Linking Disability and Intercultural Studies: The adaptation journey of the visually impaired migrant in Ireland

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DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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ABSTRACT

Linking Disability and Intercultural Perspectives: The adaptation journey of the visually impaired migrant in Ireland

This study focuses on the lived experiences of the visually impaired migrant in Ireland and this is the first study to document the lives of these members of Irish society. It examines how visually impaired migrants are simultaneously adapting to their disability and a new cultural environment while living in Ireland. In so doing this study aims to link the two academic fields of Intercultural Studies and Disability Studies and theoretical underpinnings for this study are drawn and woven together from both fields. As such this study draws from the development of theories relating to disability as well as the intercultural aspects of migration.

Qualitative in-depth semi-structured interviews were conducted with 22 participants living in the larger Dublin region, which comprised of two groups; migrant users and providers of services for the visually impaired. Data analysis was assisted through the software package Atlas.ti. A grounded theory approach to collecting and analysing data was adopted as this facilitates the flow from raw data to codes to concepts. Purposive sampling was employed and the typical method of grounded theory of constant comparison was not used, rather interviews were analysed individually once they were all completed then compared. Research findings indicate that the cultural perceptions of disability may help or hinder the individual's adaptation process both to their visual impairment and to living and integrating into a new culture in Ireland. Findings cluster around the three areas of cultural perceptions of disability, support networks and cultural barriers to adaptation. Synergising theoretical concepts and data steered the development of a new integrative model

which identifies the inhibitors and facilitators for the process of adaptation to visual impairment for a migrant in Ireland.

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LIST OF ABBREVIATIONS

AMA	American Medical Association
BCODP	British Council of Organizations of Disabled People
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
CIL	Centre for Independent Living
CRMPI	Committee on Rating of Mental and Physical Impairment
CWR	Community Resource Worker
DHHS	(United States) Department of Health and Human Services
DMIS	Development Model of Intercultural Sensitivity
ESRI	Economic and Social Research Institute
FRS	Family Reunification Scheme
ICF	International Classification on Functioning, Disability and Health
ICIB	Irish Citizen's Information Bureau
ICIDH	International Classification of Impairments, Disabilities and Handicap
IGDB	Irish Guide Dogs for the Blind
JAWS	Jobs Access with Speech
MO	Mobility Officer

NCBI	National Council for the Blind of Ireland
NCCRI	National Consultative Committee on Racism and Interculturalism
NLBD	National League of the Blind and Disabled
PPS	Personal Public Service Number
REC	Research Ethics Committee
VEC	Vocational Education Committee
VI	Visual Impairment
UPIAS	Union of Physical Impaired against Segregation
WHA	World Health Association
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

The study of immigration is by its very nature interdisciplinary (Pedraza 1991: 304)

Visual impairment has largely been sidelined in ethnic minority research and visual impairment research has similarly ignored ethnic minority research. (Morajaria-Keval and Johnson 2005: 2)

1.1. Introduction to the Research Subject: Bridging Disability Studies and Intercultural Studies in a Grounded Theory Framework

The thesis opens with two sections. Firstly, the principal research concern and research questions of the study are presented, the context within which the study is located in Ìntercultural Studies relating to migration and Disability Studies, the purpose of the research and the motivations driving it. The second section offers a short outline of each chapter of the thesis.

This study investigates the adaptive journey of visually impaired migrant in Ireland. Little attention has been given on an international level into the lives of visually impaired migrants but most specifically the case of visually impaired migrants in Ireland has hitherto not received any academic research attention. Therefore, this study is the first of its kind in Ireland and hence a timely research subject. This study also draws on an interdisciplinary framework and endeavours to bridge the gap in Irish academic research between the disciplines of Disability Studies and Intercultural Studies. It draws upon existing research within both fields of academic inquiry and acknowledges international research conducted which also aims to voice the views and attitudes of migrants with disabilities such as research carried out in the UK on service provision for visually impaired ethnic minorities (Morajaria-Keval and Johnson 2005).

In the EU Network of Experts of Disability Discrimination report conducted in 2004 the principal investigator, Theresi Degener, acknowledges that the Irish definition of disability:

> Does not portray disabled persons as helpless or needy, because it makes no assumptions about the effects of a given impairment or malfunction. It is not based on a "truly disabled" notion and it covers past, present, future and imputed disabilities. It thus can be regarded as truly endorsing the social model of disability (Degener 2004: 8).

The Irish definition recognises past, present and future implications of disability and is firmly rooted in an impairment understanding as advocated by the social model of disability, discussed in detail in chapter two.

The Irish Disability Act 2005 provides a statutory foundation for accessible public services. Sections 26, 27 and 28 of the Act oblige public bodies to ensure that services and information are accessible to people with disabilities (Disability Act 2005).

Blind and visually impaired individuals are believed to comprise 8,000 of the Irish population today. This is however not an official figure but rather a statistic approximated by accrued sources from three principal organizations; The National League of the Blind, National Council for the Blind of Ireland (NCBI), St. Josephs' School for the Visually Impaired and Blind, since such an official figure has still to be recorded. With specific interest for this study no official figure of the number of visually impaired migrants exists in Ireland. However, with regard to St. Josephs' School which is the only school in the Republic of Ireland to cater for visually impaired children there is a more coherent record of migrant students. The preschool has 34 pupils of which 10 are migrant children. The primary school caters for 43

children including 9 migrant pupils. This information is significant as it gives an indication of future NCBI service users and a representation of one indication of this migrant population in Ireland.

1.2. Formulation of Research Questions

The research questions for this study are:

1. What are the experiences of visually impaired migrants living in Ireland today?
2. What factors facilitate or hinder their adaptation to their visual impairment in Ireland?
3. What are the experiences of service providers working with visually impaired migrants in Ireland?
4. What factors facilitate or hinder their ability to enable visually impaired migrants adaptation to their visual impairment in Ireland?

These questions drive this study and the aim in finding answers to them is to offer useful insights into the lives of this minority group in Ireland including those professionals who work with them in order to facilitate their adaptation process to visual impairment in the host country. This study answers the call to bridge the gap between the two disciplines of Intercultural Studies and Disability Studies which have been charged with "mutually ignoring one another" (Morajaria-Keval and Johnson 2005). In so doing, this study highlights the challenges of cultural differences for visually impaired migrant service users and providers of services for visually impaired and the opportunities to overcome them through mutual cultural understanding.

1.3. Contextualizing the study: immigration research

This study draws upon, and adds to, an existing body of research exploring the experiences of migrants adapting to living in Ireland. Integration is defined by Rinus Pennix (2003: 1) as "the process by which immigrants become accepted into Irish

society, both as individuals and as groups". Acceptance is at the heart of this definition. This is a key concept in this current study since how a visually impaired migrant adapts to their visual impairment hinges on whether or not they are "accepted into Irish society". Specifically, in the case of a migrant with a visual impairment this can be dependant on whether or not they feel their status not only as a migrant but, moreover, as a person with a disability is accepted into Irish society. For a migrant with a visual impairment acceptance into Irish society may be based not only on their acceptance for their migrant status but perhaps more significantly for their status as a visually impaired person.

Pennix (2003: 1) highlights the need to acknowledge integration as a process between two parties, the immigrants and the receiving society and moreover it is "the interaction between the two that determines the direction and the ultimate outcome of the integration process". Thus, as Fanning (2011: 7) emphasises the capacity of the immigrant to integrate "depends on the means to do so as well as upon the desire to do so". The "means to" integrate encompasses factors related to both parties to the immigrant him/herself and the way in which the host society facilitates the integration process. Philip Watt Director of the former National Consultative Committee on Racism and Interculturalism (NCCRI)[1], in the first issue of *Translocations: The Irish Migration Race and Social Transformation Review* in 2006, associated integration with 'a range of targeted strategies for the inclusion of particularly marginalised groups'. Thus he emphasises the role of the "receiving society" in the integration process.

[1] NCCRI was formed in 1998 and was closed in 2008 due to government cutbacks. For more information about the organization consult: www.nccri.ie.

In their pioneering study relating to the health of asylum seekers "Asylum in Ireland: A Public Health Perspective" Begley et al (1999: 50) examine the health consequences for asylum seekers, defining integration as the "state in which universal human needs can be met, which offers the most potential for the person to achieve complete physical, mental and social wellbeing." This definition is grounded in the belief that a migrant's general health status is the barometer with which to measure successful integration into Irish society. This perspective on integration supports this current study's interest in examining the experiences of migrants whose health, specifically visual health, is at the forefront of their integration experience. Essentially, integration into Irish society for the visually impaired migrant is intrinsically linked to being accepted as a person with a disability.

A key factor identified in existing studies related to integration is migrant legal status (Dayton-Johnson *et al* 2007; Penninx and Martiniello 2004; ICI 2008; 2011 Fanning 2009; 2011). A recent report by the Immigrant Council of Ireland (ICI) titled "Getting On: From Migration to Integration" (ICI 2008a) traced the experiences of four migrant groups, of Chinese, Indian, Lithuanian, and Nigerian migrants in Ireland. This leading report notably recognises the migrant's legal status as the most influential factor in "shaping his/her experience of living in Ireland and subsequent level of integration". The term 'asylum seeker' is tantamount with, as Fanning (2009: 85) acknowledges, "refugees who have yet to be accepted by the state". Hence the "means to" integrate for the migrant is suspended until the state decides his/her fate, and thus asylum seekers exist in a state of 'limbo' (Begley et al 1999; Irish Times 2004; Fanning 2009; ICI 2011). During the time in which asylum cases are in process, entitlements to state assistance are severely limited. For example, since direct provision was instigated in 1999 weekly social welfare rates have not

increased from the meagre €19.05 per adult and €9.53 per child (Fanning 2009: 68). Economic challenges for migrants are found to be directly linked to a decline in health. In addition, unequal access to healthcare services can contribute to developing healthcare problems and/or the worsening of existing medical conditions (Begley et al 1999).

In their most recent report in April 2011, the ICI in collaboration with NASC, the Irish Immigrant Support Centre directly relate the stratification of rights given to migrants with "unequal access which has a direct impact upon our migrant community's sense of belonging and their ability and/or willingness to participate fully in Irish society" (ICI 2011). Begley et al (1999) examine the health consequences for asylum seekers who experience unequal access to social services in Ireland. Their study (1999: 3) focuses on the voices of what it refers to as the "consumers: those for whom protection and integration is potentially a matter of life and death."

Firstly, Begley et al's (1999) study identifies health and social needs as most urgent when asylum seekers first arrive in Ireland. However, due to what they refer to as the "unduly protracted" (1999: 16) length of time that it takes to determine asylum case, asylum seekers risk deterioration of their health during this "administrative limbo" (1999: 42). They advise that "proper assessment of these needs would result in an early resolution of urgent problems before they affect the health and social well-being irreversibly" (1999: 48).

In the case of this current study the urgent health issue at stake is deterioration of sight. This study draws on and adds to the findings of Begley et al's research,

examining the migrant's legal status in relation to accessing services, specifically critical services for visual impairment in Ireland.

Hofinger's (1996: 23) study "An index to Measure Legal Integration" found that "systematic prolongation of legal differences between citizens of a state and migrants reinforces social discrimination against the latter". Thus, migrant status can generate tensions through creating a divide between "nationals" and "non-nationals" which can promote an environment of ethnic nepotism. Fanning (2009: 142) describes ethnic nepotism as referring to "the case for excluding immigrants from welfare solidarities developed around citizenship". The 2004 Referendum on Citizenship in Ireland reflects this attitude. Particularly worrying is the trend to view ethnic nepotism as 'natural' rather as Fanning (2009: 142) argues a "hypothesis about how groups might behave". As such ethnic nepotism depicts a social landscape in Ireland which Fanning asserts is "part and parcel of a larger culture of anxiety that now impedes the integration of immigrants". In the case of the visually impaired migrant in this study should their needs be neglected in favour of "nationals" the risk of exclusion could have detrimental repercussions for both their physical and mental well-being. Thus, in the face of the temptation towards ethnic nepotism Fanning (2009: 3) argues the objective should be to "close the gap between 'nationals' and 'non-nationals' for the sake of future cohesion". This current study through exploring the case of the visually impaired migrant adjusting to their sight loss in Irish society gives a new perspective into migrant experience of integration where the "national" and "non-national" identity boundaries may be blurred in light of the shared experience of sight loss. At the same time however, the potential risk of exclusion for a migrant with a visual impairment may not only disable his/her

opportunity to integrate into Irish society but in doing so also *simultaneously* immobilize the capacity to adapt to their disability.

Another key finding in Begley et al's (1999) research is to stress the strong association between an asylum seeker's ineligibility to work and "marginalisation" resulting in "psychosocial ill health, which may become permanent" (Begley et al 1999: 41). This insight is especially significant in relation to this current study as the specific migrant group is already coping with visual health problems which may be compounded by a barrier posed by migrant legal status should access to appropriate care services be denied.

