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Articles

Individuals With Visual Disabilities and Substance Use Disorders: Recommendations for Counselors

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Given the prevalence of substance use disorders in individuals with visual disabilities, counselors must be prepared to address the distinctive needs of this population. The authors summarize evidence-based interventions, offer contextual considerations, and provide recommendations for counselors.

Keywords: visual disability, substance use disorders, counseling, interventions

According to the Centers for Disease Control and Prevention (CDC; 2011), more than 1 million Americans are legally blind and 12 million are visually impaired. The terms *visual impairment* and *low vision* are often used interchangeably and indicate vision loss that may be severe enough to hinder one's ability to complete daily activities while maintaining some degree of usable vision (American Foundation for the Blind, 2008). However, there are no commonly recognized definitions for visual impairment and low vision (National Federation for the Blind, 2016). For the purposes of this article, we use the term *visual disability* to encompass a broader view of individuals who have significant vision loss and total blindness.

As the U.S. population ages and changes demographically, the number of people with visual disabilities is projected to double by 2030, and the impact of vision loss will grow significantly (CDC, 2011). The prevalence rates of mental health concerns, including substance use disorders (SUDs) and comorbidity, among individuals with a visual disability are higher than those of the general population (Koch, Nelipovich, & Sneed, 2002). *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) updated the criteria for SUDs and based the disorder on evidence of impaired control, social impairment, risky use, and pharmacological indicators (tolerance and withdrawal); the number of

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diagnostic criteria met by the individual will determine the level of severity (mild, moderate, or severe). Specifically, Koch et al. (2002) and the National Association on Alcohol, Drugs, and Disability (NAADD; 1998) reported that 50% of individuals with visual disabilities meet diagnostic criteria for SUDs. Koch et al. also asserted that comorbidity may exacerbate other disability concerns, thus worsening existing diagnoses and contributing to potentially fatal consequences.

In addition, research has confirmed that individuals who present with dual diagnoses are typically not receiving appropriate treatment and comprehensive services (Csiernik & Brideau, 2013; Helwig & Holicky, 1994). For example, Davis, Koch, McKee, and Nelipovich (2009) examined the training that certified rehabilitation counselors received when working with clients with visual disabilities who had existing alcohol and drug abuse concerns. Davis et al. assessed the helping professionals' attitudes and knowledge when working with this population of clients and found that the participants had a negative view of their clients, believing that they were more difficult to work with because of the generalization that people with visual disabilities and SUDs are "uncooperative" or "unmotivated." Davis et al. established that the participants' attitudes toward this specific population could potentially hinder treatment with their clients. Typically, helping professionals do not provide comprehensive services desperately needed to treat this population and feel ill prepared to treat co-occurring conditions (Csiernik & Brideau, 2013). Thus, lack of formal cross-training among helping professionals is another barrier for clients who present with a visual disability and SUD (Horowitz & Reinhardt, 2006).

Overall, counselors must be prepared to address the complex, multidimensional needs of individuals with visual disabilities and SUDs. The pervasiveness of SUDs among individuals with visual disabilities, the distinct psychosocial concerns, and the historically insufficient treatment are just some of the issues to which the counseling profession must attend. Therefore, the purpose of this article is to (a) provide a summary of the potential factors that contribute to individuals who present with SUDs and visual disabilities, (b) summarize evidence-based strategies and interventions, (c) offer multicultural and contextual considerations, and (d) provide implications and recommendations for counselors.

Potential Correlations

The prevalence rate of SUDs among individuals with visual disabilities is over 50% (Koch et al., 2002; NAADD, 1998; Novotna et al., 2017). Koch et al. (2002) hypothesized that there are three potential interactions between visual disabilities and SUDs. Type I is the preexisting SUD, which may be due to the psychosocial consequences of the visual disability, including lack of emotional equilibrium and excessive emotional, familial, social, and vocational concerns. Type II is the SUD preceding the onset of the

visual disability. Type II individuals may have adjusted to their disability, but they experience the harmful SUD effects that have been linked to self-medication for grief, anger, and frustration. Over time, because of the SUD, these individuals may begin to lose adaptive coping strategies previously used to adjust to their disability. Type III is when the visual disability and SUD occur concurrently; thus, individuals may misuse substances as a coping mechanism to deal with frustration over the disability and ease the adjustment process. All of these interactions can complicate treatment, and counselors are faced with the challenges of treating these issues simultaneously.

