loss group, they had to learn how to cope with the physical and practical problems, as well as the psychological implications, and changes in status and roles.

A Priority Status Passage: the Crisis

Every individual has to deal with a number of status passages occurring at one time; however, some status passages may be so demanding that they produce a crisis which floods the lives of the passagees. During this time the crisis takes precedence, and other
passages remain static.

Certainly, the early period of blindness is likely to present a crisis. It is the most difficult period, since, in a way, the individual is in 'suspended animation'. They will be forced to follow a status passage which is undesirable, usually irreversible, and probably unscheduled (even though early signs may be apparent).

Crisis can be seen as a turning point in a person's life: it is likely to be an acute situation which involves stress. Davis (1963), in a study of polio, described four stages of crisis: 1) the prelude stage, when the illness does not appear to be serious and does not warrant concern. 2) The warning stage, when the seriousness of the condition becomes clear, but there may still be ambiguity and doubt as to its final outcome. 3) The impact stage, when the full severity of the condition is made apparent and the crisis becomes more acute. 4) The inventory stage, when an assessment is made and preparation for adjustment occurs. Crisis is particularly evident when severe impairment occurs suddenly and the prognosis is that the impairment will be permanent. This then is more than a temporary crisis; it involves the passagee reassessing his or her life and following an unexpected status passage. The stages Davis proposed were common amongst the sample and can be illustrated by the following respondent.

Mr. Stafford was a graphic artist when he suddenly lost his sight at the age of 24. He was hospitalised for six weeks and had three operations on his sight; however, during the first stage, Mr.
Stafford was not unduly concerned about his prognosis because of the amount of medication he had been given:

"At first I didn't realise what was happening - I was so drugged up I couldn't think about what might happen in the future;"

and because he had been told that the operations were likely to return his sight.

During the second stage, when he began to be concerned about the outcome of his condition, "fear set in". During the third stage, when he was informed that his visual loss was irreversible, Mr. Stafford said that "all normal life ceased" for a few months during this crisis period. He said that when he did finally think about the future he felt his prospects were "disastrous". As Mr. Stafford was a graphic artist his loss of sight "ruined" his occupational career.

However, after several months he entered the fourth stage and began to assess what he could do, within the limits of his blindness. He chose to train as a piano tuner and then followed this career. Mr. Stafford said that, for him, the crisis had not been resolved until he began to make plans for his future.

The crisis period for the respondents was generally short-term, and mainly occurred when the eye condition became acute, and there had to be a cessation of previously-held roles and responsibilities. For example:

"The worst thing is that you think you won't be able to carry on as before ... I remember thinking 'how will I look after my family?' ... how could I work now I was
blind?" (Mr. Fuller)

Another respondent said:

"When it happens, it's impossible to think of anything else ... all my plans had to go out of the window ... I thought, this is it, there'll be no normal life after I'm blind." (Mr. Morris)

Whether there was slow deterioration, or gradual loss, over three-quarters of the respondents suggested that there had been a crisis period connected with their loss of sight. All these respondents suggested that the crisis did not begin to be resolved until steps were taken to aid adjustment, for example, when rehabilitation training began. The crisis which occurs when people become blind usually results in other status passages being taken.

Multiple Status Passages

Glaser and Strauss (1971) point out that each individual can experience a number of status passages, and that while some are independent, others compete for time and energy. They go on to say that:

"Multiplicity of passages, may, however, help to ease the passagee's life, providing that at least one passage supports or helps the other." (p. 142)

Nevertheless, the main problem when someone is faced with various passages, is deciding on their degree of priority. The individual may have to do a certain amount of 'juggling'.

When visual loss occurs the blindness passage will predominate; but it can act as the catalyst for a number of status passages. This can be well illustrated by the following respondent.
Although Mr. Edwards had experienced defective vision for a number of years, severe impairment leading to blind registration did not occur until he was aged 35. He did not regard himself as having any disability until this time and said that he had previously "enjoyed good health". At the time when his sight suddenly became seriously defective he was employed as a gardener and lived with his wife on the estate of his employer. On losing his sight he experienced a period of hospitalisation; as a result of this, and the prognosis that his visual loss was permanent, he was sacked by his employer. He was thus made blind, jobless and homeless at almost one stroke. At the same time, his wife found she was pregnant. This was an accidental pregnancy, as they had resolved to remain childless, as Mr. Edward's condition was hereditary. Thus, these events led to him having to face concurrent crises, and a multiplicity of passages: becoming blind, being unemployed, being homeless, and preparing for parenthood. These passages had varying degrees of priority as to the amount of attention they needed.

The need to have a home presented an immediate and pressing problem: "more than the loss of my sight at the time". When this was achieved, Mr. Edwards and his wife concentrated on his visual loss and subsequent rehabilitation necessary to give him mobility and the vocational skills to gain employment.

Some passages allow a degree of control on the part of the passagee, but they are often assisted and perhaps controlled by certain agencies rather than the individual concerned. In the above case, once visual loss occurred, decision-making was largely in the
hands of health, housing and blindness agencies. (Agency involvement is discussed in Chapters 7 and 8.)

Confirmation of a Change in Status: Registration

The process of becoming blind is seldom a clear cut one, but the act of registration is seen as a turning point for most people. The person who began a status passage as someone who had defective sight, may view registration as marking an end to being regarded as a 'normal' individual and the confirmation of an alternative status. (The majority of respondents used the term 'normal' to refer to their previous status, and to refer to those with sight.)

Twenty-nine respondents viewed registration as marking the beginning of a change in their status, even though their vision may have been severely defective prior to this. Twenty-two of these expressed a reluctance to register as blind. Nine respondents said that they were not concerned about registration. The rest of the sample could not remember how they felt at the time of registration. Both Abel (1976) and Fitzgerald (1970) found that there was a reluctance to register among those they studied.

Abel (1976) found that two-fifths of those she studied with visual impairments (total sample: 270) "worried" about the idea of being placed on the blind register. She stated that many felt that all hope was lost once they were placed on the register. Other reasons for not wishing to be registered included: a dislike of the procedures involved; financial worries (loss of occupation or independence); "social aspects" such as consequences for the
family; and not wishing to be labelled blind.

In the present study, those who expressed concern about being registered did so for a number of reasons. Like the group Abel studied, some did not like the idea of the bureaucratic procedures involved in registering and gaining assistance; others felt it was going to be a self-fulfilling prophecy, and that it was the "final step". Twenty of the respondents said that they did not wish to be registered as they would no longer be "normal" or "ordinary"; eleven of these respondents were concerned with the stigma they felt was attached to blindness (see Chapter 9).

Seven said that they were confused by the criteria which formed the basis for blind registration. It is widely believed that those who are registered as blind have a total loss of sight, when the actual figure is approximately three per cent of the blind population who have no visual perception. As the following respondents show, they did not initially think that they fitted the criteria for blind registration:

"I was shocked ... I didn't think you could see and be registered blind ... a lot of people can read very well and yet they are called blind." (Mr. Davenport)

"I was surprised, and so was my family, when I was still able to read, and yet I was registered. I've lost that now but I can distinguish objects and colours." (Mr. Johnson)

The act of registration can have profound effects on the individual.

"I was fighting it up until then (the blindness), but the moment the consultant said 'you'd better be registered as blind', that was it ... Until then, most of the time anyway, I was carrying on almost normally,
even though I couldn't see a lot, but afterwards, it all became so traumatic." (Mrs. Walsh)

"I felt there were no benefits to being registered. It was a bit traumatic, it was the step that finally convinces one that this was permanent, there was no returning to 'normality'. It makes things worse, it's rather like having a touch of 'flu and having it confirmed by the doctor, it makes you feel ten times worse." (Mr. Fuller)

Respondents who did not express any reluctance to register, did not see it as worsening the effects of blindness. For example, Mr. Williams:

"The opthalmologist very diffidently asked whether I minded if I was registered blind ... I didn't mind in the slightest, my approach was purely pragmatic, what is the disadvantage? Nothing except some people's pride; it's a fact I am blind, I see no reason not to accept."

This group consisted mainly of those who had a history of blindness in the family. It would appear that familiarity with blindness prior to loss eased the passage from sightedness to blindness, and that the actual registration was simply seen as a formality.

Even though there was some reluctance to register, nineteen said that it had been helpful to them. The most commonly cited reason given was that they had received practical help in the form of advice and aids from blindness agencies. The second most common reason was that they were given financial help. Eight said that the greatest benefit was that it facilitated social contact. In three cases the label of 'blind' was actually welcomed in that the respondents felt it helped justify to others that their visual state was a "recognisable defect".
As already suggested, registration is a form of ceremony. It implies that the blindness is permanent; while some respondents said that they did not mind being registered, others suggested that the blind role might overwhelm other roles and statuses. In addition, as will be shown (in later chapters) the degree of control of the passage may be taken from the passagee and handled by agents. During the rehabilitation process the passagee is likely to follow the passage with others, whereas during the early stages the passagee may only communicate with family members about their blindness. Those who did not have a history of blindness suggested that during the early period of their blindness they felt isolated from other blind people, and were following the passage alone.

During the early period of blindness, the passagee has to learn to cope with physical and practical problems of loss. There is also a need to cope with the psychological implications of blindness.

Psychological Reactions to Blindness

As noted in Chapter 3, Scott (1969) proposed that there was a psychological explanation for blindness behaviour, that is, those who become blind must encounter a number of stages before adjusting to blindness. Writers such as Blank (1957), Carroll (1967), and Fitzgerald (1970) indicated that sudden loss of sight produces a sense of 'shock', and certainly, this term was the most frequently used by the respondents in the present study. This 'shock' is more diffused and pervasive when slow deterioration occurs and blindness is anticipated.
Blank (1957) sees the early period of blindness as being one of despair, following a specific pattern:

"The shock (of sudden blindness) consists of depersonalisation followed by depression. The depersonalisation usually lasts two to seven days. The patient is immobile, or almost so, facial expression is blank, there is a generalised hypoesthesia and anesthesia, and mutism, or speech is meager, slow, muted. Superficially, the condition may resemble catatonia... the depression which follows may be an acute reactive depression or an agitated depression ... and it is a state of mourning for the loss of the eyes." (p. 11-12)

The loss of sight is frequently regarded as being similar to the loss of a loved one, and thus the symptoms are similar to those which arise when the death of someone is faced. Bereavement usually constitutes a crisis for those concerned and, when it involves severe disability, the grief is for the "loved function" (Hallenbeck, 1967) which is permanently lost.

Bowlby (1960) presents an overview of reactions to loss, outlining five typical responses: 1) that there is thought and behaviour still directed toward the lost object; 2) that the afflicted person has strong feelings of hostility; 3) those suffering loss make various appeals for help; 4) that despair, withdrawal, regression and disorganisation occur; and 5) there is reorganisation of behaviour directed toward a new object. Cholden (1954), a psychiatrist, studied the reactions of those newly blinded. He found that depression followed loss, and that the patient suffered self-recriminations, feelings of hopelessness, self-pity, and suicidal thoughts.

Shakespeare (1975) suggested that denial is a frequent occurrence
when disablement occurs:

"Denial may occur; a refusal to accept that anything is wrong; this is seen as the individual's way of unconsciously protecting himself from a too sudden shock, and has been noted particularly in cases where the handicap is acquired suddenly." (p. 22)

Shakespeare feels that there are several ways the individual may react: 1) denial; 2) anxiety and depression may arise as a result of the loss of former self and former skills; 3) regression, and overdependence; 4) increased egocentricity (that is, becoming more demanding and intolerant of others); 5) withdrawal of contact with others; and 6) feelings of inadequacy.

Fitzgerald (1970) carried out a study of reactions to loss of sight in a group of newly blinded adults of working age. He concluded that the mourning for loss is a necessary part of adjustment and that the "grief syndrome" must occur before this is possible. Fitzgerald specified four stages occurring after loss: 1) there is a period of disbelief; 2) this is usually followed by protest; 3) depression occurs, and 4) finally, "recovery".

Fitzgerald suggests that good adjustment is achieved by anticipatory mourning, that is, by anticipating blindness. Denial is also seen as being valuable in the initial stages. He further suggests that remaining in a familiar environment, therefore experiencing little disruption, aids adjustment. Fitzgerald argues that bad adjustment occurs as a result of: holding false hopes of a return to sight; denial over an extended period (often reinforced by faith healers); social isolation; other illnesses; and concurrence of other problems. In this study, carried out in London
in 1967, of 66 subjects (35 men and 31 women), it was found that over eighty per cent of the subjects experienced a high level of depression. Other symptoms included anxiety, crying, withdrawal, somatic complaints, anger, weight change, lowered self-esteem, guilt, shame and self-blame. After three months several of these symptoms decreased, but were still at a high level. Fitzgerald concluded from his study that the recognition of a new identity was important in adjusting to visual loss.

The present study does not substantiate the view that gaining a new identity aided adjustment; indeed, most respondents said that they had made great efforts to retain their old identity (see Chapter 9). All respondents were asked what experiences they had during their early period of blindness. Some of the symptoms Fitzgerald cited were indeed reported, for example, depression, anxiety, crying, guilt and shame, and lowered self-esteem. Four respondents described their loss of sight as causing "absolute grief"; two of these had a gradual loss and two a sudden loss of sight. Nine of the respondents said that they were so severely depressed that they required treatment for this condition. Others said that they felt "rather depressed", "very anxious", but nineteen respondents said that they were "not bothered" by depression. It should be said that eighteen of these had experienced a slow deterioration of sight. The respondent in this group who experienced a sudden loss said "I didn't have time to be depressed." (Mr. Johnson). This is not to say that this group were not concerned about their blindness, nor that it was not a traumatic experience, but rather the feelings about loss were more diffused. This is in contrast with Fitzgerald
(1970) who found that although a third of his respondents had a slow deterioration of sight and thus could have anticipated their blindness, they experienced the same depression and anxiety as those who had a more sudden loss. Fitzgerald did suggest that anticipatory mourning could aid adjustment, and it seems from the present study that a lengthy warning of loss did prevent the severe depression that Fitzgerald found in his study.

Fitzgerald conducted his study at the onset of blindness, while in the present study, retrospective accounts were obtained and this may explain the difference in reactions. The majority of those studied had been blind for at least ten years and some for almost thirty, and thus may have had difficulty in remembering exactly what occurred during the early months, or perhaps wished to diminish the early effects of blindness. It was suggested by rehabilitation staff at the R.N.I.B. Rehabilitation Centre who were interviewed in this study that "over ninety per cent" of rehabilitees who attend the centre are "very depressed when they arrive". There may be several reasons for this, for example, being away from the family and being in an unfamiliar environment. It may also be that those who have to attend the Centre have experienced major disruption to their lives, that is, needing to find new employment, and this is likely to influence their reaction to blindness. (Chapter 8 discusses the effects of disruption to occupational career.)

It is impossible, with a retrospective study, to establish exactly what early reactions did occur. However, it seems from this study
that the most common pattern was the following: 1) shock at sudden loss or severe deterioration; 2) uncertainty about prognosis and the future; 3) non-acceptance that permanent blindness would occur; 4) feelings of dependency; 5) rationalising loss; and 6) accommodating the blindness into the individual's life. Twenty-eight of the respondents appeared to follow this pattern, while nine described the type of experiences and pattern of responses suggested by Fitzgerald (four in the sudden loss group). The other five respondents did not fit either pattern.

The following two cases illustrate the variety of responses to blindness which can occur. The first has been taken from the pilot study but shows what might be described as an 'extreme' response to blindness. Both respondents suffered from diabetes and experienced a sudden loss of sight.

The first respondent, Mrs. James, was 35 years old when she experienced a sudden, total, loss of sight. The loss occurred on a Saturday afternoon, with no prior warning, and yet this respondent returned to her employment on the following Wednesday, because she "didn't want to mope around at home". She said she had never experienced depression, guilt, severe anxiety, or a change in self-esteem as a result of her blindness. She was perhaps fortunate in that her occupation as a physiotherapist (a job commonly-held by blind people) enabled her to continue her occupational career undisturbed. She also had a supportive spouse, remained in her original environment, and developed a number of interests which required no sight. Her status passage from being sighted to being
blind produced little difficulty, other than having to learn to cope with practical problems such as communicating, household and occupational tasks, and mobility.

At the other extreme, a man from the present study, Mr. Downes, experienced most of the symptoms described by Fitzgerald. That is, he suffered from depression, withdrawal, loss of weight, self-blame, and lowered self-esteem. His blindness had led to a loss of job, and "rejection" by his spouse. His life, therefore, had been severely disrupted by his blindness. Mr. Downes had been blind for seven years at the time of interview, but he said that he had not completely adjusted to his blindness and still suffered severe bouts of depression and "suicidal thoughts".

It does seem that, contrary to what some researchers suggest, it is not necessary for specific stages to be followed before adjustment can take place. Adjustment will be influenced by a number of factors, including the personality of the individual, the life events that occur after loss, and whether previous roles and status can be retained. As the following chapters will show, reactions to blindness, and ways of dealing with it, varied amongst those studied.

**Summary**

Those who begin a blindness career will have to negotiate a number of status passages. The earliest passage will be that of going from sighted to blind status. Each passage has a number of properties; in particular, it has a temporal dimension, and the rate and length
varied amongst those studied. The majority of those studied had blindness passages which were scheduled, that is, they had a gradual deterioration of sight, but most had not prepared for blindness. Both those who experienced gradual loss and those who had a sudden loss, regarded it as traumatic, and initially had difficulties in coming to terms with blindness. Blindness generally produced a period of crisis, and in some cases led to multiple status passages occurring concurrently. Registration as blind was seen as confirmation of a change of status, and over half of those studied expressed some reluctance to register. Although reactions to loss varied, and it did not appear to be necessary for individuals to go through specific stages before adjusting to loss (in particular, depression), a common pattern did emerge. This pattern involved shock, uncertainty, non-acceptance, feelings of dependency, rationalising the loss, and finally, accommodating the blindness. Thus, the early period of blindness is usually one of disruption; it changes the status of the individual, and it can produce psychological problems. As will be shown in the following chapters, those who lose their sight are likely to have to cope with the physical, practical, psychological, social and occupational effects of blindness.
Those who become disabled will be faced with a "relatively unknown and threatening life situation" (Hilbourne, 1972, p. 127), and will have to deal with the changes that are brought about by disability. As the previous chapter suggested, the act of registration as a blind person can be seen as the end of the time when 'normal' or 'able-bodied' status can be held. Even when slow deterioration occurs, registration is usually seen as the beginning of a blindness career during which various status passages may have to be followed. One of these will be the rehabilitation passage: whatever the individuals' personal circumstances, they will have to learn to adjust to blindness, whether by obtaining assistance from agencies, or by overcoming their problems by themselves, or with family support. This chapter is mainly concerned with rehabilitation through agency involvement. Although specifically dealing with rehabilitation in the context of blindness, much of the discussion applies to other types of disablement.

Rehabilitation theorists and practitioners argue that the aim of rehabilitation should be to enable the rehabilitee to achieve maximal functioning. However, it has been suggested by societal reaction theorists that rehabilitation agencies reinforce the deviant role. In particular, Scott (1969) (see Chapter 3) argues that blindness agencies socialise the adventitiously blind into the blind role. It is therefore worth considering how agencies deal with their clients, thus the views and experiences of respondents,
as well as the views held by rehabilitation staff are included.

The goal of the majority of severely impaired people will be to learn to adjust to their impairment, and develop skills in order to retain independence. Those who become blind will have to cope with a number of difficulties, some of which were identified by Abel (1976). She studied the period of onset of blindness until registration. The three main categories of problems which occurred during this period were described as being of a practical nature, that is concerned with "orientation in the home", mobility, and reading and writing. A fourth category of problems came under the heading of increased dependency. There was also a fifth category which covered problems not of a specific nature, for example, that the eye condition had disrupted the individual's "whole life". Abel found that the desire to be independent was generally held amongst those studied.

In the rehabilitation world, everyone talks about 'independence', and yet it is difficult to test the norms of independence: how many able-bodied people could say that they do not depend to some extent on support from others to survive physically or emotionally? They may use specialists to carry out tasks which they cannot do, for example, mending a roof, fixing a car, and so on. Others may use supportive aids such as drugs to reduce stress, increase vitality, or produce sleep. Alcohol and cigarettes, for instance, perform a variety of functions. So what then, is independence? It seems from the present study that independence was seen by most of those studied as retaining formerly-held roles and responsibilities, not
relying on others for too much self-care, and primarily, holding employment.

When blindness occurs, there is inevitably a need to obtain some assistance from those who have sight. How this is accepted by the individual is likely to depend on personality, attitudes towards disability, and previously-held roles. Some of those who become impaired may have been fiercely independent prior to loss, and it may come as a severe blow if they have to depend on others in any way. However, this previous 'independence' may also be an asset in that the individual is likely to fight the problems associated with blindness. Others, who have always depended on others for help, both emotionally and practically, may find it easier to accept being cared for by others. Whatever level of independence is sought by the individual, some adjustment to blindness is necessary.

It could perhaps be asked here, what is adequate adjustment? Shakespeare (1975) feels that there are a number of psycho-social factors which are applicable to both the disabled and the able-bodied. She also suggested that independence was important, and in addition, having an awareness of reality; retaining adequate personal relationships; having "reasonable emotional maturity"; and the ability to pursue appropriate goals were necessary to successful adjustment. According to Gowman (1957) writing specifically of blindness, the individual must develop a working relationship with the self and others. Gowman also suggests that an acceptance of a lower level of functioning is necessary. Adjustment involves coping with blindness, and it is likely to depend on
previous and present experience, as well as hopeful prospects. In the present study, the respondents were asked what factors aided adjustment. The following five factors were most frequently cited: 1) retaining employment; 2) having a supportive family; 3) having a positive attitude towards overcoming obstacles; 4) retaining previous roles and responsibilities, for example, supporting the family; and 5) being accepted by others. Eight respondents specifically mentioned assistance from rehabilitation agencies as aiding their adjustment. In order to learn to adjust to blindness, the newly blinded may seek the assistance of agencies.

Rehabilitation can be seen as a process of socialisation, and as Albrecht (1976) says, frequently connotes the idea of "patient passivity and dependency". That is, they are controlled by agencies. During this socialisation process the rehabilitees may be encouraged to adopt new attitudes towards the self, and the disability, to adopt specific patterns of behaviour, and even encouraged to accept a new identity. Certainly, societal reaction theorists such as Scott (1969) feel that those entering rehabilitation as blind people must adopt behaviour and attitudes appropriate to this role.

Of course, some of those who become seriously impaired may wish to have their rehabilitation passages guided, or even controlled by agencies. Glaser and Strauss (1971) suggest that there are two ways the shape of a passage can be controlled by agencies: 1) by controlling the details of the passage, and 2) by controlling the type of recruits.
Firstly, they state:

"One basic way of controlling the shape of status passage is to prescribe its direction and schedule. Temporal and directional signs ideally are clearly defined and announced. Agents and passagees can expect what the shape of the passage will be with a strong degree of certainty before entering and while they are in it." (p. 58)

They argue that if the passage goes out of shape then it is possible to identify the reasons. On the other hand, those passages which do not have a defined direction, or that may vary in terms of timing, are more difficult to prescribe and control by either agents or passagees. If the passagees put their faith in the agents, they will expect them to read the signs of the passage, and hope that they will take pains to ensure that it does not get out of control.

Secondly, the way the shape of a passage can be controlled is if the agents prescribe the type of recruits they feel are suitable:

"Getting those agents and passagees requires well-organized and conceived processes of recruitment as the basic means for filling the prescriptions. Otherwise the alternative dimensions upon which a passagee or agent are recruited can vary too easily, and later the recruiter may find the wrong person has been recruited." (p. 59)

When the passagees have been recruited, the agents will then implement programmes which will reflect the agencies' ultimate goals. Although some argue that the rehabilitee is passive and thus controlled by agents, some writers suggest that the disabled individual has some degree of internal control over the rehabilitation passage (Roth, 1963; Safilios-Rothschild, 1970; Albrecht, 1976). Albrecht suggests that both agents and
rehabilitees are involved in the rehabilitation process, and that successful treatment depends on agreement between both groups.

The rehabilitation passage is a particularly difficult one for both agents and passagees to control. Some other kinds of passages do allow for direction and timing to be defined, for example, academic courses where various hurdles, in the form of attendance, projects and examinations, need to be completed on a specified time scale. It is possible for the passagee to opt out, or to get behind on the schedule; however, generally agents can control the outcome. On the other hand, rehabilitation programmes are not generally planned for each individual at the onset of disability. Thus the passage may be unpredictable, and out of the control of either agents or passagees. However, the stages that can be encountered by those of working age who become blind are: 1) onset of symptoms; 2) treatment; 3) registration; 4) assessment of need; 5) contact with agencies dealing with rehabilitation (further assessment); 6) access to resources; 7) training given; 8) employment; and 9) follow-up and aftercare. These stages are examined in more detail later, but first, it is necessary to examine definitions of rehabilitation, and rehabilitation services. The concept of rehabilitation will affect the goals of rehabilitation staff and subsequently, the way that clients are dealt with by staff.

General Definitions of Rehabilitation

Definitions of rehabilitation provided by practitioners and theorists are generally all-embracing, for example:

"In its broadest sense, rehabilitation of the sick and
injured means the process of restoring them in the greatest measure possible, to health, working capacity and social independence." (Dept. of Health for Scotland, 1946)

The following definition of medical rehabilitation is also similarly comprehensive:

"Medical rehabilitation has the fundamental objective not only of restoring the disabled person to his previous condition, but also of developing to the maximum extent his physical and mental functions." (World Health Organisation, 1958)

The Tunbridge Committee (1972), reviewing rehabilitation programmes, suggested that the World Health Organisation's definition should be taken into account, but that it was also important to consider the rehabilitees' morale, motivation, and their relationships with both the community and the rest of society.

The Committee felt that the success of rehabilitation was dependent on a number of factors: age, mental and physical health, the type of work previously held (and which could be obtained after disablement), the life style and social environment of the individual, the attitude of family and friends, latent abilities, and the level of motivation of the individual. That is, medical, personal, psychological and social factors were all relevant to the chances of successful rehabilitation.

Litman (1962), examining the effects of self-conceptions on rehabilitation, also saw rehabilitation in terms of achieving maximum functioning:

"Physical rehabilitation, broadly defined, envisages the maximal physical, mental, social, vocational, and
economic recovery possible for any given condition." (p. 353)

This definition, like those cited above, seems to suggest that unless 'success' is gained in all areas, complete rehabilitation will not have been achieved.