The issue of the language barrier in hindering the integration process to new socio-cultural environment has been addressed in several studies specifically related to health (Bischoff et al 2003; MacFarlane et al 2009; De Maesschalck 2011). For instance, a language barrier has been shown to hamper the development of social networks and social capital (Pfeffer and Parra 2009; Ryan et al. 2009). Recent studies by the Department of Education and Science (DES 2007) and the Economic and Social Research Institute (ESRI 2009) inspected the impact of the language barrier for newcomer school children's integration and both studies reported that poor language skills were the principal determinant of poor social integration. Poor language skills can also result in poor migrant health (Begley et al 1999) and a language barrier poses challenges for both the service user in accessing services and service providers in delivering the services (Fanning 2009: 71). Begley et al (1999: 82) recognise the health benefits in empowering "newly arrived asylum seekers with the required English language skills as soon as possible…not least, a greater capacity to satisfactorily communicate confidentially their own health needs". Fanning

concurs with this view (2011: 146) recommending that "obligatory English-language and skills training…would yield dividends in terms of better health and well-being".

Findings of this study would support this recommendation and moreover call for enabling access to English language training for particularly vulnerable migrant groups with specific health problems, in this case visual impairment as a matter of urgency. This is discussed in greater detail in Chapter 7's analysis of findings and in Chapter 9's discussion of findings.

This current study adds to existing research which examines the barriers to integration specifically migrant legal status, language and cultural perceptions of gender. These potential obstacles to integration for a visually impaired migrant into Irish society are examined in relation to their particular significance for the case of the migrant who is coping with *simultaneous* adjustment to a new cultural environment and sight loss. Therefore, the findings in this study relate to and support previously documented barriers to integration in the context of immigration into Irish society. The contribution this study makes is to highlight the increased challenges these barriers may create for migrants with a visual impairment. Furthermore, the experiences of this migrant group in Irish society may challenge perceived wisdom regarding migrant's integration experience.

This current study records the experiences of both 'consumers' and the providers of services, in this specific case for visually impaired migrants in Ireland. In doing so the aim is to examine both service user and provider's perspectives on how best to facilitate adaptation to visual impairment for migrants in Ireland. Fanning (2009: 86) describes asylum seekers "as the poor relatives within Ireland's immigrant communities. Overall, they are just a small minority within a larger minority". The

case of the visually impaired migrant could be viewed as an even smaller minority within a minority. In examining the case of this group of migrants the aim is to contribute to research in the area of Disability and Intercultural Studies and additionally attempt to bridge the disciplines which have been considered to mutually ignore one another (Morajaria-Keval and Johnson 2005).

1.4. Bridging Intercultural Studies and Disability Studies

A general overview of the research in the area of Disability Studies, particularly in relation to the blind and visually impaired, demonstrates a tendency to focus on the topic of provision of services, issues of employment and equal rights (Conroy and Flanagan 2001; Equal Opportunities Unit. 1997). Thus, issues of culture and provision of services for migrant service users are largely overlooked (McDonagh 2002). An aim of this study is bridge the gap between the two academic fields in an Irish context through the investigation of the case of the visually impaired migrant in Ireland. It is important to note that the issue of disability and ethnic minorities has been raised by Irish academics (Zappone 2001; Pierce 2005). So that this study is an answer to the recommendation that research into the lives of "people at the intersections of two groups - minority ethnic people and people with disabilities…seeks to break new ground (Pierce 2005: 4).

1.5. Presentation of Thesis Outline

This study follows a grounded theory perspective which is reflected in the order of the chapters.

Chapter Two - presents a review of the relevant theories and models in the field of Disability Studies. It sketches the historical foundations of this field of inquiry

tracing its roots from the moral model of understanding disability, the medical perspective of disability to the current appreciation of disability through a social model lens. Each model is outlined and linked with relevance for this study's concerns with the experiences of the visually impaired migrant service user and professionals working with them.

Chapter Three - presents the study's methodological approach. The qualitative research design, data collection and analysis within a grounded theory approach are discussed in depth. In addition, this chapter includes a discussion of the ethical issues, limitations of the study and reflection on the research process.

Chapter Four - introduces the study's research participants. The personal profiles of the participants include their motivation to migrate to Ireland, the length of time living in Ireland, language issues, length of time living with sight loss in Ireland, home and host support networks at time of arrival in Ireland and whether or not support ties have strengthened since sight loss progressed. This chapter marks the start of tracing the experiences of the visually impaired migrant and service providers who work with them in Ireland.

Chapter Five - focuses on the cultural perceptions of disability in this study. Cultural perceptions of disability are considered from moral, medical and social perspectives.

Chapter Six - presents support networks both from the home and host community for the visually impaired migrant in Ireland are the focus for analysis. Home community support networks identified are family, friendship and support from religious communities. Host community support networks identified in the school,

work and religious setting. Peer support is identified through connection with host services for visual impairment.

Chapter Seven - explores the cultural barriers which hinder visually impaired migrant service users accessing and engaging with host services for visual impairment. These are migrant status, language barrier and cultural perceptions of gender. The impacts of these cultural obstacles for professionals working with visually impaired migrants are also explored. Finally, the concept of cultural competence is explored.

Chapter Eight - presents theories within the field of Intercultural Studies which demonstrate relevance for the current study in accordance with a grounded theory approach. Each of the theories is presented in relation to its applicability to the study's research findings. The theories are examined on three levels, cross-cultural, societal and individual in the context of their relevance for the data unearthed in this study.

Chapter Nine - represents the culmination of the three data analysis chapters' findings identifying and examining the facilitators and barriers of positive adaptation to visual impairment for migrants in Ireland.

Chapter Ten - presents the thesis conclusions, discusses the study's contribution to knowledge and makes recommendations arising from findings and identifies areas for further research.

1.6. The Timing of the Literature Review within Grounded Theory Framework

Deciding when to engage with the literature is a basis of great debate within grounded theory research. Glaser and Strauss (1967) the founders of grounded theory condemned the notion of engaging with the literature prior to entering the research field. The suggestion that the literature should not be consulted prior to primary investigation directly opposes a traditional approach to research procedures. Figure 1 highlights the distinguishing features of what Jones (2005:145) refers to as a conventional approach such as found in quantitative research where hypothesis-testing would follow the literature review. However, it should also be added that qualitative studies can also employ an initial literature review. Here the first stringed sequence of Figure 1 specifically relates to when to engage with the literature; this is intrinsically linked with the testing of a particular hypothesis following the literature review in contrast to the goal of theory development in the qualitative approach of grounded theory. As Jones (2005:145) states, grounded theory "takes a research approach, which is contrary to most of the more conventional research models" as shown in the second stringed sequence of figure 1.

In this study there are two literature reviews, firstly, a review of the literature in the field of Disability Studies and secondly Intercultural Studies. The decision when to consult and review literature was made in conjunction with arguments proposed by grounded theorists. In this study both a more conventional and grounded theory approach are adopted in relation to engagement with literature. Therefore, the timing of the first literature review, that of Disability Studies, is located at the outset of the study in Chapter 2 and the second literature review that of Intercultural Studies is located subsequent to the data analysis. Consequently grounded theory studies may

be presented in a somewhat unconventional manner in comparison with hypothesis testing research methods (Charmaz 2006).

1.7. Argument against Early Engagement with Literature

The argument against engaging with the literature at the start of the research study is that prior knowledge of literature will manipulate the entire research process, in particular the data collection and analysis stages. Glaser and Holton (2004: 12) state that extensive reading of the literature prior to data gathering "runs the risk of clouding the researcher's ability to remain open" and in essence researchers are encouraged to "learn not to know" (Glaser 1992). Charmaz (2006: 165) suggests that delaying the literature review can help:

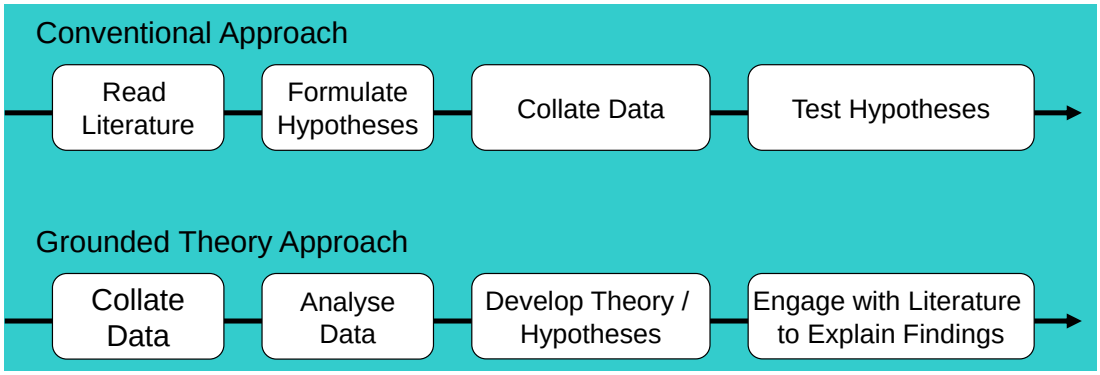
> to avoid importing preconceived ideas and imposing them on your work. Delaying the review encourages you to articulate *your* ideas.

In relation to the coding process, most specifically the initial phase of open coding the researcher is encouraged to code spontaneously (Charmaz 2006). With prior knowledge of the field of Intercultural Studies, there was a pre-existing background in the literature but there was no return to the literature in Intercultural Studies field until completion of data analysis as this study pursues the approach adopted by Charmaz (2006) and remaining open to new ideas so as to facilitate as creative category building as possible. Therefore, in this sense this study followed the grounded theory approach to delaying literature review until data analysis stage was complete. Nevertheless, it is pertinent to note that:

> Exposure to knowledge cannot simply be put aside and wiped from the mind as if it has never existed. (McCallin 2003: 206)

In addition, engagement with the literature in the field was focused on the relevance of theories for this specific study.

Figure 1 Conventional versus Grounded Theory Approach to Engagement with Literature (Jones 2005: 145)



1.8. Argument in favour of Early Engagement with Literature

The principal argument in favour of reviewing the literature early on in the research process is to discover whether the research question the researcher is interested in answering has already been resolved (Chiovitti and Piran 2003; McCallin 2003b), Thus, locating a gap within a discipline is generally the first step in the process (Cresswell 1998; Hutchinson 1993). Another significant factor is that early engagement with the literature acquaints the researcher with what are referred to as 'sensitising concepts' (McCann and Clark 2003a; Coffey and Atkinson 1996).

In the case of this study on visually impaired migrants, as I was a novice to the field of Disability Studies I felt it necessary to familiarise myself with the literature in order to assess whether a similar study had been in conducted in Ireland and worldwide. This was the first task in this study's research process. In addition, an understanding of certain terminology in relation to visual impairment adopted in the literature which was either mirrored or rejected by the participants, gave invaluable richness to the overall research process. I strongly felt that delaying engagement with

literature in the field of Disability Studies was not a workable option for this study. Nathaniel (2006) suggests that chiefly for PhD candidates the notion of no prior engagement with existing literature at an early stage in the research process is not a practical course of action. This study concurs with this opinion and therefore the review of Disability Studies is located at the outset.

CHAPTER 2: Disability Studies Literature Review

Definitions, rationality and structure are ways of seeing, but they become prisons when they blank out other ways of seeing

(Ammons 1997)

2.1. Chapter Outline

The focus of this chapter is to review and critically evaluate definitions of disability and impairment and simultaneously trace the development of various disability models and theories. This chapter has three main parts:

1. Definitions of disability
2. Models relating to disability
3. Theories relating to visual impairment

The precise definition of disability and impairment significantly affects the development of theoretical frameworks and models which in turn holds the potential to impact on the creation of policy for education, medical, social and political institutions in a wider social context. The language adopted in defining disability possesses the latent power to discriminate or include a disabled person in society.

The second section of the chapter investigates precisely when and with whom the model or theory originated and subsequently explains its exact nature. In addition, models and theories are classified and grouped into appropriate and clustered themes within the field of Disability Studies. The third section focuses on theories and empirical studies specifically related to visual impairment.

2.2. Analysis of World Health Organization (WHO) Definitions of Disability

The International Classification of Impairments, Disabilities and Handicaps (ICIDH), developed in 1980 by the World Health Organization (WHO) was designed to provide a framework to organise information about the consequences of disease. An ongoing revision process is considering social, behavioural and environmental factors to refine the concept of 'handicap' and fill the gap as classifications of diseases fail to account for the variety of experiences of people who live with health conditions, and the ICIDH (WHO 1980).

The classification distinguishes between three key concepts:

1. Impairment
2. Disability
3. Handicap

Impairments are correlated together with abnormalities of body structure and appearance and with organ or system function, resulting from any cause; in principle, impairments represent disturbances at the organ level. Impairments are permanent or temporary differences in structure and function and essentially for the purposes of classification they are observable and measurable. Disabilities reproduce the consequences of impairment in terms of functional performance and activity by the individual; disabilities thus represent turmoil for the individual person. Handicap relates to the disadvantages experienced by the individual.

The adverse impact of the impairment on the individual's actions and behaviours will effectively lead to a limitation on the regular activities they can perform. The ICIDH define this limitation as:

> Any restriction of lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO 1980: 26-8).