Clients experiencing both the SUD and visual disability face exceptionally difficult medical, psychological, vocational, and social challenges (Davis et al., 2009; Koch et al., 2002). Researchers have found several risk factors that increase substance use. For example, individuals who have a difficult time adjusting to their visual disability and/or who experience discrimination or isolation because of the disability have shown increased substance use (Brooks, DiNitto, Schaller, & Choi, 2014). Moreover, negative self-perception, harmful perspectives from others, general lack of knowledge, and enabling attitudes are also risk factors (Helwig & Holicky, 1994; Ueda & Tsuda, 2013). The impact of acquiring a visual disability has a profound influence on the lives of these individuals. Galvani, Livingston, and Morgan (2016) explored the perspectives of participants and the correlation between vision loss and substance use and found that participants experienced feelings of shock when they acquired their visual disability, which later progressed to depression, a sense of uselessness, and loss of autonomy and independence. Therefore, processing the loss of sight and adjusting to one's visual disability are theoretically necessary to combat mental health issues, specifically SUDs (Helwig & Holicky, 1994; Ueda & Tsuda, 2013).

Strategies and Interventions

Treatment of SUDs among individuals with visual disabilities involves accurate evaluation, appropriate interventions, and prevention efforts (Brooks et al., 2014). The following sections outline suggested strategies and interventions for individuals with visual disabilities and SUDs with regard to assessment, individual counseling, family counseling, peer support programs, and group counseling interventions.

Assessment

Counselors working with clients with visual disabilities should always assess and screen for SUDs because of the high probability of these co-occurring (Brooks et al., 2014). One particular measure to screen for SUDs is the CAGE Substance Use Screening Tool, which includes the CAGE Questions Adapted to Include Drug Use, or CAGE-AID (Davis et al., 2009). CAGE is

an acronym of the four questions in the assessment (cut, annoyed, guilty, eye-opener). Another SUD screening instrument is the Substance Abuse in Vocational Rehabilitation Screener (Novotna et al., 2017), which expands on the specificity and sensitivity while also minimizing respondent burden. Furthermore, Laplante-Lévesque, Hickson, and Worrall (2013) validated the use of the Transtheoretical Model of behavior change (also known as the Stages of Change Model) and treatment matching when working with individuals with sensory disabilities. The integrative framework of the model can be used to assess and understand the process of intentional behavioral change and maintenance of positive behaviors. The Stages of Change Model assumes that behavioral changes do not happen in one step but through a series of distinct, predicable stages. For a particular problem behavior, the stages (precontemplation, contemplation, preparation, action, and maintenance) can be sequential but can also be cyclical. Counselors must be aware that clients may revisit earlier stages, and they must successfully identify what stage the client is at and tailor interventions to the distinct stage (Petrocelli, 2002).

Notably, counselors should not only rely on personal observation and self-report from the client receiving services but also try to access additional clinical information. Rather than using one method for evaluation, counselors should use assessments that encompass multiple sources of information to obtain an extensive perspective of the client's history, level of functioning, and extent of distress (Substance Abuse and Mental Health Services Administration [SAMHSA]; 2009). Some examples of sources include (a) biological measures (e.g., urine testing, hair follicle testing, blood testing); (b) collateral sources of information, such as from family, friends, and other service providers; and (c) reflective data, including past evaluations and discharge summaries (Novotna et al., 2017; SAMHSA, 2009).

Individual Counseling

Counselors typically address myriad presenting issues when counseling individuals with disabilities, such as comorbidity concerns (i.e., SUDs, depression, anxiety), low socioeconomic status, unemployment, isolation, discrimination, poor quality of life, and minimal social support (Brooks et al., 2014; Erickson, Lee, & von Schrader, 2016; Helwig & Holicky, 1994; Horowitz & Reinhardt, 2006; Koch et al., 2002; Nyman, Dibb, Victor, & Gosney, 2012; SAMHSA, 2011). All of these factors may contribute to SUDs (Helwig & Holicky, 1994). For example, individuals with visual disabilities encounter stressors adjusting to a society that is designed for sighted individuals, and they experience the double stigma of (a) having a disability and (b) admitting to substance use (Csiernik & Brideau, 2013). Furthermore, individuals with visual disabilities encounter problems with mood management, low self-esteem, self-efficacy concerns, social connectedness, identity confusion, and feelings of loss (Dodds, 1989; Dodds et al., 1994; Thurston, 2010). Therefore, counselors must recognize

the spectrum of issues and emotional impact individuals experience when acquiring a visual disability and provide appropriate support during the transition process (Thurston, 2010). Specifically, counselors must attend to the grief and loss issues involving the visual disability and SUD, because risk increases when an individual has difficulty adapting to the disability (DiNitto & Webb, 2012).