The above definitions also imply that there is a standard of normality with regard to health, against which disablement can be measured. According to the World Health Organisation (1958), normal health exists when there is complete physical, mental and social well-being, "rather than solely an absence of disease". However, few people could achieve such an optimum state of health, and furthermore, the health of an individual is likely to fluctuate over time. As Safilios-Rothschild (1970) suggests:

"Even if accurate and operational indexes could be established to measure this ideal and comprehensive state of health, very few people would be judged healthy." (p. 55)

Health and illness are also culturally defined and therefore, it is not possible to employ universal concepts. As Safilios-Rothschild goes on to say:

"At the most general level, health and illness may be conceptualised in terms of collective types of perception and labeling and pathological conditions and modes of reacting to them prevalent in a particular culture or subculture. The process of perceiving, defining, and reacting to symptoms is largely influenced by the values prevailing in a cultural milieu, especially those values concerning health, illness, and sick role, required levels of role and task performance." (p. 58)

As Blaxter (1975) suggests, there is a "continuum between sickness and health"; thus defining someone as either healthy or sick, will depend on cultural and social norms, reflected in legal and medical
definitions, public expectations, and self-definitions. One element of sickness or disablement is that it inevitably causes a disruption to the career of the individual, though the level of disruption will vary according to the condition, the attitudes of the individuals concerned, and whether it acts as a catalyst to other events. It might be preferable then, to propose that health is that state in which the individual's life is undisrupted or not unduly disturbed by symptoms of illhealth.

The World Health Organisation suggests that rehabilitation programmes should have two main aims, both of which relate to their idea of normality in health. First, rehabilitation should restore the disabled person to his or her previous condition, and second, it should develop to the maximum extent physical and mental functioning. However, it is not clear what is meant by "previous condition", for example, the individual may never have achieved the norms of health. Indeed, definitions which suggest that a return to a previous condition, or which aim for complete 'maximal functioning' in all aspects of a persons' life, may be too ambitious. Perhaps the procedures and objectives of rehabilitation should be "ameliorative" rather than "curative" (Neff, 1970). That is, in reality, rehabilitation agencies may only be able to assist in minimising the disabling effects of impairment.

None of the definitions of rehabilitation include the temporal aspect of rehabilitation; some disabled people might be 'rehabilitated' in a matter of months, while others might take a number of years. Furthermore, the definitions usually apply to
rehabilitation which takes place with agency involvement, and while there is continued contact between agency and rehabilitee, even though the rehabilitation process goes on after agency involvement has ceased.

Rehabilitation Services

Services providing rehabilitative assistance in Britain are both statutory and voluntary (see Chapter 4 for an outline of the development of services for the blind). The main emphasis of these services is on re-employment. Developments in rehabilitation occurred post-war, when there were large numbers of people needing to be assisted, retrained and reintegrated into society. This rehabilitation mainly centred on occupational retraining. As Topliss (1975) found in her study of the development of welfare provision in Britain; the criteria for eligibility for retraining were based on the capabilities of the individual, and the opportunities in the labour market.

More general assistance became a matter of right after the 1970 Chronically Sick and Disabled Persons Act came into force. This laid the responsibility for providing facilities and services at the door of social services departments, which until then, had been provided at the discretion of the local authority. Nevertheless the organisational changes resulting from the 1970 Act were not wholly to the benefit of the blind. Until then there had been specialist blind workers, but subsequently responsibility was transferred to general social workers.
Those who become disabled can approach rehabilitation agencies for themselves, or be sought out by the agencies. The former group are likely to have their own idea of what specific services they required from these agencies. Likewise, the agencies will have their own concept of the ideal rehabilitee. As Blaxter (1974) says:

"Agencies necessarily have their own definition of their proper clients, and the goal of the rehabilitation process which is envisaged, explicitly or implicitly, may vary from agency and between agency and client. These varying definitions may be crucial to the career of the disabled person, for his pathway is dependent on the way in which he is defined." (p. 209)

Blaxter (1976) further suggests that the "ideal client" must be motivated, cooperative, and be willing to use existing capabilities, as well as having already acknowledged the disability.

Safilios-Rothschild (1970) found from a search of medical and sociological literature that expectations about how the rehabilitee should behave came under five headings:

1) Once the degree of physical disability has been established, the individual should learn to "live with it".

2) The individual should utilise to the full remaining abilities, within the limitations of the impairment.

3) The disabled person should be motivated and cooperate with the rehabilitation staff in trying to overcome the problems associated with the impairment.

4) The individual is no longer exempted from social roles and must become independent.

5) That those of working age should seek "gainful employment".

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Safilios-Rothschild suggests that rehabilitation agents define goals, as well as appropriate self-concepts and motivations, without consulting their rehabilitees. She argues that the above expectations put various pressures on the disabled individual. She feels that those who are unable to become independent may feel frustrated, guilty, inadequate, and depressed. She suggests that others may go to extremes in trying to diminish the effects of their impairment, causing them to have psychological and social problems.

Safilios-Rothschild's findings are interesting because they contrast with Scott's (1969) views that rehabilitation agencies put pressure on blind people to take up the dependent role. Perhaps there are different expectations of blind people than of those with other disabilities. Certainly Scott suggests that blindness workers regard blindness as constituting a serious disability:

"The personal conceptions that blinded persons have about the nature of their problems are in sharp contrast with the beliefs that workers for the blind share about the problems of blindness. The latter regard blindness as one of the most severe of all handicaps, the effects of which are long-lasting, pervasive, and extremely difficult to ameliorate." (p. 77)

Scott states that the 'blind role' is perpetuated by blindness agencies, and that their 'clients' are likely to become helpless and dependent.

As stated earlier (Chapter 3), although Scott identified two approaches towards rehabilitation in the United States, the restorative and the accommodative approach, he found the latter approach was more widely adopted.
From an examination of blindness agency reports, publicity material, and discussions with agency personnel, it seems that agencies in Britain employ both the 'restorative and the accommodative approach in rehabilitation. There are services aimed at training people to retain independence, and for those of working age, to gain employment. However, there are also residential establishments housing the blind, and providing sheltered and home employment.

The main agency dealing specifically with the blind, the Royal National Institute for the Blind, states that the aim of rehabilitation is to increase the capabilities and performance of their clients, and to give them independence. They suggest:

"... services must be structured and presented in such a way that blind people are able to lead integrated and independent lives within the community, and to achieve, through the fulfilment of the basic human right to work, recognition of their true worth as men and women in society" (Aston, 1978, p. 4).

There is emphasis on retraining and 'fitting' the individual for work.

"Whether they are just starting work or are in the middle of working life, they need help both to adjust to their blindness and to learn new ways of organising their lives so that they can continue to earn their own living and keep their independence. Ideally, this help should be available as soon as they lose their sight." (R.N.I.B. publication on Employment, 1980, p.1)

The R.N.I.B. run an occupational and rehabilitation centre for the newly blind (to be discussed later), and the staff state that they aim to encourage the rehabilitees to gain confidence, give them skills in mobility, self-care, home maintenance, and importantly, to guide them towards occupational retraining. They propose that an
ideal rehabilitee would be "fit, willing, and able to work". The rehabilitation staff also suggest that motivation on the part of the rehabilitee was of prime importance.

The Rehabilitation Passage

Those who become blind can come into contact with a number of agencies: initially they will be involved with medical agencies, and the next likely point of contact is with local authorities, via social workers. Following this they can become involved with a variety of agencies dealing with general rehabilitation, employment training, or, for example, providing guide dogs.

It seems from the evidence of both agency staff and respondents that there is often little coordination between agencies. Because of this, the shape of a rehabilitation passage may not be well-defined. Individual agencies do not plan all the stages in a rehabilitation passage, and thus, are unlikely to be able to inform passagees about all the stages they will encounter.

The scheduling of the rehabilitation passage can vary according to the eye condition, the needs of the individual, the way it is directed by agencies, and the life events which occur after loss. Although the blindness passage is an undesirable one, the rehabilitation passage is more likely to be entered willingly.

Those following a rehabilitation passage will encounter a number of stages from the onset of blindness. Although there may be what Blaxter (1975) describes as a "rehabilitation pathway", the same
stages may not be followed, automatically, by all newly blinded individuals. Typically, however, a blind person of working age could pass through the following stages:

1) The onset of symptoms and subsequent impairment.
2) Referral to ophthalmologist (by G.P.), diagnosis and treatment.
3) Registration (by ophthalmologist), referral to local authority social services departments.
4) Need assessed, and rehabilitation programme planned, including social mobility and occupational training.
5) Individual put in contact with various agencies, for example, R.N.I.B., Employment and Training agencies, Guide Dogs for the Blind, other more specific organisations, and self-help groups.
6) Resources made available to client, both manpower and provision of aids.
7) Assessment and specific training given. In the case of those who are employable, occupational training.
8) Placement in employment (or self-employment).
9) Follow-up and after care by all agencies (including the continued provision of aids).

This is an 'ideal type' passage, and in practice is not followed as a matter of course by every rehabilitee. As was pointed out in the previous chapter, blindness usually occurs over a period of time, and therefore the timing of the passage may vary considerably. In addition, as will be shown later, respondents lacked awareness of the facilities that could be offered to them.

To illustrate the two extremes of the rehabilitation passage, the
following examples illustrate: a) an individual who followed all the stages, and b) an individual who followed only the first three stages. The number of the stage is given in brackets.

a) When Mr. Rogers experienced an onset of symptoms of visual loss (1), he was referred to an ophthalmologist by his general practitioner (2). Mr. Rogers had two phases in his loss, losing first the sight of one eye, and the sight of the other five years later. He registered as blind two years after onset (3). Because he had been forewarned that he would eventually become blind, he said he began his 'rehabilitation' before he completely lost the sight of his second eye. He obtained the assistance of a social worker.

"I wanted to be prepared and I was lucky enough to have a social worker who helped me prepare for the future."

She found a home teacher who taught him Braille, even though at the time he could still see enough to read with aids: "It was very difficult to learn - you want to cheat all the time." However, he felt it was "worth persevering", and had a "good working knowledge" before he became totally blind. His social worker also gave him advice about what facilities would be available to him when he did become totally blind, and advised him to contact the R.N.I.B. and employment services (5).

At the time of visual loss, Mr. Rogers had been a chargehand in a factory and the social worker (and subsequently rehabilitation staff and the Blind Persons' Resettlement Officer) thought that capstan lathe operating would be the most suitable employment. He attended the R.N.I.B.'s occupational rehabilitation centre and
then, the Manpower Services Commission's engineering centre (6 and 7). It was at the latter that he totally lost the sight of his eye. When he returned home, his social worker suggested that he obtain a guide dog, increase his mobility training and encouraged him to join a self-help group. She assisted in making arrangements with the appropriate organisations. (Continuation of stages 4 and 5)

Placement in employment was arranged by the Blind Person's Resettlement Officer, who supervised his entry during the first week at the company (8). Mr. Rogers said that the social worker, mobility officer, and the Resettlement Officer "continued to help" even after he was "well settled into the job" (9).

Mr. Rogers was quite happy for these agents to take control, and he admitted that he had "little say" in his rehabilitation. However, fourteen respondents criticised the lack of liaison between the agencies, the absence of formalised planning during the early stages, and the little information given about facilities. Indeed, Mr. Rogers was fortunate in having a social worker who made arrangements between the various organisations and kept him fully informed of the services and aids available to him.

b) The experience of Mr. Hall was not as satisfactory as that of Mr. Rogers. This respondent followed the first three stages of the rehabilitation passage, that is, the onset of symptoms, referral to an ophthalmologist, and registration. Mr. Hall said that he was "... told nothing. I just drifted after I lost my sight." Although he did receive a visit from a social worker after he had been
registered, his needs were not assessed. He said:

"All she told me was that there was a club for blind folk in the next town ... I did go, but they were all ancient ... I was only 32 at the time ... I didn't even know I could get a wireless for the blind. I wasn't told anything about retraining and possible employment."

Mr. Hall lost his job as a packer after spending some time in hospital (for another disorder), but eventually he regained employment after applying for a local job he had seen advertised (he had reading ability). The year before he was interviewed he had become unemployed, but although only 45 years old, said that he did not think he would become employed again.

This last case illustrates the fact that many of the respondents were poorly informed about the services and facilities that could be offered to them. For example, seven of the respondents did not know that the R.N.I.B. supplied aids to the blind, one respondent thought that they only ran residential centres for old people, and twelve respondents did not know that the R.N.I.B. were involved in employment placement. Over half of those studied showed little knowledge of the numerous organisations which offered assistance to blind people and yet many of these said that they would have welcomed more help during the early stages.

The most likely point of contact after medical treatment is with social workers. The type of information they provide will depend on the individual social worker, the information they are able to obtain, the resources available to the social services department, and the time they have to deal with their clients. In general, the respondents were given little advice by their social workers.
Rehabilitation training is carried out in various ways. Some regional voluntary groups offer mobility and self-care training, and some areas have self-help groups. However, assessment and basic occupational training is carried out at a centre run by the R.N.I.B. The Centre is discussed in some detail for three reasons: 1) over half the respondents attended; 2) agency involvement with rehabilitation is a central interest to this study; and 3) the training offered forms the basis of many of the occupations obtained by respondents (dealt with in the following chapter).

The Rehabilitation Centre

This training centre, based at Torquay, offers assessment, mobility, and skills training for those of employable age. Twenty-six respondents attended the centre and their views and experiences, as well as the goals of rehabilitation staff will be examined in this section. It should be said that most of the respondents attended the Centre over six years ago and there have been personnel and policy changes since that time.

The Centre receives approximately four hundred clients each year, which is less than a quarter of those who register in the working age category. Those who attend are usually recommended to do so by social workers or employment personnel. An important part of the training involves providing rehabilitees with mobility skills. There is also training in domestic and self-care skills. Although the Centre offers basic occupational training, rehabilitation staff state that their main aim is to assess the potential skills of the
rehabilitees, and then direct the rehabilitees to further training. They offer facilities to give assessment on light engineering skills, commercial skills, and craft skills, such as basket making.

The majority of the respondents who attended the Centre said that they hoped they would receive assistance to gain re-employment. However, half of the twenty-six respondents said that prior to attendance they were unsure of the type of training that would be offered to them. They had not had the stages of their rehabilitation passages mapped out for them and were not well-informed about what would be offered to them.

For example:

"I felt totally 'green' about Torquay - I had not been prepared at all." (Mr. Oakley)

While others thought it would be a panacea:

"I thought that it would solve my problems going to Torquay. I didn't realise that they only catered for those who had low expectations of our futures." (Mr. Cole)

While another:

"I thought that it would enable me to get a job, but I had no idea what was available; I had heard of brush making and I remember hoping that I wouldn't end up doing that." (Mrs. Blackman)

Views were obtained from all the respondents studied on the type of training offered. These could be broadly classified into five groups:

Group I: Those who attended and felt that training was extremely beneficial (5 respondents).

Group II: Those who attended but had no strong views either way on
Group III: Those who attended and who said that the training was insufficient to their needs (13 respondents).

Group IV: Those who refused to attend the Centre because their fore-knowledge of the system and the training, which they thought might be of little value, discouraged them from attending (7 respondents).

Group V: Those who did not attend because they had no specific needs (9 respondents).

The first three groups will be discussed in this section.

The Views and Experiences of Rehabilitees

Group I

The first of these groups can be illustrated by Mrs. Blackman. She had been a shop assistant when she suddenly lost her sight. She was "badly shocked" by her loss and spent several months receiving medical care for depression. She said that help given by both her husband and mother eventually enabled her to face her blindness. Mrs. Blackman said she had always had some abhorrence towards blindness and felt that it would be "better to be dead".

She was persuaded to attend the assessment centre by her husband and a social worker. Mrs. Blackman did not want to attend, mainly because she was reluctant to leave her home, but also because she "didn't know what they would expect" of her. Once she began the course, she said that she "enjoyed it immensely". She felt that she benefitted from being with other blind people, many of whom were "worse off" than herself.
The rehabilitation staff suggested that she train as a typist and she was "more than willing" as she had "always" aspired to gaining an "office job". Mrs. Blackman also learned to be mobile while at the Centre.

She described the rehabilitation staff as "friendly and helpful" and the atmosphere as "quite good fun". She said that her training had been "more than satisfactory", particularly as she obtained employment as a typist shortly after attending the Centre.

Mrs. Blackman was not typical of the sample studied. She was without criticism of the Centre and felt that it had made a significant contribution in shaping her passage through rehabilitation, and subsequently, her occupational career. She did not mind the staff taking complete control, and fortunately for her, their goals coincided with her own.

Although four other respondents were in Group I, they had not achieved what Mrs. Blackman regarded as upward social mobility (in her view working as a typist was a much higher position than being a shop assistant). These respondents had all been in manual occupations and three were subsequently retrained as lathe operators and one as a basket maker.

An interesting example of a respondent who was without criticism of the Centre, and yet who did not appear to be reconciled to his blindness, is the following.
Mr. Phillips was high in his praise of the Centre and its staff, stating that they were "wonderful", "cheerful", and "gave him confidence", and yet, at the time of interview, he said that he lacked confidence and felt "very bitter" about his blindness. Mr. Phillips felt very grieved by his loss and said that he held a pessimistic view of the future.

However, short-term, he felt rehabilitation training had been of value: he enjoyed being "one of a number", anonymous, with others suffering the same plight. He particularly liked the camaraderie at the Centre, and said that he was reluctant to leave as, life was "much easier" while he was there.

He said when he returned home, he lost his confidence again. His wife had taken over "most of the responsibilities", even though he was employed and making a financial contribution. He described his life as consisting of working and sitting at home "doing nothing".

The respondents in this group all had few expectations before they attended the Centre. They said that they were happy to let the staff decide on what training they should receive. These passagees allowed the balance of control to be shifted towards agents, that is, rehabilitation workers, and shape the direction of the passage. They had all been unskilled workers prior to visual loss. The other common factor amongst this group was that they liked being with a group of blind people. As Glaser and Strauss (1971) point out, status passages can be pursued alone, or in a group. While some may
choose to follow a solo passage because they have no desire to share the experience, others may wish to follow a passage with a group in order to communicate with fellow passagees. This was certainly the case for those in Group I. They felt that meeting other people who were also blind made them 1) feel less isolated, and 2) feel better because there was "always someone worse off".

Group II

Those who were in this group, that is, those who neither particularly liked nor disliked the Centre, and had few comments on the training given, were also those who did not have well-conceived expectations of the training. As one person said: "I thought it was something everyone who went blind did". Most of the comments received from this group were such as: "The staff were nice/helpful/friendly"; "The training wasn't bad/quite useful/suitable" and so on. Two respondents in this group suggested that the staff did "as best they could", particularly as far as occupational training was concerned. As Ms. Purvis said:

"There are very few jobs available for blind people ... they have to train us for those few jobs, after all, there's no point in training us for jobs we'll never get."

Others defended the type of occupational training given:

"It's obvious the training isn't going to suit everybody but they do their best, they're such a funny lot the rehabilitees how can they keep everybody happy?" (Mr. Oakley)

"The staff try to help as best they can, but you're only there for a few months, you have to help yourself - learn after you leave as well." (Mr. Harris)

One respondent, Mr. Stevens, was quite satisfied with the training
he received, but felt that blind people (and at that time a high percentage of staff recruited had to be blind) should not help the blind. He said it would be preferable for the sighted to provide instruction as they tended to be "more sympathetic", whereas those who had been without sight for some time were not so "understanding" towards those in the early stages of blindness. Another respondent also said that the staff were "successful in manoeuvring in their own environment" but were sometimes intolerant of those who do not "catch on quickly" (Mr. Hawkins).

The respondents who formed Group II had a variety of occupational backgrounds, from personnel manager, to gas fitter.

**Group III**

The above groups expressed little criticism of the training they had received, whereas Group III respondents were quite vociferous in presenting their criticisms. The most significant feature of this group was that they all stated that they had had specific expectations of what the Centre should, and would, offer before attending. Seven respondents were very strong in their criticism and dislike of the rehabilitation centre, in particular, of the general ethos held by the staff.

The main criticism was of the lack of control that they themselves had over planning their occupational careers. Another major criticism from Group III was that the only training they were offered was for 'traditional' occupations for the blind (see Chapter 8), although they had a wide range of occupational
experience.

Many of the respondents in this group said that they had to accept the staff's suggestions as to the occupational career they should follow. For example, Mr. Fellowes said that when he attended the Centre:

"It all failed as far as I'm concerned ... I was told with a capital T to become a capstan lathe operator."

He was reluctant to go into light engineering, but was advised that his geographical area dictated that engineering would be the best occupation. Mr. Fellowes thought that he was capable of more than this. He said that he had missed out on his education (his previous occupation was as a van driver), but would have liked the opportunity of training "for something worthwhile, like a social worker". He did not know whether this was an unrealistic ambition, but was upset by the response of rehabilitation staff, who "just laughed". He was very bitter about his experience.

In one case, a man who had been in his late twenties when he attended the Centre, was able to speak seven languages fluently:

"I was sure before commencing rehabilitation that I would be able to use these languages in some way - the B.B.C. had a monitoring service at the time and I thought that perhaps I could get a job there. I approached them (the B.B.C.), but they were unsure how I could cope with it ... When I went to Torquay I asked - but not forcefully, you understand, I was rather timid then - whether I could be trained for such a job. They were negative about it, suggesting that there was a job for a lathe operator locally ... they thought this more suitable ... If only I had stood up for myself." (Mr. Franklin)

It should be pointed out that the above man had only been in England for three years (he was of Turkish extraction) and was, at
the time, rather grateful for anything that could be done for him.

Earlier in this chapter, it was suggested that a means of controlling the shape of a status passage, is by the agencies defining the type of recruits they would handle. In fact, the Centre does not have direct control over entrants because other agencies such as social services or employment agencies often suggest that someone should attend. Thus, rehabilitation staff may have to exert some control over passagees if they see the passage going out of what they regard as the prescribed shape.

Because this attempted control by rehabilitation staff upset so many of the respondents, it is worth pursuing in more detail. Certainly, other literature on the subject of rehabilitation suggests that rehabilitees often have problems in gaining control of their own passages. For example, Safilios-Rothschild (1970) carried out a search of literature on the rehabilitation of people with various disabilities. She found that the common wish of agents was that their disabled "clients" should behave in a specific way. Safilios-Rothschild further suggests that the ideal rehabilitee is a compliant one:

"... with total acceptance of the rehabilitation staff's definition of the disability, as well as their formulation of rehabilitation's goals". (p. 80)

Her findings suggest that because of this, those with good educational qualifications and a sense of creativity often withdraw from a rehabilitation agency.

This also seems evident from the present study; many of those who
had professional or highly skilled occupations did withdraw, or not attend, the rehabilitation Centre.

For example, Mr. Roberts had been a civil engineer and contacted the R.N.I.D. and Job Centre when he lost his sight. He wanted suggestions as to what career he could follow.

"They really couldn't think of anything ... because I'd said I was a civil engineer they really thought I'd be happy on the shop floor ... they seemed to have little idea of what a civil engineer did ... I thought I would give Torquay a try, but I couldn't even stick it out for a week ... I want nothing to do with any of them now."

Certainly those who had high expectations of what rehabilitation would offer were sometimes disappointed. Mr. Cole had held a senior managerial job prior to loss and suggested that the Centre was "totally unsuitable" for people who held professional occupations. There were several instances of people who were offered what they saw as inferior occupations. These respondents saw the rehabilitation experience as being "demeaning" and "worthless". In fact, six respondents stated that although they objected to the occupations which were selected for them, at the time, they felt that they had not enough "strength of mind" and determination to resist what was offered to them.

It seems evident from this group that the only way they could gain control of their passage, was by "rebelling". However, even if the rehabilitee does rebel, if the system does not make provision for individual needs, there may be little alternative help available. Garland-Minton (1974), writing an autobiographical account of his loss of sight, found that when he refused to carry out certain
'vocational' tasks at the Centre, he was regarded as being uncooperative. He had previously been employed as a management consultant, and yet, he states, it was suggested by the rehabilitation team that he receive training in light engineering. He had no wish to do so, and yet no further suggestions could be made. He further states, as some respondents suggested, that those who assessed him were unsuitable to judge someone with his previous experience.

An example taken from the pilot study shows the differing goals of rehabilitation staff and rehabilitee. Mr. Davis had been studying for a degree in geography when he lost his sight due to a car accident. It was a total loss and Mr. Davis had experienced a long period of hospitalisation. He stated that he did not know what to expect when he went to Torquay, but hoped that he would be trained to "get about" and gain communication skills, and thus be able to resume his studies. He said that the tasks he was given at the Centre were low-level and not challenging. He was also "dismayed" when he found that the assessment would be carried out by "low calibre staff", such as the woodwork supervisor.

Towards the end of his three month stay at the Centre, a representative of the R.N.I.B. (probably an Employment Officer) sat on a panel with the Head and other members of staff. The staff put forward the suggestion that he should be trained as a typist. Mr. Davis said he was "horrified" by this. He said that the Head and members of staff were extremely upset by his behaviour at the Centre, and the fact that he would not accept their dictates. Mr.
Davis said that he was described as being "disruptive" and a "troublemaker". (In fact, Mr. Davis did eventually obtain a degree in social administration, and, at the time of interview was training as a social worker.)

One of the respondents from the present study, Ms. Simmons, who was a graduate chemist and teaching at the time of her visual loss, stated that she was "unpopular" with the staff because she also had certain goals she wished to achieve at the Centre. When these goals were not met she "complained bitterly". She said:

"I wanted to be helped to develop skills in order to carry on teaching; having enough sight to read with aids I felt it wouldn't be too difficult ... they couldn't give any constructive advice about how I could organise my day-to-day work ... I would have also expected some help over the depression I was experiencing - but if you were miserable you were treated like a naughty child ... I had to leave after a few weeks because I was becoming more depressed and despondent. It was all a waste of time ... The problem is, if you tell them what you think of their training, they treat you as though you don't know what you're talking about, as if you don't know what's best for yourself ... Oh no, they didn't like me one bit ... I wasn't docile you see."

There are many examples of respondents who suggested that they had differing goals from the rehabilitation staff. It seems that the staff had certain definitions of the rehabilitees, and a particular view of what capabilities they should have, even though they must have encountered evidence to the contrary.

All those in Group III suggested that rehabilitation workers expected rehabilitees to adopt a particular role. Certainly, during the time when many of the respondents attended the Centre, staff encouraged rehabilitees to believe that blindness would lead to a
new identity. For example, Mr. Davis said that the first lecture he and other "inmates" received on arrival, informed them that they were now "blind people" and as such should have lower expectations than when they were sighted. Although some might argue that this can be the case, respondents who encountered this attitude found it very disheartening.

For example, one of the respondents, said he was made to feel both "inferior" and a "failure". Mr. Wright said that the staff were impatient with him and discouraged his ambitions, reducing his expectations of a successful future, and making him "lose dignity".

Another respondent described the Centre as "Torquay Horror Camp" and said that it was a "dreadful experience". Mr. Cole described the activities as "tedious", "not worthwhile", "pathetic", and the staff as being "patronising".

A further respondent regarded the activities as inadequate:

"I couldn't believe how bad it was - it was like a holiday camp - there was not enough concentration on getting us fitted for the outside world, they just kept us 'busy'. Actually, it upset me to be with lots of people in the same position as myself (blind), all doing pointless tasks." (Mr. Brewer)

The views put forward by this group on the inadequacy of rehabilitation training, and the conflicting goals of rehabilitees and rehabilitation staff, have been substantiated by published autobiographical accounts, and other literature on blindness. In particular, it goes some way to support Scott's (1969) thesis (see Chapter 3) that the blind role has to be learnt, and that it is the
very agencies which exist to assist people with defective sight which encourages them to take up this role. What the present study shows is that, in the past, rehabilitation staff did seem to see blindness as limiting the individual's career and scope for future development. However, unlike the agencies described by Scott, the British agencies do not see the blind role as necessarily leading to helplessness and dependency, but rather as one which involves the individual developing specific characteristics and holding 'traditional' employment. As eleven of the respondents said, the services were geared to those with total loss of sight, and the "lowest abilities". It was suggested by those dissatisfied with the services that they were encouraged to be docile, accepting rehabilitation workers' dictates, and to accept that opportunities would now be limited.