The three classifications are conceptually distinct. Impairment refers to consequences of disease or injury as experienced by the body; disability to disease consequences as experienced by the person and handicap, to disease consequences as experienced in person-environment circumstances. The final category, handicap recognises six essential 'survival' roles: orientation, physical independence, mobility, occupation, social integration and economic self-sufficiency. When the individual, owing to their own impairment, fails to or is restricted in fulfilling these fundamental roles, this demarcates the social disadvantage for the individual. Here the ICIDH (1980: 14) defines handicap as:

> A disadvantage for a given individual, resulting from impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex and social and cultural factors for that individual)

The cause of the individual's handicap is connected with the specific medical impairment and not the social conditions. As the ICIDH illustrates that:

> A disadvantage accrues as a result of (the individual) being unable to conform to the norms of the universe. Handicap is thus a social phenomenon representing the social and environmental consequences for the individual stemming from the presence of impairments and disabilities. (WHO 1980: 28)

Figure 2, represents this classification and clearly depicts one-way arrows, linking disease to impairment and disability to handicap. The arrows shown in Figure 2 outline a typical causal pattern, not a necessary causal pattern; although the different consequences of disease or disorder typically progress in the order shown so that in particular cases any of the progressions may be reversed, arrested, or omitted. Each term in the model refers to a different "plane of experience" of the consequences.

Figure 2 ICIDH Classification, WHO 1980

This classification is not without criticism. The following section details the rationale which culminated in this classification as well as its critiques.

2.2.1. International Classification of Impairments, Activities and Participation

In 1993, the World Health Organization (WHO) began a revision process of the 1980 ICIDH, across all three dimensions – impairment, disability and handicap. The aim of this was:

> To provide a more coherent and widely applicable set of classifications, which will be conceptually valid and useful (WHO 1993).

The ensuing new draft ICIDH-2, proposes three dimensions; impairment, activity and participation and a support annexe: contextual factors. The most significant difference between the WHO's original classification and ICIDH-2 is the recognition of contextual factors. The addition of contextual factors in understanding disability demonstrates a shift from defining the problem of disability within the individual to acknowledge the dynamics of the social environment.

The term 'disability' has been replaced by the neutral term 'activity' and challenging circumstances in this dimension are described as 'activity limitation'. Similarly, 'handicap' has been replaced by 'participation'; challenging circumstances in this dimension are described as 'participation restriction'. The term 'disablements' has

been included as an umbrella term to cover all the challenging dimensions of the ICIDH-2, that is, impairments, activity limitations and participation restrictions, either together or separately (WHO 1997). The activity dimension of ICIDH-2 is defined:

> In the context of health condition, activity is the nature and extent of functioning at the level of the person. Activities may be limited in nature, duration and quality (WHO 1997: 27).

Significantly, in this revision of the original WHO classification, closer attention is paid to the limiting quantifiers of an activity with an acknowledgment that:

> For most people the ability to carry out an activity is not an 'all or nothing' phenomenon. Activities may be carried out with varying degrees of ease or difficulty, or as components of different types of behaviour (WHO 1997: 27).

Furthermore, it recognises the role of assistive technology and aids in supporting the performance of an activity for the impaired individual. (WHO 1997) The role of assistive technology for visually impaired individuals cannot be underestimated in its role in creating the opportunity to enhance societal participation: for example, the use of Job Access with Speech (JAWS) software programme allows visually impaired individuals engage in computer-based work.

2.2.2. ICIDH-2 Revised: International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health is a further revision of the ICDH. It represents the World Health Organization's framework for measuring health and disability at both individual and population levels. The ICF was officially endorsed internationally by 191 WHO Member States, in the 54th World Health Assembly, on May 22nd 2001 (World Health Association (WHA)

Resolution 54.21). The key difference between the ICF and earlier WHO classifications is that it acknowledges that every human being can experience health difficulties and thus experience some degree of disability and so it:

> 'Mainstreams' the experience of disability and recognizes it as a universal human experience. By shifting focus from cause to impact, it places all health conditions on an equal footing, allowing them to be compared using a common metric: the ruler of health and disability. Furthermore, the ICF takes into account the social aspects of disability and does not consider disability only as 'medical' or 'biological' dysfunction. By including Contextual factors, in which environmental factors are listed. The ICF permits the impact of the environment on the person's functioning to be recorded.
>
> (http://www.who.int/classifications/icf/en)

The ICF identifies three levels of human functioning at the level of: specific body, body part, or the whole person in a social context. Disability involves dysfunction at one or more of these levels so recognizing levels of functioning as *impairment*, *activity limitation* and *participation restrictions*. The ICF states:

> Previously, disability began where health ended. Once you were disabled, you were in a separate category. We want to get away from this kind of thinking. (ICF 2001)

The International Classification of Functioning, Disability and Health (ICF) moved towards a bio-psychosocial model which recognises the interface between health conditions and contextual factors. These contextual factors include the environment: attitudes, legal structures, how the individual experiences disability. Personal factors in this context include; gender, age, coping mechanisms and education. This perspective reflects the changing attitude towards understanding disability and is of particular relevance to this thesis as it embeds disability into its social context. At the core of the ICF's understanding of disability are the criticisms of past moral and medical based approaches to disability which hold the individual solely responsible

for his/her disability. Both the moral and medical models of disability are assessed in the following sections of this chapter 2,3-2.2.3.

In light of this view of disability, the following section will trace the development of disability models and theories which both contrast and influence this perspective.

2.3. Review of the Moral Model of Disability

Up until the mid 1800s, disabilities and the people who had disabilities were considered from a moral model perspective:

> Somewhere in the backs of our minds we associate disabilities with sin, evil and danger. (Bowe 1978: 109)

The moral or religious model (Bowe 1978) refers to the attitude that people are "morally responsible" for their own disability, including, on the extreme level, as a result of depraved actions of parents if congenital, or as a result of practicing witchcraft if not. In this context disability is perceived as:

> Divine retribution for sinful deeds, as retribution and preparation for the hereafter; as a warning to one who strays from the path of the devout, or as a test of a person's faith (Florian 1982: 292).

Negative attitudes towards people with disabilities are identified as a major obstacle in individual's adaptation to their disability as they impose an additional requirement of coping for the person with the disability (Florian 1982).

Omigbodun et al (2001: 192) acknowledge that the societal perception of disability will influence the attitude towards an individual with a disability:

> Myths about what causes disability have marked affects on societal attitudes towards persons with disabilities. The belief systems in the society surrounding causation of disabilities greatly influence the degree of sympathy received.

Inherent in Omigbodun et al's (2001) statement is that the causes of disability are based on myths, with the central myth being that an individual who is born with impairment is being punished by God.

Yet this point of view that this causation of disability is a myth is based on Western tradition. In other cultural communities as expressed in the second line of Omigbodun's statement, the cause of disability is understood in terms of their 'belief systems'. Therefore, in a culture that believes disability exists as proof of wrongdoing in a past life, this is not a myth but instead a perceived cultural reality. Consequently, subsequent attitudes and behaviours towards disability and people with impairments will reflect the deep belief that disability is a 'curse'. As such, in contrast with a community which believes people with impairments can make valuable societal contributions, the societal response will lack encouragement and sympathy. Lack of societal encouragement for individuals with impairments is discussed in the context of this study's participants' home country experiences in Chapter 5.3.

This model views disability as linked to sin and evil (Mackelprang and Salsgiver, 1999). While this view was popular during the Middle Ages, there still is evidence of its existence today. Biblical references to physical and mental impairment as 'punishment from God' for one's immoral acts or those of one's parents are cited to support moral understanding of disability. For example, in the Old Testament (Leviticus), Moses is cautioned that one of the penalties of sin is the loss of sight, and in Job and Judges, there are frequent examples of blindness inflicted as punishment, often by God.

Holding this moral perspective encourages discrimination as the individual with impairment and their family are shunned by the community as they are considered to represent God's disdain. Hence, they are discriminated against based on the existence of their 'abnormal' trait and consequently targeted for negative labelling, prejudice and ultimately excluded from the community. In Nigeria and Kenya, disability is associated with punishment for past wrongdoings while in India, Hindus who represent eighty five percent of the total population believe that "disability is a consequence of misdeeds performed in the previous life (often referred to as the doctrine of Karma)" (Sharma 2005: 3). Moreover, any efforts to assist a person with impairment may be deemed a "defiance of the wills of Allah or as interference with a person's karma" (Harriss-White 1996: 7).

Karma is connected with the birth of a child with impairment. Thus, impairment is viewed to represent 'divine justice' (Rao 2001). Alur (2001), in her study on attitudes towards disability in India, demonstrated that disability is not seen as something 'normal' or 'natural,' rather it is seen as an 'evil eye' followed by feelings of guilt, stigma and fear. These negative attitudes pose a major obstacle in rehabilitation and the process of adjustment to impairment, as they impose an added requirement of coping with a society's negative view (Florian 1982). For the individual with impairment, this model is particularly oppressive as it has been associated with shame on the entire family. Families can hide the member of the family with impairment away, withdrawing them from school and excluding them from any chance at having a meaningful role in society. This model supports general social exclusion and self loathing. The moral model views disability as a punishment inflicted upon an individual or family by an external force which can be due to misconduct by the person with impairment, someone in the family or community

group. The disability can stigmatize a whole family, lowering their status or even leading to total social exclusion, or it can be interpreted as an individual's inability to conform within a family structure. On the other hand, it can be seen as a necessary adversity to be suffered before some spiritual reward (Landsman 1999; Ingstad 1997).

It is an extreme model which can exist in any society where deficiency is linked to ignorance, fear and prejudice. This model is relevant in this study in understanding the cultural background of the perception of visual impairment by migrant service users in order for host service providers to fully grasp the impact of such cultural perceptions of disability. The way in which the moral perception of disability can inhibit migrant's adaptation to visual impairment is analysed in detail in Chapter 5.

Shapiro (2000) argues that negative myths persist in the entrenched prejudices towards individuals with impairments and contribute to negative behaviour towards children with disabilities at school. Intolerance towards people with impairments rooted in a moral approach to disability is found to results in behaviour which can harm a visually impaired individual's adaptation to their disability, which in turn inhibits their integration into society (Livenh et al. 1997; Olkin 1999; Link et al. 1999; Cook 1998; Smart 2001). This study concurs with disability scholars who equate the social rejection towards individuals with impairments with intolerant social attitude rooted in moral understandings of disability. The study's motivation for examining this moral model is to understand the perspective of visually impaired migrants towards his/her own disability and how home cultural perceptions can challenge the ability to adapt to disability. In order to discover the lived experiences of this minority group in Ireland it is necessary to gain an insight into the 'cultural

baggage' brought with them to Ireland. Thus, firstly understanding this moral perception of disability facilitates a subsequent critical analysis of the impact for migrant service users' adaptation to his/her visual impairment in Ireland.

2.3.1. Critique of the medical model of disability

This section examines the perspective towards disability informed by the medical model. As medicine began to develop in the 19th century, along with the more significant role of the physician in society, a shift in power from religious to medical understanding of disability took place. Since most impairment has medical origins, people with impairments were expected to benefit from coming under the direction of the medical profession. However, this model maintains its roots in a religious belief system in which disability was often, and may still be, viewed as an individual and/or familial moral defect or the product of sin, of the person with impairment or their parents, as outlined in the moral model. In contrast, physical and mental wholeness is considered both righteous and moral. Swain et al. (2004) argue that the medical model appears thus to attach medical corroboration to these religious beliefs. It aims to diagnose and classify illness and conditions

Any economic or social deprivation encountered by disabled people was located within the individual and their impairment (Swain et al. 2004: 41). Following this assumption the medical model views disability purely as a medical problem of the individual, thus without any discrimination between the impairment faced and the disability itself.

Oliver (1990) argues that within this framework, the problems related to disability are located within the individual. Crow (1996) highlights that, according to this approach a person's functional limitations that are impairments are considered

specifically to represent the primary basis of any disadvantages he or she experiences. Defined as such the medical model has clear economic implications, as the inability to perform socially valued roles, in relation to work, results in 'role failure'. Liachowitz (1988) claims that people with impairments, in their failure to contribute economically to society are often labelled as 'burdens' or 'drains', due to their inferiority in the labour market.

As this model originated within the medical profession, it places full responsibility upon the individual with impairment and their functional limitations, which in turn require rehabilitative assistance. Consequently, this person is viewed as in need of society's charity. Oliver (1990) asserts that the medical model equates disability with personal tragedy as the main focus is on what people cannot achieve. Correspondingly, the medical model considers the problems associated with impairment to reside within the individual. In other words, if the individual is cured then these problems will not exist. In accordance with the medical model understanding of disability society has no underlying responsibility to make a place for individuals with impairments, since they live in an outsider role waiting to be cured.

Talcott Parsons (1951) theorized that the individual with impairment is in the 'sick role', According to Parsons (1951), the sick person is expected to perceive being sick as undesirable and subsequently has a duty to strive to 'get well' (Parsons 1951: 436-7). The concept of the sick role is integral to understanding the medical model approach to disability. Parson (1951) identified the sick role as requiring patients to yield their autonomy to professional direction, and apply all of their efforts to the definitive objective of complete recovery. When people are sick, they are excused

from the normal obligations of society, such as attending school, employment and taking on family responsibilities. They are also expected to submit to the authority and power of the medical profession, so as to get better. As such, this model is of direct relevance to this study in relation to home cultural perceptions of disability from a medical perspective.