Ebener and Smedema (2011) explored SUD recovery and adaptation to a physical disability and reported that quality of life is an indicator of both recovery and adaptation to a disability. Although little is known about the multifaceted relationship between adaptation to disability and recovery, some common variables can be identified, including health status, life satisfaction, spirituality, and community involvement (Ebener & Smedema, 2011). It is imperative for counselors to address adaptation to disability and recovery simultaneously; improvements in one area may lead to progress in the other (Ebener & Smedema, 2011). Furthermore, research has demonstrated that assimilative coping, which involves efforts to change one's situation in the face of obstacles in order to pursue goals, was beneficial for individuals with visual disabilities (Boerner & Wang, 2012). When adapting goals, counselors can assist clients and encourage flexible coping through goal engagement/disengagement and goal adjustment (Boerner & Wang, 2012).

SUDs typically prevent adequate resolution of feelings concerning the disability, but once SUD issues are addressed, the counselor can attend to clients' unresolved feelings regarding the disability (Helwig & Holicky, 1994). Studies have demonstrated the importance of clients working through their adjustment to blindness by (a) self-awareness of visual disability, (b) self-identification as individuals with a visual disability, (c) perceived social support, and (d) perceived well-being (Senra, Vieira, Nicholls, & Leal, 2013). Senra et al. (2013) found that clients' personal awareness of disability could be closely related to the way clients experience the disability versus being associated with the disability. Therefore, it is important for counselors to process how clients experience the disability and their coping or lack thereof. Furthermore, it is important to assess the extent in which clients consider their visual disability to be part of their identity. Counselors must also assess clients' perceived social support, which can be a mediator for mental health concerns (Senra et al., 2013). Finally, activities of daily living and clients' well-being must be considered when counseling clients with visual disabilities and SUDs (Senra et al., 2013). Once the counselor attends to the adjustment to blindness concerns, sobriety can be maintained (Helwig & Holicky, 1994).

Family Counseling

DiNitto and Webb (2012) suggested that family, friends, and caregivers may enable the use of alcohol or drugs among individuals with visual disabilities, which will affect treatment. Families must be challenged on enabling and manipulative behaviors that can be exacerbated by a family member's disability, as well as deal with their own feelings of grief, loss,

anger, guilt, and frustration (Helwig & Holicky, 1994). From a family systems perspective, the family members and the person with the disability are all part of a complex system in which preexisting patterns, norms, roles, and communication styles are established, and this system may exacerbate the presenting issues and concerns (Bambara et al., 2009). When engaging family members in the substance use treatment process, counselors must provide psychoeducation to teach them how to recognize subtle signs of substance use and how to assist their loved one in maintaining sobriety (Novotna et al., 2017). Counselors can also encourage family members to seek out organizational support groups, such as Al-Anon (for family members of alcoholics), Nar-Anon (for family members of addicts), and Adult Children of Alcoholics (for adult children of alcoholics and addicts). These peer support programs can assist with the emotional healing process and recovery.

Research suggests that, in addition to the individual adjusting to his or her visual disability, family members also go through the adjustment-to-blindness process (Bambara et al., 2009). The unique effects of visual disabilities and family members' emotional adjustment are often disregarded (Bambara et al., 2009). Thus, evaluating family functioning, emotional concerns, grief, and chronic sorrow must be considered. Characteristics of chronic sorrow include a perception of sadness to a situation with no foreseeable end; sadness that is recurring, is progressive, and can intensify; and sadness that triggers family members to think about losses or disappointments in their lives (Lindgren, Burke, Hainsworth, & Eakes, 1992). The hardships or adverse events that caregivers experience as they provide care may also contribute to caregiver stress (Tan et al., 2012). Lyonette and Yardley (2003) found that caregiver stress increased because of feelings of guilt, duty, responsibility, and lack of choice, as well as perceived disapproval from others if they choose not to provide care for their loved one. Although providing care for a loved one with a disability can be stressful and emotional for the caregiver, the caregiving role can be a rewarding experience and is oftentimes reported as a privilege (Bordonada, Feather, Ohrt, & Waddington, 2018). For those who provide care, maintaining responsibilities and activities outside the home, such as being employed or engaging in leisure activities, provides a sense of normalcy for them (Bordonada et al., 2018). Therefore, to address caregiver stress, counselors should prompt caregivers and families to reflect on the positive emotions they experience, as well as encourage them to continue with responsibilities outside the home (Bordonada et al., 2018). Thus, if counselors address clients' concerns about their adjustment to blindness, they should bear in mind that factors such as adequate emotional and instrumental support can protect clients against substance use and other negative health outcomes (Bambara et al., 2009).