However, as will be shown, there were many in the study who rejected the expectations of agencies (see Chapters 8 and 9). Those in Group III, who were critical of the rehabilitation training they had received were mainly in professional or highly-skilled occupations (although there were exceptions), and those who had specific expectations of what the training should offer.

As already pointed out, there have been staff changes at the R.N.I.B.'s Centre since the majority of those studied attended, and it is suggested by the Head and staff, that policy changes have taken place. Nevertheless, current staff were asked to comment on many of the criticisms raised.
The Views of Rehabilitation Centre Staff

The above points and criticisms were raised with rehabilitation personnel at the Centre. The Head of the Centre (who has held this position for the past seven years), also had a similar experience to some of the respondents. He had been an articulated accountant prior to registration, and it was suggested by rehabilitation personnel that he train as a lathe operator. He had no wish to do this, and he subsequently trained as a home teacher for the blind. The Head said that he could therefore sympathise with these respondents, and others like them, whose own goals did not match those of rehabilitation workers. He hoped that his staff were now more flexible and accommodating towards their clients. He also recognised that, in the past, staff were perhaps not of a high calibre, and most had not received training in dealing with newly-blinded people. Those employed as rehabilitation workers were often those who had themselves received training at the Centre and were retained to train others. The Head stated that he was trying to change this and was now employing some staff who had teaching qualifications, and also a qualified social worker. (The Head was also a qualified social worker.) He said he would like the Centre to "become a type of polytechnic".

The Head and other members of staff stated that they do not dictate to the rehaibilitees what specific occupational training they should subsequently take. Their function is to provide "general work", that is, typing, Braille, crafts, and basic engineering, and see whether people have an aptitude for any of these areas.
The staff say that they are flexible and meet their client's needs, but that they must have "realistic aspirations". One member of staff stated that they realised that there are certain tasks which cannot be achieved by the client, but that they "do not see this as a failure". They aim to give rehabilitees self-confidence, a better self-image, and the "gaining of capabilities". The Head further suggested that rehabilitees should be able to "reflect for themselves by talking to others".

Commenting on the limited opportunities offered for occupational training, staff said that there were two reasons for this. One was that they had insufficient financial resources to allow the kind of training they would like to offer. The other reason was that this was largely related to the available opportunities in the employment field. The Head felt that there was a need to seek out new types of employment and make maximum use of the new technologies available, for example, word processors and closed circuit television. Staff were aware that the public image of blindness often incorporated the idea that blind people became beggars or basket makers. The Head said he was reluctant to retain craft training, but had been instructed to continue with it by R.N.I.B. headquarters.

The Head, and other members of staff, said that in the past (when most of the respondents attended) the attitude of staff had been more paternalistic and re-inforced the blind role. The Head at that time, and his wife were called 'father' and 'mother' by some of the
rehabilitees, and the emphasis was on trying to provide a cheerful and accommodating environment. Rehabilitees were taught to use skills as though they were totally blind, whatever their degree of sightedness. Since the present Head's appointment, the emphasis has been on encouraging the use of residual vision. He has instituted testing for levels of sightedness at the Centre, as he had found that the level of sightedness reported by ophthalmologists did not always match their own observations of rehabilitees' abilities.

It has already been suggested that agencies perpetuate the stereotypes of blindness. The rehabilitation staff at the Centre did agree that stereotyping has been involved in dealing with rehabilitees, although, as the Head said, he is trying to avoid this by producing a "better model" of blindness, that is, one that allows for individual differences and needs. They say that they aim to prevent impairment from becoming a handicap.

Because interaction between staff and rehabilitees was not observed in any detail, it was not possible to examine the extent of control that was exerted on the latter. The staff suggested that there was a balance of control between them and those negotiating the rehabilitation passage. That is, although they claim to guide, and try to shape a particular passage, they only did this with the cooperation of the passagee.

Adjusting to Blindness

Although 'rehabilitation' often implies that there is agency involvement, many people who become blind go through a process of
what one man described as "rehabilitating themselves". It was stated above that there were two further groups of respondents (Groups IV and V) who did not receive formal rehabilitation assistance. There were seven respondents in Group IV who refused to attend because they said they had heard adverse reports about the training, and thus were discouraged. Group V consisted of nine respondents who had no specific needs, that is, they received local assistance, retained previous employment, or were able to cope without outside help. Both groups showed a common purpose, that is, that they wished to control their own passages, and in some cases, were 'proud' to follow solo passages. (Although there were some respondents who did not receive assistance through a lack of awareness of availability.) Thus those in Groups IV and V did not attend for a variety of reasons: 1) they did not need training; 2) they thought that the training offered was unsuitable; 3) they did not want to be with other blind people (twelve respondents were very adamant about this); and 4) were reluctant to leave their families.

Respondents in all groups, however, experienced difficulties similar to those reported by Abel (1976). The respondents had to cope with the problems of communication, reading and writing. Other problems which occurred mainly during the early period of blindness came under the heading of increased dependence, and were as follows: eating, selecting objects, orientation in the home and other environments, shaving or applying make-up, carrying out household duties, continuing with interests/hobbies, shopping (locating items and dealing with money), being unable to recognise
people and being disorientated in group discussions. The loss of mobility, was also high on the list. Difficulties experienced in gaining employment were cited as the most important by three-quarters of the respondents. It should be pointed out that many of these difficulties were of a short duration, for example, finding orientation in the home. Those who had a very gradual loss of sight experienced the least difficulty with these practical activities.

To overcome these problems, the assistance of regional voluntary groups and self-help groups was often sought. Regional associations, such as the Southern and Western Regional Association for the Blind provide advice, information, and organise mobility and some rehabilitation training. Many associations, and some local authorities, organise self-help groups.

**Self-help Groups**

Those who joined self-help groups did so for several reasons: for help and advice on practical difficulties; mutual association and a need to share experiences with others; social activities at group sessions; and having "somewhere to go".

Fourteen of the respondents had, at some time in their blindness careers, attended self-help groups. Of these, two had not found these groups helpful; both respondents felt that these groups were aimed at older blind people. The other twelve had found some value in attending; seven were involved with self-help groups at the time of interview. One of these regarded her self-help group as being
particularlly valuable.

Ms. Ludlow did not go through formal rehabilitation training because she was able to retain her employment, but she did need assistance with mobility and self-care skills.

"It was so useful, there was a nearby group, and their leader was the dynamic sort. She really organised me ... I was taught deal to with little things like putting on make-up and pouring the kettle. Most important, she trained me to become mobile; if she hadn't I wouldn't have been able to carry on working."

Other respondents also referred to the assistance they had been giving with personal care and domestic problems. However, by far the greatest benefits derived from these groups were those of the sharing of problems. As Mrs. Matthews said:

"I went to a self-help group for a year. It was the best thing I could have done. Although most of the people were much older than me, and some were extremely pessimistic, it made me realise I wasn't so badly off. At least I was going to be able to work. I think all disabled people benefit from mixing with others who are disabled. Only the disabled know what it's really like."

Another respondent also suggested that he preferred to be with blind or other disabled people, rather than those who were able-bodied. Mr. Wright said that the former group "understood the problems" and that "only they can offer any real advice".

The respondents who felt that self-help groups were valuable in facilitating the sharing of experiences said that it reduced their isolation. It was also a place where social activities (for example, games and 'outings') were organised and thus was particularly valuable for those who were unemployed. Of the seven still attending at the time of interview, six were unemployed, and
The Role of the Family

Many of these difficulties in adjustment were overcome by the individual, without formal assistance. Often it was family and friends which helped the individual. Two-thirds of the respondents said that they had received a considerable amount of support from their families during the early period of their blindness career and that this had aided their adjustment. Although most respondents said that there was a temptation for the members of the family to fuss and overprotect.

In five cases, where the spouse was present at interview, this protectiveness was still apparent. For example, in one interview the wife continually fussed over her husband, and made it clear that she "had to do everything for him" (Mr. March). In another case, a wife insisted on answering the questions for her husband (Mr. Thomas) stating that it was "obvious that a blind person is unlikely to be employed" and that "of course he doesn't go anywhere alone". In these cases, the respondents, or their wives, emphasised that blindness brought dependency. Over-protectiveness can lead to the newly blinded person feeling that they cannot be reintegrated into society. One respondent stressed that he did not have the confidence to "face" those other than family and a handful of work colleagues (who "understood" him); he also preferred to be with other disabled people rather than the "able-bodied" (Mr. Wright).

An extreme example of enforced dependence was given by a
rehabilitation worker, of a man who lost his sight in his early forties, was subsequently made unemployed, and rejected by his wife and children. He returned to his mother's home and she insisted he slept in her bedroom. She washed and fed him with a spoon and generally "treated him like a baby". After six months, a social worker recommended his removal and he entered a residential rehabilitation centre for the disabled. He eventually gained mobility, self-care skills, and became employed in a sheltered workshop.

Staff at the R.N.I.B. rehabilitation centre suggested that a "considerable number" of their rehabilitees had been overprotected by their families, sometimes to the extent of being fed. However, the staff showed differing attitudes about whether the families of rehabilitees should be included in rehabilitation training. One member of staff, for example, suggested that rehabilitees should spend "twelve weeks away from the family" in order to become independent. On the other hand, the Head felt that taking people away from home could be "detrimental" to their relationships and could result in marital breakdown. The Head of the Centre said he would prefer to see "people kept in their homes", and training for both the rehabilitee and the family provided in their geographical area.

Overprotected individuals such as those cited above are unlikely to be encouraged, or perhaps allowed, to adopt previously-held roles. It should be said, however, that often the families of people who are newly blind can play a valuable part in giving support and
twenty-two of the respondents stressed that help from the family was most important. The supportive network generally consisted of spouses and/or close relatives. Some respondents said that their problems would have been more severe if they had been living alone:

"Help from authorities is needed if you live alone. If you've got a good family and all stick together, that helps, it's a different problem if you haven't got anyone ... I carried on as if I never suffered from blindness, carrying on as normal as possible." (Mr. Mitchell)

Others stated that they "wouldn't have made it", and "would have been shattered" without familial support. Another respondent said:

"The family didn't make me feel awkward or odd ... At the beginning some relatives did fuss a bit more ... one aunt was very protective, like a praying mantis, as soon as I put a cup down she was there ..." (Mr. Stafford)

The general view was that the most useful way they could be treated was for others to expect them to try to continue as before, that is, retaining the status quo. Obviously some could not do this, and others admitted that in the early days they did not want to retain previous roles and responsibilities. As one respondent said:

"At first you want to sink into it all, let everybody do things for you, it's so much easier than struggling yourself ... it's only later that you realise that you can't always depend on other people." (Mrs. Massey)

The spouse in particular played the most vital role in "giving confidence":

"If I hadn't had my wife I'd have just shut myself away; she gave me the motivation to get on my feet again." (Mr. Sims)

Mr. Williams said that his wife had made an important contribution to his successful adjustment. He said that his wife always "assumed" he "could do things". When he went to a self-group he was
asked whether he could do up his tie, use a knife and fork, and so on. Mr. Williams said that he was surprised to be asked these questions as he had never stopped doing these things.

Almost three-quarters of the respondents said that, in time, over-protectiveness was reduced. Respondents did suggest, however, that this protectiveness could be useful at first, although long-term it was undesirable if independence was to be achieved. For example, Mr. Williams said that "being watched, but not overprotected, is vitally important".

However, much some of those who become blind wish to the contrary, the loss of sight is likely to produce increased dependency. When severe deterioration occurs, there will have to be at least some reliance on those with sight. This may be in the area of receiving assistance with daily living activities, with having communications written or read, or receiving aid with mobility. Over two-thirds of those studied had to receive regular sighted assistance in varying degrees. Even those who considered themselves "very independent" were often only able to be 'independent' with the assistance of a spouse. They did not tend to regard this as a dependency problem. They suggested that their independence arose from the fact that they were able to obtain employment and/or could follow various outside activities.

Although almost all of those who were working made their own way to and from work, three respondents relied on receiving regular lifts from their spouses. One of these, Mr. Williams, was adamant that
blind people should become independent, suggesting that "too many blind people become helpless". He saw his independence in terms of holding employment, retaining previous social roles such as a Sunday school teacher, and continuing with previously-held interests such as concert-going.

However, he admitted that if changes had to be made in his mode of travel, or destination, he would be faced with problems. Although Mr. Williams had retained his previous status and said that "life is barely changed", he also said:

"I never go anywhere without an escort. My wife takes me to and from work. I couldn't get about alone."

At this point in the discussion his wife interjected and said that he was "very mobile", but Mr. Williams corrected her:

"Yes, I am when I'm at work. The building is six stories with long corridors, and I like to think I know all of them. I do carry a cane, but that's to indicate that I'm blind to new members of staff, or visitors... But coming back to this business of travel, no, I would be very much afraid to go on buses."

As Mr. Williams's case illustrates, those who wish to achieve independence, may only be able to do so if they can elicit the assistance of someone with sight, and thus could not be said to hold the same level of independence they held prior to blindness. Nevertheless, both those who obtained assistance from agencies, and those who did not, generally regarded successful adjustment in terms of independence.
The rehabilitation passage is an inevitable one after blindness occurs; every individual must learn to adjust to loss. Adjustment was seen in terms of regaining independence, that is, retaining formerly-held roles and responsibilities, and not relying on others for considerable self-care. Those who become blind can seek assistance from blindness agencies; in this study those who did, showed varying degrees of satisfaction with the assistance given, from those who were without criticism to those who felt it totally unsatisfactory. The former group mainly consisted of those who had formerly held manual and semi-skilled occupations, and had few expectations of training. On the other hand, those in the latter group had professional and skilled backgrounds and had specific expectations of rehabilitation training. There were also those who did not contact agencies for assistance, either because they had no need of it, or because they had heard adverse reports of the training which deterred them; some of these obtained the assistance of self-help groups. Over half the respondents suggested that family support and encouragement was more important than formal assistance. The most important objective of most of those studied was to be rehabilitated to be able to take on the work role.

Summary

The rehabilitation passage is an inevitable one after blindness occurs; every individual must learn to adjust to loss. Adjustment was seen in terms of regaining independence, that is, retaining formerly-held roles and responsibilities, and not relying on others for considerable self-care. Those who become blind can seek assistance from blindness agencies; in this study those who did, showed varying degrees of satisfaction with the assistance given, from those who were without criticism to those who felt it totally unsatisfactory. The former group mainly consisted of those who had formerly held manual and semi-skilled occupations, and had few expectations of training. On the other hand, those in the latter group had professional and skilled backgrounds and had specific expectations of rehabilitation training. There were also those who did not contact agencies for assistance, either because they had no need of it, or because they had heard adverse reports of the training which deterred them; some of these obtained the assistance of self-help groups. Over half the respondents suggested that family support and encouragement was more important than formal assistance. The most important objective of most of those studied was to be rehabilitated to be able to take on the work role.
The previous chapter discussed the rehabilitation passage, and it indicated that the employment passage was closely linked to it. Those studied were of working age, and thus, the main priority when blindness occurred was to learn skills in order to retain or obtain employment.

This chapter looks at employment outcomes to establish if, and how this goal was met. The occupational mobility of the sample was analysed, examining previously-held and present occupations. Although this was carried out by using a social grading scale (Goldthorpe and Hope, 1974), the employment outcomes have also been collapsed into four categories. These categories were:

1) retention of previously-held employment; 2) obtaining 'non-traditional' employment, that is, employment gained in competition with the able-bodied; 3) obtaining 'traditional' employment, that is, occupations which have been deemed 'suitable' for blind people; and 4) unemployment. The reasons for these various outcomes are discussed, and in particular, the role of agencies in determining the type of employment gained.

Work performs a variety of functions and these will be discussed in some detail later in this chapter; however, prior to this, the importance of the work role will be briefly considered.
The Work Role

Those who become disabled and seek out the work role may only view themselves as rehabilitated if they gain that role. It was suggested in previous chapters (Chapters 1 and 7) that the definitions of disablement are related to occupational capability. Thus the services dealing with disablement are frequently concerned with giving their clients occupational skills. As Safilios-Rothschild (1970) says:

"Because the emphasis of rehabilitation services has been and to a considerable extent continues to be the vocational rehabilitation of disabled people, rehabilitation success has very often been measured on the basis of whether or not the individual returns to work." (p. 217)

Shakespeare (1975) found in a study of disablement:

"To be able to find work and to keep it is one of the most important aspects of social adjustment and there is some evidence that being employed is a good general indicator of overall adjustment." (p. 31)

Both rehabilitee and rehabilitation staff may see successful adjustment in terms of re-employment. The desire for employment is, of course, common to the able-bodied. In industrial societies, the work role is highly valued and impinges on all aspects of an individual's life. For example, the type of occupation held can greatly contribute in determining status, income, political attitudes, and interest (Cotgrove, 1967).

The work role can perform a number of functions. Hayes and Nutman (1981), who carried out a study of the psychological effects of unemployment, proposed that work has seven main functions; it: 1) provides an income; 2) fulfils a need for activity; 3) structures time; 4) is a creative activity; 5) facilitates social interaction;
6) is a source of identity; and 7) it provides a purpose to life. (These functions will be considered further in this chapter.)

To many people the work role is their most important, as Hayes and Nutman say:

"Work roles are not the only roles which offer the individual the opportunity of being useful and contributing to the community but, without doubt, for the majority they are the most central roles, and consequently people deprived of the opportunity to work often feel useless and report that they lack a sense of purpose." (p. 43)

Neff (1968) sees work as:

"... a kind of subculture, complete with traditions, customs, laws, rituals, compulsions, rewards, and sanctions." (p. 23)

He says that training in work habits is imposed on children in most organised societies, and that there is a widespread societal expectation that most healthy members of society will perform some type of useful work. Those who are unable to work (that is, to find paid employment), may believe themselves to be 'useless' and may feel that other roles do not compensate for employment loss.

Neff found that rehabilitation and employment agency personnel dealing with the disabled observed that there was a high valuation placed on work. However, Neff stated that re-entry into a work environment is likely to be difficult for the following reasons:

1) functional abilities can be impaired and thus aptitudes for specific types of employment may be limited;

2) the disabled person may have to cope with negative and aversive feelings which some disabilities engender in other people (both employers and co-workers); and
3) a disability may distort or block the development of the "work personality". As work behaviour is learned behaviour, those who are forced to remain out of the work environment for some time due to impairment may find it difficult to be re-socialised into the role of worker.

This learned work behaviour is described by Gross (1958) as "occupational colleagueship". That is, in a work environment there will be: 1) exercise of control over entry of new members; and 2) a distinct work style, in terms of dress, speech, marks of identity, adding up to a feeling of solidarity among workers. The result of this is that the worker is likely to 'act' and 'look' appropriate to the particular occupation. Those who are disabled in some way do not easily fit into this "occupational colleagueship", not only because their physical appearance may not present 'wholeness', but because special concessions may have to be made to that person. For example, aids may have to be provided, toilets adapted, or extra assistance given. An employer may bear in mind the occupational group norm when selecting new personnel and thus be reluctant to introduce a new member of the work force who requires special attention.

Those who become blind have a number of difficulties in obtaining employment. Because of these difficulties, the assistance of specialised agency personnel may be sought.

**Employment Services**

When someone becomes blind and wishes to continue in the work role,
they can approach agencies which deal specifically with finding employment for blind people. There are two main agencies: the Royal National Institute for the Blind's employment service, and the Manpower Services Commission (M.S.C.), via their Job Centres.

The training and placement of those seeking commercial, professional, or craft occupations is handled by the R.N.I.B. They run commercial colleges, a clinic of physiotherapy, and establishments teaching piano tuning, furniture production, and basket making. They also have an assessment and rehabilitation centre (discussed in Chapter 7).

The M.S.C. deals with training and placement of manual workers. This is handled by Disablement Resettlement Officers (D.R.O.s), Blind Persons' Resettlement Officers (B.P.R.O.s), and Blind Persons' Training Officers (B.P.T.O.s). The M.S.C. run engineering and related skills courses, and referral to these is often made by R.N.I.B. rehabilitation staff.

These agencies may find employment for disabled people in three areas: sheltered employment; home industries; and open industry. The majority of the occupations located for the blind are likely to be 'traditional' occupations.

Employment personnel (both R.N.I.B. and M.S.C.) stated in interviews that sheltered employment (that is, in workshops employing solely disabled people), and home industries for the blind, were alternatives when no other avenues were open to the
prospective employee. These schemes were regarded as being valuable, but all staff interviewed suggested that placement in open industry was a mark of success for them, and the employee. That is, if a blind person successfully obtained a job in competition with sighted people, this was seen as an achievement by both staff and respondents. Employment staff said that it was, however, very difficult to convince employers that blind people could be as capable as those with sight. In order to encourage employers, a scheme was introduced in July 1977, providing a weekly contribution to the employer for six weeks when they accepted a disabled employee on trial. Employers can also be given grants for equipment and conversions. All companies employing more than twenty staff are legally required to employ a three per cent quota of disabled people, under the Disabled Persons (Employment) Act (1944). In practice, it is a difficult regulation to enforce and several employment staff expressed the view that it was virtually impossible to prosecute erring employers. It is obviously difficult when someone with a disability is rejected by an employer, to prove that they were discriminated against solely due to their disability. In addition, employment personnel are reluctant to put pressure on employers; as a Disablement Resettlement Officer put it:

"We put a great deal of effort into building up good relations with employers, so when they only employ ten disabled people instead of fifty, we have to be grateful that they employ those ten ... any mention of enforcement of the scheme might put other possible employees in jeopardy."

Employment personnel said that they try to win over potential employers by suggesting that disabled employees are usually "more
productive than able-bodied ones". It might be argued that these claims, although seen by personnel as positive, only leads to further stereotyping of disabled people. However, many of the respondents did say that they made great efforts to be efficient employees, feeling that if they were frequently absent, or low in productivity, this would be blamed on their blindness.

Employment personnel stated that where possible, they try to convince employers that the newly blinded person may be able to remain in their original employment, or perhaps be offered alternative employment within the organisation. (Grants and aids are available to assist this reinstatement.) They stress that the advantages are familiarity with the company's routines, and savings on recruiting and training expenses. Employment personnel suggested, however, that reinstatement is likely to depend on how "good" the employee has been at the previous job, the length of employment with the company, the type of work available, and whether the employee can cope with this work.

It was suggested by employment personnel that blind people face particular problems in gaining employment. As one B.P.R.O. put it:

"They face enormous obstacles - people think that blind people can't do anything, it's hard convincing employers that they can."

Two-thirds of the working age blind are unemployed, and employment personnel suggest that this is likely to rise due to general employment problems. In the present study, twenty-nine people were in employment, eleven unemployed, and two were housewives.
In the previous chapter, the control of the rehabilitation passage by agents was discussed. It was shown that, to a large extent, these agents can dictate the types of employment blind people can obtain; that is, they offer training for about half a dozen 'traditional' occupations. Those who accept the training and are placed in employment by agencies are likely to have a smoother employment passage than those who wish to compete for 'open' employment. Where control is held by agents they will select a 'suitable' occupation and arrange training, for example, if a geographical area has light engineering companies, a newly blinded male is likely to be advised to train as a lathe operator, whatever his previous occupational experience.

Those who do not accept the advice and retraining offered by these agencies, either because they have no needs, or because they do not wish to be trained for these 'traditional' occupations, generally have to shape their own passages, and often negotiate a solo passage.