2.3.2. Critiques of the medical model

From an analysis of the Disability Studies literature the key criticism of the medical model which emerges is that it is limiting in nature and neglecting societal contribution in general (Hunt 1966; Oliver 1983, 1990, 1994; Barnes 1990, 2003; Hahn 1988, 1985; Smart 2001; Thomas 1999, 2002). The original argument against the medical model's definition of disability and the source of what was to give rise to the social model of disability may be found in an essay entitled *A critical condition* published in 1966 by Paul Hunt. A wheelchair user, Hunt opens his paper by saying the location of the *problem of disability*:

> [L]ies not only in the impairment of function and its effects on us individually, but also, more importantly, in the area of our relationship with normal people. If everyone were disabled as we are, there would be no special situation to consider. This focus on the ways in which we are set apart from the ordinary, does not mean that I see us, as really separated from society. In fact the reverse assumption underlies everything I write. We are society, as much as anybody, and cannot be considered in isolation from it. (Hunt 1966: 1-2)

Hunt's point is that in aligning the problem of disability solely with the disabled individual as the medical model advocates the role of society in general and the disabled member's part in it iseliminated; as a result the disabled individual is Isolated.

According to Hunt (1966: 3-9), people with impairments are isolated from the social environment because they pose five principal *challenges* to society, based on a medical understanding of disability. Firstly, they are viewed as 'unfortunate', since they are unable to 'enjoy' material and social advantages of modern society. Secondly, they are deemed 'useless', because they are thought not to be able to contribute to the 'economic good of the community' relying instead on charity and feeling of less worth than the 'breadwinner'. Thirdly, they are branded as 'different' and minority group members because, for example, like ethnic minority groups they represent a minority group in society and as such are perceived as abnormal and different. Fourthly, a crushing feeling of oppression is created due to society not allowing the individual with impairment to challenge its view of disability. Hence, potential for independence and educational pursuits shrink. Finally, they are considered 'sick' compared to people who are relatively healthy, and whose morality is challenged by people with disabilities. The key point is then that the medical approach of disability views the challenges generated not to be society's responsibility but rather the dilemmas of daily life living with impairment which reside with the individual to tackle and attempt to surmount.

The ultimate goal of the medical model approach is to eradicate the impairment by changing the person with the core focus on normalizing the individual.

Hunt (1966: 4) is critical of the goal of normality:

> Normality is so often put forward as the goal for people with special handicaps that we have come to accept its desirability as a dogma. But even if one takes a common sense meaning for the word- being like most people in our society – it is doubtful if this is what we should really fix our sights on. For one thing it is an impossible achievement, at certain levels anyway. Obviously we cannot be physically normal, so are doomed to be deviants in this sense at least.

The disabled individual according to the medical model must attempt to overcome impairment though disabled individuals inherently deviate from what is perceived as normal (Goffman 1963: See Stigma and Deviance theories section 2.3.4). Therefore, efforts to achieve the goal of normality are wasted. Shakespeare (1994: 89) in assessing the concentration on "the need for adjustment, mourning, and coming to terms with loss" as supported by the medical model highlights that it breeds a "negative self-identity". This experience of disability as a negative identity arises out of a process of socialisation, or in the context of social relations, in which impairment is the sole focus of analysis. Grief and loss are turned inwards, and suffering focuses on the self.

The medical model views disability as an individualised experience and as such the structural and cultural context is not challenged. .Difference is evaluated as a medical tragedy or ignored. In order to evade what Hunt (1966: 6) calls "the curious stares", (this is discussed in Chapter 5 in section 5.6), the minority group member becomes familiar with, and the impaired individual must recognize as Shakespeare (1994: 92) observes that according to a medial approach to disability assimilation is the name of the game. This point is noteworthy also for its parallels with Intercultural Studies literature, discussed in Chapter 8 with relevance to Berry's (2006) acculturation strategies. The medical approach focuses on particular groups of people with impairment, for example, the blind or epileptics. In other words, individuals with a visual impairment are assimilated into one group defined by their impairment and are thus referred to by this trait, 'the blind' or indeed 'the disabled'. Special needs education which recognises the diversity in disability is unlikely to exist in countries where disability is viewed through the medical model lens as attested by migrant service users in this study.

Hahn (1985; 1988) recognises that the medical model approach of separating individuals into diagnostic categories is necessary for medical purposes. However, Hahn (1985 : 87) believes that ignoring the social implications of categorization according to abilities ultimately has a dehumanizing impact upon the individual as categorization tends to objectify people with disabilities and results in the segregation of disability: the blind girl, the Down's baby. In this study a parent of a child with visual impairment reports that the child is considered a 'second category child' in their home country. This case and other medical model perspective circumstances are discussed in Chapter 5. Hahn (1988: 33) believes this medical system of categorization:

> Has fragmented the disability community by stressing the functional traits that divide them rather than the external obstacles they face a common problem (Hahn 1988: 33).

According to Hahn (1988) the subordinate, inferior status of people with disabilities is reinforced by the power differential present in the medical model. Owing to the medical model's reliance on the expertise and education of physicians and their diagnostic systems, individuals with impairments have been "socialised to assume a compliant, passive role" (Hahn 1988: 89).

Jenny Morris, (1991), the feminist disability scholar agrees with Hahn that the medical model approach subordinates the individual with impairment. Morris (1991) extends his argument by further highlighting the exclusion of people with impairments from debate and decisions on disability issues and policy decisions, as they are not considered the remit of people with impairments themselves. She draws attention to the challenge of expressing experiences of disability being articulated by those who have not experienced disability themselves:

> One of the most important features of our experience of prejudice is that we generally experience it as isolated individuals. Many of us spend most of our lives in the company of non-disabled people, whether in our families, with friends, in the workplace, at school and so on. Most of the people we have dealings with, including our most intimate relationships, are not like us. It is therefore very difficult for us to recognize and challenge the values and judgments that are applied to us and our lives. Our ideas about disability and about ourselves are generally formed by those who are not disabled. (Morris 1991: 37)

The sense of being ostracized from their own situation of disability may lead individuals, as Higgins (1992) asserts to feel like foreigners in their own country. This study addresses the sense of isolation which may potentially be compounded when the individual is coping with the simultaneous challenge of disability and migrant status. The concept of isolation is addressed in Chapter 7's discussion on cultural barriers to accessing and engaging with services for the visually impaired in Ireland.

Hahn (1985; 1988) concludes his criticism of the medical focused understanding of disability by terming it a *metahandicap*. Thus he evaluates the model itself as a core instigating factor to prejudice and discrimination in society. By focusing attention away from the social and physical environments, Hahn argues that the medical model is silent on issues of social injustice. Furthermore, powerful professions and policy-making bodies have endowed the medical model with the appearance of science, objectivity and reality, thus, legitimizing the *handicapism* of the general population. Hahn (1993) advocates replacing the functional limitations of the medical paradigm, with a minority group model. The minority group model promoted by Hahn (1993) postulates that the issues faced by people with disabilities are essentially similar to socio-cultural barriers facing other disadvantaged groups for example ethnic minority groups. Consequently, Hahn (1991) argues that the

problems of a person with a disability must be refined, to necessitate socio-political solutions. Instead of focusing sole attention on the individual or clinical remedies Hahn (1991) calls for changes in public policy. where the phenomenon of disability as perceived as the communal responsibility of society. Thus according to the minority model approach as opposed to medical the means of repairing the difficulties faced by people with impairments can largely be achieved by environmental adaptations that facilitate the full participation of people with disabilities in society.

Hahn (1993) is one of the principal supporters for civil rights for disabled people. His work along with other disability rights activists (Kailes and Weil 1985; Longmore 1993; Mackelprang and Salsgiver 1996; McAweeney, Forchheimer and Tate 1996; Renz-Beaulaurier 1998; Tower 1994) were a crucial part in the reformulation of the concept of disability within a socio-political context. This involves processes which challenge views of people with disabilities as incapable, powerless and passive and it establishes people with disabilities as the experts on disability and disabled people's definitions as the most appropriate approaches to disability, rather than the traditional domination of medical professionals.

Byrne, Barnes and Oliver (1991) positively evaluate the impact of this shift towards self-organization by disability rights activists:

> The move towards self-organization has prompted increasing numbers of disabled people to adopt a shared political identity which in turn has helped to build a new mood of confidence. Disabled people no longer ask for change, but demand it. They are prepared to use a whole range of tactics in pursuit of their demands, including direct action and civil disobedience. (Byrne, Barnes and Oliver 1991: 12)

In contrast to the medical model a social approach to disability transforms the understanding of disability to encompass the role of the social environment to oppress or empower people with impairments as Shakespeare (1994: 90) notes,

> Result of the experience of oppressive social relations and rather than viewing the disabled as a victim to their tragic circumstances, recognizes the possibilities for changing society, empowering disabled people and most significantly "promoting a different self-understanding".

Morrison and Finkelstein (1992: 22) argue that people with impairments themselves must assume responsibility for eradicating the victim role:

> To encourage the growth of a disability culture is no less than to begin the radical task of transforming ourselves from passive and dependant beings into active and creative agents for social change.

The aim of the socially orientated perception of disability is to challenge stereotypes, build cohesion, and recount new stories which contradict the established medical model approach.

2.3.3. Analysis of the contribution of medical model

It is important to present the counterargument from the medical standpoint and also acknowledge the positive role the medical model plays in the development of the understanding of disability. Shah and Mountain (2007) for instance, advocate the medical model for psychiatric diagnosis.

Nevertheless, while no one believes as Smart (2007) asserts that the medical professionals deliberately created injustice and discrimination, the result of the medically focused understanding of disability has unfortunately been inequality. Disability scholars (Oliver 1983; 1990, Barnes 1990; Shakespeare 1992) argue that disability has been misrepresented as purely a health concern and because of this

discrimination and prejudice based on disability result, but also frequently remain unrecognized. It does not offer a realistic perspective from the viewpoint of people with impairments themselves. In sum, the concept of being 'abnormal' is the most challenging. Also, the model imposes a paternalistic approach to problem solving which, although perhaps well intentioned, concentrates on 'care' and ultimately provides justification for institutionalization and segregation. This restricts disabled people's opportunities to make choices, direct their lives and develop their potential. Research participants in this study recount their experience of the impact of their home cultural perception rooted in the medical model has upon their quality of life.

Despite such critical disapproval, a constructive impact of this model is that it paved the way for more progressive stances towards disability. The medical definition of disability, which encourages explanations in terms of the features of an individual's biology, has generated new ways of thinking about disability to include a social, cultural and political context. The potential to listen, to incorporate the opinions of people with impairments themselves and the birth of a new academic field, Disability Studies, dedicated to the promotion of dynamic discussion surrounding disability related issues and the promotion of individual's with impairments rights, may be evaluated as a direct response to the challenge posed by the prior moral and medical model definitions of disability.

The following section analyses the development of this progress to the formulation of the social model and its various offshoots. It begins with a review of deviance theories and the concept of stigma which heavily influenced the advance of the social model of disability.

2.3.4. Analysis of the development of the social model: deviance theories and the concept of stigma

This section explores the concept of stigma proposed in several deviance theories. It was initially Friedson (1965) who theorized that people with impairments are social deviants, by using the term in the context of rehabilitation. His overall argument was that if it can be identified why some people are brought into conflicts with society's values, it will be evident what needs to be changed in order for them to become accepted by the non-disabled Erving Goffman built on Friedson's work by developing of the concept of stigma .

Goffman (1963: 3), in his classic formulation, defines stigma as "an attribute that is deeply discrediting" and proposes that the stigmatized person is reduced "from a whole and usual person to a tainted, discounted one". Goffman (1963: 4), highlights the processes of social construction as central to stigma which he defines as "a special kind of relationship between an attribute and a stereotype". Furthermore, he asserts that stigma is embedded in a "language of relationships". Goffman (1963: 2) argues that stigma arises as an inconsistency between "virtual social identity" which is how a person is characterised by society and "actual social identity" which are the attributes actually possessed by the individual.

Goffman (1963) identifies the need to distinguish between "virtual social identity" that is created for an individual and their "actual social identity". Goffman (1963: 13) defines the difference between the two identities as "stigma" where the inconsistency is "incongruous with our stereotype of what a given type of individual should be".

Goffman (1963: 24) sums up his argument by stating:

> Stigma…is the situation of the individual who is disqualified from full social acceptance.

The research participants of this study recount experiencing social exclusion as a consequence of stigma related to the cultural perception of disability.

Building on Goffman's seminal work, Crocker et al. (1998: 505) define stigma as occurring when an individual is believed to pose, what they describe as an "often objective" attribute or feature that conveys a devalued social identity within a social context. Identity is then socially constructed by defining who belongs to a particular social group and whether a characteristic will lead to a devalued social identity in a given context. In this study devalued social identity can negatively impact adaptation to visual impairment as outlined in Chapters 5 and 6. Like Goffman, Crocker et al. (1998) propose that stigma, at its essence, is a "devaluing social identity" (1998: 505) and also assert the role of the persuasion of power in determining one's susceptibility and possible response to stigma.