Peer Support Programs and Group Counseling

Self-help support groups are a key component to informal care and provide focused goal setting, support, and structure (Moos, 2008). Alcoholics

Anonymous is the most well-known and available peer support, 12-step program in the United States; the only requirement to join is to have a desire to stop using (Branscum, 2010). However, the Self-Management and Recovery Training (SMART; www.smartrecovery.org) peer support recovery program has been proven to be ideal for clients with disabilities and supports rehabilitation counseling practices (O'Sullivan, Blum, Watts, & Bates, 2015). SMART emphasizes individual empowerment with cognitive-behavioral and rational-emotive techniques to nurture change in abuse patterns. Through facilitated support, SMART affirms independent and autonomous living and considers each person's unique needs when adjusting to a disability (O'Sullivan et al., 2015). Thus, when exploring options with clients, counselors must consider peer support groups, given that social support has been shown to be critical for long-term recovery rates (O'Sullivan et al., 2015) and a common issue for clients with visual disabilities (Brooks et al., 2014; Nyman et al., 2012). O'Sullivan et al. (2015) noted that adjustment to a disability was not a focus of the SMART program and may need to be addressed in counseling.

To address adjustment-to-blindness concerns, Ueda and Tsuda (2013) explored the outcomes of a structured group counseling approach for adults presenting with psychological distress associated with acquired visual disability. They found that group counseling combined with individual cognitive behavior therapy was more helpful than group or individual counseling alone. Ueda and Tsuda provided a detailed overview of 10 structured group counseling sessions, including the theme for the session, psychoeducational content, and stress reduction exercises.

Contextual Considerations

Individuals with visual disabilities encounter additional stigma related to negative public and professional attitudes (Koch et al., 2002; Novotna et al., 2017). These attitudes include viewing the individual as incompetent, incapable, and lacking intelligence because of the disability (Csiernik & Brideau, 2013). Studies suggest that helping professionals' attitudinal accommodations are often the most important adjustments made to ensure positive treatment outcomes (Novotna et al., 2017). Therefore, counselors should familiarize themselves with the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016), as well as the social model of disability (Baker & Donelly, 2001) and capabilities framework (Burchardt, 2004) before engaging clients with visual disabilities in counseling.

Theorists influenced by the social model of disability contend that perception and the client's environment shape social experiences; thus, counselors must confront attitudes toward disability and endorse principles of inclusion that emphasize equality, acceptance, and valued engagement (Baker & Donelly, 2001). Moreover, the capabilities framework is a holistic,

social justice initiative that considers disability through one's capabilities (Burchardt, 2004; Mitra, 2006). Counselors should recognize the capabilities framework and understand the effect society has on clients and the barriers faced by clients with disabilities, specifically visual disabilities. Counselors must also value client empowerment, whereby clients can fully participate, collaborate, and integrate into their community (Smart & Smart, 2006). By maximizing the potential of the client and maintaining a range of balance and purposeful direction, counselors can increase clients' overall wellness (Roscoe, 2009). Therefore, counselors must recognize the reality of the stigma and isolation experienced by those with visual disabilities (Dodds et al., 1994) and, in recognizing this, decrease the risk of SUDs (Brooks et al., 2014). For a detailed summary of facilitating the counseling process through the models of disability, see Smart and Smart (2006).

Spirituality is a critical aspect of wellness and quality of life, and the role of spirituality in coping with a visual disability is a significant predictor of adaptive coping behaviors (Yampolsky, Wittich, Webb, & Overbury, 2008). Yampolsky et al. (2008) investigated existential and religious well-being in 85 participants with visual disabilities. They found that existential and religious well-being led to adaptive coping behaviors, including maintaining positive outcomes, such as high self-esteem, life satisfaction, and functioning in daily life, despite the psychological distress experienced by the individual with a visual disability. Thus, integrating spiritual well-being tenets into counseling can be helpful when counseling clients with visual disabilities and SUD concerns. What is also essential is addressing the multitude of barriers these individuals experience on a daily, even hourly, basis.

Implications and Recommendations for Counselors

Research suggests that utilization rates of substance use treatment facilities by individuals with disabilities are roughly half the rates of clients without disabilities (Novotna et al., 2017). Consequently, individuals with visual disabilities face a host of programmatic and environmental barriers when trying to obtain appropriate supports from counselors (SAMHSA, 2011). Csiernik and Brideau (2013) outlined several barriers clients with visual disabilities encounter that counselors must take into account to meet the needs of their clients. First, counselors must provide these clients with alternative formats (e.g., Braille, assistive technology, or large print) to promote the therapeutic process and enhance participation in treatment (Csiernik & Brideau, 2013). Second, counselors must be willing to communicate and collaborate with other service delivery systems in which the client is involved (Helwig & Holicky, 1994; Koch et al., 2002; Novotna et al., 2017). For example, creating a professional dialogue with the vocational rehabilitation department not only enhances services for clients but also is best practice when working with individuals with disabilities (Weinstock & Barker, 1995). Third, it is important for counselors to remove the architectural