**Occupational Mobility**

The following table gives details of the occupations held by the sample at the time of interview; it also gives details of sex, age, marital status, degree of sightedness, and previous employment.
<table>
<thead>
<tr>
<th>CATEGORY OF PRESENT EMPLOYMENT</th>
<th>NAME</th>
<th>SEX</th>
<th>AGE</th>
<th>MARITAL STATUS</th>
<th>LEVEL OF SIGHT</th>
<th>AGENCY CONTACT</th>
<th>PREVIOUS OCCUPATION</th>
<th>PRESENT OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RETAINED</td>
<td>Hawkins</td>
<td>M</td>
<td>39</td>
<td>M</td>
<td>3</td>
<td>/</td>
<td>Personnel Manager</td>
<td>Head of Personnel Dept.</td>
</tr>
<tr>
<td></td>
<td>Johnson</td>
<td>M</td>
<td>45</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Teacher</td>
<td>Teacher</td>
</tr>
<tr>
<td></td>
<td>Massey</td>
<td>F</td>
<td>36</td>
<td>M</td>
<td>3</td>
<td>x</td>
<td>Solicitor</td>
<td>Solicitor</td>
</tr>
<tr>
<td></td>
<td>Mitchell</td>
<td>M</td>
<td>30</td>
<td>M</td>
<td>3</td>
<td>x</td>
<td>Tobacconist</td>
<td>Tobacconist (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Williams</td>
<td>M</td>
<td>56</td>
<td>M</td>
<td>1</td>
<td>x</td>
<td>Accounts Manager</td>
<td>Recreational &amp; Sports Manager</td>
</tr>
<tr>
<td></td>
<td>Cole</td>
<td>M</td>
<td>45</td>
<td>M</td>
<td>3</td>
<td>/</td>
<td>Senior Manager</td>
<td>Electronics Consultant (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Connelly</td>
<td>M</td>
<td>43</td>
<td>M</td>
<td>2</td>
<td>/</td>
<td>Office Supervisor</td>
<td>Grocer (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Berry</td>
<td>M</td>
<td>39</td>
<td>M</td>
<td>3</td>
<td>x</td>
<td>Printer</td>
<td>Wood Sculptor (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Jones</td>
<td>M</td>
<td>51</td>
<td>M</td>
<td>3</td>
<td>x</td>
<td>Legal Clerk</td>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
<td>Elderfield</td>
<td>M</td>
<td>44</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Accountant</td>
<td>Insurance Broker (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>McCarthy</td>
<td>M</td>
<td>38</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Salesman</td>
<td>Export Sales Manager</td>
</tr>
<tr>
<td></td>
<td>Morris</td>
<td>M</td>
<td>40</td>
<td>S</td>
<td>2</td>
<td>x</td>
<td>Quantity Surveyor</td>
<td>Lecturer</td>
</tr>
<tr>
<td></td>
<td>Sims</td>
<td>M</td>
<td>51</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Carpenter</td>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
<td>Austin</td>
<td>F</td>
<td>24</td>
<td>S</td>
<td>3</td>
<td>/</td>
<td>Clerical Worker</td>
<td>Telephonist</td>
</tr>
<tr>
<td></td>
<td>Bates</td>
<td>F</td>
<td>37</td>
<td>M</td>
<td>2</td>
<td>/</td>
<td>Nurse</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td></td>
<td>Blackman</td>
<td>F</td>
<td>40</td>
<td>M</td>
<td>1</td>
<td>/</td>
<td>Shop Assistant</td>
<td>Audio Typist</td>
</tr>
<tr>
<td></td>
<td>Chambers</td>
<td>M</td>
<td>60</td>
<td>S</td>
<td>1</td>
<td>/</td>
<td>Dustman</td>
<td>Basket Maker (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Davenport</td>
<td>M</td>
<td>31</td>
<td>S</td>
<td>3</td>
<td>/</td>
<td>Salesman</td>
<td>Computer Programmer</td>
</tr>
<tr>
<td></td>
<td>Edwards</td>
<td>M</td>
<td>48</td>
<td>M</td>
<td>1</td>
<td>/</td>
<td>Maintenance Engineer</td>
<td>Basket Maker (Self-employed)</td>
</tr>
<tr>
<td></td>
<td>Fellows</td>
<td>M</td>
<td>54</td>
<td>M</td>
<td>3</td>
<td>/</td>
<td>Van Driver</td>
<td>Lathe Operator</td>
</tr>
<tr>
<td></td>
<td>Franklin</td>
<td>M</td>
<td>51</td>
<td>M</td>
<td>1</td>
<td>/</td>
<td>Army Captain (Turkish)</td>
<td>Lathe Operator</td>
</tr>
</tbody>
</table>

(cont. over page)
<table>
<thead>
<tr>
<th>CATEGORY OF PRESENT EMPLOYMENT</th>
<th>NAME</th>
<th>SEX</th>
<th>AGE</th>
<th>MARITAL STATUS</th>
<th>LEVEL OF SIGHT</th>
<th>AGENCY CONTACT</th>
<th>PREVIOUS OCCUPATION</th>
<th>PRESENT OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRADITIONAL</td>
<td>Ludlow</td>
<td>F</td>
<td>25</td>
<td>S</td>
<td>1</td>
<td>x</td>
<td>Garage Attendant</td>
<td>Telephonist</td>
</tr>
<tr>
<td></td>
<td>Marlow</td>
<td>M</td>
<td>36</td>
<td>S</td>
<td>1</td>
<td>✓</td>
<td>Store Buyer</td>
<td>Audio Typist</td>
</tr>
<tr>
<td></td>
<td>Matthews</td>
<td>F</td>
<td>32</td>
<td>S</td>
<td>1</td>
<td>✓</td>
<td>Undergraduate - History</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td></td>
<td>Phillips</td>
<td>M</td>
<td>30</td>
<td>M</td>
<td>1</td>
<td>✓</td>
<td>Farm Labourer</td>
<td>Lathe Operator</td>
</tr>
<tr>
<td></td>
<td>Purvis</td>
<td>F</td>
<td>22</td>
<td>S</td>
<td>2</td>
<td>✓</td>
<td>Unemployed</td>
<td>Audio Typist</td>
</tr>
<tr>
<td></td>
<td>Rogers</td>
<td>M</td>
<td>42</td>
<td>M</td>
<td>1</td>
<td>✓</td>
<td>Chargehand</td>
<td>Assembler</td>
</tr>
<tr>
<td></td>
<td>Stafford</td>
<td>M</td>
<td>28</td>
<td>S</td>
<td>2</td>
<td>✓</td>
<td>Graphic Artist</td>
<td>Piano Tuner</td>
</tr>
<tr>
<td></td>
<td>Wright</td>
<td>M</td>
<td>36</td>
<td>D</td>
<td>3</td>
<td>✓</td>
<td>Television Engineer</td>
<td>Assembler</td>
</tr>
<tr>
<td></td>
<td>Brewer</td>
<td>M</td>
<td>28</td>
<td>M</td>
<td>3</td>
<td>✓</td>
<td>Local Government Clerk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Downes</td>
<td>M</td>
<td>41</td>
<td>D</td>
<td>1</td>
<td>✓</td>
<td>Driver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fuller</td>
<td>M</td>
<td>53</td>
<td>D</td>
<td>2</td>
<td>x</td>
<td>Manager - Production</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hall</td>
<td>M</td>
<td>45</td>
<td>D</td>
<td>3</td>
<td>x</td>
<td>Packer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harris</td>
<td>M</td>
<td>24</td>
<td>S</td>
<td>2</td>
<td>✓</td>
<td>Gas Fitter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>M</td>
<td>56</td>
<td>M</td>
<td>3</td>
<td>x</td>
<td>Ferry Pilot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oakley</td>
<td>M</td>
<td>50</td>
<td>M</td>
<td>3</td>
<td>✓</td>
<td>Electrician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roberts</td>
<td>M</td>
<td>36</td>
<td>D</td>
<td>2</td>
<td>✓</td>
<td>Civil Engineer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Simmons</td>
<td>F</td>
<td>27</td>
<td>S</td>
<td>3</td>
<td>✓</td>
<td>Teacher</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stevens</td>
<td>M</td>
<td>32</td>
<td>S</td>
<td>2</td>
<td>✓</td>
<td>Librarian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thomas</td>
<td>M</td>
<td>57</td>
<td>M</td>
<td>1</td>
<td>x</td>
<td>Lorry Driver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clayton</td>
<td>F</td>
<td>55</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Housewife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walsh</td>
<td>F</td>
<td>50</td>
<td>M</td>
<td>2</td>
<td>x</td>
<td>Housewife</td>
<td></td>
</tr>
</tbody>
</table>

Explanation of Categories:

Sex:  
M = Male  
F = Female

Marital Status:  
S = Single  
D = Divorced  
M = Married

Level of Sight:  
1 = Total Loss  
2 = Light/Dark Perception  
3 = Reading Ability

Agency Contact (occupational retraining/assistance):  
✓ = yes  
X = no
In order to assess the occupational mobility of the sample, the Goldthorpe and Hope (1974) Social Grading of Occupations scale was used. This scale was developed from a study involving the grading of occupations in terms of "prestige" or "social standing". The following table shows the occupational mobility of males.

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Scale Value of Previous Occupation</th>
<th>Mobility*</th>
<th>Scale Value of Present Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Berry</td>
<td>37.60</td>
<td>D</td>
<td>32.61</td>
</tr>
<tr>
<td>2. Brewer</td>
<td>69.14</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>3. Chambers</td>
<td>18.36</td>
<td>U</td>
<td>41.18</td>
</tr>
<tr>
<td>4. Cole</td>
<td>66.11</td>
<td>U</td>
<td>73.06</td>
</tr>
<tr>
<td>5. Connelly</td>
<td>56.95</td>
<td>D</td>
<td>38.96</td>
</tr>
<tr>
<td>6. Davenport</td>
<td>39.85</td>
<td>N/A</td>
<td>**</td>
</tr>
<tr>
<td>7. Downes</td>
<td>27.23</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>8. Edwards</td>
<td>50.90</td>
<td>D</td>
<td>41.18</td>
</tr>
<tr>
<td>9. Elderfield</td>
<td>76.29</td>
<td>D</td>
<td>69.56</td>
</tr>
<tr>
<td>10. Fellowes</td>
<td>27.23</td>
<td>U</td>
<td>35.55</td>
</tr>
<tr>
<td>11. Franklin***</td>
<td>-</td>
<td>N/A</td>
<td>35.55</td>
</tr>
<tr>
<td>12. Fuller</td>
<td>66.11</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>13. Hall</td>
<td>62.19</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>14. Harris</td>
<td>61.14</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>15. Hawkins</td>
<td>76.29</td>
<td>S</td>
<td>76.29</td>
</tr>
<tr>
<td>16. Johnson</td>
<td>65.85</td>
<td>S</td>
<td>65.85</td>
</tr>
<tr>
<td>17. Jones</td>
<td>39.85</td>
<td>U</td>
<td>61.14</td>
</tr>
<tr>
<td>18. March</td>
<td>65.85</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>19. Marlow</td>
<td>52.80</td>
<td>D</td>
<td>34.62</td>
</tr>
<tr>
<td>20. McCarthy</td>
<td>39.85</td>
<td>U</td>
<td>62.19</td>
</tr>
<tr>
<td>21. Mitchell</td>
<td>38.96</td>
<td>S</td>
<td>38.96</td>
</tr>
<tr>
<td>22. Morris</td>
<td>76.29</td>
<td>D</td>
<td>61.14</td>
</tr>
<tr>
<td>23. Oakley</td>
<td>50.90</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>24. Phillips</td>
<td>31.49</td>
<td>U</td>
<td>35.55</td>
</tr>
<tr>
<td>25. Roberts</td>
<td>70.92</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>26. Rogers</td>
<td>50.90</td>
<td>D</td>
<td>35.55</td>
</tr>
<tr>
<td>27. Sims</td>
<td>43.25</td>
<td>U</td>
<td>61.14</td>
</tr>
<tr>
<td>28. Stafford</td>
<td>32.61</td>
<td>U</td>
<td>41.18</td>
</tr>
<tr>
<td>29. Stevens</td>
<td>70.92</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>30. Thomas</td>
<td>27.23</td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td>31. Williams</td>
<td>62.19</td>
<td>S</td>
<td>62.19</td>
</tr>
<tr>
<td>32. Wright</td>
<td>54.12</td>
<td>D</td>
<td>35.55</td>
</tr>
</tbody>
</table>

* D = Downward mobility  U = Upward mobility  S = Static
** Computer Programmer; not graded by Goldthorpe & Hope
*** Turkish Army Captain
Table 10 shows that, of those who were in employment at time of interview, four males retained their previous occupational status; eight lowered their status; and eight increased their status. However, it should be said that these changes were slight in a number of cases. The most significant decreases in status were those of Rogers (50.90 to 35.55) and Wright (54.12 to 35.55). The most significant increases were those of Jones (39.85 to 61.14) and Sims (43.25 to 61.14). Both these men were social workers.

The occupation of computer programmer was not graded in the scale; however, the respondent had previously been a salesman and regarded his new occupation as equivalent in status. In addition, one respondent had been a Turkish army captain, and thus this occupation was not graded; in this case, the respondent regarded his new occupation as a lathe operator as being lower in status.

In some cases the ratings should be interpreted with caution. For example, it would seem that Chambers had increased his status from 18.36 to 41.18. His previous occupation was as a dustman and he became a basket maker. It may be, however, that this 'traditional' blind occupation is not as highly rated as the scale suggests. Furthermore, one respondent, Morris, appeared to have a drop in status, 76.29 to 61.14, but the respondent regarded the occupation of lecturer as equivalent in status to that of quantity surveyor, the occupation he had previously-held. Ten males were unemployed at time of interview and thus had experienced a decrease in status.
Table 11
Occupational Mobility
Females

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Scale Value of Previous Occupation</th>
<th>Scale Value of Present Mobility</th>
<th>Scale Value of Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Austin</td>
<td>34.62 D</td>
<td></td>
<td>27.10</td>
</tr>
<tr>
<td>2. Bates</td>
<td>61.14 S</td>
<td></td>
<td>61.14</td>
</tr>
<tr>
<td>3. Blackman</td>
<td>34.62 S</td>
<td></td>
<td>34.62</td>
</tr>
<tr>
<td>4. Clayton</td>
<td>Housewife</td>
<td></td>
<td>Housewife</td>
</tr>
<tr>
<td>5. Ludlow</td>
<td>18.36 U</td>
<td></td>
<td>27.10</td>
</tr>
<tr>
<td>6. Massey</td>
<td>76.29 S</td>
<td></td>
<td>76.29</td>
</tr>
<tr>
<td>7. Matthews</td>
<td>Student N/A</td>
<td></td>
<td>61.14</td>
</tr>
<tr>
<td>8. Purvis</td>
<td>Unemployed N/A</td>
<td></td>
<td>34.62</td>
</tr>
<tr>
<td>9. Simmons</td>
<td>Housewife</td>
<td></td>
<td>Housewife</td>
</tr>
</tbody>
</table>

The above table shows that three females retained their previous status; one female had slightly decreased her status, while one female had slightly increased hers. One respondent was unemployed and also experienced a decrease in status. Two of the respondents retained their previous status as housewives. One of the respondents was unemployed, and one a student when sight was lost, thus mobility cannot be measured accurately; however, both regarded gaining employment as upward mobility.

By using this scale, and considering the respondents' own views of mobility, eleven respondents retained their status, eleven increased their status, and twenty decreased their status.

It has been suggested by previous research that downward social mobility is inevitable after blindness, or other disablement occurs (Sainsbury, 1970; Fitzgerald, 1970; Hilbourne, 1972; Abel (1976) and Blaxter, 1976). In particular, both Hilbourne and Abel found
that as sight deteriorated there was a transfer to less demanding occupations, and thus lower status occupations. It would seem that the present findings go some way to support this in that almost half the sample reduced their occupational status; and a quarter were unemployed.

Although the Goldthorpe and Hope (1974) scale does provide a useful indicator of occupational status, it does not fully convey the occupational changes which were experienced by the respondents. It was thus preferable to examine the categories of employment that were obtained by respondents, that is, whether they were able to retain the employment they previously held, whether they gained traditional employment for the blind, or non-traditional employment, or whether they regained any employment.

**Retained Employment**

Retaining the employment which was held prior to blind registration had been the goal of twenty-nine of the respondents at the time of registration. However, only eight did initially retain previous occupations, and five were with the same organisation at time of interview.

Four of those who had continued to be retained were in professional and managerial positions; these were a teacher, solicitor, senior manager, and head of a personnel department. The fifth respondent in this group was self-employed as a tobacconist.

Of this group, two of the respondents had sought occupational
assistance from agencies; this was mainly for advice on how to cope with the existing occupation.

The retention of employment will depend on the following: 1) the attitude of the employer; 2) the type and size of company, and whether, if the previous occupation cannot be continued, there are suitable alternatives; 3) the 'value' of the employee, dependent on qualifications, experience, and length of time with the company; 4) the nature of the tasks involved; 5) the nature of the eye condition: rate of onset and whether prolonged absence results; and 6) the attitude and motivation of the employee.

The four respondents who were employees had been with their organisations for an average of eleven years. This, combined with their qualifications and experience, encouraged their employers to retain them. For example:

"I wasn't a partner when I lost my sight but I'd been with the practice for several years, and I think I was felt to be valuable enough to keep on." (Ms. Massey, solicitor)

"Because I'd been there for eight years teaching in a boy's grammar school the Head knew my work, and gave me every assistance." (Mr. Johnson)

The other respondent in this group, Mr. Hawkins, not only retained his employment, but received promotion eighteen months after he registered as blind. He had previously been employed as a personnel manager:

"I had been with the company for so many years, I expected to be promoted long before I became registered as blind ... I had so many problems ... so much treatment, that it was probably delayed because of this ... No-one, least of all myself, could see any reason why I shouldn't run the department." (He became head of
Although it may be impossible to continue in some previously-held occupations due to both the extent of visual loss and the nature of the tasks, an alternative job may be offered. For example:

"I couldn't carry on working as accounts manager - it was essential to be able to look at the figures ... when I still had some vision, I did continue with a magnifying glass ... when I lost my sight totally, I had to give up the job." (Mr. Williams)

While Mr. Williams was receiving extensive treatment on his eyes, his employers "created a job" for him.

"It was a sideways move really - I don't feel I've dropped my status at all ... In fact, I enjoy being recreational and sports manager more because I've got to know everyone in the company."

Mr. Hawkins was one of the respondents in this group who sought occupational assistance from an agency:

"At one point they (medical personnel) thought my sight would go completely so I contacted the R.N.I.B. to see what sort of job I could do if I became totally blind ... They thought I could continue with my job even if I was 'total' ... We (the R.N.I.B. employment officer, the then head of department, and Hawkins) sat down to work out how I could cope ... Luckily I have kept my ability to read."

Another respondent, Mr. Mitchell, did approach the R.N.I.B. to obtain advice on how he could continue with his business as a tobacconist, but he

"... received no help at all ... They were useless, all they kept on about was that I could get a wireless for the blind ... Even though I was registered, they suggested that I call them again when my sight got worse - cheerful thought, wasn't it?"

One of the ways that employment can be lost is through the often lengthy treatment of the eye condition. Mr. Williams felt that his employers had been "very sympathetic" and "tolerant" when he was unable to work for two "extensive periods" (sixteen months in
Another respondent who received extensive treatment, Mr. Johnson, a teacher, said he tried, if possible, to fit his treatment into school vacations.

"Eventually I had to give in to the idea of becoming blind, but I was offered a couple of operations which might slow down the process ... I was lucky enough to enter hospital at the end of the summer term and returned again in the autumn. In fact, I've hardly missed any school; I think the Head appreciated this."

Mr. Johnson said that his continued attendance may have influenced the Head's decision to retain him.

There did not seem to be any relationship between the degree of sightedness and retention. The respondents who retained employment had varying degrees of sightedness, from total blindness to reading ability. However, all said that they received, in varying degrees, sighted assistance. Three of the respondents had secretaries, but, like the other two respondents, also obtained help from their spouses (all five were married).

A common characteristic among this group was that they all said they were determined to hold on to their occupations, and as one respondent said: "fought to minimise the disruption to my life" (Mr. Williams).

Certainly retaining employment means that there is likely to be minimal disruption as previous status and roles are held; thus self-esteem is likely to be retained.
Non-traditional Employment

If previously-held employment cannot be retained, a suitable alternative is to gain 'open' employment, that is, employment gained in competition with the able-bodied. This non-traditional employment was obtained by eight respondents, however, four of these were self-employed.

This group had previously been employed in professional, managerial and intermediary, non-manual, and skilled occupations.

Of the eight respondents, three sought occupational assistance from agencies.

Gaining non-traditional employment will depend on similar criteria to that which applied to retaining employment. That is, employers' attitudes, the experience and qualifications of the individual, the tasks involved, and the motivation of the individual, are all important. Another important factor is whether the individuals can resist the control of agencies who try to guide them into traditional employment.

The respondents were all asked about the degree of satisfaction they had with their employment. Those who were self-employed suggested that it was necessary for them to form their own businesses in order to gain satisfaction from work. All four respondents in this self-employed group had experienced difficulties in gaining other employment. The following
illustration is of a respondent who had been in a senior managerial position when he lost his sight. Mr. Cole said that he "did a very silly thing" in that while receiving medical treatment, he resigned from his company.

"After a few months I began to regret giving up my job; I decided to contact them (his employers) and ask if they could take me back. They were very polite, but said that the job had been filled ... Altogether I'd been unemployed for a year before I decided I must pull myself together ... I was 38, which made it more difficult, it was impossible to find anything suitable ... I then thought the best thing was to become self-employed - I'd had a lot of experience in the electronics field so I put it to good use."

Another respondent, Mr. Connelly, had been an office supervisor, but said that after applying for "hundreds" of jobs, "ended up in the grocery business". He was satisfied with this work, but he said he had considerable difficulty in gaining it. He said that his major problem had been persuading the bank manager to extend credit to him: "I know it was due to the blindness". Mr. Connelly felt that the bank manager held stereotyped views about the blind, believing them to lack any abilities and this led to a reluctance to lend money.

Mr. Cole and Mr. Connelly had both sought assistance from the R.N.I.B. and M.S.C., but had found the advice they received unsatisfactory. Mr. Cole regarded the advice given by R.N.I.B. staff that he train as a lathe operator, as "ridiculous". He felt that this was below his capabilities and his occupational status. He said that he was an "ambitious man" and had set himself goals which he knew he would eventually achieve.
Mr. Connelly suggested that the advice given to him was "demoralising". He was advised to train as a typist:

"I had held a position of authority and had no wish to become a subordinate - it didn't seem right ... I just couldn't do it, I would rather have done nothing than become just a typist ... I then went to the Employment. The B.P.R.O. was quite helpful ... he suggested an alternative might be to set myself up in business ... he'd known a couple of blind chaps do that."

The other two respondents who became self-employed were working as a wood sculptor and an insurance broker, and both derived satisfaction from self-employment.

The respondents who had gained non-traditional employment on the 'open market' were all satisfied with their employment. The first of these, Mr. Sims, had been a carpenter at the time he lost his sight, but eventually gained employment as a social worker.

"If I hadn't lost my sight I'd never have thought of taking up social work. I enjoy the social contact - I didn't have much of that in my previous job - I enjoy helping other people with their problems. I suppose this in itself puts my condition into perspective."

Mr. Sims' employment passage had been a difficult one with long periods of unemployment. He said that during these periods he had been despondent, but "pressed on" to gain work because of "self-esteem, my family, and my 'bloodymindedness' ". Mr. Sims had not contacted the agencies for occupational advice, even though he did experience difficulties; he said that he preferred to "muddle through" on his own.

Another respondent, Mr. McCarthy, decided not to seek occupational advice and retraining because he had "heard what it was like from a friend"; the R.N.I.B. rehabilitation centre was described to him as
being "like Butlins, but that's not funny when you want help to find a job". He also experienced a long period of unemployment. Mr. McCarthy said that he would rather be unemployed than take "something unsuitable". He had been employed as a salesman when he lost his sight:

"I thought they (employment agencies) would suggest engineering, but I had absolutely no interest in that. I thought if I was trained, I'd be pigeon-holed. Anyway, during the two years of unemployment I became quite depressed ... it didn't really sort itself out until I became employed again. I thought I was on the scrap-heap."

With "reluctance", Mr. McCarthy then learned to type and obtained employment. After a few months he became a supervisor, and eventually, an export manager. He said that he had been fortunate in joining a company that recognised his capabilities.

Like most of the respondents in his group, Mr. McCarthy made numerous applications when job seeking, but with little success.

"Most people ignored the letters - in the end I resorted to omitting the fact that I was blind - I was offered a couple of interviews, but when they found out I was blind, they didn't want to know."

The employment passage may not be a smooth one, people may experience some reversibility, that is, periods of both employment and unemployment. The following example of a respondent who was in non-traditional employment illustrates this reversibility, but also points out the psychological benefits of retaining a job after blind registration.

Mr. Jones had been able to retain his employment as a legal clerk after he registered as blind.
"All the staff, and the clients rallied round ... I rehabilitated them ... instead of my reading through legal documents, the clients read them to me."

Mr. Jones remained in this occupation for seven years after registration. For various reasons he wanted to change employment and was advised by the R.N.I.B. to train as a computer programmer. Mr. Jones was the only respondent in this group who accepted advice from an agency. He did train, but despite applying for forty-two jobs, he was unable to find employment.

Mr. Jones was then unemployed for four years, however, he said that:

"... being unemployed later wasn't so bad. I knew I was capable of doing a job ... if I'd been unemployed straightaway I would have been knocked for six."

Eventually Mr. Jones became a vocational officer, once again, with the assistance of the R.N.I.B., and at the time of interview was employed as a social worker.

In this group, the level of sightedness ranged from light and dark perception to reading ability. Seven were married, and four of these obtained regular sighted assistance from their spouses to carry out their occupations. One respondent who was unmarried and who was employed as a lecturer, obtained regular sighted assistance from a sister, and occasionally from colleagues.

Although most of the respondents in this group had experienced difficulties in negotiating their employment passages, they were all highly motivated to obtain non-traditional employment. They had all set themselves goals to try to retain their previous
occupational status and gain employment to match their capabilities. This they all did. Gaining non-traditional employment helped them to retain self-esteem, in that they were carrying out work which was usually done by the able-bodied, thus giving them the opportunity to retain 'normal' status.

**Traditional Employment**

Traditional employment covers a range of occupations from basket making to physiotherapy. Sixteen of the respondents were in this group. They had all lost their previous occupations around the time of registration. These occupations were non-manual, semi-skilled, and unskilled.

All but one of this group had been involved with agencies within a year of registration. All fifteen had accepted the guidance of these agencies.

All respondents were asked about the degree of satisfaction with their occupations; most respondents were satisfied, but it depended on the type of occupation. The most satisfied were those holding professional occupations as physiotherapists.

One of the most traditional forms of employment for the blind is basket making. In the present study, two people were self-employed basket makers, and a further respondent was being trained. They were employed under the 'home industries' scheme; these schemes are organised by local authorities or voluntary associations. The Manpower Services Commission provides the financial resources for
running the schemes, providing equipment and working accommodation, and the local authority provides cash payments to augment the home workers' earnings. Although self-employed, once in this occupation, individuals have little say in what they produce, or on their outlets. They are, however, able to work at their own pace.

All three respondents were guided into this employment by the R.N.I.B. Two of the respondents were previously unskilled, while the third was semi-skilled. All of these respondents felt that there was little opportunity for blind people in open employment and thus, were pleased to be offered any type of employment.

The two respondents already employed in this industry found it fairly satisfying, although one, Mr. Edwards, found it isolating and said that he would "prefer to work with other people". He said he therefore made great efforts to meet others, belonging to two self-help groups, and two voluntary associations.

The other respondent, Mr. Chambers, said that he actually preferred working alone and enjoyed the "freedom" of self-employment. He had been blind for almost forty years, and said:

"You can work at your own pace at home. I worked in a workshop for two years (18 years previously) but there was more pressure there ... here it's up to me how much I do - if I don't work, I don't get paid."

Another traditional occupation is piano tuning. One respondent, Mr. Stafford, who was previously a graphic artist, retrained as a piano tuner. He was "very disappointed" to give up his profession, but as a keen musician "piano tuning was a good alternative". He felt,
however, that it did not match his previous occupational status. He suggested that "blind people have to make compromises and accept what is offered to them".

Other common occupations for the blind are lathe operating and light assembly. As was discussed in the previous chapter, this employment was frequently suggested to newly blind males attending the R.N.I.B's Centre. There were three respondents who were lathe operators and two who were assemblers. Their previous occupations ranged from skilled manual to unskilled. Of the five respondents, four felt "quite satisfied" with this employment. For example, the following respondent had been a van driver:

"I'm lucky to have a job, so I'm not going to knock it. I miss driving, but I quite enjoy being with my mates, it makes up for the monotony of the job." (Mr. Fellowes)

Another respondent said:

"There's not much a blind person can do, but lathe operating is something you can do the same as a sighted person ... I've been told I'm better than some sighted, by my foreman ... I've got a skill now, I used to be a labourer on a farm." (Mr. Phillips)

The respondent who did feel unsatisfied with his employment had previously been a chargehand, and supervised a number of staff. Mr. Rogers became an assembler because he, and the employment agencies, said there was no alternative. His dissatisfaction largely arose from the belief that he could still supervise staff, but had "not been given the opportunity". He regarded his present employment as being "too low grade".

There were six respondents in commercial occupations, all females.
Four had previously been in non-manual occupations, one was in an unskilled occupation, and one unemployed. All but one expressed satisfaction at obtaining employment.

The respondent who expressed dissatisfaction, suggested that her employment prospects had been curtailed by her blindness. She was employed as a clerical worker in a local government department at the time of registration, and said that she had anticipated good career progression. However, when she lost her sight she was advised by the R.N.I.B. to become a telephonist. Although she was able to read with aids, she said that her previous employer did not think that she "could cope with the job", and she did not try to persuade him otherwise.

A further traditional occupation for the blind is physiotherapy (there is a training centre for the blind run by the R.N.I.B.). There were two physiotherapists in the sample, and of all those in traditional employment, appeared to be the most 'happily' established and very satisfied with their employment.

One of the respondents had been an undergraduate prior to registration, while the other had previously been a nurse. When the latter respondent, Mrs. Bates, became registered as blind, it seemed to both her and the R.N.I.B. that physiotherapy was a "natural progression". Ms. Bates had one of the least complicated employment passages. After she lost her sight she had to give up her job, and was unemployed for three months; however, she was aware for two of these months that she would become a
physiotherapist.

