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THE CARING ORTHOPTIST

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Abstract

This paper gives a general overview of counselling situations in an ophthalmological/orthoptic practice or hospital eye clinic. It suggests ways orthoptists may be able to handle these situations especially when confronted with a distressed or anxious client. Emphasis is placed on allowing clients to work through the crisis point through patience, empathy and good listing skills.

Key words: *Counselling, blindness, low vision.*

INTRODUCTION

In many instances, orthoptists are the first eye-care professionals with whom a client has contact within a private ophthalmological/orthoptic practice or hospital eye clinic. Consequently, orthoptists may find themselves in a position where many questions are directed at them or where the client is in an anxious or depressed state. How does the orthoptist handle these situations, particularly if the client has not specifically asked for any help but is obviously not coping?

Counselling is a process which is usually planned and has specific goals.[1] A counsellor is not necessarily a person who has been especially trained in the area of counselling but can simply be someone who is dealing with people and is in the position of offering advice. Orthoptists usually take on this role to some extent.

An orthoptist is sometimes still perceived in a different light from that of a medical practitioner. Accordingly, clients may direct more questions to the orthoptist than to the ophthalmologist because they feel more relaxed with him/her. In addition to this, when coming into contact with someone who obviously has some knowledge of eye conditions, the tendency for clients may be to immediately seek advice on the many questions that may have arisen since the eye condition first became known.

As it is recognised that each individual has needs that are unique, this paper does not attempt to discuss all the various counselling situations that may arise. Rather, it gives a general overview on how to handle common situations that the orthoptist may encounter. This will be done by considering the following questions:

Question 1

How do you recognise if a client does not fully understand the implications of the eye condition present and whether or not they are coping with the situation?

Question 2

How do you cope with the many questions asked by a client about the eye condition present?

Question 3

What do you do if you are confronted with a distressed person in the clinic?

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Question 4
Who do you go to for follow up help?

QUESTION 1
Being able to recognise body language is a very useful skill to have when attempting to gain some insight into what a client is thinking or feeling. For example, sitting on the edge of a chair "fidgeting", or not making eye contact with the examiner may indicate a nervous state, reflecting a fear of the unknown and a first time experience in an eye clinic. They may also be indicating that the client is not understanding all that is being said or is not coming to terms with the eye condition present.

The client's line of questioning can also provide hints as to their understanding of the eye condition. However, one must be careful not to interpret that someone is familiar with the medical facts, just because he is using ophthalmological terms such as "refractive error". They may have picked up the words during many visits to ophthalmologists but may never have had them fully explained.

When clients do not ask any questions this can also indicate a lack of understanding of the diagnosis. The client may have been frightened to ask questions in the past, thus creating a situation where he has not had any feedback on the implications or prognosis of the eye condition.

An appropriate way to handle the above situations is to encourage conversation with the client. This can be done by explaining each test that is performed or simply talking about topical events (should the time permit) to help "break the ice". This will allow the client to be more at ease and will let them know that the examiner cares about them as an individual and not just another ocular condition that has walked into the room. In a relaxed state the client is more likely to return the conversation and let you know where they stand.

The orthoptist should always find out what their exact role is in the clinic, determining with the ophthalmologist how much they can say to the client. Orthoptists should recognise that they are a professional and in a professional relationship with an ophthalmologist and should communicate as such. If the orthoptist's role is clearly defined in the first instance, including what extra things they can do (such as follow up phone calls), then a better working relationship with employer and client can be obtained.

At any time, the fact that a client is distressed should be immediately reported to the ophthalmologist. This will enable the client to be seen by the doctor as soon as possible and also prepare the doctor for a longer than normal consultation.

At the end of each busy day it is worthwhile for the orthoptist and ophthalmologist to talk to each other for a few minutes about any anxious clients or interesting cases they may have encountered during the day. This provides a supportive and learning environment for both and can prepare each for any future similar cases.

QUESTION 2
It is important to be a good listener and immediately answer any appropriate questions. If it is not possible to answer any of the client's questions fully it is not a good idea to attempt to answer them at all or give your opinion, especially if it relates to the prognosis of their eye condition or a particular factor of that condition that may have a number of reasons for its presence. Instead, the relevant questions should be written down and handed to the doctor. One should never be too proud to acknowledge that another person may be better qualified to answer their questions.