In analysing the psychological definitions of stigma Parker and Aggleton (2003) express concern that the stigmatized person's viewpoint is neglected as the focus is excessively on forces located within the individual rather than the myriad societal forces that shape exclusion from social life Link and Phelan (2001) propose a sociological definition of stigma as an umbrella concept that links interrelated stigma components. Similar to the social psychological definitions the first four elements, of their definition namely, *labelling*, *stereotyping*, *cognitive separation* and *emotional reactions*, identify social processes that take place within the socio-cultural environment whose effects can be observed within the individual. Nevertheless, in the fifth component of Link and Phelan's (2001) definition, *status loss and*

discrimination, they also include *structural discrimination*, when institutional practices disadvantage stigmatized groups. Link and Phelan (2001) consider that the stigma process depends on the use of social, economic and political power that instils the preceding stigma elements with discriminatory consequences. Link and Phelan's definition is positively assessed by Yang et al (2007) for representing a critical step towards identifying stigma as "processual and created by structural power" (Yang et al 2007: 1530).

Yang et al's (2007) theory of stigma focuses on the 'lived or social experience' this denotes:

> the felt flow of engagements in the local world….a local world is a 'social network', an ethnographer's village, a neighborhood, a workplace setting, or an interest group. (Yang et al 2007: 1528)

Most significantly, in these local worlds is that "something is at stake" for the individuals involved (Yang et al 2007). Their perception of stigma draws on and adds to Kleinman's (1999: 1528) acknowledgement that:

> Daily life matters, often deeply…Moral experience refers to that register of everyday life and practical engagement that defines what matters most for ordinary men and women.

The inclusion of the real impact of stigma on the individual in their local world is of concern to this thesis which examines the real lived experiences of visually impaired migrants in Irish society. They are a group that may experience stigmatization on two counts: for their disabled status and their migrant status. Yang et al. (2007) are sceptical of the social psychological approach to stigma:

> Primarily regard the social aspects of stigma as a psychological variable (i.e., 'social identity' as applied to an individual), as an environmental stimulus that the individual appraises or responds to, or as societal or cultural stereotypes. (Yang et al. 2007: 1530)

In contrast Yang et al (2007) believe that the focus should be on the moral experience which allows a:

> Re-conceptualization of how the so called 'others' constitute the world of stigma. These are the ones doing the stigmatizing, but they can also be members of a peer group, social network or system of care (e.g., parents, doctors). (Yang et al. 2007: 1531)

This approach is of relevance to this thesis in relation to the research participants' experiences of being stigmatized by members of their own home culture. From a cross-cultural perspective, stigma appears to be a universal phenomenon, a shared existential experience (Link et al. 2004).

Mayor and O'Brien (2005) propose to integrate the concept of an identity being under threat with stigma. This is a transactional analysis of stress and coping strategies enacted by the individual. The social elements of Major and O'Brien's (2005) theory consist of the immediate situational cues, which convey risk of being devalued and collective representations knowledge, cultural stereotypes that influence appraisal of threat to one's well being. At the core of these two formulations is the concept that stigma biases individuals to pitiable outcomes by intimidating self-esteem, academic achievement, and mental and physical health.

Finally, most significantly, stigma theories contribute to the broadening of the definition of disability to encompass the social environment. The following section evaluates the social model of disability examining its early beginnings with the critical work of American sociologist Nagi (1965), to its current dominance within Disability Studies.

2.3.5. Analysis of Nagi's functional-limitations model of disablement

Nagi (1965)'s contribution to the understanding disability is the construction of a framework that differentiated disability from three other distinct yet interrelated concepts: active pathology, impairment, and functional limitation. Nagi (1965: 101-3)) evaluates each concept in relation to one another:

4. *Active pathology* involves the interruption of normal cellular processes and the simultaneous homeostatic efforts of the organism to regain a normal state.
5. *Impairment* refers to a loss or abnormality at the tissue, organ, and body system level. Active pathology usually results in some type of impairment, but not all impairments are associated with active pathology (e.g., congenital loss or residual impairments resulting from trauma).
6. *Functional limitations* to represent restrictions in the basic performance of the person. An example of basic functional limitations that might result from a cerebrovascular accident could include limitations in the performance of locomotor tasks, such as the person's gait and basic mobility.

Nagi's framework contradicts the traditional medical model of disability that focuses purely on pathology and cure.

Nagi (1965: 103) indicates that:

> While disability indicates the existence of an impairment which limits the individual's functioning, it may not be associated with the presence of disease as in the case of healed amputations and residual polio.

Nagi (1965: 103) implies that while in some instances, a causal relationship is apparent, preliminarily with pathology and then moving from impairment to functional limitation and finally to disability, this also is not always the case. Nagi

(1965) argues that disability behaviour is influenced by activities outside the individual as well, specifically, the "definition of the situation by others, their reactions and expectations" (Nagi 1965: 103).

Nagi's definition of disability asserts that disability may or may not result from the interaction of an individual's physical or mental limitations with the social and physical factors in the individual's environment. Nagi particularly focuses on the concept of disability as representing the fissure between a person's capabilities and the demands created by the social and physical environments (Nagi 1965, 1976, 1991). This is a fundamental distinction of critical importance to scholarly discussion and research related to disability phenomena, as it represents a pioneering shift from medical dominance which culminates in the formulation of the social model of disability.

In his more recent discussions on disability Nagi (1991: 315) analyses several other factors aside from functional limitation that can impact upon the individual. These include:

> (a)the individual's definition of the situation and reactions, which at times compound the limitations; (b) the definition of the situation by others, and their reactions and expectations--especially those who are significant in the lives of the person with the disabling condition (e.g., family members, friends and associates, employers and co-workers, and organizations and professions that provide services and benefits); and (c) characteristics of the environment and the degree to which it is free from, or encumbered with, physical and socio-cultural barriers.

The inclusion of 'socio-cultural barriers' is particularly relevant for this study specifically in Chapter 7's discussion on the challenges they present for migrants accessing and engaging with services for visually impaired in the host environment.

In analysing Nagi's framework to understanding disability, his key contribution is considered as the extension of the disability definition beyond the physical status or mental state of the individual. In doing so, the Nagi model which realigns the distinction between disability and impairment, hence represents the first relational model of disability and paves the way towards fresh conceptions of disability, initially with the disablement model developed by Vertbrugge and Jette (1994), and most significantly the social model of disability (Oliver 1981) and its numerous variants.

2.3.6. Analysis of the Disablement Process Model

Vertbrugge and Jette (1994) disablement process model builds on the classification framework developed by Nagi (1965).

Vertbrugge and Jette (1994: 2) employ the term "process" to characterize the dynamic and changing nature of disablement, for instance, the variation in type and severity of functional consequences over time and the factors that affect their direction, pace, and pattern of change. The disablement process model therefore contrasts with the medical model in which a disease or diagnosis, rather than a person, is treated. This model asserts that multiple pathologic conditions may, and often do exist in individuals.

In Nagi (1965, 1976, 1991)'s framework pathology represents a break in normal body processes, while the body attempts to restore that normal state. Its association with disease as well as traumatic injury is considered as part of the definition, but its relationship to diagnoses is not spelled out. Pathology in the Vertbrugger and Jette (1994) model of disability in contrast refers very specifically to biochemical and physiological abnormalities that are detected and medically labelled as disease,

injury, or congenital or developmental conditions. Vertbrugger and Jette (1994) highlight many of the bodily changes represented by pathology are not always directly measurable in medical practice where detection relies on evaluation of apparent signs and symptoms. Their viewpoint requires a diagnosis, since it represents a pathology that has satisfied clinical significance and can therefore be considered public. Consequently, undiagnosed pathologies would not be included in this version of the concept. In this study of visually impaired migrants, some of the research participants, owing to cultural perception of disability, may not have received a medical diagnosis of their condition. This model would be problematic for cases of undiagnosed visual impairment as they would not be included. The diagnosis experience in relation to cultural perception of disability causation is outlined in Chapter 5.

Vertbrugge and Jette (1994)'s model defines disability as a broad range of role behaviours that are relevant in most people's daily lives. Five commonly applied dimensions of disability evolved from this approach (Vertbrugge and Jette 1994: 4-6).

> 1) Basic activities of daily living (BADL)—including behaviors such as basic personal care;
> 2) Instrumental activities of daily living (IADL)—including activities such as preparing meals, doing housework, managing finances, using the telephone, shopping;
> 3) Paid and unpaid role activities—including occupation, parenting, grand parenting, student roles;
> 4) Social activities—including attending church and other group activities, socializing with friends and relatives; and
> 5) Leisure activities—including sport and physical recreation, reading, distinct trips, and so on (Vertbrugge and Jette 1993: 4-6).

Vertbrugge and Jette (1994: 4) attempt to distinguish the 'main pathways' of the disablement process from factors assumed or viewed to influence the enduring

process of disablement. They argue that one might analyze and explain disablement relative to three sets of features: predisposing risk factors, intra-individual factors, and extra-individual factors as follows:

1. *Risk factors* are phenomena that are present before the onset of the disabling event such as socio-demographic background, lifestyle, and biological factors.
2. *Intra-individual factors,* those that operate within a person, such as lifestyle and behavioural changes, psychosocial attributes and coping skills, and activity accommodations made by the individual after the onset of a disabling condition.
3. *Extra-individual factors* which are outside or external to the person. They pertain to the physical as well as the social context in which the disablement process occurs. Environmental factors relate to the social as well as the physical environmental factors that bear on the disablement process. These can include medical and rehabilitation services, medications and other therapeutic regimens, external supports available in the person's social network, and the physical environment (Vertbrugge and Jette 1994: 4-6).

Verbrugge and Jette (2004) thus extend Nagi's Disablement Model to encompass both social and medical aspects of disability. They set out to clearly differentiate the 'main pathways' of the disablement process from factors hypothesized or known to influence the ongoing process of disablement. As such, it can be analysed as providing the bridge towards independent living and the social model of disability.

2.3.7. The Independent Living Movement

The independent living movement was formed by individuals with disabilities who, aggravated with their exclusion from society, began to organize and create a program for action, following the same principles of civil rights movements in Europe and the United States during the period of 1966 to 1968. The independent living movement aims to address discrimination and advocate for the supportive services that are fundamental for full participation in the community and society. Roberts (1989: 238-39), one of the originators of the independent living movement emphasizes four principles at the heart of independent living as: self-determination, self-image and

public education, advocacy, and service to all. The independent living model is based on this movement and was initially developed by Gerben DeJong in the late 1970s. DeJong (1979) proposed a shift from the medical model to the independent living model and encompasses five other social movements to the evolving movement for independent living for people with disabilities which are the civil rights, consumerism, self-help, de-medicalization, and de-institutionalization (DeJong and Raymond 1983: 5)

The independent living model is as result founded on a consumer driven movement that promotes autonomy and self-help and the subtraction of societal deterrents. The core concept of this model is that current socio-political structures generate access barriers for and dependency in impaired people resulting in disability. This perspective places problems or 'deficiencies' in the society, not the individual so that issues such as social and attitudinal barriers are presented as the valid problems facing people with disabilities. The solutions are located in modifying and 'fixing' society, not the individuals themselves and individuals are encouraged to make their own decisions. In essence, the independent living movement endeavours to empower people with impairments to conduct their lives as independently as possible and therefore is of relevance to this study.

In Ireland the first Independent Living Centre was established in 1992 at Carmichael House in Dublin:

> Our purpose is to empower and enable people with disabilities to achieve Independent Living as a Human Right. We will strive to ensure that people with disabilities can actively participate as equal citizens, with the choices, control and responsibilities that this implies through action research, support and advocacy. (CIL 2010)

Today in Ireland there are twenty four Centres for Independent Living nationwide, all established and operated by people with diverse impairments at a local level (CIL 2010). The NCBI's mission statement (NCBI 2011) reflects this independent living model perspective as it aims:

> To enable people who are blind and vision impaired to overcome the barriers that impede their independence and participation in society.

One of the chief goals of NCBI Rehabilitative Training Centre (NCBI 2011) to is to conduct:

> training in mobility and independent living skills and providespractical solutions to enable people with sight loss to carry out everyday tasks safely and independently. This service can support people to effectively use their remaining vision or mobility aids and to develop skills so they can get around with greater independence.

The positive impact of the host cultural perception of disability and the support provided by the NCBI in relation to visually impaired migrants' potential to adapt to visual impairment is analysed in Chapter 5.

2.3.8. Analysis of the social model of disability

The development of the social model of disability is traced to the work firstly of Saad Nagi and later to the independent living movement (ILM 1972; DeJong 1979). An assessment of independent living movement demonstrates that through advocating a process of de-institutionalization, the trend towards disabled people moving out of institutionalized care into community residential care was activated (ILM 1972; DeJong 1979). This move is positively evaluated as a process of normalization which encouraged integration of people with disabilities into mainstream society. In the UK and Ireland, the social model of disability provides the structural analysis of disabled people's social exclusion (Oliver, 1983; 1990; CLI

1992; Enable Ireland, 1992). The social model emerged from the intellectual and political arguments of the Union of Physical Impaired against Segregation (UPIAS). This association formed after Paul Hunt, a former resident of the Lee Court Cheshire Home in the UK, wrote to *The Guardian* newspaper in 1971, proposing the creation of a consumer group of disabled residents of institutions. In forming the organization and developing his ideas Hunt collaborated with Vic Finkelstein, a South African psychologist, who was exiled to Britain following for his anti-apartheid activities. It is interesting to note the roots of the social model in the collaboration between a disability and anti-apartheid activist, as the goal of this study is to bridge the gap between the fields of Disability and Intercultural Studies or indeed renew the relations. Tom Shakespeare (1996: 197) evaluates UPIAS as:

> A small, hardcore group of people with disabilities inspired by Marxism, who rejected the liberal and reformist campaigns of more mainstream disability organizations such as the Disablement Income Group and the Disability Alliance.