"I'm sure that the knowledge that I could be re-trained helped me considerably. The R.N.I.B. were marvellous, helpful and reassuring when I needed it. Of course, I was upset at losing my job, and of course, my sight, although I thought that eye problems would occur, there is a history in the family ... My husband thought I might like to remain at home, but I've never been much of a housewife ... I feel I've been lucky, I do enjoy my work, although of the two I'd rather be nursing."

Only one of the respondents carrying out a traditional occupation obtained this employment without the assistance of agencies. Ms. Ludlow was employed as a garage attendant when she lost her sight, and it was at her employer's suggestion that she was retained as a telephonist. (She taught herself to use the switchboard, with a colleague's assistance.)

Those in traditional employment had varying degrees of sightedness, and thus this appeared to have no influence on employment outcomes. The majority of those respondents received some sighted assistance with everyday living, but little to carry out their occupations.

It can be seen from the occupations held by this group that wider employment patterns are reflected. That is, the males were guided into light engineering, whereas the females were advised to take up commercial and 'caring' occupations.

It has been pointed out that this group had previously held non-manual, semi-skilled, and unskilled occupations. This is likely to have influenced their acceptance of traditional forms of employment. Indeed, for some there had been little change in occupational status, and most expressed feelings of satisfaction.
about their employment.

The majority of these respondents had accepted the guidance given to them by agencies. They were generally pleased that they had been assisted to find any form of work. Because the work role is seen to be so valuable, gaining employment had aided this group's adjustment to blindness, as it had done for those in retained, and non-traditional employment.

**Unemployment**

Eleven of the respondents were unemployed at the time of interview, but only one of these had been unable to gain any work since registration. This group's previous occupational status ranged from professional to unskilled. Of these respondents, seven had received occupational assistance from agencies.

The reasons for the respondents inability to find employment fell into eight categories: 1) nature of job; 2) status retention; 3) employers' attitudes; 4) decline in traditional employment; 5) agency inadequacy; 6) market forces; 7) location; and 8) motivation.

1. **Nature of Job**

Lack of vision inevitably excludes individuals from carrying out certain occupations, and problems relating to the tasks involved were high on the list. For example, white collar and professional workers face communication difficulties. They may have to deal with large amounts of written communication, which a sighted person
could give a cursory glance to establish what is being conveyed. However, even when sighted assistance is given, it often proves to be a tedious task when the person reading the communication is unfamiliar with the area being discussed, and is unable to establish the essence quickly. Those in the higher echelons of management can usually have assistance in the form of a secretary or personal assistant, however, those lower down the scale may not 'merit' the appointment of a full-time reader. As was pointed out in earlier sections, these individuals may have to secure the assistance of a member of family to cope with employment.

Other occupations which had been held by the unemployed group, included a driver, ferry pilot, electrician, civil engineer, and librarian. All these jobs involved tasks which need a reasonable level of sightedness and therefore could not be continued when blindness occurred.

2. Status Retention

A further reason for difficulty in gaining employment was an unwillingness to retrain for occupations not matching those previously-held. The following respondent illustrates this reluctance.

When Mr. Fuller lost his sight he was employed as a production manager in a pharmaceutical company. His work had been "all important" to him, and after he lost his work, he felt he would never be "normal again". He was also very concerned about his material circumstances as his job had commanded a high salary, plus
perks, such as a car. Since his loss he said that his family had experienced financial hardship and the quality of his "life style had been diminished". Mr. Fuller did gain some employment eighteen months after his loss; this was supervisory, but he left because his "status was so much lower - I couldn't take it."

After two years of unemployment Mr. Fuller contacted agencies for help. However, he said:

"Rehabilitation training couldn't offer me anything ... if I'd been forced to work on the shop floor it would have made everything seem even worse ... I would have been really bitter ... I just couldn't see myself working on the shop floor, not after I'd held a managerial position."

Mr. Fuller said that he preferred to be unemployed, rather than accept a lower occupational status.

3. Employers' Attitudes

Employers' attitudes were seen by the respondents as presenting the greatest problem in their attempts to seek employment. Many of the respondents suggested that employers reflected public stereotypes about blindness and that employers were "prejudiced". The respondents said that many employers believe that individuals lose all their abilities and that they cannot envisage how a potential employee can cope without sight.

Respondents also suggested that employers believe that the blind employee would require too much assistance from sighted staff, and that this would cause unrest.
A further reason was that employers fear that the blind persons' safety would be at risk, for example they may not be able to escape easily if there was a fire.

Two respondents said that blind people were seen as a financial risk, particularly in small companies.

"Many employers don't realise that you can be healthy and blind ... they seem to think that you'll be off sick all the time. I was off 17 days in 20 years when I was employed." (Mr. Oakley)

"... they don't think you'll be able to work to full capacity ... but when you're blind you have to work that much harder to prove yourself ... You have to be better than 'normal' people." (Mr. Downes)

Rejections for jobs were usually seen in terms of blindness, rather than age, inappropriate qualifications, or other reasons. Both those who were unemployed at time of interview, and those in other groups, regarded the application form as a major barrier to re-employment. That is, whatever their previous experience and qualifications, the statement of blindness was likely to devalue this. Some respondents admitted that, at some time, they had omitted a declaration of their blindness after a succession of refusals. (These respondents thought that it might give them a fairer chance.) The respondents said that the response became more favourable when they did not provide information about their impairment.

However, when they were interviewed, the deliberate omission sometimes upset recruitment staff. For example, Mr. Brewer said that after he had written hundreds of letters he "resorted to omitting the fact that I was blind". He said that when he "turned
up to the interviews" he was often "rudely treated because I hadn't told the 'truth' ".

Frequently, respondents stated that employers didn't understand that they could still be capable after becoming blind.

"Lack of knowledge ... ignorance, they think if you can't see you don't have any sense." (Mr. Downes)

As far as safety was concerned, Mr. Downes said "...it's safer working in a factory, than crossing a busy road".

The belief that employers were reluctant to take on blind staff was supported by some of the rehabilitation and employment personnel. One said: "No-one wants to employ a blind person!" This employment officer felt that a major reason for their reluctance was that they did not want the "responsibility". As he said " 'blind' conjures up visions of people falling all over the place!" This, along with the other reasons cited above, makes it difficult for employment personnel to convince employers who have no experience of blindness, to take on blind staff.

4) Decline in Traditional Employment

Due to the rapid change in industrial technology, there is a decrease in demand for traditional occupations for the blind, for example, lathe operating and telephony. There is also considerable competition from foreign imports for craft industries, such as basket making. However, there are growing opportunities for blind people to become computer programmers.
5) Agency Inadequacy

It was suggested by the respondents that employment services for the blind tend to be remote. Although there is specialised provision offered by the M.S.C., there are only thirty-five Blind Persons' Resettlement Officers covering the whole of Britain. (There are 500 officers dealing with general disabilities.) The respondents felt that it was difficult for these officers to get to know their clients, or for them to build a relationship with potential employers. The R.N.I.B. also has a small number of employment officers, and these were seen as even more inaccessible by the respondents.

Employment staff did support the view that it was difficult to cover adequately such a large geographical area; however, the staff felt that they provided a valuable service to blind people.

The goal of these agencies is to place a person in employment; however, some respondents argued that placement was their only concern, rather than the quality or type of employment. Although the desire for employment was a common goal among the sample, eleven respondents felt that it was important to obtain work which had the same occupational status as that previously held. The agencies said that they were not simply concerned with placement but did try to meet the individual's goals, although opportunities for the employment of those without sight were limited. Employment officers did agree, however, that it was more difficult to place those who were in professional or highly-skilled occupations because they were often unwilling to be trained for the
'traditional' occupations more readily available to the blind.

6) Market Forces

At the time the sample was interviewed there was a considerable increase in general unemployment. Both respondents and employment personnel thought that this would hit blind, and other disabled, people badly. Several respondents felt that their chances of gaining work were becoming slimmer every day:

"When there are so many able-bodied on the market - they're not so interested in the disabled. In this area you get dozens of people after just one job." (Mr. Harris)

7) Location

The geographical location of the blind person's home can affect their employment chances. Many of those who were unemployed lived in areas where there was little industrial development. There was an unwillingness to move to other areas, and a reluctance to seek work which would involve difficult travel arrangements. Seven of the respondents who were unemployed said that they did not want the "domestic upheaval", and four of these thought it would be just as difficult to find employment in other areas.

8) Motivation

It was difficult to assess the level of motivation of these respondents. Many said that they remained unemployed for many of the reasons specified above. However, they all said that during the first two years (on average) after registration they were motivated to find work, but when they experienced a lack of success, this discouraged them. Most had obtained some work during their
It was proposed (in Chapter 2) that one of the effects of blindness was that occupational changes would take place. Of those studied, five respondents had continued to retain their previous employment; eight had obtained non-traditional occupations; sixteen had gained traditional employment for the blind; and eleven were unemployed. It can be seen then that changes in employment were experienced by the majority of the respondents, and that employment career was disrupted.

Functions of Work

It can be seen from some of the illustrations already given, that the work role performs a number of functions. As mentioned earlier in this chapter, Hayes and Nutman (1981) proposed seven main functions of work. These will be explored in the light of the findings from the present study.

1) Work provides an income

Hayes and Nutman suggest that if money were a sole motivation to work, individuals would cease working if their material needs were satisfied. In a study of attitudes towards work, Morse and Weiss
(1955) questioned four hundred men, asking whether they would continue to work if they inherited enough money to allow them to cease. They found that eighty per cent stated that they would continue to work. However, there were class differences: sixty per cent of those in middle class occupations would continue in their present occupations, whereas thirty-four per cent of manual workers wished to remain in theirs.

In the present study, the financial benefits of employment were not seen as a prime motive for gaining work, rather it was seen in terms of giving the respondents respectability. For example, phrases such as "wanting to earn an honest living" were used.

"I would rather work and earn £30 per week than sit at home and be kept." (Mr. Franklin)

Seven respondents specified that paid employment enabled them to comply with their obligations, for example:

"I was married, therefore I had a responsibility ..." (Mr. Elderfield)

However, none of the respondents saw income as the main reason for working.

2) Work fulfils a need for activity

Hayes and Nutman suggest that work provides an environment for activity. Morse and Weiss (1955) found that thirty-two per cent of people they studied felt that work kept them occupied (and interested), ten per cent stated that it was healthy for them to work, and ten per cent said that they would not know how to spend their time if they did not work. Neff (1968) found that the main reason why the disabled people he studied wished to work was that
they wanted to relieve inactivity and boredom.

In the present study, twenty-four respondents said that they needed work to be occupied. Seven of these respondents said that it was more important for blind people (and other disabled people) to be employed. They argued that able-bodied people could find activities outside of work, whereas the possibilities were more limited for the blind. Three respondents said that it was a 'duty' for society to provide work for the blind as a compensation for their loss of sight. Several respondents said that it would be "easy to become apathetic" or "give in to laziness", if they did not work. They also suggested that having to obtain work forced them to learn mobility skills, for example:

"I was still working when my sight became really bad - I got hold of a white stick and forced a colleague to come out with me and I found my way around my place of work ... I really taught myself, it was necessary if I was to carry on working." (Mr. Jones)

3) Work structures time

This is linked with the above. Hayes and Nutman state that the activity of work lends structure to both days and weeks and helps differentiate between weekends and holidays. They also suggest that it provides a "timetable for progressing through a career" (p. 40). The people they interviewed found the loss of work disorientating because of this lack of structure. Even searching for work was seen as a way of developing a schedule for the day.

This was supported by the majority of respondents. As two respondents said:

"When I was unemployed I could see no point in getting
This lack of structure affected the careers of the unemployed, in that there were no specific stages to encounter, nor goals to be reached. For example, the following respondent felt that he was "drifting" through his life.

"You feel time passing, but nothing is happening to you." (Mr. Roberts)

Three of those who were unemployed at time of interview said that they had to force themselves to do certain activities at specific times during the day, as one said: "it gives you some sort of routine".

4) Work is a creative activity

Hendrick (1943) proposes that people wish to work so that they can use their "muscular and intellectual tools". He feels that there is a "work principle", that is, satisfaction can be derived from the efficient use of the central nervous system which enables the individual to have control over his or her environment. Neff (1968) and Hayes and Nutman stated that work can satisfy the need to create, or master part of the environment.

It could be argued, however, that many occupations do not allow creativity and mastery over an environment. Certainly, some of the occupations held by the respondents were seen as tedious and repetitive, but those who carried out these tasks, still derived some sense of achievement. Those who had previously held professional and skilled occupations did, however, try to retain or
obtain employment which gave them satisfaction from the actual tasks carried out. However, whatever the type of occupation held by the respondents, employment was highly valued, and thus seen as an end in itself.

5) Work facilitates social interaction

The workplace provides the opportunity for social contact. Herzberg, et al (1957) reviewed fifteen studies involving 28,000 workers. The most frequently mentioned aspect of work which provided satisfaction was the "social aspect of the job". Morse and Weiss (1955) also found this in their study.

Almost three-quarters of the respondents studied said that social contact provided by work was a "very important" aspect of employment, although only five felt it to be the most important. Many of these respondents suggested that working prevented them from being isolated, and that it enabled them to be reintegrated into society. They saw it as an opportunity to be with able-bodied people. Those who were in employment often pointed out the benefits of this: "it keeps you in touch with what's going on" (Mr. Franklin); "you have to make an effort to consider others and not just yourself" (Ms. Blackman); "it's great when you're accepted by your work-mates" (Mr. Fellowes); and "it's such a social thing, going to work" (Mr. McCarthy).

6) Work is a source of identity

Hayes and Nutman state that work is seen as an indicator of status for both individuals, and their families. They suggest that paid
work acts as a source of independence, and that those who become unemployed will experience "identity strain".

This was seen as being the most important function of work by those studied. This was for a number of reasons: it gave a sense of self-esteem; it provided status; it provided the opportunity to prove capabilities; it made them "feel normal"; and it gave independence. (This is further discussed later, and in Chapter 9.) As one respondent said:

"The worst time was when I didn't have a job ... I felt like I was on the scrap heap." (Mr. Rogers)

Employment diminishes the disabling effects of blindness, and helps the individual to become independent and thus overcome the blind role.

7) Work provides purpose to life

Hayes and Nutman state:

"A person's contribution to producing goods or providing services forges a link between the individual and the society of which he or she is a part." (1981, p. 43)

They suggest that those who are unable to work are likely to feel useless.

Certainly, in this study, the term "useless" was frequently used. Often the respondents said: "I don't want to be useless/We are seen as useless/I felt useless"; even if they regarded themselves as capable, they felt that sighted people did not. How much this is due to their blindness, and how much due to their loss of employment, is difficult to assess; however, it was apparent that
those who became re-employed had a higher level of self-esteem and that the work role had aided their adjustment.

As the above discussion shows, the work role was seen as an important one, and had a number of functions. In order of importance it: 1) was a source of identity, giving status, self-esteem, an opportunity to prove capabilities, and independence; 2) provided social contact; 3) satisfied a need to be occupied and structure time; and 4) provided an income.

It can be seen from the above discussion, that the work role was highly valued by those studied. Thus, those who remain unemployed are likely to experience various problems.

The Effects of Unemployment

Blaxter (1976) suggests that there is a correlation between disablement and downward mobility, and that there is a high proportion of disabled people who are unemployed. Amongst the blind it is two-thirds of the working age population.

It was stated in the foregoing section that the work role gives a sense of identity. People are often identified by their type of occupation in new encounters, and the question "what do you do", is usually an opening question. As Hayes and Nutman (1981) state:

"Knowledge of the occupational status of a person not only gives one cues as to how to relate to him or her, but often provides cues as to the content of the interaction." (p. 6)
Those who are both blind and unemployed may, therefore, experience a dual problem, in that both statuses have a negative evaluation.

The loss of the work role can affect the self-concepts of both the able-bodied and the blind. As Jahoda (1979) states:

"Employment also provides some definition of one's position in society, status and identity. Of course people may resent the particular status accorded to their particular job and try to change it. But this is different from having no defined position. The unemployed suffer not only from the absence of status but even more from an undermining of their sense of personal identity." (p. 313)

Those who become unemployed may follow a number of stages; for example, Eisenberg and Lazarsfield (1938) state:

"We find that all the writers who have described the course of unemployment seem to agree on the following points. First there is a shock, which is followed by an active hunt for a job, during which the individual is still optimistic and unresigned; he still maintains an unbroken attitude. Second, when all efforts fail, the individual becomes pessimistic, anxious, and suffers active distress; this is the most crucial state of all. And third, the individual becomes fatalistic and adapts himself to his new state but with a narrower scope. He now has a broken attitude." (p. 378)

That is, there is a transitional cycle involving shock, followed by optimism, leading to pessimism, and finally fatalism. Other writers also describe loss of employment as causing shock and many adverse effects on individuals (Briar, 1977; and Hayes and Nutman, 1981).

It is difficult in a study of this type to separate the effects of blindness and those of unemployment. It was stated (in Chapter 6) that most of those who become blind, experience shock; as they frequently lose their employment at this time, it is not easy to isolate to what degree the shock is caused by job loss. It was,
however, suggested by three respondents that losing employment was worse than losing sight. As one said:

"...it was a considerable blow to my self-esteem, I felt I'd never be able to do anything again." (Mr. Fuller)

Mr. Fuller also felt that his loss of employment had put additional strain on his marriage, and thus contributed to his marital breakdown.

Another respondent said:

"Losing my job was dreadful, disastrous, you don't realise how much your job is part of you ... People always ask you what you do for a living. Mind you, if you're blind you're not really expected to have a job ... I've got used to being blind, sometimes I even forget that I am, but being unemployed, I'll never get used to that." (Mr. Brewer)

A further respondent, who saw the loss of employment as being worse than blindness said that being unemployed made him feel "inferior":

"Sometimes I just can't face people. I know I'll never get a job and that my life is passing by ... Some blind people manage to keep working, but they're the lucky ones ... but me, well, I've lost a lot of my self-respect since I became unemployed. It's not just the blindness." (Mr. Hall)

The respondents who were unemployed said that they had been through varying stages: the order of these stages varied, but included: anger, disillusionment, bitterness, apathy, and resignation. All the respondents who were unemployed at time of interview suggested that they were resigned to being unemployed. The following respondent illustrates this resignation:

"I could cope with my blindness better when I was employed, I know that .. but it was really terrible being unemployed. I was terribly upset at first ... I became disheartened when I'd written dozens of
applications ... Yes, I've probably given up. I'm fed up with trying ... I'll just have to get some interesting hobbies ... I joined a self-help group, that helps." (Mr. Stevens)

This respondent, however, suggested that his blindness legitimated his unemployed status:

"It used to worry me being unemployed, but I don't think people can blame me. Most blind people can't get work."

Although there were degrees of resignation amongst the unemployed respondents, all of this group described the unemployed role as increasing the problems of blindness. Like many of the other respondents, the majority of this group regarded employment as being desirable, giving dignity and self-esteem to the individual, and providing a sense of purpose. There was a generally-held view that unemployment increased the isolation of blind (and other disabled) people, and emphasised their deviance from the rest of society. Those who were unemployed generally saw their blindness as disabling.

Summary

The occupational mobility of the sample was analysed using the Goldthorpe and Hope (1974) scale. This indicated that almost a quarter of the respondents retained their status, almost a quarter increased their status, and almost half decreased theirs. Because there were difficulties in analysing mobility in this way, it was found to be more effective to divide the employment outcomes into four categories: 1) the retention of previous employment; 2) the obtaining of non-traditional employment; 3) the gaining of traditional employment; and 4) unemployment. Five respondents
retained their occupations; eight gained non-traditional employment; sixteen gained traditional employment; eleven were unemployed; and two remained as housewives. Thus, employment changes occurred for the majority of respondents. The work role was seen as highly desirable by the majority of respondents, and those who were employed felt that it had contributed to their adjustment to blindness. On the other hand, those who were unemployed suggested that blindness was a considerable problem, and that it had caused a permanent disruption to their lives. Those who were in employment equal in status to that previously held were the most satisfied with their occupational outcomes. Those in traditional employment were generally happy to be employed, even if the work was not what they would previously have chosen. Those in traditional employment had mainly been guided by rehabilitation and employment agency personnel, whereas those in non-traditional employment had achieved this, in most cases, without agency involvement. Work was seen as fulfilling a number of functions, in particular, giving a sense of independence, providing status, restoring self-esteem, and providing the opportunity for social contact. Many of those who were employed at time of interview, and some of the other respondents, suggested that society's misconceptions about blindness were reflected by employers, and they were prevented from demonstrating their capabilities.
Those who are adventitiously blinded encounter various status passages and roles in their blindness careers. As previous chapters have indicated, the problems of becoming blind are not simply those that arise from the physical condition. Certainly those who are severely visually impaired will have to face a world designed for the sighted, and to adjust they will need to develop alternative ways of dealing with daily living activities. However, many of the problems blind people face are those concerned with the social implications of visual loss. Furthermore, societal reaction theorists suggest that those who become blind, or disabled in some way, are encouraged to adopt specific behaviour as a result of society's expectations and treatment of the visibly impaired.

This chapter examines what it is like to be blind, and how those studied felt they were perceived by the sighted. It assesses whether the blind can be regarded as a deviant group, and whether blindness is a stigmatising condition. It also examines social roles, and the self-concepts of those studied. As self-concepts are produced by social interaction, the problems that occur in relationships between the sighted and non-sighted are discussed.

**Societal Response to Blindness**

It has already been stated that there are a variety of beliefs held by the sighted about what constitutes blindness behaviour. Those with sight may not understand the reality of blindness and the
extent of limitations, nor may they recognise that the blind form a
heterogeneous group with differing personalities, abilities and
needs. This, of course, applies equally to those with other
disabilities. Dewey and Humber (1951) state:

"Whether a particular physiological or anatomical
abnormality places a person within an advantaged or
disadvantaged minority depends not upon the biological
fact itself, but also upon society's evaluation of it.
Taken by itself no biological variation constitutes a
social or personal problem." (p. 390-391)

Perhaps Dewey and Humber are taking an extreme view in proposing
that it is only society which causes a problem. It is perhaps
obvious to say that there are inherent practical problems arising
as a result of blindness. Nevertheless, they are making an
important point, shared by many writers on disability, and
particularly, on blindness (see Chapter 3). For example, Lukoff and
Whiteman (1961) state that the blind are treated with prejudice,
which is often expressed in the way organisations handle blind
people.

"Blind persons possess a trait to which society
frequently responds in prejudiced ways. Although this
prejudiced response is not so systematic and uniform as
has sometimes been asserted, the private and public
welfare structure and special legislation for the blind
indicate that it is not a superficial response but one
that manifests itself in very highly organized ways of
dealing with the blind." (p. 249)

Writers who researched the sighted's attitudes towards blind people
found that there was a variety of stereotyped assumptions (see
Chapter 3). These beliefs fall into three categories, concerning:
1) the personalities of blind people, for example, some view the
blind as innocent, sinister, wise, or stupid;
2) the way they feel about their blindness, that is, that they feel
frustrated, bitter melancholic, self-pitying, and are envious of
3) the abilities they subsequently develop, that is, to compensate for their blindness they develop good memories, an acute sense of hearing and touch.

A predominant attitude held by the sighted is that the blind are helpless and dependent. What is more, society tends to see blindness as a problem which requires help from the sighted. Whatever view of blindness is held, it is likely to lead to certain expectations of behaviour from all blind people.

The attitudes of the sighted were not examined directly or systematically in this study, but over the period of this research, the views of a large number of people, unconnected with blindness, have been gained informally. Frequently, when the subject of blindness was raised with people, the most common sentiment expressed was that "it would be terrible to be blind". Generally it was seen as the worst impairment that a person could experience. Often people talked in hushed tones, and with a sense of gravity. Some were concerned with the practical details, "how can they find their way around?" and "how do they manage with everyday tasks?" Most surprise was shown when 'untraditional' occupations held by some of those studied was mentioned. Many people still seem to associate blindness with basket making or begging. Frequently people used specific stereotypes, describing blind people as "nice/cheerful/sad" and so on. Unless these members of the sighted world had ever encountered someone who was blind, almost without exception they saw blindness as being both incapacitating and
leading to those who were 'afflicted' following 'abnormal', and often, isolated lives.

These general views were reflected by employers. Several discussions (again informally) took place with those in a position to recruit employees. The most common view was that they would be reluctant to offer employment to someone who was blind, mainly for the following reasons: that too much assistance might be needed; that there was a safety risk; and fundamentally, they did not think that blind people could be fully capable (see Chapter 8).

It does seem, then, that those who are blind are regarded as being different from the general population. Whether this constitutes a form of deviance will be considered.

**Blindness as Deviance**

The concept of deviance is often used to identify those who commit criminal acts, but it is proposed by several writers on disablement that those who are physically or mentally impaired can also be regarded as deviants (including: Lemert, 1951; Mankoff, 1970; and Hilbourne, 1972). Although definitions of deviance are inexact, generally, the concept has been used to study those who are seen as committing normative violations. To understand deviance it is important to look at the environmental context, as Clinard (1974) says: "Deviance is a created situation", and those who are deviant do not comply with social norms, that is, "standardised ways of acting, or expectations governing limits of variation in behaviour" (p. 5). Deviance involves judgement to define it, and power to
There is nothing inherently deviant in any human act; something is deviant only because some people have been successful in labelling it so." (Simmons, 1965, p. 223)

It is suggested by those who propose a labelling approach to the study of deviance that the label is so powerful that once attached, it may encourage the labelled to commit further deviation.

It does seem from most uses of the term deviance, that those who deviate have some control in that they are free to follow the career path they have chosen. Therefore, can those who are disabled be assigned the deviant role? Mankoff (1970) argues that they can, but that there is a distinction to be made between two groups of rule-breakers. Mankoff describes "achieved rule-breaking" as that which involves an individual taking part in rule-breaking activity (usually of a criminal nature) and following a deviant life. He goes on to propose that "ascribed rule-breaking" occurs when those with visible impairments are given deviant status because they do not conform to social norms. This status is usually acquired without the wishes of the impaired individuals. Although these two groups may have different ways of becoming deviant, they may be treated in similar ways, for example, given inferior status, shunned by other members of society, and have their behaviour and actions judged in terms of their predominant attribute.

The severely impaired do not generally seek out the deviant role, and may make considerable efforts to avoid the role. This may be difficult as treatment from others can be pervasive. As Freidson (1970) says, 'handicap' is seen as:
"... an imputation of difference from others, more particularly, imputation of an undesirable difference. By definition, then, a person said to be handicapped is so defined because he deviates from what he himself or others believe to be normal or appropriate." (p. 205)

Hilbourne (1972) further suggests that:

"To be labelled as handicapped is in some sense to be assigned to a category of deviance and to be extruded from the full social acceptance that would otherwise be one's due." (p. 297)

If the above proposals are to be accepted it can be argued that those who are disabled are set apart from the rest of society, and are seen as holding inferior status to those who are able-bodied. Certainly, during the International Year of the Disabled in 1981, when disabled people were given more access to the media, a continual cry was that they were treated as second class citizens. Many said that a 'them' and 'us' situation existed between the able-bodied and disabled, and they argued that the disabled were seen as being deviant from the rest of society.