barriers to help clients access appropriate treatment (SAMHSA, 2011). For example, counselors must orient clients to the layout of the building and assist clients in locating important features of the building, as well as use large-print font on signs and include Braille on elevator buttons and room numbers. Finally, overarching environmental barriers must also be taken into account, including housing and transportation concerns, as well as absence of employment and educational opportunities (Novotna et al., 2017). Thus, having an accessible environment will increase clients' participation in treatment (Csiernik & Brideau, 2013) and be compliant with the Americans With Disabilities Act of 1990.

In addition, when working with a client with visual disability, counselors must not only process the client's experience as a person with a disability but also acknowledge that this identity is simply one part of the client's identity (Smart & Smart, 2006). Smart and Smart (2006) recognized the importance of social justice and advocacy, which may need to occur outside the individual counseling session. Counselors must also establish professional relationships with agencies to which clients with disabilities are typically referred (i.e., vocational rehabilitation) to enhance care (Csiernik & Brideau, 2013; Helwig & Holicky, 1994; Smart & Smart, 2006). To strengthen treatment, counselors must demonstrate clinical competence.

Maintaining and continually enhancing clinical competence will increase the likelihood that counselors are able to assess and identify SUDs in clients with visual disabilities (Helwig & Holicky, 1994). The value in training culturally competent counselors has been empirically validated around heightening counselors' personal awareness, knowledge, skills, and action competencies (i.e., MSJCC; Ratts et al., 2016) to meet the needs of culturally diverse clients. Naturally, the counseling profession has placed disability competence under the MSJCC framework. Overall, multicultural competence is a multifaceted process and may develop during one's pre- or posteducational training (Barden & Greene, 2015). By bolstering MSJCC, counselors will be prepared to address the multitude of concerns that clients with visual disabilities and SUDs face.

To increase professional preparation and competency related to clients with disabilities and their families, counselors must receive adequate cross-training to promote integrated treatment and services (Brooks et al., 2014; Csiernik & Brideau, 2013; Horowitz & Reinhardt, 2006). Therefore, counselor educators must be prepared to integrate disability-related information into counselor preparation programs (Feather & Carlson, 2017). For more than 40 years, researchers have argued that counselors are not adequately prepared to offer services to individuals with disabilities (Feather & Carlson, 2017; Korineck & Prillaman, 1992; Lebsock & DeBlassie, 1975; Milsom & Akos, 2003). Hence, counselor education must continue to implement appropriate curriculum to address concerns regarding individuals with visual disabilities and SUDs, as well as decrease the gap in the literature related to this population.

Research on individuals with visual disabilities and SUDs is currently nonexistent (Brooks et al., 2014). Therefore, future research will need to explore why individuals with visual disabilities are at considerably higher risk of developing SUDs than are members of the general population. Research has suggested that rates are high because of numerous risk factors, including social integration; difficulty adjusting to visual disability, discrimination, and isolation (Brooks et al., 2014); attitudinal, programming, and environmental barriers (Csiernik & Brideau, 2013; Novotna et al., 2017); need for interdisciplinary collaboration (Helwig & Holicky, 1994); and service gaps (Koch et al., 2002). However, probability samples and empirical studies are lacking. NAADD (1998) and Koch et al. (2002) estimated that 50% of people with visual disabilities may have coexisting SUDs. Thus, we suggest exploring the current prevalence of SUDs among individuals with visual disabilities because of the dated research. Finally, little is known about the multifaceted relationship between adaptation to disability and SUD recovery (Ebener & Smedema, 2011).

Conclusion

It is clear that the impact of having a visual disability is far reaching. The pervasiveness and mental health concerns, including SUDs and comorbidity, among individuals with visual disabilities are at rates that are higher than those of the general population. Furthermore, there are few studies investigating the prevention, intervention, and treatment of individuals with visual disabilities and SUDs. Counselors must recognize the broad spectrum of issues relating to acquiring a visual disability, because risk of SUDs increases when individuals have difficulty adapting to their disability. In addition, family members' functioning and coping must also be taken into account. Research has confirmed that individuals with visual disabilities are protected against SUDs and other negative health outcomes when their families have adapted to their disability. The counseling profession must be active in the research and add to best practice to serve this population. Most important, counselors can play a dynamic role in treating clients with visual disabilities and SUDs and promoting greater life satisfaction.

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