Analysis of the UPIAS highlights its chief objective to replace segregated facilities with opportunities for people with impairments to participate fully in society, to live independently, to undertake productive work and to have full control over their own lives. The UPIAS policy statement (UPIAS 1974) asserted that disabled people were defined as oppressed group in society and stressed that social barriers were the main impediment to full societal participation, as stated:

> We find ourselves isolated and excluded by such things as flights of steps, inadequate public and personal transport, unsuitable housing, rigid work routines in factories and offices and a lack of up to date aids and equipment.

An assessment of the UPIAS demonstrates that it was their dynamism that drove the subsequent development of the UK disability movement and disability studies.

Following the UPIAS policy statement (1974) the British Council of Organizations of Disabled People (BCODP) set up an alliance of groups of people with disabilities in 1981, assuming the UPIAS approach to disability. Finkelstein and the other BCODP delegates to the first Disabled People's International World Congress in Singapore later that year, worked hard to have their definitions put into universal worldwide action (Driedger 1989). At the same time, Finkelstein and Swain were working with the Open University to create an academic course which would promote and develop disability politics (Finkelstein 1998). Joining the team was the disabled academic Mike Oliver (1983) who quickly adopted the structural approach to understanding disability. The term 'social model of disability' is credited as being coined by Oliver in 1983.

In contrast with the original UPIAS Statement of Aims (1974) which identified social problems as an additional burden for people with impairment to deal with, an evaluation of the Fundamental Principles of Disability (UPIAS 1976: 14) document demonstrates that it extends this position to identify society as the disabler:

> In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments; by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society.

A critical examination of the UPIAS's key fundamental principal of disability (1976:14) the essential ingredients of the social model can be detected. That is to say the distinction between disability which is viewed as social exclusion and impairment which is viewed as physical limitation, and, furthermore, the assertion that people with disabilities are an oppressed group. Disability can now be perceived to be analysed, not in functional terms but as:

> The disadvantage or restriction of activity caused by a contemporary social organization which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. (UPIAS 1976: 17)

In assessing the contribution of the UPIAS it is this redefinition of disability is that sets the UK social model apart from all other socio-political approaches to disability and what paradoxically gives it both its strengths and weaknesses. Oliver (2004:19) highlights the key difference between the individual (or medical) model and the emerging social model:

> Models are ways of translating ideas into practice and the idea underpinning the individual model was that of personal tragedy, while the idea underpinning the social model was that of externally imposed restriction. (Oliver 2004: 19)

Hasler (1993) in assessing the contribution of the social model of disability identifies its political, instrumental and psychological effectiveness for people with impairments. Oliver (2004: 30) highlights the role of the social model as a "practical tool, not a theory, an idea or concept": the onus rests with society to lift the burdens which have been imposed and to enable disabled people to participate as full members of society. In employing the social model 'tool' Oliver (2004) asserts the positive impact on the emotional well being of people with disabilities improved self-esteem and the encouragement of a sense of pride in a collective identity.

An analysis of the social model demonstrates the promotion of a shift in terminology surrounding disability. For example, the word 'invalid' stressed a sense of personal deficit or failure which was associated with the medical model of disability began to be substituted with language such as *independent living*, *enabling environments* and *empowerment.* Thomas (2002: 1) evaluated the fresh approach to disability in terms of social inclusion:

> The emergence of the social model of disability meant that disability now resided in a nexus of social relationships connecting those socially identified as impaired and those deemed non-impaired or 'normal', relationships, that worked to exclude and disadvantage the former while promoting the relative inclusion and privileging of the latter.

Shakespeare (1996:99) further highlights the potential of this new definition of disability to create positive self identities:

> [A]n outcome of social processes or as constructed or created category which views negative self-identity as a result of the experience of oppressive social relations, and focuses attention on the possibilities for changing society, empowering disabled people, and promoting a different self-understanding.

This definition is very significant for this study, as it acknowledges the potential for people with impairments to change their society and if the individual is in conflict with societal opinion of disability encourages a redefinition of identity.

An analysis of the social model identifies the role of appropriate service provision for people with impairments. Oliver (1996: 32) identifies a lack of appropriate disability services as debilitating:

> It is not individual limitations, of whatever kind, which are the cause of the problem, but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken in its social organization.

Through discussions and assessment of people's experiences of discrimination, the independent living movement firmly rejected the "negative implications of the individualistic medical model approach to disability" and called for "an emphasis on the exclusion and discrimination disabled people face daily" (Oliver and Barnes 1998: 70). The objective in applying a social model 'tool' towards understanding disability is to lift the burden from the individual, thus endorsing a positive self-identity. Oliver and Barnes (1998: 77) evaluate the new positive self identity in terms

of growing from "the redefinition of self and recognition that the personal is political". The impact of the social model for visually impaired migrants is discussed in Chapter 5.9-13 in relation to increased opportunities due to societal acceptance and inclusion which facilitates more successful adaptation to visual impairment.

There has inevitably been some criticism of the social model for example Shakespeare and Watson (1997) contend that the social model cannot address the experiences of disabled people. They cite Finkelstein as one of those who consider the linking of personal experience and impairment as diluting the effectiveness of the social model (Watson 1997: 293). At the heart of the social model is the socio-political drive to combat socioeconomic oppression and to transform the structures that marginalize and dismiss the capabilities of impaired people and in order to do so Oliver (2004) argues that the personal experience and impairment are inextricable.. From its fledgling foundations with the UPIAS to the multitude of variant social understandings of disability, the emergence of the social model of disability has undeniably modified how disability and impairment are evaluated. The final key section examines the theories relevant for social adaptation to visual impairment which are significant throughout the data analysis chapters of this thesis.

2.4. Differentiating between congenital and acquired visual impairment: locating the research

This final section of the Disability Studies literature review focuses on the theories which relate specifically to sight loss which are considered relevant to this study's research on the migrant's adaptation to visual impairment in Ireland. This third main section of this literature review chapter consists of five interrelated parts:

1. Coping with sight loss: stages of adaptation

2. Models of adjustment to sight loss
3. Rehabilitation services: increases self esteem: facilitates adaptation:
4. Being perceived as a burden: lowers self esteem: hinders adaptation
5. Affective social support facilitates adaptation.

Firstly it is important to differentiate the difference between congenital and acquired visual impairment in distinct approaches to adaptive learning. Falvo (1991: 255) firstly asserts that:

> [Individuals who have congenital blindness] because of their lack of visual experience in their environment, such as observation of tasks or behaviour of others, must learn by other means concepts that sighted individuals often take for granted.

Secondly Flavo (1991: 2550 states:

> Individuals who lose their vision later in life have the advantage of being able to draw on visual experiences in the environment as a frame of reference for physical concepts, but they may find it more difficult to accept their blindness than those who have never had vision.

This study is interested in examining the different cultural approaches to disability that facilitate or hinder migrant's adaptation in the host environment. Therefore, it is important to emphasize that criterion for participant selection was not whether an individual had congenital visual problems or whether they acquired their visual impairment later in life. Rather, research participants were selected owing to their migrant status in order to examine the challenges of acceptance of disability posed by cultural barriers.

2.4.1. Empirical studies related to stages of adaptation to sight loss

Across theoretical studies within the field of Disability Studies, specifically in the field of rehabilitation research, two principal points have emerged in

relation to adaptation to disability. Firstly, that adaptation to disability necessitates a multidimensional reaction (Livneh and Antonak 1997; Shontz 1975) which is secondly exceptional in its individual nature (Livneh and Antonak 1997). An assessment of the literature on visual impairment highlights that the concept of adaptation is frequently substituted with other terms for example, such as coping (Lazarus and Folkman 1984; Brennan et al. 2001), strategies (Brennan and Cardinali 2000) or adjustment (Teitelman and Copolillo 2005). Shontz (1975) emphasizes four coping stages following realization of disability that are universally perceived:

1. Shock accompanied by feelings of detachment
2. Encounter phase accompanied by feelings of panic and helplessness
3. Retreat accompanied by feelings of denial
4. Reality Testing accompanied by psychological growth

Lazarus and Folkman (1984: 142) consider coping as:

> Constantly changing cognitive and behavioural efforts, to manage specific external and or demands that, are appraised as taxing or exceeding resources of the person.

From their perspective (1984: 143), a key concept in coping is management of stress associated with disability which can involve:

> Minimizing, avoiding, tolerating and accepting the stressful conditions as well as attempts to master the environment.

In the context of the visually impaired migrant this involves efforts to master changed status, for example, through learning new skills such as long cane and Braille, to orientate themselves without vision. Furthermore, owing to their migrant status they may be required to master cultural and linguistic skills to orientate themselves in new cultural environment, such as learning English.

The stage model approach of adaptation to disability evaluates adaptation as a gradual coping process not a single event (Shontz 1975; Livenh et al. 1997). Livneh and Antonak (1997: 8) examine adaptation in terms of the individual's involvement in:

(1) active participation in social, vocational and avocational pursuits
(2) successful negotiation of physical environment and
(3) awareness of remaining strengths and assets and existing functional limitations,

Fulfilling these three key requirements; 1) participation 2) negotiation and 3) limitation awareness within the social the environment is consequently integral to successful adaptation. Adaptation to disability thus relies on the person with impairments' societal participation. This study draws on this framework in understanding disability to examine the case of the visually impaired migrant's ability to adapt to their visual impairment in Ireland.

2.4.2. Analysis of models of adjustment to visual impairment

This section presents two key models of adaptation specific to adaptation to visual impairment which are considered relevant for this study.

Baus (1999) investigated the psychological aspects of visual impairment which draw on her experiences of working in local and national organizations for the blind in Germany. Her research highlights the relationship between sight loss and associated shock experienced by individuals following realization of sight loss. Baus's (1999: 43) associates the shock of sight loss with the grieving process

> If the outset of visual impairment is sudden, a sensation akin to shock is the first experience. People whose sight gradually deteriorates live with a constant threat…Similarly to the loss of a loved one, be it through

> separation or death…the most varied sensations arise which can be grouped together as grief processes.

In this current study as participants are experiencing sight loss while removed from their home country they may experience grief on two levels as a result of separation from family due to migration and most significantly owing to their visual impairment.

From her analysis of participants' lived experiences of adjusting to sight loss Baus (1999) developed a model of adjustment to visual impairment. Four phases are emerged from the analysis. The process is assessed as non-static in nature (Table 1).

Table 1 Phases of Adjustment to Visual Impairment (Baus 1999)

Phases of Adjustment	Emotional State	Behaviour
Phase 1.	Unwillingness to face the truth	State of paralysis to protect against emotions Impairment denied
Phase 2.	Recommencement of emotions	Violent sensations of protest; anger, rage, fear directly at outside world
Phase 3.	Depression	Realization life changed. Constant confrontation between loss and search for new possibilities
Phase 4.	Changed Relationship between oneself and world	Gradual willingness to participate and adjust to life without sight

Baus (1999: 44) purposely does not to define the fourth phase "acceptance" as it denotes an "end position" which she believes is not appropriate:

> Process of adjustment to disability will never be quite finished and that we may at any time come into contact with our loss or grief.

This caution not to label the final phase of her model, as acceptance, correlates with research in the field of Intercultural Studies in relation to a migrant's adjustment to

living in a new cultural environment. The correlation with what Baus (1999) theorizes as the appropriate counselling response provides a practical applicability to this model. The theoretical model developed from this grounded theory study and presented in Chapter 9 bears in mind Baus's (1999) recognition of linking the phases of adjustment with impact on provision of counselling services.

UK researcher Thurston (2010) conducted a qualitative study with 18 participants all of whom had a recognisable eye condition which resulted in sight loss. The objective of the study was to investigate the emotional impact of sight loss and the counselling experiences and needs of this group. The research study was motivated by the researcher's own unexpected diagnosis of sight loss and subsequent frustration with not having emotional needs met by service providers.

Four main categories were generated from the data analysis of qualitative interviews.