Deviance, then, is reliant on societal reaction, that is, it is an audience which labels an individual, or a group, as having characteristics or behaviour different from 'the majority'.

Labelling refers to the classification and categorisation of behaviour and subsequent grouping of individuals into types. It also refers to the way in which attitudes of some people may influence an individual's behaviour. That is, a set of stereotypical views can lead to an individual adopting the role expected of him or her. Berger and Luckman (1969) state that:

"... the reality of everyday life contains typificatory schemes in terms of which others are apprehended and
'dealt with' in face-to-face encounters" (p 45).

As was suggested by Scott (1969), these stereotypical assumptions may act as a guide to behaviour, and produce what Merton (1957) describes as a "self-fulfilling prophecy". For example, those who have a visual impairment may find the label of 'blind man' overpowering and a type of behaviour is produced which both the blind person and the audience believe conforms to a specific prescribed role. For example, if the sighted confer on the visually impaired person the role of helpless, he or she may accept it. In contrast, some may aggressively reject their 'assigned' role to the extent that they would refuse any offers of assistance because they see it reinforcing the stereotype of helpless.

It might be asked how far do those who are labelled go in assisting in being labelled? Levitin (1979) suggests that many of those with a physical handicap do take an active part in the process, insisting that they are defined in ways preferable to them. Levitin carried out a study of both those who were permanently disabled and those who had a temporarily disabling condition. She found that those who had a permanent disablement tended to disavow their deviance, but emphasised that the disability was only a "small part" of the total person. On the other hand, those with a temporary disablement tended to avow their deviance by immediately referring to their injury, but emphasising the temporariness of it. Levitin found that those who were disabled:

"... recognized the devalued statuses their recent illness of injury had brought them, but they vigorously and systematically tried to influence the context of their deviant label and role in ways most favourable to themselves" (p. 225).
This study has not observed the interaction between the sighted and non-sighted to see whether there are signs of the latter being treated as deviants, but many of the respondents said that their blindness led to them being treated as such, though often using the terms, "not normal", "different", or "not human".

Society may consider that the blind deviate from the norm in three ways:

1) They do not have functioning eyes and thus do not comply with the norms of wholeness.
2) Their physical appearance may be different, for example, constantly moving eyes.
3) They have different personalities and behaviour from the 'normal' population.

The first point is illustrated by one of the respondents:

"When you are blind it's obvious that you are seen as different - I didn't expect it to be so different - most people are able-bodied, aren't they? When you're not able to see then people are bound to treat you a bit funny. They certainly won't treat you in an ordinary way, like before." (Mr. Stevens)

The second point is illustrated by a respondent who described herself as having "odd" eyes. Ms. Austin had some sight which she thought was a disadvantage in personal interaction:

"I'm able to see their reaction. It really hurts. I think it's harder to have some sight than be total... The worst thing is when I go into shops. Often the assistants don't know I'm looking at them (she has non-directional gaze). They sometimes make comments - they act as though I can't hear as well - they imply that I'm 'batty'."

There are numerous examples to illustrate the third point, that the
sighted believe that the blind have different personalities from the 'normal' population. For example:

"I do hate being treated with such deference. Some people behave as though everything I say must be so 'sensible' and serious, because I'm blind ... Everyone thinks I'm so good-tempered too - it's rubbish, I often get cross, but I feel I must hide it because people don't expect it of me." (Mr. Sims)

"I think people assume that the blind are always cheerful, or if they are not then they think it's up to the sighted to cheer them up." (Mr. March)

"I think we can get away with murder. If I'm cantankerous they blame it on my being blind. They don't think that maybe I'm just a bad-tempered fellow. My family know me and don't let me get away with it, but my workmates bend over backwards when I'm in a bad mood. They think blindness is so terrible that I've a right to be cross at times." (Mr. Wright)

One respondent, Ms. Austin, said that she "hated sighted people" thinking that blind people are "so nice". She said that during the early period of becoming blind, she was "particularly obnoxious" in order to break the stereotype. Others also suggested that, during some periods of their blindness careers, they showed some resistance towards being treated in a specific way, and were sometimes "rude" or "aggressive" towards their potential helpers. However, the respondents suggested that it was "much easier", "kinder" and "more sensitive" to accept the assistance given them, even if it was unnecessary.

A few respondents suggested that those with sight thought that a 'sense of humour' was an unexpected characteristic in a blind person. Sighted people may expect those who are blind to take their blindness seriously and find it "offensive" if it is treated trivially by the 'afflicted' individual. Five respondents said that
they tried to make others relax, perhaps by being jovial, and even cracking jokes about their lack of sight. These people said, however, that some people regarded that their jokes about such a "serious matter" were in "bad taste", and that this frivolous attitude only served to generate more unease.

"I had a good sense of humour before I lost my sight - I used to be a bit sarcastic, you know, but it doesn't go down as well now ... trouble is, I don't know whether they think I'm putting it on because I'm blind." (Mr. Fuller)

Most of the respondents said that all blind people were 'lumped together' as a group. As one respondent said:

"They've all seen blind beggars, so they think we're all the same." (Mr. Rogers)

Or another:

"They (the sighted) have no idea, I didn't. They still think of Blind Pugh with his stick and cup. It isn't like that." (Mr. Fuller)

One of the main arguments put forward by about a quarter of the respondents was that it was very difficult to convince the sighted that their range of personalities, attitudes, and behaviour were as widely different as the general population. They argued that even if sighted people did come across someone who was leading a 'normal' life and had a "good and important job", they would be seen as the exception that proved the rule. A social worker dealing with rehabilitees at the R.N.I.B. rehabilitation centre suggested that "the media" were responsible.

"They portray blind people as being anything but what they are; for example, as having some kind of extra-sensory perception, fantastic hearing, etc. The blind are a minority group. You can't put yourself in the place of a blind person and this worries them (the public), they are frightened by the abnormal."

Because those who are blind are frequently treated as an
homogeneous and deviant group, they are likely to have to face stigmatisation.

Stigmatisation

Many writers have proposed that those who have visible impairments will experience stigmatisation (among them Goffman, 1963; Richardson, 1971; Hilbourne, 1973; and Blaxter, 1976). Scott (1969) in particular, sees blindness as a stigmatising condition:

"Blindness is a stigma, carrying with it a series of moral imputations about character and personality. The stereotypical beliefs I have discussed lead normal people to feel that the blind are different; the fact that blindness is a stigma leads them to regard blind men as their physical, psychological, moral and emotional inferiors. Blindness is therefore a trait that discredits a man by spoiling both his identity and his respectability." (p. 24)

The origin of the term stigma is that it is a brand, or a mark of shame. Goffman (1963) argues that many impairments carry a social stigma, for example, deafness, epilepsy, as well as blindness. He states that if someone has an attribute which is discrediting, it will be regarded as a stigma. Goffman refers to those without an apparent stigma as 'normals', and goes on to say that normals discriminate against the stigmatised, regarding them as being not quite human. To support his argument he cites cases of people whose life had been completely changed due to disfigurement. For example, he talks of a middle-aged woman who had previously had an active social life, but after the removal of the distal half of her nose, refused to leave her home. There is also much psychiatric evidence to support Goffman's views, which suggest that those with a visible disfigurement find it difficult to come to terms with both themselves and others.
In our society there is a great emphasis on images, particularly the 'body beautiful', good health, and wholeness in physical appearance. Kessler (1953) states that "imperfection in nature is always more or less abhorrent to the human mind" (p. 19), and that the human form is only really acceptable when it is normal; if it deviates in any way it may appear to be repulsive to some. The disabled person, write Barker and Wright (1953):

"... is regarded by himself and others as inferior, not only with respect to his specific limitations, but as a total person. He may feel shame, inferiority, even worthlessness ... They are confronted with a serious situation because two basic needs of man are the need for self-esteem ... and the need for social status." (p. 18)

In the present study, two people suggested that blindness gave them a sense of shame. Those who did talk about shame suggested that they had been responsible in some way for their loss of sight. They could not explain why they felt shame, but Mr. Downes stated that he was "just ashamed" of being blind, and disliked new encounters because of his condition. However, many of the other respondents had experienced feelings of inferiority, low self-esteem, and "embarrassment" at some point in their blindness careers.

Blaxter (1976) stated that the perception of stigma depends upon the nature of the impairment. She carried out a study of people with a variety of impairments. She found that blindness was regarded as a stigma, but not as much as, for example, spasticity or multiple sclerosis. Blaxter found that her respondents:

"... defined themselves as normal except for a handicap which was entirely physical, but it seemed to them that they were being defined as abnormal in character, or intelligence, or mental condition. They were being labelled in ways which they felt to be entirely wrong
The respondents in the present study showed similar attitudes to those expressed by the subjects in Blaxter's study. Most of the respondents in the present study did not see their impairment as a handicap in itself, rather it was defined as such by others.

Richardson (1971) also carried out a study of "handicap, appearance and stigma". He asked children (in London) between the ages of 10-11 to rank 21 pictures of differing appearance in order of preference. He found that from most to least liked, preference was shown for a non-handicapped white child, a non-handicapped black child, facial disfigurement, use of a wheelchair, crutches and leg braces, obesity and amputations. This indicated, as Blaxter found, that stigma was related to the kind of impairment. Blindness is sometimes high on the list of stigmatising conditions as Barshay (1964) and Siller et al (1967) found in studies of preference ordering.

Those who are impaired in adulthood are the most likely to be aware of stigmatisation, in that they have previously been accorded the kind of respect which indicates that they are accepted; then, because their sight has become impaired, they have been "generalised into a gestalt of disability" (Gowman, 1957, p. 198).

Goffman, in his analysis of stigma, discusses the management of identity, implying that it is a prime concern of the stigmatised when they are not interacting with people of "their own kind". He argues that it is difficult for those with some form of stigma to...
decide what is the correct form of self-presentation, usually resulting in the stigmatised acting out the prescribed role.

In the present study, twelve of the respondents actually used the term stigma; however, most of the respondents suggested that there was some sort of negative labelling attached to blindness. Most of the discussion of stigmatisation was abstract rather than tangible, and concerned feelings rather than concrete incidents they had encountered.

Those who specifically mentioned stigma, saw it in terms of, for example, being prevented from obtaining employment because employers hold the view that the blind person is "somehow offensive and probably inferior" (Mr. Jones). As another respondent said:

"When you are blind, there is a stigma attached to it. There's no doubt about it, you'll never be the same ... I'm sure that's why we find it so difficult to be accepted as employees." (Mr. Thomas)

As the discussion on registration showed (Chapter 6), some respondents were reluctant to register because they regarded blindness as a stigmatising condition. Five expressed the view that the mobility aid was a visible sign of stigma: "I didn't want to be seen with a white stick" (Mr. Rogers).

Casual encounters presented the most problems. All the respondents cited incidents of having their escorts addressed, and asked, through them, what they would like to eat or drink. This was seen as being particularly invidious as they felt that assumptions were made about their level of mental functioning.
Someone (from the pilot study) who was visually impaired for a number of years, and who regained substantial sight, had made an informal study of the problems faced by blind people. Mr. White regarded blindness as a stigmatising condition. He said that the blind were "marked out as a group; you have to be thick-skinned and try to ignore the stigma". Mr. White described his worst experience:

"I was handed some silver coins while waiting for a tube train. I didn't have the heart to hurt their feelings, but I was extremely embarrassed and humiliated and thought about it for days after."

It was suggested earlier (in this chapter, and Chapter 3) that it was a commonly-held view that blind people became beggars. Mr. White felt he had been treated "like an impoverished beggar"; in performing this 'charitable' act, the sighted person was devaluing the status of the blind person.

Many of those working with the blind also supported the view that blindness was a stigmatising condition. Among these were some who were themselves visually impaired, and were able to give first hand information. There were numerous examples; the following two were of incidents that occurred in the vicinity of the rehabilitation centre at Torquay. A member of the R.N.I.B. headquarters was assisting some of the rehabilitees into a mini-bus in the centre of town and overheard some women say:

"Isn't that nice that they've got their own bus, and don't they dress them nicely too."

The man who related this remark (who was himself registered as blind) said that it was typical, in that people thought that the
blind were "like dummies" or "helpless babies" and were invariably cared for by others. This R.N.I.B. employee suggested that blind people were stigmatised in a number of ways:

"Sighted people think that blindness leads to a degeneration of the whole person, they think that it makes you stupid, but worse, they think there is something unwholesome about blind people... We can put up with the stigma, being viewed as something apart, but the worst thing is being treated as though we're useless and helpless;"

A mobility officer illustrated what he felt was the most common view of blindness, that is that they are helpless, by the following: the mobility officer was training a fairly new rehabilatee. He insisted that the woman being trained walked along the road on her own, but within his view; an observer turned to her companion and said "How cruel, how could he let her do that, they wouldn't allow that sort of thing in Brum, you know!" The mobility officer said that "everyone who becomes blind has to put up with this sort of thing". He went on to say: "I haven't met one blind person who hasn't got tales to tell which concern (sic) with stigma."

Hilbourne (1972) recognises that stigma does present a problem to the blind, and other disabled people, but also reaffirms Goffman's view that a "courtesy stigma" arises due to association with the stigmatised person.

"Although the actual organic deficiency giving rise to a handicap may be confined to one individual, the disabilities which arise from it are not his alone. A physical disability handicaps not only the person to whom it occurs, but frequently those who enter into social relationships with him. It places limitations and constraints on them which, if it were not for the presence of a disabled person, they would not encounter." (p. 498)
According to Hilbourne, the disabled person's associates will have a courtesy stigma due to 1) association; 2) modification of behaviour; and 3) limitations on ability to perform certain tasks. He suggests that obligations in a family will be different, and that additional tasks will have to be performed.

Although this study did not examine the effects on the family, seven of the spouses sat in throughout the interview, and discussed the problems which arose for the family. It was certainly apparent that the spouses did experience a number of limitations, in particular, having to provide assistance in helping with communications and escorting the blind person. However, whether they were also viewed as having a stigma was not discussed, although three spouses talked in terms of blindness having a negative evaluation.

It was proposed earlier (Chapter 3) that stereotyped assumptions and stigmatisation were likely to result in producing blindness behaviour. Scott (1969) also expected that the misconceptions held by the public were likely to lead to a change in the way the blind person regarded him or herself, and in particular, the adoption of the blind role.

**Social Roles**

It has already been stated that any status passage involves the individual assuming a number of roles. Linton (1936) suggested that every person in society occupies multiple statuses, and each status
has an associated role. However, Merton (1957) argues that each status involves an array of associated roles, forming a role-set. A role can only exist in a relationship to other roles, for example, vendor and purchaser, or father and son. Roles also vary in their degree of importance, and in their duration: someone may hold a managerial role and a husband role, which are both likely to be seen as important and long-term, whereas the roles of railway passenger, pedestrian, or cinema-goer, although perhaps occurring frequently, may not hold much importance for the individual.

However, Scott saw the blind role as one of helplessness, docility and dependence, and as a role that overwhelmed all others. He felt that the majority of newly blind people would be encouraged to take up this role. The present study considered whether this did actually occur. Before discussing how far the blind role was adopted by those studied, two other roles encountered in the blindness passage will be considered; these are the sick role and the disabled role.

Those who become blind, are, initially, likely to encounter the sick role. When slow deterioration of sight occurs the individual will have to adjust to coping with poor vision and yet continue in the role of the well person. As the loss becomes more acute, the individual may be faced with hospitalisation, and with assuming the sick role and potential disablement. For those with sudden loss, the first stage of blindness is likely to be a traumatic one, perhaps complicated by illness-related factors. Shakespeare (1975) states:
"Being sick, handicapped or disabled involves playing a particular part in relation to other people, and expecting others to perform roles appropriate to a sick person. This usually involves expecting to be looked after, absolved of responsibilities, and acquiesced to."

(p. 21)

Once an individual has assumed the sick role, he or she should: 1) be able to relinquish any social responsibilities and role activities; 2) not be responsible for the illhealth; 3) be dependent on others for care; 4) have a desire to get well; and cooperate by taking medical advice. (Parsons, 1951; Safilios-Rothschild, 1970)

It might be argued that it is quite possible for someone to fall 'sick', but not fit the criteria of the sick role. For example, 1) some people who become sick may try to continue with their role responsibilities (much will depend on the extent of the sickness); 2) some people may be 'blamed' for falling ill or becoming impaired (racing car crash victims, alcholics, or drug addicts); 3) some people may be unwilling to recover; and 4) not all those who are sick will seek medical assistance.

Freidson (1961) suggests that although the illness or impairment may not be motivated by the individual, they are expected to exhibit appropriate illness behaviour. Certainly, those in the study who did have to take on the sick role felt it to be one of dependence and incapacitation, and several expressed a reluctance at having to take up the sick role. For example, the following respondent described hospital as making him "very ill".

"I don't know why, I just couldn't stand it. I wasn't in pain with my condition, I didn't see why I had to be
there all the time ... I had three operations and from February to May I lost two and a half stone. I felt so ill. As soon as I got out I started to feel better. I was very depressed in hospital, going down hill... Every day I was thinking 'what do I do now, I'm only 35, what am I going to do for the rest of my life.'" (Mr. Oakley)

Another respondent said:

"Before I went into hospital I felt perfectly well, except for my eyes ... once I was in there I felt frightened ... it's enough to make you ill." (Mr. Phillips)

Those who experienced sudden loss did not say that they had been concerned about taking up the sick role, whereas over a third of those whose loss had occurred more slowly felt it to be an unwelcome role. The former group did have more illness-related factors, for example, three lost their sight as the result of accidents, and another (Mr. Franklin) was the victim of an attack. Nevertheless, all the respondents who were hospitalised said that during this time they were totally dependent. They only began to get a clearer idea of how to deal with their blindness once they relinquished the sick role and could regain some of their previous role responsibilities.

The sick role can apply to those who have a temporary illness as well as those who will become disabled in some way. When a permanent impairment arises, there will come a point when those treating the medical condition see the sick role as being no longer appropriate. The individual may then be encouraged to take up the disabled role. Although the disabled role has often been discussed in similar terms to the sick role, this can be seen as inadequate for a number of reasons:

1) The sick role is a temporary state, whereas disability is
invariably permanent.

2) Role responsibilities and relationships may be affected more considerably.

3) The disabled person is likely to have to develop new skills to cope with the impairment and learn to live with lower functional ability.

4) The disabled role may be seen as being a deviant one by both the disabled person and other members of society. The major differences between the sick role and the disabled role, is that, generally the former is seen as passive, whereas the latter is seen as active whereby the individual has to learn to adjust to disability, and then perform behaviour appropriate to that role.

Safilios-Rothschild (1970) suggests that rehabilitation agents expect rehabilitees to take an active part in the rehabilitation process, and attain maximal functioning. On the other hand, Scott (1969), suggests that both agents and sighted people regard the blind role as one of helplessness, dependence, and passivity, and thus those who become blind are encouraged to take up this role. However, it seems from the evidence of the present study that only five of the respondents could be described as holding the blind role as described by Scott. All five respondents were unemployed and relied on their spouses to carry out most of the responsibilities they had previously-held. As this was a retrospective study, it was not possible to identify what had lead to this dependency. All five respondents held the view that blindness was severely disabling, and that their loss of employment was solely due to their blindness; they also held the view that
blind people could not take a full part in society. It would seem from the evidence of others who had succeeded in retaining a dependent role, that personality factors played a significant part in adjustment, outcomes, and attitudes towards blindness. In addition, having protective spouses may also facilitate the taking of the blind role, if the individual is so inclined. Four of the other respondents in the unemployed group were living alone, and these did not show the degree of dependency, nor passivity of those who had spouses. It seems likely that because they did not have regular familial support, they had to take control of their own careers, and show some independence.

As has already been shown, there were diverse responses to blindness, and the majority of those studied were able to adopt a variety of roles. What was apparent was that during the blindness passage, a number of specific roles had been taken, including the sick role, the disabled role, and the blind role. Indeed, two-thirds of the respondents said that at some time they experienced increased dependency and feelings of helplessness. However, these dependent roles were held for varying durations.

It was apparent that those who had some familiarity with blindness, through contacts with blind relatives, were generally those who had not seen the condition as disabling during the early period of blindness. Of course this was dependent on the role model. Thirteen of the respondents had a family history of blindness. Five of these respondents had experienced a gradual loss of sight during their teenage years. Of the other eight respondents who had a history of
visual impairment in the family, three thought that they might experience visual problems, even before there were any signs of symptoms. Those who had contact with role models felt that having some knowledge of blindness had helped them. Two respondents in particular said that these role models had guided their own reaction to blindness, and subsequent outcome. As one respondent said:

"My mother was registered as blind, although she was able to read with an aid. No-one was really surprised when I started having problems, although, of course they (her parents) were upset. In my teens it was O.K., I just needed very strong glasses, it was only when I was twenty-four that things took a turn for the worse. I suppose it did help having seen how my mother coped, if you don't know anyone who is blind, it must be very frightening." (Mrs. Massey)

Mrs. Massey's mother provided a suitable role model (as she was described as being independent and having numerous interests), and was frequently referred to during the interview.

Mr. Sims also cited a relative who was seen as an ideal role model. He had an uncle, who although almost totally blind, travelled around the world for a great deal of his life. Mr. Sims felt that he, like his uncle, had not "been defeated by blindness. He had a more adventurous life than most people".

In addition to having some familiarity with blindness, obtaining the work role also greatly assisted adjustment to blindness (see Chapter 8). It appears then, that it is possible for blind people to become independent, and adopt various roles; nevertheless, they will inevitably be faced with status changes. These changes can affect self-concepts.
Self-concepts

The term self-concept refers to the individual's attitudes about the self. Scott (1969) states that:

"A man's self-concept consists of the attitudes, feelings and beliefs he has about the kind of person he is, his strengths and weaknesses, his potentials and limitations, his characteristic qualities, and so forth." (p. 14)

It has been suggested by several authors that a sudden alteration in an individual's body is likely to result in an altered concept of self (Barker and Wright, 1953; Dembo and Wright, 1956; Litman, 1962; and Safilios-Rothschild, 1970). Litman (1962) says:

"In addition to coming face to face with the realistic limitations and adaptations imposed by his condition, he must also modify his concept of self." (p. 555)

Is the self so vulnerable? According to Mead (1934) the self is the conscious part of the individual, the part which is developed as a reaction to others. One of the most important aspects of the self is its ability to change: it is dynamic and may be in a continuing state of development as a result of encounters with others. This experience forms the building bricks of self. The socialisation process leads to the appearance of the self, and it is primarily the attitudes of others which are responsible for its development. This is described by Cooley (1922) as the "looking glass self", that is, the individual is a reflection of the views others hold about him or herself.

Self-concept is largely formed by the categorisations others make about the individual in social encounters. The individual can expect to be placed in a particular category and thus may act
accordingly. The individual will receive negative or positive reinforcement for behaviour. An individual will perhaps produce in others some stereotyped assumptions about the type of individual he or she is, and these may or may not be thought to fit. The problem for those who become impaired in adulthood, is that they may, initially, be unused to being treated in a specific way by the able-bodied.

Several writers suggest that severe impairment is likely to result in a negative concept of self. Litman (1962) found that there was a direct relationship between a person's conception of self and his or her response to rehabilitation (and therefore adjustment to a change in body). In his study he found that those with poor self-conceptions lacked initiative and motivation to cooperate in their rehabilitation programme and therefore were unsuccessful in "accepting their disability". Whereas those who felt the reactions of others towards the disability were favourable, and had a sense of personal adequacy, actively involved themselves in trying to rehabilitate successfully.

On the basis of her examination of autobiographical accounts of the physically impaired, Wright (1947) suggests that:

"When a person has a well-balanced, accepting attitude toward his disability he is more likely to feel that others question him and stare at him because they simply wonder about him... If, however, the person basically rejects his disability and himself, he will tend strongly to resist the curiosity of others, feeling that he is being regarded negatively, with aversion and pity. His self-concept defines for him the kind of person he is as an 'object' of stimulation to others." (p. 209)
A study carried out by White, Wright and Dembo (1948) gave some idea of the self-feelings associated with disability. They carried out a study of hospitalised amputees and plastic surgery cases and found the following reactions:

1) fear that it was not "me as a person but my injury" that was of primary importance to other people;
2) fear that the injury devalues the person;
3) guilt connected with the feelings of being a burden;
4) conflict between the desire for dependence; and
5) feelings of self-pity.

Another reason for self-concepts being altered due to disablement may be that roles are altered. As Shakespeare (1975) suggests, previously a man may have seen himself as provider for a family, felt that he was an organiser, or an adviser, and that changes in these roles may lead to a reshaping of self-perceptions.

It seems likely, then, that those who become blind will have their self-concepts affected by societal response. As a few respondents suggested, only those with "thick skins" or high levels of confidence will fail to be affected in some way by that response.

Twenty-three respondents said that during the early stages of blindness, pressure to behave in a way which fitted the pre-conceived ideas of the sighted was quite great. However, it could not be established how far this permanently affected self-concepts. They made comments such as:
"It's amazing really, suddenly I was treated as though I was old, and a bit slow ... but people fall over backwards to be kind, but you really want to be treated like everyone else ... at the beginning you become used to being treated as though you can't do anything and you think 'blindness must mean you're hopeless'. You change your ideas about yourself." (Ms. Blackman)

"... you begin to wonder if you are different because you're blind." (Mr. Phillips)

Hilbourne (1972) has suggested that disablement will affect the social worth of the individual. This was an aspect of blindness which distressed six of the respondents, and others, particularly those who were unemployed, intimated that it had caused them some concern. One of the comments sums up the views of others in this group.

"I want to be able to contribute something to society, I'm always at the receiving end ... it's made me lose my pride ... I feel I'm a second-class citizen now. I don't think I'm of much use; even if I did, I wouldn't be given the chance." (Mr. Harris)

Most of the respondents referred to the stereotyped assumptions society made about blind people. Indeed, they may have been guilty of holding these views themselves, while sighted. How do these assumptions now fit in with their own knowledge about blindness?