Clients feel more at ease if they are asked whether or not they have any questions or concerns about their eye condition. It is important that they are fully informed of the medical facts but the information should be given in such a way that others do not have to pick up the pieces.

An illustration of this is that of a 35 year old man who was told that he had retinitis pigmentosa and would eventually go blind. This was the only information given to him. Not knowing anything about the condition, on returning home from the doctor's surgery he

consulted a medical dictionary to learn more about his eye condition. To his great concern he found many other conditions and syndromes that can be associated with retinitis pigmentosa. Fearing the worst for himself and his family he became very anxious every time his children complained of a sore eye. Fortunately, in time, and after meeting others with the same condition, he became more aware of his condition and its implications for the future. If he had been properly counselled in the first instance, he could have been spared many anxious years.

When clients are given a visual acuity recording this should be fully explained. In most instances it is more valuable to inform the client of the functional implications of a certain degree of visual impairment. Advice should be individually tailored to his own unique situation, rather than spending much time in explaining what the figures represent. Unless one is working with acuity recordings on a regular basis, the notations are often difficult to fully comprehend in the context of every day situations.

It must be understood that one short session in a busy clinic is usually insufficient for the client to absorb all of the necessary information. Follow up appointments or telephone calls can be very useful, even if they are only designed to give the client a second opportunity to understand his eye condition in a more comprehensive way by asking additional questions that he may have forgotten to ask during the initial consultation. This is an area where I feel orthoptists can be used more, perhaps on days when the ophthalmologist is performing surgery.

QUESTION 3

The first thing to ascertain when encountering an anxious person in the clinic is the reason for his distress. Perhaps the client's agitation is because of a long wait to see the doctor, or he may have learnt that his eyesight will deteriorate to the point of blindness and has not accepted this circumstance. Or maybe he has just witnessed a bad car accident before arriving at the clinic and is in a state of shock. Again these factors can be exposed more readily if the client is made comfortable and is given time to relax and an opportunity to air his feelings.

When listening to the client it should be done with empathy. While it is important to project yourself into the client's problem, one must be careful not to overdo it. It is important to recognise a client's anxiety and it must be remembered that if a client is angry or sad it does not follow that they are depressed.

A useful technique is to mirror or clarify a feeling expressed by saying such things as:

"I guess you felt angry about that"

or

"That seems to have been very frustrating"

One certainly should not say such things as:

"There is nothing to worry about"

or

"Oh come on, everything is OK"

It would be more appropriate to say:

"Are you OK?

Is there something I can do?"

or

"do you want to talk about it or just sit there quietly"

Once the client becomes more relaxed it may be useful to ask him:

"Have you been to an ophthalmologist before?"

If not, you can explain the system and any tests you are about to administer. This will help to lessen the anxiety.

The environment a distressed person is placed in can prove to be a vital factor in helping him feel at ease to discuss his problem. Fundamental things such as a cup of coffee can be a practical way to help calm the situation. The orthoptist must present as being relaxed and try to normalise the client's anxiety. The presence of a box of tissues is one way of indicating to the client that he is not the first person to shed tears in the clinic.

QUESTION 4

As each client has his unique problems the decision as to where to go for follow-up help will be dependent on his individual needs. To prepare for all counselling situations, a clinic should always have a resource file listing professionals.

that clients can be referred to for extra assistance. This list should include such professionals as social workers, psychologists, family therapists or psychiatrists if the case is severe.

A list of agencies handling specific disabilities should also be left, such as the Royal Blind Society for blind and visually impaired clients.

Clients can often be referred to the local community health centre where additional information and resources may be available.

Some situations may be simple and easily solved in the clinic. After recognising the exact nature of the problem, follow up telephone calls or appointments, including a long consultation, may be all that is necessary to rectify things.

CONCLUSION

As can be seen by the above discussion, the essential ingredients of successful counselling are time, patience and empathy of how clients may feel. There are several ways in which professionals who do not have the opportunity for further training, may attempt to acquire the skills necessary for appropriate counselling. These will include gaining experience, teaching about the subject, listening to what people are saying whilst attempting to analyse why they may have said a certain thing, as well as talking to social workers about any anxious cases they have encountered.

The total management of clients should include provisions for their general well-being and opportunities for them to fully come to terms with their situation by giving them a complete explanation of the eye condition present. The orthoptist can help to achieve this by becoming a caring mediator between doctor and client.

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Recommended Reading

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