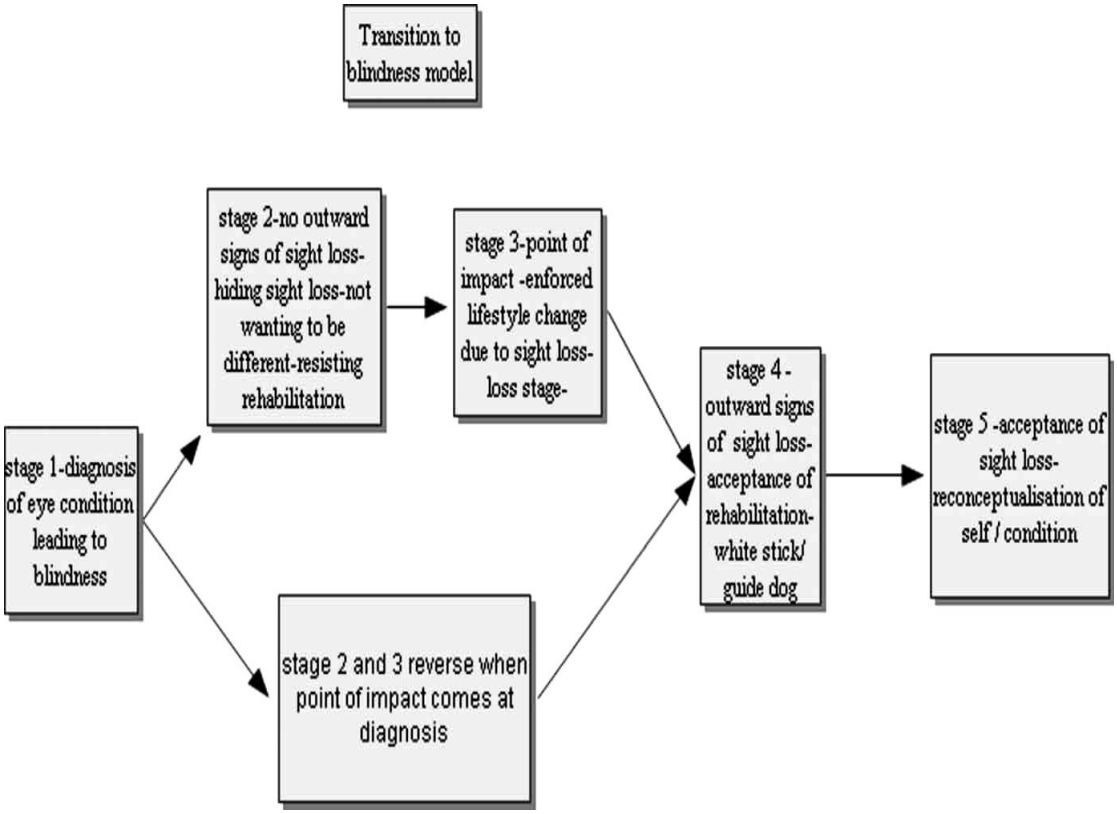
> 1) making the transition to blindness; 2) counseling perceptions and experiences; 3) suggestions for improving services; and 4) the effect of the researcher's visual impairment on data collection. (Thurston 2010: 5).

Thurston's (2010) qualitative study documented the lived experiences of the participants' journey from diagnosis to rehabilitation. The study's chief findings are as follows:

- 8 of the participants in the study spoke about feeling isolated from others.
- 16 participants expressed a negative view of rehabilitation
- 12 participants emphasised the benefits of being socially integrated into the community prior to sight loss
- Informants described a lack of emotional understanding and support from the health professionals they encountered at the time of receiving a diagnosis, and an absence of acceptance within society as a whole.
- All participants felt that it would have been good to have had the opportunity to have someone to talk to about their feelings, around the time of their diagnosis (Thurston 2010: 6-7).

Thurston (2010) formulated a useful theoretical model of the transition from sight to blindness from these findings (see Figure 3).

Figure 3 Theoretical Model of the Transition Process from sight to blindness (Thurston 2010).



This model builds on the approach of development stages of integration of disability (Shontz 1975; Charmaz 1995; Gill 1987; Baus 1999; Salick and Auerbach 2006). The first stage in the transition to living with sight loss centres on the diagnosis experience. This correlates with this study's starting point in its discussion of cultural perceptions of disability associated with disability causation as outlined in Chapter 5.

This diagnosis stage is marked with emotions of shock and grief which correspond with Baus's (1999) first phase of adjustment to visual impairment. Participants in Thurston's study report feeling lack of autonomy in the diagnosis experience. In this

study, in Chapter 5 a comparison is drawn between a service user's experiences of diagnosis in their home and host country. Stage two of Thurston's model corresponds with Baus's (1999) phase two where the individual is in denial about changing status from sighted to visually impaired individual. The duration of this stage is dependant upon the time span in which sight deteriorates. During this period the individual may demonstrate reluctance to engage with assistance because at this point in the adjustment they have yet to accept their sight loss. In this study this stage also corresponds with Bennet's (1986) second stage "denial" model of developmental intercultural sensitivity.

The third stage is called 'point of impact' and marks the realization of sight deterioration. This is a critical moment for individuals to process the transformation which is occurring. This can be evaluated as a dynamic model which facilitated flexibility in the order of stages depending most significantly on the point of impact. It is not until stage four which can be compared with Baus's (1999) vaguer understanding of reconnection with society that the individual begins to slowly implement visible signs of blindness into their lives, for example engaging in mobility training. The key difference with Baus's (1999) model is that Thurston's (2010) model identifies "acceptance" for the final stage of the process. Nevertheless, it also recognises the role of re-conceptualising the individual's sense of self as Baus's model does. In evaluating the applicability of her model Thurston (2010) does not claim it to be prescriptive but rather emphasises that the goal is to further understand the complex process of transition from sight to sight loss :

> A helpful conceptualisation for understanding some of the issues involved in the process of transition from sight to blindness. What is advocated is that this is a process needing to be studied in greater depth. That process is the transition from being sighted to becoming blind.

> Understanding this process may help the development of effective psychological interventions. The concept of point of impact may be particularly significant in relation to the provision of counseling, because it is largely at this stage that the person is likely to experience the strongest emotional response.

The model generated from the data gathered for this current study into the experiences of visually impaired migrant and professionals working with them illustrated in Chapter 10 subscribes to the same understandings as Thurston's model (2010). It does not aim to generalize about the migrant service users' experience of adapting to sight loss but rather express that individual journeys can be traced and compared to provide support when most needed. It is also significant for this study that the point of impact is highlighted as a critical period in the adjustment process so that strong emotional behaviour may be responded to appropriately. The process of transition from sight to sight loss may be considerably more complex when the individual is experiencing this at a time when they are not in their own home culture. Thurston's (2010) study's findings are related to this current study's findings in Chapter 10.

Although Smart (2001) is critical of stage adaptation model's lack of consideration of prejudice and discrimination which many people with disabilities face she recognises its potential to foster optimism. This is because the stage model builds the foundation from which to support people with disabilities as it assists service providers in tracking the process of adaptation. In turn this enables service providers to select the most appropriate rehabilitation goals, at a given stage. Furthermore, Smart (2001: 246)) emphasises the potential of the stage model approach to encourage linking individuals in support groups "who have experienced the same

disability". In the case of this study this means connecting individuals with visual impairment as owing to the reality that:

> group members may be at different stages in the adaptation/response process, members learn from the experiences of others…and can do much to promote hope.. (as) group members know that others understand their experiences. (Smart 2001: 246)

The concept of peer support and its benefits for facilitating positive responses to visual impairment for service users and their family are discussed in Chapter 6.7-7.1 of this thesis and relevant Disability Studies literature which addresses the issue of social support for visually impaired is examined in the final section of this chapter.

As this thesis examines the impact of cultural perceptions of disability on visually impaired migrants' societal participation therefore their adaptation is examined in relation to how negative attitudes towards disability can inhibit individual's potential to rehabilitate, re-enter society and increase quality of life.

2.4.3. Rehabilitation facilitating adaptation: increasing quality of life

This section examines the role of rehabilitation is facilitating adaptation to disability and consequently increasing an individuals' quality of life. In the context of disability rehabilitation Bishop (2007: 235) highlights the subjective nature of the adaptation process firmly locating the process within the individual's "personal and subjective analysis of his or her total situation". This point is relevant for this study as it acknowledges the whole life experience of the individual who is coping with impairment. In the case of this study the individuals' migrant status is a key factor in his/her 'total situation' of sight loss.

Affective adaptation hinges on affective societal acceptance which facilitates societal participation of people with disabilities (Livenh and Antonak 2007). They (Livenh and Antonak 2007: 131) align affective adaptation with 'affective acceptance' which they assess to be an:

> Active pursuit of personal, social and for vocational goals, including successful negotiation of obstacles encountered during the pursuit of these goals.

In the case of a visually impaired individual affective adaptation according to this understanding would mean, in spite of visual disability, he/she would fully participate within the social environment. In order to successfully negotiate the visual world an individual with a visual impairment needs to learn skills to adapt and integrate into society and engaging with professional support in visual rehabilitation can facilitate the process.

In their longitudinal study involving case studies with 95 elderly people adjusting to sight loss Boerner et al. (2006: 479) acknowledge the complexity of visual rehabilitation and most significantly its fundamental role in facilitating adaptation to sight loss:

> Vision rehabilitation is multifaceted and includes low vision clinical services which focus on learning to use one's remaining vision, training in orientation and mobility skills and in conducting everyday tasks, as well as training in the use of various types of assistive devices... While the major focus of vision rehabilitation is to affect level of functional ability, a related goal is to generally help people adjust to life with chronic impairment. Thus, rehabilitation can affect the way one learns to cope with vision loss in terms of changing how a person may feel or think about their vision, or what they may actively do to deal with their vision problem.

Moreover, Boerner et al. (2006: 480) highlight the potential of engaging with rehabilitative services in developing coping skills to deal with sight loss:

> The use of rehabilitation services may affect a person's coping, either because it encourages particular kinds of coping strategies, or because it enhances a person's awareness for the problem, which may in itself influence the overall level of coping activity.

In this current study engaging with rehabilitative services is related to individuals' ability to adapt to their visual impairment.

Bearing this understanding in mind, it follows that the potential for affective acceptance which is associated with adaptation may be negatively impacted within a socio-cultural framework that does not facilitate access to rehabilitation services for visually impaired members of society. This is because such services are demonstrated to enable visually impaired individuals overcome barriers posed by their impairment. Webson (1997) alluded to the fact that in most developing countries, resources and rehabilitation services are very limited and in many cases services do not exist at all. A key example of rehabilitative work that enables social participation for visually impaired is learning mobility training to enable visually impaired individual to travel independently. The association of acceptance with adaptation is examined in relation to the service users' process of adaptation throughout the data analysis chapters.

Gill (1997) suggests that integration is central to adaptation: individuals ought to integrate into society, integrate with the disability community, and within themselves integrate their similarities and differences with others. Social integration has been associated in Disability Studies literature with positive adjustment to physical disability for example in research related to adaptation to chronic illness (Charmaz 1995) and visual impairment (Salick and Auerbach 2006). (Livenh and Antonak 1997; 2007) assert that acceptance from others and of themselves is vital to

successful integration The fundamental association of integration with adaptation is appropriate for this current study as it creates a strong link to intercultural concerns with adaptation in cross-cultural contexts. In addition, the essential elements required for successful adaptation recommended by Livneh and Antonak (1997; 2007) correlate with the concept of quality of life. Sustaining positive levels of quality of life may be vital to adaptation as Diener and Diener (1995) assert that a positive individual quality of life facilitates increased opportunities for social and personal advancement and stronger coping resources which enables adaptation.

Allen's (1990: 49) study on patterns of adjustment to sight loss reported that visually impaired persons defined their adjustment in terms of "being able to carry out their normal activities in as independent a manner as possible and achieving a reasonable perspective about their impairment." In contrast, therefore an inability for a visually impaired individual to both cope practically through engagement in everyday tasks and emotionally manages his/her visual impairment would indicate poor levels of adaptation to visual impairment.

Horowitz et al.'s (2003) study on adjustment to sight loss for elderly people found that the negative impact of sight loss on functional ability and social activities put individuals at risk for depression and poorer perceived life quality. Karlsson's (1998) study on psychological distress related to sight loss highlighted an important factor for adaptation to vision loss as engagement with rehabilitation services, which was identified as an independent predictor of decreased depression.

Understanding the integral relationship between adaptation, societal and personal acceptance, rehabilitation and overall social integration provide the framework for

analysing the experiences of this current study's migrant participants' process of adaptation to visual impairment in Ireland.

2.4.4. Evaluation of concept of being labelled a burden for lowering self esteem

This section reviews the literature which addresses the concept of being labelled a burden. Misajon (2002: 48) identify the person with disability's perceived sense of control as crucial component in coping with impairment as "feelings of vulnerability and helplessness can be offset by generating a sense of personal control over the illness" or disability. However, personal control over disability is dependent upon learning in the case of visually impaired person the orientation skills to manage independently as otherwise helplessness and reliance on others may be an unavoidable situation. This breeds the concept of being a burden. Radley (1994: 148) acknowledges the negative impact of becoming a burden on others' has for individual's identity as he states:

> To those whose illness becomes incapacitating it can have profound effects on the person's social identity. Now unable to fulfill past obligations, the person can no longer claim with authority the identities that are based upon doing these things. Worse still, s/he may come to feel useless to self and others.

In this study the concept of being a burden, following this understanding of the concept is analysed in relation to negative home community support in Chapter 6.5.

2.4.5. Evaluation of the role of social support in adaptation to visual impairment

Social support for the visually impaired to protect against isolation is the basis for much research in Disability Studies literature (Baus 1999; Burmedi et al. 2002;

Percival and Hanson. 2005; Bruce et al. 2007; Percival and Hanson 2007). Turk (1979: 291) analysis of individuals who are coping with chronic illness and disability found that they face the challenges of "loss of key roles; disruption of plans for the future; distressing emotions such as anxiety, depression, resentment and helplessness."