The following comments illustrate this:

"I was ready to face the world after rehabilitation. I didn't see myself as having too many problems once I became mobile again, but I found that people expected me to be helpless, that brings you down, you know. I suppose I was the same though, I thought that blind people didn't do much, I mean you see them walking around with their white sticks, you can't imagine them leading a normal life. I was just as guilty you see, but now I'm blind myself I know I could cope if I was given the chance." (Mr. Fuller)

"I didn't want to be like other men. I used to think most of them relied on begging, or the Welfare. But I had to fight to prove myself. It's not the blindness
which is the problem, it's more what other people think of you. I suppose others you've interviewed have told you this before, but it's so annoying, you feel you're an 'invalid'. Now it doesn't worry me, I know I can still do a job - my wife and friends know what I can do - you have to prove to others that you're no different from before loss." (Mr. Connelly)

A further comment from one of the respondents illustrates that he continued to hold stereotyped views about blindness:

"It's so difficult to convince people that you're as normal as you were before, that you begin to act as they want you to. After a while you could easily become a 'typical' blind person." (Mr. Downes)

In the early stages, the adventitiously blinded may be unsure about what blindness involves. Will they now have to be dependent, feel grateful for charity, enter a sheltered workshop, what is the reality of blindness? The early stages can bring confusion and apprehension:

"At first I didn't know what was happening. I was treated like a baby, helpless and useless... I didn't know anyone who was blind, so I wondered what it would do to me. You think at first, you can't do anything, then you're told by them (social workers, etc.) you can. When you're back in the real world, no-one expects you to be able to do anything." (Ms. Walsh)

Initially many respondents felt that they were "devalued", and that the loss of sight was so pervasive that it had affected the whole individual. However, this feeling was not long-lasting for most of those studied. As one respondent said "the change was nowhere near as difficult as people would imagine" (Ms. Massey). Five respondents said that they had been "completely changed" by their blindness; these were the respondents who appeared to hold the blind role. These were all respondents who were unemployed, and that may have influenced the way these individuals viewed their blindness.
Self-esteem

Those who become disabled may have their self-esteem affected. Esteem is the level of favourability the individual has towards the self. All the respondents studied said that, at some time during their blindness careers, self-esteem had been lowered by their loss of sight, however, the majority felt this was temporary. Whether self-esteem continued to be affected was also dependent on whether the work role was retained; those who were unemployed suggested that they had a low level of self-esteem.

A frequent comment was that their level of self-esteem had declined immediately after severe loss: "my level of esteem plummeted" (Mr. Stevens) and "you hit rock bottom, you have no self-respect" (Mr. Downes). Some suggest that it is a battle to regain esteem: "you have to fight to gain back your self-esteem" (Mr. Fuller). Others felt that there were specific solutions: that they would like to "regain employment ... to gain self-esteem".

Self-esteem may be affected in three ways:
1) by the life events that occur, for example, loss of employment, or rejection by a spouse;
2) by the way the individual has always viewed 'the blind', for blindness may have been abhorrent; and
3) the actual physical consequences may lower esteem, the individual may find it offensive to be without eyes and have a damaged body.
The first way self-esteem may be influenced can be illustrated by a respondent who experienced a number of adverse life events. Mr. Downes had lost his sight when he was 36. His job had involved considerable driving and Mr. Downes had made the decision to relinquish his job. The company he worked for could offer no alternative employment. Although he was subsequently trained as a lathe operator, he had experienced only short periods of employment in the seven years since registration.

Mr. Downes said that he and his wife had experienced "difficulties" during his period of hospitalisation. He described her as being:

"... rather frightened of the whole thing. She hated hospitals anyway, and didn't like to visit me there. Her main concern when I came out was whether I'd be able to work again ... We had always been used to going out a lot, but that had to stop... I think she was ashamed of me."

Mr. Downes' wife left him about a year after he was registered as blind. He said he was not sure whether she left because she found "the blindness difficult to cope with", or whether it was "because our life style had changed".

This respondent said that he had not only been rejected by employers, and his wife, but also by most of his friends. He had been a keen amateur footballer, but when he could no longer play, this particular social network disintegrated. As to other friends, he stated "it was O.K. when I had money in my pocket, but when all this happened, they weren't interested".

Mr. Downes regarded his blindness as being the catalyst which led
to his losing his job, wife and friends. He said that this combination of events, put his "self-esteem at its lowest".

The second way self-esteem can be affected, that is, as a result of individual's pre-conceived ideas about blindness, can be illustrated by the following respondent. Mr. Morris frankly admitted that the concept of blindness had been abhorrent to him prior to loss.

"I felt any disablement would have been a disaster to me ... I know that I used to think of disabled people - the blind - as almost another species. It sounds terrible, but I would never have anything to do with anyone who was disfigured, or who had something wrong with them. I always had this fear of it happening to me, it sounds ridiculous, but I used to think whatever was wrong with them might affect me ... I thought if I was blind it might be better to be dead, I never wanted to be one of them."

Mr. Morris was very open in his views on how he regarded all disabled people prior to his own loss, and described how, when he knew he was going to be blind he felt overwhelmed with fear. One of his greatest concerns was that he would be "lumped with all the blind". He suggested that because he had felt "so strongly about disability" that it was hard for him to come to terms with his own impairment. "I completely lost confidence ... I didn't want to face anybody". He said it took him several years to recover his self-esteem and suggested that he achieved this largely because he was able to regain satisfying employment.

Finally, self-esteem may be affected by an individual holding an unfavourable view of the damaged body. Only one respondent in this study stated that they had considerable problems coming to terms
with the idea of no longer being a 'whole person'. Mr. Marlow stated that the physical consequences of his loss (he had both eyes removed) made him feel "repulsed".

"I don't think I would have minded so much if I could have kept my eyes, but they had to be removed, eventually I had artificial ones ... it's rather sickening at first."

Mr. Marlow had previously been very keen on sport and on physical fitness and this may have contributed to his reluctance to accept that his body had been damaged.

"I found it very difficult to face people ... I wondered if they felt as I did about the eyes (artificial ones); yes, I'm used to it now, but I can't say I am the same person as before."

It can be seen from the above previous discussion that, in general, the respondents managed to regain their self-esteem, and that their self-concepts were not affected long-term. The blind role had been encountered but most respondents had succeeded in adopting a variety of roles, and indeed in retaining many of the previously-held roles and responsibilities. Certainly those who become blind do change their status, and are subject to being treated as being deviant from the rest of society, and the condition regarded by others as a form of stigma. However, although this treatment is likely to present blind people with considerable difficulties in many areas of life, and in particular, in them being denied occupational opportunities, it does not necessarily permanently influence the way they regard themselves, or their behaviour. Nevertheless, one of the greatest problems blind people face is in dealing with public stereotypes, especially in social interaction.
Social Interaction

Interaction is what has been described by Kuhn (1962) as a "social act". Firstly, in a new encounter, interaction begins with a cognitive process, that is, a judgement of identities gained by means of visual and auditory clues. Secondly, there is a working agreement based on the establishment of identities and the negotiation of interactive roles leading to a plan of action. Thirdly, if successful, a realisation of objectives is achieved, or alternatively, a conflict situation may occur. In any interaction, each individual brings a set of identities, goals and likely problems.

Davis (1961) points out that interaction between the disabled and non-disabled imposes considerable strain on both participants, particularly when the interaction is occurring for the first time. Davis says that any encounter between a disabled and an able-bodied person will be subject to ambiguity.

Other psychological and socio-psychological research has shown that interactions between "physically impaired" and "physically normal" persons are "anxiety-laden", taking the form of "stereotyped, inhibited, and over-controlled" experiences (Kleck, 1966). Richardson and Royce (1968) found in sociometric studies with children that the presence of a visible physical impairment is a serious deterrent to the formation of friendships.

Societal labelling of the visually impaired as having specific characteristics leads to problems of interaction for both groups.
Four ways in which interaction strain can occur are:

1) if there is ambiguity in establishing the identity of the blind person, that is, when it is not obvious that there is visual loss;
2) when sighted interactants believe that those who are blind have a specific role;
3) if the sighted interactant is embarrassed by the situation; and
4) if the sighted interactant addresses the blind person's companion, rather than the blind individual.

Ambiguity often arises when the blind person does not declare him or herself as having visual loss, for example, by not carrying any props which would indicate this. The blind person may, or may not, be trying to conceal the condition, but the sighted interactant may be confused when the other person's actions 'seem odd'. The converse can also arise, when a person has been prepared to meet someone designated as blind, but is confronted with someone who shows little obvious signs of this.

There were numerous examples of this ambiguity provided by the respondents. Of the fifteen respondents who were able to read (with the use of low vision aids), over half stated that they took some effort to 'pass' as unimpaired when they could, but admitted that this sometimes caused confusion for others. When a sighted person is confronted by someone who does appear to be blind, they are faced with the problem of how much assistance they should offer. Many respondents suggested that some sighted people try to 'take over' and they frequently mentioned being dragged across a road unwillingly because they happened to be standing near the edge of
One of the commonest comments made by the respondents was that they were ascribed the blind role by others, and that surprise was expressed when they did not fit the appropriate role. In particular, those who did not hold what is regarded as 'traditional' employment experienced this.

As one of the respondents said:

"It seems that if you're employed as a brush maker, then that's alright, but tell them you're an electronics consultant (his occupation) then it 'blows their mind' ... This was difficult to swallow but I'm used to it now. Of course, your family and friends are great, they know what you can do - but it's the others, they're the problem."

In addition, if someone has interests which seem more suited to the sighted, then "disbelief" is sometimes shown, as Mr. Sims indicated. His main interests outside his employment as a social worker were in mountaineering and sailing.

"It's not that much more difficult for me now, than when I had sight. I need sighted assistance, but I contribute just as much to the team ... I get really fed up with people saying 'how amazing!'"

Many people are embarrassed by blindness. They are unsure how to behave in the presence of a blind person, and in particular, whether they should use words such as 'look' or 'see'. Most of the respondents had experience of dealing with people who did not want to use these 'taboo' words. For example, hesitating when they were about to say "see you next week". Respondents said they could "feel them burning with embarrassment", or "feeling dreadful", if they said something like "I got blind drunk". All the respondents said that they continued to use these 'sensitive' words in the ways that
sighted people used them, saying "I look forward to seeing you", or "Oh yes, I see that", and so on (this was very apparent in the interviews).

The respondents also felt that people who did not know them would also be embarrassed if they referred to an object, without describing the object. However, some of the respondents found this a source of annoyance, for example, someone offering food and saying "would you like some of this", without actually saying what this was. Some sighted people appeared to be concerned if they mentioned television, or films, but as the respondents said, they were often likely to have 'seen' the programmes referred to by the sighted person.

Eight of the respondents did say that they had experienced difficulties, at first, with work colleagues. Mr. Phillips said that when he first joined a company as a lathe operator, people were "shy and nervous" of him. He said that people avoided talking to him; and certainly once he did get to know them, they admitted that they had been apprehensive at first. He felt that they "did not want to bring up the subject" (of his blindness) and therefore were inhibited about approaching him. After a few months he said he was no longer picked out as the "blind chap", and that he was now "included in the teasing" (which he liked). Others also suggested that they were more comfortable if people teased them as they felt that the taboos were no longer recognised, and this made them feel socially accepted. It has been suggested by Davis (1961) that stigmatised people should take the initiative in social
interaction, and define the situation for others with whom they interact. Certainly, three of the respondents stated that it was up to the blind person to make the sighted interactant feel at ease.

As Mr. Franklin said:

"The sighted are scared by no eye contact. They are afraid of the serious face of the blind man ... blind people must go out of their way to help, they mustn't stay in their shell."

As Mr. Franklin pointed out, one of the problems of interaction is the lack of eye contact. Visual signals are used as a means of adding information to the dialogue. Eye contact, the length and amount, and facial expression is used to indicate what response verbal communication is receiving. About a quarter of the respondents mentioned this as being an initial problem to them, but after a while, they tended to concentrate on the tone of voice, and gained signals from this. However, they did feel that lack of eye contact may be disconcerting for the sighted interactant.

Other aspects of interaction which were regarded as annoying by the respondents have briefly been referred to earlier in this chapter. The main one was having the escort addressed on behalf of the blind person. Some of the spouses also said that this was "very annoying". When asked how they dealt with this, the spouses would say something like "I don't know, you ask him!"

When the respondents talked about the difficulties of interaction it was generally those that arose in new encounters. They frequently referred to the misconceptions which were held about blind people; the following comments illustrate that generally the
respondents felt that there was a negative evaluation made of blindness.

"People think that because you can't see you must be soft in the head." (Mr. Downes)

"I'm often treated as though I'm stupid." (Mr. Elderfield)

"The biggest problem for the blind is convincing people that we are 'normal'." (Mr. Fuller)

"Communication between the sighted and the non-sighted is made difficult because they hold negative preconceptions." (Mr. Cole)

"I can put up with the blindness, but I get fed up with being treated as though I'm an idiot." (Mr. Harris)

Most of the respondents found the way people reacted to them irritating, although during the early period of their blindness careers many had found societal reaction very distressing. There was a general sense of resignation, and acceptance, that they would often be treated as helpless, inferior, stupid, deaf, and so on. Nevertheless, not all comments about the public were adverse, indeed, it was common for respondents to both criticise and praise the general public. The following comments illustrate this.

"I have always found people willing to help me, both when I'm travelling and at work." (Mr. Sims)

"It was only when I lost my sight that I found out how kind people could be." (Mr. March)

"I have mainly met with great consideration from sighted people." (Mr. Fuller)

"In Britain there is a tradition of charity; people are very open-hearted." (Mrs. Massey)

Even though the blind are often treated sympathetically, many of the problems that arise are social. As many of the respondents said, they could cope with the physical loss, but the social implications of loss continued throughout their blindness careers.
Although most of the social problems did arise from new, and sometimes casual, encounters, more permanent relationships could sometimes be affected.

**Social Exchange**

Discussions in this, and in previous chapters, have shown that there is a desire for independence and equality on the part of blind people. However, as Scott (1969) pointed out, relationships between the sighted and the blind are often those of social dependency. Certainly, one of the problems encountered by the respondents is that reciprocal relationships often become more difficult after loss. As one of the respondents, a social worker, suggested earlier, the sighted feel that it is somehow unexpected that someone who is severely impaired should help someone who is likewise situated. Most of the respondents felt that blindness does enforce some dependency, but this may be at differing levels, and for some, may be temporary.

Social exchange theory, as proposed by Blau (1964) suggests that human relationships are based on reciprocity, that is, social actions are motivated by the returns that they will produce. In a work setting, a superordinate will give advice and attention to a subordinate and will be rewarded for giving time to this activity by receiving esteem from the latter. In the case of the blind, they may be continually being 'done to' by others, for example, receiving sympathy, financial assistance, and practical assistance from others. Those who supply these acts may be rewarded by gratitude, but perhaps they do not expect to receive equal returns.
Thus, blindness can bring about inequality, not just in casual relationships, but in relationships with family members. Almost a quarter of the respondents reported this as being a problem to them. These respondents felt that being at the 'receiving end' devalued their status and made them inferior.

As the following respondent illustrates:

"I felt that the burden of responsibilities fell on my wife. I could no longer take a share in organising our lives – she was doing everything."

Mr. Berry said that this inequality was a major problem for him and his wife because they had tried to establish an equal relationship in the twelve years of their marriage. Both Mr. Berry and his wife said that they had shared all the decision-making, financial responsibility, and household chores. When he lost his sight they both felt that this equality had been dissolved. As Mr. Berry said: "I felt that she (his wife) was doing all of the giving, and I, the taking." However, during the interview, his wife intervened and said that she had not felt like that during the early stages, but the respondent re-iterated that this was how he had perceived it. When Mr. Berry began working again he said that he could once again take a fuller part in the relationship and that it was, at the time of interview, on a "more equal footing".

An example of how reciprocity was seen as being of great importance in a relationship was illustrated by another respondent, Mr. Franklin. He met his wife while he was undergoing operations on his eyes. "She was nursing me and knew all the problems, before we were married. It's just as well, she had to see me through over seventy
operations." The couple, however, both emphasised that neither party viewed the other as being the receiver, rather than the giver, and that their relationships was "mutual". Mrs. Franklin talked at length about the "confidence" that her husband had given her, and the "encouragement to become a health visitor". Mr. Franklin said he had taken equal responsibility for raising their three children, and during periods of unemployment, had taken over all household responsibilities.

There were, on the other hand, those who suggested that blindness had led to them no longer being an equal partner. For example, Mr. Fuller said that this had contributed to his wife leaving him. He also felt that, in terms of employment, he was no longer seen as equal to other workers:

"You're devalued as a man - you are no longer a 'marketable commodity'."

He believed, as some others did, that blind people were seen as inferior, and thus could not play a full part in both relationships, and in the employment field.

It has already been suggested that the view of blind people being inferior and lacking in capabilities affected employment opportunities. Even if a potential employee does get an interview, the interview itself might present problems. The blind person applying for a job may be put into the position of social dependency. In the interview situation, the employer will designate a certain role to the interviewee, and designate his or her own role in terms of how the interviewee is viewed. For example, the
employer may see him or herself as a possible benefactor, negotiating the chances for the blind person to prove a worthy cause.

Scott (1969) and Hilbourne (1973) discuss the employment interview. The problem is, the interviewer may not know how much, or how little the person can see. The interviewer may have to help the person to a chair, locate an ashtray, and perhaps guide him or her to a toilet. An unequal situation can arise, reinforcing the pre-conceived roles; there may be a degree of unease on both sides. In an interview between a sighted interviewer and non-sighted interviewee, the normal rules of conduct and expectations of behaviour may be suspended. Hilbourne sees the interaction between the disabled and non-disabled as likely to lead to the "disabling of the normal", and thus the interviewer may lose control of the interview.

The interview is the necessary gateway to employment. If the blind person seeking employment is 'fortunate' enough to gain an interview, the pre-conceived ideas about blindness will have to be fought. It could be argued that there is inequality between the interactants when both are able-bodied. However, in the case of the impaired individual he or she must convince the potential employer that blindness does not confer a lot of other discrediting attributes.
It has been shown that blindness can present many problems, especially those which arise as a result of the views the public hold about those without sight. Many of the respondents felt that blind people were treated as deviants and that blindness was a stigmatising condition. Most of the respondents felt that blind people were regarded as an homogeneous group, and that they had a wide range of personalities, attitudes and behaviour. Difficulties often arose in social interaction, in particular, because sighted interactants were embarrassed about the blindness and tried to avoid taboo words. During blindness careers, the sick and disabled role is likely to be encountered. However, although it has been suggested that those who lose their sight will be socialised into the blind role, it was evident that few respondents could have been said to hold this role. Indeed, most of the respondents were able to obtain a variety of roles. However, it did seem that self-concepts were likely to be affected, even if only temporarily, by visual loss, and certainly, a loss of self-esteem was common to all, at some period during the blindness career. One of the difficulties which arose from blindness was that reciprocal relationships were sometimes difficult, and that sighted people often tried to place the blind into social dependency.

Summary

It has been shown that blindness can present many problems, especially those which arise as a result of the views the public hold about those without sight. Many of the respondents felt that blind people were treated as deviants and that blindness was a stigmatising condition. Most of the respondents felt that blind people were regarded as an homogeneous group, and that they had a wide range of personalities, attitudes and behaviour. Difficulties often arose in social interaction, in particular, because sighted interactants were embarrassed about the blindness and tried to avoid taboo words. During blindness careers, the sick and disabled role is likely to be encountered. However, although it has been suggested that those who lose their sight will be socialised into the blind role, it was evident that few respondents could have been said to hold this role. Indeed, most of the respondents were able to obtain a variety of roles. However, it did seem that self-concepts were likely to be affected, even if only temporarily, by visual loss, and certainly, a loss of self-esteem was common to all, at some period during the blindness career. One of the difficulties which arose from blindness was that reciprocal relationships were sometimes difficult, and that sighted people often tried to place the blind into social dependency.
When blindness occurs in adulthood every aspect of the individual's life is likely to be affected, including career, status, roles, occupation, relationships, self-concept, and interests. One of the greatest changes is in the way the individual is subsequently perceived by others. Those who become adventitiously blinded will go through a process of adult socialisation, and societal norms will influence this process. It has been suggested by other writers that blindness behaviour is inevitably determined by societal reaction, and that people with defective sight will be socialised into a specific blind role. Although it is accepted that stereotyped assumptions about blindness can influence social interaction and opportunities open to blind people, it does not necessarily permanently affect the way blind people act, the way they perceive themselves, nor do they inevitably take up the blind role.

This chapter summarises the findings of the present study; discusses two theoretical approaches to the study of disablement; examines the blind role; gives recommendations about rehabilitation services; assesses the objectives of the present study; and gives suggestions for future research.

There has been no previous study of the long-term effects of visual loss in adulthood. There have been a number of American works which considered adjustment, but like two previous British studies by
Fitzgerald (1970) and Abel (1976), they concentrated on the early period of blindness. The blindness career, however, is a long-term one; thus a more adequate treatment was to study people who had been blind for varying durations and include those who had been blind for a considerable number of years. A career is a continuous process during which various status passages, social roles, and life events can be encountered. The advantage of using a career model was that it was possible to examine the subjective and objective elements of a blindness career. This has enabled an overall picture of blindness to be presented, from the early period of becoming blind, to showing what it is like to be a blind person.

Although this is a study of blindness, much of what is said can be generalised to other disabled groups. Blindness is often referred to as being separate from other disabilities; indeed, blind people themselves often refer to 'the blind' and 'the disabled'. Nevertheless, blindness can be seen as a form of disablement for it involves functional limitations. Both blindness and disability can be defined in four ways, that is: 1) determined by social norms; 2) legally (generally associated with the ability to work); 3) medically; and 4) by self-definitions (Blaxter, 1974).

The career of disability begins with severe impairment and continues throughout the individual's life. Even though the individual may learn skills to overcome the practical problems of blindness, the status of blind person will, in most cases, always be held. Whatever activities are performed, whatever behaviour is exhibited, and whatever successes are achieved, the sighted are
likely to judged these in the context of blindness. It is difficult for the blind individual to escape from the label, even though he or she may successfully adjust and lead a life little disrupted by visual loss.

Summary of Findings

This section briefly summarises the findings of the research project. This research has been structured using a limited set of concepts, mainly those of career, status passage, social role, deviance, stigma, and self-concept. At the beginning of the project the following questions were posed: 1) How do people cope with visual loss and what affects their adjustment? 2) Do they follow a specific rehabilitation pathway? 3) Does their occupational status change when blindness occurs? 4) Are their roles and self-concepts affected by becoming blind? 5) Are blind people imputed with deviant status? 6) Is blindness a stigmatising condition?

Blindness can result in the initiation of a number of status passages. The most significant is the passage from sightedness to blindness. This passage is often a lengthy process; blindness generally occurs after slow deterioration of sight, rather than through sudden loss. Although blindness may be scheduled, that is, there are early symptoms of visual loss, registration as blind may not take place until several years after onset. The duration of the blindness passage can vary greatly, from a matter of days to several years. Those who experience gradual loss may be aware that blindness will result from their defective eye condition;
nevertheless they may not prepare for blindness. Indeed, resistance to accept that blindness will occur, and delay in learning to deal with the practical, psychological, and social consequences of visual loss is common.

The majority of those studied had experienced a gradual deterioration of sight; however, many of the respondents in this group, and those who experienced sudden loss, said that losing their sight had been a shock and a traumatic experience. Prior to registration, reluctance to accept that blindness would be inevitable was common, and hope for a cure, or an amelioration of sight, continued to be held even though the prognosis had been determined. For some, hope of a reversal in the condition was held even after registration; as many conditions are not static and some individuals can experience periods of total loss, perhaps followed by reading ability, these hopes are not always unrealistic.

Over half of the respondents stated that they were reluctant to register as blind. There were several reasons for this resistance: 1) it was seen as an unwelcome change in status; 2) there was a dislike of bureaucratic procedures; 3) there was a commonly-held belief that only those with total loss were eligible, thus those with reading ability did not believe that they fitted the criteria; 4) some who had reading ability believed that it would be a self-fulfilling prophecy if they did register and that they would become totally blind; and 5) that blindness was regarded as a stigmatising condition. Those who did not mind registering said they did so to receive practical help in the form of advice and
aids, financial help, and the opportunity for contact with other blind people. Indeed, some of those who had shown an initial reluctance to register also found that there were benefits to be derived.

Reactions to blindness varied. Although with a retrospective study it is difficult to assess the psychological impact of blindness during the early period of loss, it was apparent that while some were 'devastated' by their blindness, others were accepting and little affected by it. The most common pattern which emerged was that there was: 1) shock; 2) uncertainty; 3) non-acceptance of loss; 4) increased dependency; 5) rationalisation of loss; and 6) accommodating the blindness. Notably this pattern did not include the periods of depression which proponents of the psychological explanation of blindness behaviour (see Chapter 3) see as an inevitable part of becoming blind, although there were instances of severe depression occurring.

Those who experience severe visual loss will follow the status passage from sightedness to blindness; but other passages, such as the rehabilitation passage and the employment passage are also likely to be negotiated. Those who become blind will have to deal with a variety of problems, many of these of a physical and practical nature, for example, becoming used to fragmented vision, learning to be mobile, dealing with self-care and domestic activities, and relearning communications skills. For those of working age, some of the most important skills to be learnt are those associated with employment, thus the assistance of agencies
may be sought by those who have employment problems after blindness occurs. Both the rehabilitation passage and the employment passage were considered in some detail in this study.

The rehabilitation passage was one of learning to cope with visual loss, regaining independence, and adjusting to blindness. The majority of respondents referred to six factors which aided adjustment: 1) retaining employment, even if it involved a change of occupational status; 2) retaining other previously-held roles and responsibilities (for example, being head of a household); 3) receiving support from family members; 4) personality traits and motivation, that is, being determined to overcome obstacles; 5) receiving assistance from rehabilitation agencies; and 6) being accepted by sighted people.

The rehabilitation passage consisted of a number of possible stages: 1) onset of symptom; 2) treatment; 3) registration; 4) assessment of need; 5) contact with agencies dealing with rehabilitation; 6) access to resources; 7) training given; 8) employment; and 9) aftercare. In practice, few followed all the possible stages. Of the forty-two respondents, twenty-six received formal rehabilitation assistance, mainly to obtain occupational skills. Whether all the stages were followed depended on the eye condition, the needs of the individual, the individual's awareness of facilities, the way the rehabilitation passage was directed by agencies, and the life events which occurred after visual loss.

The degree of satisfaction with rehabilitation services varied
amongst those studied: there was some criticism and comment on the lack of liaison between agencies, and on the lack of information provided about facilities. Of those who received training, some praised rehabilitation workers for giving them support and confidence, while others criticised them for using stereotypes in dealing with rehabilitees, making them feel inferior, encouraging them to have lower expectations, and trying to channel them into a narrow range of traditional occupations. Those who praised the services provided were those who had previously-held manual and semi-skilled occupations, while those who were vociferous in their criticism had mainly professional and skilled backgrounds. The latter group had entered the rehabilitation passage having specific expectations of the type of training they should be offered. That is, they generally wished to receive assistance in learning to deal with the blindness, and to obtain skills in order to continue with their previously-held occupation, or to gain one of a commensurate status.

Almost a quarter of the respondents had gained assistance from belonging to self-help groups, mainly because they could share their problems with others and take part in social activities. However, two-thirds of the respondents suggested that they had received their greatest assistance and support from their families, and over half regarded this help as being more important than that received from other sources.

When a person becomes blind in adulthood, it is likely that he or she will experience occupational changes. The most usual reason is
that it may not be possible to carry out a particular occupation with limited or no sight, for example, being a pilot. Another reason is that there may have been prolonged absence from the occupation due to treatment for the eye condition. A further, and important reason, is that employers are often reluctant to employ blind people; they regard them as being both a financial and a safety risk, as not being fully capable, and as being in need of assistance from sighted staff.

In the present study, occupational mobility was measured; it was found that almost a quarter of the respondents retained their occupational status, almost a quarter increased theirs, and almost half experienced a decrease in status. However, it was felt that the Goldthorpe and Hope (1974) scale used did not truly reflect employment outcomes, and thus occupational status was categorised into four sections: 1) retained employment; 2) non-traditional employment; 3) traditional employment; and 4) unemployment. An eighth of the respondents retained employment; a fifth gained non-traditional employment; a third gained traditional employment; and a third were unemployed (including two housewives). The majority of the respondents had changed their occupations. Those who were in retained or non-traditional employment had, at the time of losing their sight, held professional, managerial and intermediary, non-manual, and skilled occupations. Those who were in traditional employment had previously held non-manual, semi-skilled and unskilled employment; in fact, this group's occupational status was little changed. The majority of those in traditional occupations had their employment passages guided by
rehabilitation and employment agencies, whereas those in non-traditional employment generally controlled their own passages. Whether in non-traditional or traditional employment, the majority of respondents expressed satisfaction with their work, and in holding the work role.

The unemployed group consisted of a range of previous occupational backgrounds. The reasons for unemployment fell into eight categories: 1) the nature of the job and the tasks involved; 2) the wish to retain previously-held occupational status; 3) employers' attitudes (both previous and potential employers); 4) decline in traditional employment; 5) the inadequacy of employment services; 6) market forces; 7) geographical location; and 8) the individual's personality and motivation.

Although there were differing levels of sightedness amongst those studied, there was no correlation between the degree of available sight, and employment outcomes.

Gaining the work role was seen as providing status, restoring self-esteem, helping to 'normalise' the individual, allowing for social contact, and giving a sense of structure to the day. Those who were employed were able to overcome many of the problems associated with blindness, and generally regarded themselves as being successfully adjusted to their loss. On the other hand, those who were unemployed tended to regard their blindness as disabling, and in many cases, as acting as a catalyst to a number of 'unhappy' events, for example, being rejected by a spouse.
Most of the respondents had experienced difficulties in regaining employment. The majority of respondents felt that employers held stereotyped beliefs about blindness and that they were prejudiced against them. These beliefs reflected commonly-held views about blindness held by society; these conceptions can cause considerable problems for blind people. Indeed, those who become disabled in some way may find that they no longer comply with the norms and values of the society in which they live. Whereas prior to impairment, they regarded themselves, and were regarded by others, as 'normal', they no longer fit that criteria. Those who have severe visual loss are allocated to a deviant group and are frequently stigmatised. Society may feel that they deviate in three ways: 1) they do not comply with the norms of wholeness; 2) their physical appearance may deviate from the norm; and 3) that they have different personalities from the rest of the population. The belief that blindness was regarded as a form of deviancy was borne out by those studied. They were frequently treated as though no longer 'normal' when they lost their sighted; they were assigned to an homogeneous groups, and in particular, they were regarded as being helpless and encouraged to be dependent. In new encounters they were often treated as though they were incapable, and their escorts were addressed. However, although there were criticisms of 'the public' it should be said that there were many comments about the kindness and sympathy which had been shown to them. Despite this, respondents frequently commented that it was relatively easy to overcome the physical problems of visual loss, but that the greatest difficulties were caused by societal reaction (see
The self-concepts and self-esteem of those studied had been affected at some time during their blindness careers. Lowered self-esteem could arise in three ways: 1) by the life events which occurred after loss, for example, unemployment; 2) the individual's previous perception of blindness; and 3) the lack of physical wholeness which may distress the individual. The effects on self-esteem mainly occurred during the early period of blindness when some increased dependency was experienced. A turning point for most of those studied was the regaining of the work role. In addition, those who had been able to overcome the early effects of blindness more easily were those who had some familiarity with blindness, that is, who had a family history of blindness.

The present study began with some previous knowledge about blindness. A pilot study and a wide reading of literature and research works enabled the following hypotheses to be postulated; that: 1) the blind role (as described by Scott, 1969) would not be permanently adopted; 2) there would be a variety of reactions to blindness; 3) occupational changes would result from becoming blind; 4) retention of employment would be the key to successful adjustment; 5) although the blind have to deal with stereotyped assumptions, this may not permanently influence behaviour and self-concepts, but will present considerable problems; and 6) the physical problems of loss would play a less significant part than the psychological and social implications.
The first of these hypotheses is dealt with in some detail in the following section. All the hypotheses were supported by the present research. There were indeed differing reactions to blindness; while some accepted blindness as being simply a loss of one of the senses and sought to overcome the disabling effects of blindness, others regarded it as a serious handicap which had altered the course of their lives. With a retrospective study it was not possible to isolate accurately the possible causes of the various outcomes. As already stated, having some knowledge of blindness helped respondents, but slow deterioration of sight did not necessarily protect the individual from the feelings of shock, which are to be expected of those who experienced sudden loss. In addition, pre-conceived conceptions about blind held prior to loss are likely to influence the individual's attitudes and adjustment. The most crucial factor influencing successful adjustment must relate to the level of disruption caused by the blindness. Where becoming a blind person causes upheaval in employment, relationships, and in environment, the adjustment process is likely to be lengthy and distressing. On the other hand, where the individual is able to retain the status quo, for example, retaining employment, and remaining with a supportive family, the rehabilitation process and subsequent adjustment is more easily facilitated. It is felt that personality factors play a large part in determining individual outcomes; frequently the author was informed by respondents, and often by rehabilitation workers, that those who were motivated to overcome all the obstacles which faced blind people, would do so under any circumstances.
Those who become blind will not necessarily follow the same rehabilitation pathway, neither will their outcomes be uniform. For most blind people, the goal which they and others such as their family and rehabilitation personnel set, is to achieve maximal functioning within the limitations of their blindness. Such goals will be determined by the individual's personal resources, their circumstances, others' expectations, and the desire to achieve independence. It was apparent from the present study that many of the physical and practical problems associated with blindness could be overcome. With a combination of training, aids, and determination, it was possible for the respondents to cope with a wide range of tasks, which to a sighted observer, might seem impossible; for example, a totally blind man repairing a roof (one instance from the present study).

The most notable aspect of this study was the apparent resilience of the respondents, and their ability to overcome many of the difficulties which arose from blindness. As some of the studies of attitudes to blindness show, it is frequently seen as the worst impairment that can befall a person. Certainly, during the period of this study, the author frequently came across this view from sighted people. However, it was interesting that when general disablement was discussed with the respondents, over a quarter said that if they had to be impaired they would prefer to be blind rather than have any other disability. Deafness was regarded by most of these respondents as being a far worse impairment, as it was described as being isolating. The majority of those studied led
what could be regarded as 'normal lives', pursuing everyday goals, performing a variety of activities, often little affected by blindness. Indeed, blindness was sometimes described as a minor inconvenience. It should be said, however, that most of those studied had been blind for a number of years and thus were well used to blindness. Adjustment must inevitably take place over a long period; had the respondents been studied during the early stages of blindness, their views on blindness may have been somewhat different.

When the hypothesis that occupational changes would result when blindness occurred was formulated it was anticipated that gaining traditional employment or becoming unemployed would be likely. Because training is given to blind people for so few occupations, it is inevitable, at present, that they will be guided into a limited range of occupations. It can be argued that without this training there may be more unemployment amongst blind people - at present the figure is two-thirds unemployed - nevertheless it must be said that many of these traditional occupations are unsuitable for professional and white collar workers. These groups face particular difficulties in having to deal with written communications; however, as it is estimated that over fifty percent of blind people have useful vision, it may be that too little emphasis is placed on encouraging the use of this residual vision. Certainly new technology is leading to the availability of more sophisticated visual aids and thus the wider employment of these may reduce the disablement produced by blindness.
The hypothesis that retention of employment would be the key to adjustment has been supported, and this has been discussed at some length. For those who become blind, or indeed disabled in some other way, their new status can be overwhelming. As one respondent remarked, the blind person can no longer be "unnoticeable". Thus there is a need to gain another status which may reduce, to some extent, the effects of being allocated to a deviant group. The benefits of gaining the work role have been outlined above, and it should be further emphasised that holding any employment, whether it is traditional or non-traditional, is a major factor in aiding successful adjustment.

The hypotheses concerning the effect of stereotyped assumptions, and the social implications of loss, are dealt with in the following section.

**Previous Approaches to the Study of Disablement**

The two main approaches to disablement which were considered throughout this thesis were: 1) societal reaction theory, and 2) rehabilitation theory. The former suggests that those who are disabled are designated to a deviant group, and that societal expectations will subsequently influence their behaviour. One of the foremost proponents of this theory, Scott (1969), discussing the blind, argues that the agencies which 'assist' the blind, actually socialise them into a blind role which is generally one of helplessness and dependency. Like other societal reaction theorists he suggests that agencies assist the disabled in their deviancy. On
the other hand, rehabilitation theorists and practitioners argue that the specialised form of training and assistance provided, far from segregating the individual from society, gives the disabled the opportunity to achieve maximal functioning in order that a variety of roles can be gained, thus enabling reintegration into society.

Gove (1976) says that because the concept of disability has come to be institutionalised, when people pass through agencies they are assigned either the disabled or non-disabled role. Those who are found to be disabled are then encouraged to accept their disability, and only mix with disabled people. Societal reaction theorists argue that agencies dealing with rehabilitation encourage the acceptance of this disability as also being acceptance of deviancy. Rehabilitation theorists and practitioners, however, do not regard the way they deal with their clients as assisting those who have become impaired in becoming deviant, but rather, as encouraging them to become independent. Of course, much depends on the nature and the degree of the impairment. Some conditions are so severe, for example, total paralysis, that it is difficult for individuals to lead what could be regarded as a 'normal' life, and they may be forced to be grouped with other people.

According to Scott (1969), agencies dealing with the blind, help to perpetuate commonly-held views of blindness behaviour. He states that there are various conceptions about blindness, and that these conceptions will be self-actualised by the blind (see commonsense and stereotyped explanations of blindness behaviour, Chapter 3 of
This thesis). It was suggested by Scott (1969) that those who have seriously defective sight will inevitably take on the blind role, and that only the exceptional will escape it. That is, the majority of the adventitiously blinded will be socialised into this role by social interaction with the sighted, and in particular, by blindness agencies. He implies that the majority of those with defective sight will have close and continued contact with agencies. When the present research was begun it was felt that Scott's conclusion was too simple. Although Scott's work provides a valuable starting point for the present study, it was felt to be inadequate in a number of ways. Firstly, Scott proposes that most people will adopt the blind role; he implies that the newly blinded individual begins a blindness career with no knowledge and experience of other roles. Secondly, he assumes that most newly blind people automatically become involved with blindness agencies, thus he concentrates on the effects of these agencies on the blind. Thirdly, he does not provide an analysis of the stages of adjustment which occur after blindness.

Scott proposes an "oversocialized conception of man" (Wrong, 1961). Scott implies that a person is so malleable that external forces will be an overwhelming influence on the individual. He does not appear to recognise that previous roles, the personality of the individual, and subsequent life events will also affect the roles adopted by the adventitiously blinded. Although there may be a blind role which is one of helplessness and dependency, some will not take it up at all, while others may accept it temporarily, and later in their blindness careers, adopt other roles. Although many
of those studied had encountered the blind role during their blindness careers, they had succeeded in overcoming it, and it was evident that the majority of those studied held a variety of roles. There were, however, a small number of people who continued to hold the blind role several years after registering as blind; they were unemployed and had spouses who had assumed responsibilities formerly held by the respondents.

Scott placed much blame for the adoption of the blind role on agencies. It has been stated that rehabilitation theorists and practitioners argue that agencies assist newly blind (or other disabled) people to gain skills in order to take their place in society; whereas societal reaction theorists such as Scott state that they encourage them to be isolated. Scott found that in the United States there were two main approaches to rehabilitation: 1) the accommodative approach which encourages individuals to depend on agencies where the environment is tailor-made for blind people, and 2) the restorative approach which encourages reintegration. However, he found from his own study that, generally, blind people were encouraged to be dependent, helpless, and docile.

In Britain, there is evidence of both approaches. Certainly for the working-age blind, the restorative approach is generally taken, and the view held by agencies is that their clients should develop skills in order to be useful in society. It seems from what Scott says, that agencies in the United States have a greater influence over their clients than they do in Britain. As this study has shown, it is quite possible for individuals to be 'rehabilitated'
while having little, or no contact with agencies.

The major area in which rehabilitation agencies become involved is in assessment and occupational rehabilitation. It is here that they can have their greatest influence, in that they can direct the rehaibilitees to employment which they regard as 'suitable'. Although they state that they encourage independence, it seems that these agencies hold low aspirations for their clients. There is evidence of stereotyping, which treats the individual, whatever his or her background, as though they have minimal abilities. Although this may suit the unskilled, the needs of the skilled and professional clients may not be met. Amongst those studied, one of the most disheartening aspects of becoming blind was being informed that they would be trained for employment which was felt to be below their capabilities. The most commonly held view of those studied was that agents did not take account of individual differences.

Although societal reaction theorists criticise rehabilitation agencies, and many criticisms have been made in this thesis, such agencies can provide a valuable service giving assistance, providing training, and distributing aids. Nevertheless, societal reaction theorists do made a valid point when they suggest that rehabilitation theorists and practitioners do not take account of the stigmatising effects of blindness. Certainly, there was no evidence that any of those studied had been given any assistance in learning to deal with social aspects of blindness, nor indeed, the psychological effects. Advice and training on these matters would
have been welcomed by many of the sample. It should be said that although societal reaction theorists are strong in their condemnation of rehabilitation agencies they do not suggest an alternative way in which those who become severely impaired could be dealt with effectively. Thus, the rehabilitation model is of value; even though in practice it has its inadequacies, it does at least try to deal with many of the physical problems which arise from impairment.

One of the aims of this study was to examine the commonsense and stereotyped explanations of blindness behaviour. From the present study there was ample evidence to suggest that the public do hold stereotyped assumptions about the personalities, behaviour, and attitudes of the blind. Certainly, those studied continually came up against these conceptions, particularly in new encounters. However, although social interaction did present some problems, it was evident that it was something which blind people learn to live with, even though it often caused intense irritation on the blind person's part. Hilbourne (1972) suggested that disablement "disables the normal" and certainly those studied were used to their blindness producing "strained interaction" (Davis, 1961).

How far this societal response went in influencing blindness behaviour is difficult to assess. However, from the evidence of most of those studied, it did not have long-term effects on behaviour or self-concepts. Although the majority of respondents had been affected in the early stages of their career, they had generally learnt to deal with 'misconceptions'. Certainly, most
people did not see themselves as deviants, and frequently commented that they were "normal"; however, they were aware that it was common for the public to regard them as a deviant and homogeneous group. The evidence from this study shows this not to be the case; there were a wide range of personalities, attitudes, and roles held by those studied.

**Recommendations for Rehabilitation Agencies**

A number of criticisms of the services have been made, thus a list of possible improvements to the services is presented.

1. There should be more co-ordination between agencies, and the dissemination of information regarding possible aids and assistance.

2. Ideally, rehabilitation counsellors should be employed, to liaise between medical, rehabilitation, social services, and employment services. At present, the general social worker does not have the time or resources to carry out this role adequately.

3. There should be counselling for the newly blinded person, concerning the psychological and social implications of loss. For example, training in the form of role-playing, and becoming used to dealing with the reactions of others.

4. Each blind person should be dealt with as an individual, each with differing abilities, backgrounds, experience, qualifications, personalities, motivation, and personal circumstances. It is likely that no two individuals' needs will be identical. There should be emphasis on identifying remaining abilities.
5. Rehabilitation workers should not act as authority figures and dictate the career of the blind person, but should act as trainers and consultants, continually consulting rehabilitees about their requirements. They should build-up the confidence of rehabilitees in order that they should develop the independent role. Rehabilitation staff should assist the individual in reorganising and setting new goals, and develop methods to achieve them.

6. There is a need to examine and identify alternative employment possibilities, and not channel individuals into a limited number of occupations.

7. The family should be involved in rehabilitation programmes. In the study it was shown that the respondents depended to a great extent on family support. This could more effectively be utilised by informing the family of available facilities, counselling them, and generally assisting with the rehabilitation of the family unit.

8. Organisations dealing with blind people can have a significant influence on the public. The present image of blindness is still one of dependency and helplessness. Unfortunately, the major organisations dealing with blind people are dependent on charity, and thus their fund-raising may be in jeopardy if they change the public image of blindness.

Assessment of Research Objectives

When the present research began, the following objectives were formulated:
1) To analyse the effects on those who lose their sight, in terms of stages of a blindness career.

2) To examine the early period of blindness and assess reactions to blindness and registration.

3) To investigate the rehabilitation process, the views and experiences of the sample, and to establish the extent of agency involvement.

4) To analyse the occupational mobility of the sample, and employment outcomes.

5) To assess what effect blindness had on the sample in terms of self-concepts, self-esteem, and attitudes towards blindness; in addition, to establish whether the blind are treated as a deviant group and stigmatised.

6) To assess whether the three explanations of blindness behaviour put forward by Scott (1969) were applicable, that is, that there are commonly-held views of appropriate behaviour, that public stereotypes are self-actualised, and that the adventitiously blinded go through specific stages before achieving adjustment.

7) To examine whether Scott's "blind role" was adopted by those studied.

It was felt that the above objectives were, to a large extent, met by the study. By employing a career model and examining the status passages which resulted from blindness, it was possible to examine subjective and objective aspects of blindness. The project, however, was limited by time and financial resources; thus to allow in-depth interviewing, the sample had to be kept to a manageable size. It would have been more satisfactory to have obtained a
larger sample and develop a more quantitative study, as well as a qualitative one. This would allow a more adequate investigation of areas such as the rehabilitation pathway and occupational mobility.

The attempt in this study was to gain an overall picture of blindness by examining four main areas. Because there has been no previous study of blindness careers, the present study was largely explorative, therefore it was quite broad. However, it was apparent that some areas would have benefitted from more detailed investigation, for example, the effects of deteriorating sight on occupational career prior to registration, or the effects of blindness on the family.

There was also a problem in using retrospective accounts. Many of the respondents had difficulties in remembering the early effects of blindness; therefore, this presented problems in determining patterns of reactions. It was also difficult to distinguish between cause and effect, and weight certain factors, for example, how much lowered self-esteem was caused by loss of sight, and how much by becoming unemployed. If the respondents had been studied from the point of registration, and their progress followed, this would have allowed an assessment of what led to specific outcomes.

It was also difficult to examine self-concepts. Although there are scales which measure self-concepts, these were felt to be inadequate in two ways: 1) applying these sorts of measures in a semi-structured, informal interview would not have been appropriate; and 2) these scales are designed for sighted people,
and most of the respondents would have had difficulties in using them. The author had to rely on the respondents own accounts of how their self-concepts and self-esteem had been affected.

**Further Research**

There have been few studies on the psycho-social effects of disablement carried out. This study of blindness has shown that further study of a number of areas would prove fruitful. The symbolic interactionist approach was valuable for the present study, however, a more valuable approach should also include a systems perspective. To fully understand the problems of blind people, or any disabled people, it is necessary to look in considerable depth at the social structure of society and the allocation of individuals into specific groups, ie. 'the disabled' or 'the blind'. The following areas are worthy of further investigation: a detailed study of historical perspectives; a cross-cultural comparison of rehabilitation; an in-depth study of rehabilitation and employment agencies, examining in particular, the attitudes and goals of staff; observational studies of interaction between agency personnel and blind people; observational studies of interaction between the sighted and non-sighted; a comparative study of the careers of the congenitally blinded and adventitiously blinded; an examination of a sample of employer's attitudes towards the blind (and other disabled); and an analysis of the media's attitude towards disablement.

Ideally a longitudinal study should be carried out, following the
careers of a sample of adventitiously blinded people from the point of registration. The sample size should be large enough to allow an adequate comparison of rehabilitation pathways and employment outcomes. A longitudinal study would avoid many of the problems which can arise from using retrospective accounts. It would be fruitful for any further study to examine the effects of blindness on the whole family to establish changes in role, career, and problems of interaction.
APPENDIX

INTERVIEW SCHEDULE

NAME:

AGE:

MARITAL STATUS:

MEDICAL BACKGROUND

1. What is the cause of your visual impairment?

2. If gradual loss: when did deterioration of sight begin? If sudden loss: when did loss occur?

3. When did you first visit an ophthalmologist?

4. Did you spend any time in hospital? If yes: when? - for how long? (each period)

5. Were you first registered as partially-sighted or blind? - when?

6. How did you feel about registering?

7. What degree of sightedness do you have at present? (categorised as: total loss (1), light and dark perception (2), and reading ability (3))

8. Is your condition now static?

9. Do you have any other chronic illness/disability?

FAMILY HISTORY

10. Is there a history of visual problems in your family?

11. If yes: which members?

12. What was their condition?

13. Were they registered as partially sighted or blind?

14. Did you know any other people who were p.s. or blind?

15. For those who had no family history: did you know anyone who was p.s. or blind before your own loss?

16. Those who said yes to Q11, 14 or 15: did this help in any way? If yes: how?
PROFESSIONAL ADVICE/HELP

17. Were you given any advice/help by your ophthalmologist?  
   If yes: what sort of advice?  
   - was it of value to you?

18. What happened after you were registered as blind?

19. Were you visited by a social worker?  
   If yes: what advice/help were you given?  
   - was this of value to you?  
   If no: why not?

20. Were you referred to the R.N.I.B. or M.S.C. job centres?  
   If yes: by whom?  
   - when?  
   If no: did you contact either yourself? (or other organisations)  
   - when?

21. If given help/advice: What help/advice did they give you?  
   - did this help you?

TRAINING

22. Were you given any form of training?  
   If yes: what type (social, practical, occupational, etc.)  
   If no: why not?

23. If yes: where did you receive training?  
   - when?  
   - for how long?

24. Could you describe your experience of training? (eg. how was the respondent dealt with; what suggestions as to future prospects were made; was it of value, etc.)

25. If occupational training given: did this lead to your gaining employment?

PREVIOUS EMPLOYMENT

26. Were you employed when you experienced visual loss?  
   If no: why not?

27. If yes: What was your occupation?  
   - could you describe your work?

28. In what ways did your visual loss affect your work?

29. Did you experience periods of absence from work?  
   If yes: for what reasons?  
   - for how long?  
   - how did your employer regard your absence?
30. Did you change your occupation after registration?
   If yes: did you make this decision?
   If respondent did not make decision: did your employer ask you to leave?

31. Were you offered alternative employment within the company/establishment?
   If yes: what type of job?
   - was this demotion/promotion/on a par with that previously held?
   - did you accept?
   If no: why not?
   If yes: what changes took place?
   - did you receive assistance from other staff?
   - did you receive assistance from family/friends in order to carry out your occupation?

UNEMPLOYMENT

32. Have you been unemployed at any time since registration?
   If yes: when did this occur?
   - for what period?
   - what reasons would you give for this unemployment?

PLACEMENT

33. Were you given any assistance in trying to find employment?
   If no: why not?
   If yes: who gave you assistance?
   (eg. R.N.I.B./M.S.C./other)
   - was this of value to you?

34. What comments do you have on employment services?

NEW EMPLOYMENT

35. When did you obtain your first job after registration?

36. How did you obtain this employment?

37. What was your occupation?
   - description.

38. Did this employment necessitate a move from home?

39. What sort of difficulties did you experience?
   (questions about employer, other staff/assistance, etc.)

40. What other jobs have you had since registration?

PRESENT EMPLOYMENT

41. Are you employed at the moment?
   If no: what reasons.
If yes: what is your present occupation?
- description.

42. How was this job obtained?
- when?

43. How do you get on with your employer?

44. How do you get on with other members of staff?

45. Do you require sighted assistance?

46. Do you use aids?

47. Do you experience any difficulties in this employment?
   If yes: what type.

MOBILITY

48. Do you use a white cane?

49. Do you have a guide dog?

50. If employed: how do you travel to work?

51. Would you say you can travel to most places alone, or do you need sighted assistance?

INTERESTS

52. What interests/hobbies do you have?

53. Do you belong to any clubs/associations?
   - which ones?

Comments on the interview schedule

The foregoing was simply a guide to the interview. The interview was semi-structured and the questions used focussed on certain fundamental areas. At the end of each interview there was a general discussion, which was informal and unstructured. It was largely guided by the direction the interview had taken, and by the comments which had already arisen. If the following subjects had not been raised, they were introduced towards the end of the interview: how the blind person felt the sighted viewed blindness and blind people; how they viewed blindness prior to loss; how it had affected their self-concepts and self-esteem; how it had changed their lives; whether relationships had been changed; and any problems that arose in social interaction.

These questions were not simply an afterthought; they formed an important basis of the research. However, it was felt that the questions on these often sensitive areas could not be fully formulated in advance, and was dictated by the respondents being interviewed, and the previous content of the interviews.
BIBLIOGRAPHY


Carr-Saunders, A. and Wilson, B.R. (1933), The Professions, Oxford University Press.

Carroll, T.J. (1967), Blindness: What it is, What it does, and How to live with it, Boston: Little, Brown and Co.


Chevigny, H. (1947), My eyes have a cold nose, Michael Joseph.


Cutsforth, T.D. (1951), The Blind in School and Society,


Davis, F. (1961), 'Deviance disavowal: the management of strained interaction by the visibly handicapped', Social Problems, 9,2, pp. 120-32.


Fitzgerald, R.G. (1970), 'Reactions to blindness', Archives of
General Psychiatry, Chicago, Amer. Medical Assoc.


Ford, M., and Herschel, T. (1977), In Touch, BBC Publication


Freidson, E. (1965) 'Disability as social deviance', in Sociology and Rehabilitation ed. M.B. Sussman, pp. 82-93, Cleveland: American Sociological Assoc.


Hendrick, I. (1943), 'The work and pleasure principle', Psychoanalytic Quarterly, 12, pp. 311-29.


Hewitt, J.P. (1976), Self and Society - A symbolic interactionist social psychology, Allyn and Bacon, Inc.


Hilbourne, J. (1973), 'On disabling the normal', Br. J. of
Himes, J.B. (1960), 'Measuring social distance in relations with the blind', New Outlook for the Blind, 54, 54-58.


Hughes, E. (1945), 'Dilemmas and contradictions of status', Amer. J. of Soc. (pp. 355-559)


Kahn, R.L. (1957), The Dynamics of Interviewing, New York: John Willey.


Kleck, R. (1966), 'Emotional arousal in interactions with stigmatised persons', Psychological Reports, 19, pp. 1226.


Lowenfeld, B. (1949), 'A psychological approach to blindness', J. of Exceptional Children, 16.


Ritter, C.G. (1958), 'Changing attitudes towards blindness - from the point of view of 20/20', in proceedings of the 32nd Convention of the Amer. Assoc. of Workers for Blind, Inc.


Scheff, T.J. (1965), 'Typification in rehabilitation agencies', in Sussman (op. cit)


Shakespeare, R. (1975), The Psychology of Handicap, Methuen.


Simmons, H.E. (1949), 'The attitudes of the sighted toward the blind', in Proceedings of the 23rd Convention of the Amer. Assoc. of Workers for the Blind.


Smigel, O. (1963), Work and Leisure, Univ. Press.


Sussman, M.B. ed. (1965), Sociology and Rehabilitation, Amer. Socio. Assoc.


World Health Organisation (1958) in Rehabilitation, Report of the Sub-committee of the Standing Advisory Committee, HMSO.