Charmaz (1983: 168) assesses these distressful emotions with individuals suffering with (1) leading restricted lives, (2) experiencing social isolation, (3) being discredited and (4) burdening others. To protect against excessive social restrictions Charmaz (1983) highlights the key role of strong support networks..

Radley (1994: 147) connects the concept of isolation prevalent for those coping with disability with reduced social worth as he states:

> Isolation is the consequence of people feeling, or being made to feel, that they have diminished in social worth.

This understanding is useful for this study as it not only denotes the perspective of the individual experiencing the state of loneliness but also acknowledges society as an active agent in producing isolation. During the preliminary stages of diagnosis of visual impairment and realization of sight loss, emotional and practical support from close ties is central to the facilitation of successful adaptation (Lin et al. 1999). In relation to immigration, the most significant sources of support, particularly in the preliminary stages of migration are similarly family and friendship connections as discussed in Chapter 6.

During times of transition, such as migration, and moreover, the most vulnerable time of sight loss, emotional distress is heightened. Support from family and close ties is reasoned to alleviate the sense of alienation associated with adapting to disability, as Bisschop et al. (2004: 722) find:

> Family and friends are thought to enhance psychological well-being directly by fulfilling one's need for a sense of coherence and belonging, and thus counteracting feelings of loneliness.

Rook's (1984) study investigating strategies to overcome social isolation identify the healing power of support networks to consult with or to reveal personal challenges which may boost individual well-being and may also ease coping with stress. Lin et al (1999) identify three layers of support which form a nested support system with the outer being part of the community; secondly participation in interpersonal ties and thirdly the innermost layer comprising an individual's intimate ties based on mutual trust and confiding. The three support layers impact three fundamental human levels which Krokavocova et al. (2008: 160) refer to as being:

> Emotional (love and affection), instrumental (helping hands) and informational (providing information).

In this study these support layers are represented in both the home and host community as discussed in Chapter 6. In addition, to facilitate mobility training, the mutual trust fostered in these intimate ties more is usually associated with family and close friendship ties is encouraged; service users can confide their anxieties surrounding independent travel and be secure that their confidence will be upheld with the mobility trainer.

In Reinhardt's (2001: 76) study of the role of support networks in adapting to visual impairment, he differentiates between positive and negative support. Emphasis is

placed on the vital role of high quality support, specifically in relation to adjustment to living with visual impairment, as she associates:

> Affective family support provision…with higher life satisfaction (Better adaptation to vision loss was associated with less functional disability, higher education, and higher friendship support quality.

Family support is associated with greater life satisfaction, and more positive adaptation to vision loss, while negative exchanges with family members are associated with greater depressive symptoms which inhibit the adaptation process (Reinhardt 2001).

In addition to family support crucial to protecting against isolation and facilitating the adaptation process, is engagement with rehabilitative services, as it affects quality of life and promotes successful adaptation to visual impairment (Horowitz et al. 1994; Smart 2001). Moreover, connecting with rehabilitative services offers the opportunity to potentially form ties with what Thoits (1986) terms 'similar others'. as discussed in this thesis in the context of accessing peer support from visually impaired individuals who face similar adaptation challenges.

> Peer support positively contributes empathetic understanding; as such it is considered the most significant emotional supportive mechanism for adjustment to living with impairment. Weisman (1984: 105) analyses empathetic understanding as a comprehension of the experience of someone "who is faltering and losing self-esteem". This definition of empathy is useful for this study in appreciating the value of loss of self-esteem which is significant for the participants in this study. In addition, this definition of empathetic understanding is related to struggling with difficult life circumstances.

2.5. Chapter Conclusion

This chapter has presented an extensive review of the literature in Disability Studies. The intention has been to document the complexity of the concept of disability, how

it is defined and the way in which divergent definitions may hinder or empower people living with impairment. As such this chapter provides the theoretical framework from the field of Disability Studies which acts as strong backbone to the overall study. The key models outlined were the moral, medical and social models of disability. These models will be related to throughout this study most specifically in Chapter 5. The way in which disability is perceived is dependant upon the understanding and pursuit in practical terms of these approaches to disability. The consequences of esteeming one model over another for an individual with impairment, specifically for this study, visual impairment, will be explored throughout this study. Finally, the third section of this chapter focused on the specific disability examined in this study, visual impairment. Models related to adaptation were explored and the concept of quality life was discussed in relation to societal acceptance of visual impairment. The next chapter outlines the methodology used for this study.

CHAPTER 3: Methodology

One learns people through the heart not the eyes or the intellect. (Twain 1895)

If speaking is silver, then listening is gold. (Turkish Proverb)

3.1. Chapter Overview

This chapter is made up of seven sections which together link the methodology to the central questions and aims of the research project as a whole. The chapter opens with the outline of the natural history of the research. Following this there is a discussion on two methodological approaches; quantitative and qualitative research. Ethical concerns are then outlined. Next the interview method and sampling strategy are discussed. The selection of the two participant groups; service users and service providers are discussed. Following this the specifics of the data analysis grounded theory approach are addressed in relation to (1) the coding process, (2) memo writing (3) using the qualitative data analysis software tool Atlas.ti. The final three sections of this chapter reflect on the research process, the ethical issues for the researcher and the limitations of the study.

3.2. Natural History of the Research

The ambition to pursue this research project began during my time as an Intercultural Studies tutor on the first intercultural course entitled “Living in a Diverse World” at the National Council for the Blind in Ireland (NCBI) in November 2006. At that time I had no experience working with visually impaired students and I became fascinated by the sociology of a blind culture. The first class group I taught were a very diverse group of individuals in age, gender, learning and physical ability and ethnic background. Given that I was working within a learning environment where

discussions on the topic of intercultural communication are encouraged, the opportunity arose for information and insight into individual experiences.

I was very curious as to how these students were managing adjusting to a new culture here in Ireland and simultaneously coping with adapting to a new identity as a visually impaired person. I considered whether they in fact felt they were adapting to two new cultures and had their identity changed or was in the process of change. I wanted to discover what their views, beliefs and feelings were; what was it like to be a migrant with a disability in Ireland today. Also, how would service provision for visually impaired people in Ireland compare with service provision in their home country and did divergent attitudes towards their disability in Ireland and their home country exist; If so would these attitudes impact upon their adaptation to living with their disability while adjusting to life in a new country.

Due to the nature of my teaching work at the NCBI I had ready access to potential research participants. As recommended by Kane and O'Reilly–De Brún (2001) I identified "key informants" prior to scheduling formal data collection. The objective was to familiarise myself with the research environment and uncover the perspectives of professionals with expertise in the area of visual impairment. Meetings with various representatives within the visual impaired professional community were carried out. An influential preliminary contact was the librarian, at the time at St. Josephs' School for the Visually Impaired Resource Library. She had dedicated her professional life to working with individuals with sensory disabilities and provided me with an extraordinary amount of knowledge on past and recent research into the area of service provision for visually impaired people both nationally and internationally. Moreover, as she had previously worked in the New

York Public Library, her contacts there enabled me to access valuable research journals in the field. Additionally, discussions with the US occupational therapist at St. Josephs' fostered a greater understanding of particular communication issues between the professional occupational therapist and the migrant family. She also brought a cross-cultural perspective on disability issues having previously worked in the United States of America.

This preliminary 'second source' research uncovered a strikingly scant catalogue of existing research investigating the case of the blind or visually impaired migrant both internationally and most notably in the Irish context, my specific concern. Research interest grew from observing how my migrant students were coping and managing to manoeuvre themselves linguistically, culturally and most visibly, their physical negotiation of their new environment. Kane and O'Reilly-De Brún (2001: 218) note the significance of observation by acknowledging that:

> You can use observation as a preliminary technique to get information or you can use it as a strategy in itself. It is valuable when you need to understand something in its natural setting.

As I was working with a particularly vulnerable group, whose specific physical disability would place them at an unfair disadvantage I did not feel comfortable pursuing observation as a 'strategy in itself'. Instead, I wanted to talk directly with individuals, as working at the NCBI lent me ready access to research participant groups. However, I felt I needed time to build trust before outlining my potential research including possible future interviews.

In nurturing a secure classroom setting I instilled confidence in my students to discuss sensitive issues of intercultural relations and disability; as Gillham (2000: 16) notes it is "remarkable what people will disclose if they feel you are a person

they can talk to." In so doing, I paved the way for setting up individual interviews later with a group who now felt more at ease articulating their personal stories. Furthermore, it was later at the Training Centre's inaugural award ceremony on Ash Wednesday 25th February 2009 to recognize the trainees' achievements that I met with representatives of the NCBI outside the Centre who spoke of other visually impaired migrants living in the community who were more isolated than those at the Centre. I was curious to find out how I could meet these isolated migrant service users. This was a challenging undertaking as there are no systems set up within the organization, to document and record the nationality of its service users; there are neither figures nor means of knowing which service users are migrants. Therefore, word of mouth is the most practical means of assessing service users' status. I was greatly assisted in making contact with, and later setting up, interviews with individuals outside the Training Centre, through contacts created with regional management outside the centre.

Firstly, I flagged my research project at the end of one of our regular classroom meetings and some students expressed an interest in speaking with me, others who for various reasons, for example absenteeism due to hospital appointments on the day, I approached directly. Migrant service users were also identified through regional management; in both practical and personal terms, this was a more challenging group to meet as I was an unknown person to them. Secondly, I was invited to give a presentation of my research goals and objectives to the frontline staff, the community resource workers. Afterwards we discussed our mutual concerns and interests in working with visually impaired migrants and I liaised with several staff members to set up interviews with their clients and also decided to interview them as well, as they also provided insights for the research. The research

goal then included both service users and service providers to facilitate greater understanding of visually impaired migrants' adaptation in Ireland.

3.3. Quantitative and Qualitative Distinction

The two broad approaches to conducting social scientific research are quantitative and qualitative. The decision to adopt one approach or the other is driven by the nature and scope of research questions formulated at the start of the research study. Punch (2006: 46) presents a perspective on which choice to make:

> The question of quantitative or qualitative focuses entirely on the data themselves, in which case, it really becomes; to measure or not to measure? This is because measurement is the process of turning data into numbers, and is therefore the operation which differentiates quantitative data from qualitative data.

This research is exploratory and does not intend to be statistically representative and as such the research questions which this study seeks to address are open in nature; therefore the qualitative approach is the most appropriate.

Mason (1996: 19) advises that the choice of method "should reflect an overall research strategy". This is because the methodology shapes which methods are used and how each method is then used. The decision to select a specific research framework must be rooted in its usefulness in addressing the outlined central research questions. As Robson (2002:80) states:

> The general principle is that the research strategy or strategies; and the methods and techniques employed, must be appropriate for the questions you want to answer.

The qualitative framework supports the overall purposes of this intercultural study of visually impaired migrants in Ireland.

3.3.1. The Nature of Qualitative Research

Denzin and Lincoln (2002: 3) recognise that qualitative research is interested in:

> A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self.

This approach matches the research objectives of this study which engages with the research participants in their world and endeavours to make it 'visible' to the world outside. The character of the research questions which stimulated this current study are flexible and open ended in nature. Their core interest is to explore the real life experiences of the visually impaired migrant in Ireland.

The preference in qualitative research is for meanings rather than behaviours. As Hammersley (1992: 65) states a qualitative research project attempts 'to document the world from the point of view of the people studied'. The investigative lens of this study is sharply focused on the opinions, views and beliefs of the selected participants. This is in contrast to quantitative research whose aim is to produce a set of cumulative generalizations (Silverman 2000); in qualitative research data is collected from the participant's own words which "relate to feelings, processes, actions and meanings" (Barnes and Mercer 2003: 9). For that reason a qualitative research methodology corresponds with the study's overall research goal which is to bridge the field of disability and intercultural studies.

This study bridges two academic fields of research; intercultural studies and disability. Both intercultural and disability scholars strongly advocate the application of qualitative research methods (1994; Hartley and Muhit 2003; Pugach 2001; Stone and Priestly 1996; Ting-Toomey 1983)

Disability scholars Hartley and Muhit (2003: 104) view qualitative research as:

> An opportunity of closing the gap between the science of discovery and the implementation of such discoveries.

They refer to the collection and analysis of data "based on the participants views and the way in which they make sense of the world" (Hartley and Muhit 2003). They identify a particular practical problem in using quantitative methods for disability, research namely low prevalence rates of different impairment groups.

Furthermore, qualitative research is advocated when the participant group is vulnerable as is the case when the study centres on people with impairments and even more so if these individuals are asylum seekers and migrants as is the participant profile for this study. This is another motivation for selecting qualitative research as the methodology. In addition, disability scholars, Stone and Priestly (1996: 701) argue that much scientific research has "perpetuated the marginalisation of people" so that "research has become part of the problem". Therefore, qualitative research is of key significance for disability studies. In fact, within the field of disability studies there is now a strong push towards the implementation of participatory and emancipatory research (Barnes 1990, 1989; Oliver 1992, 1999; Stone and Priestly 1996; Shakespeare 1996).

The International Classification of Functioning and Disability (ICF 2001) acknowledges that by the intrinsic complexity of the relationship between an individual's health condition, personal factors and external factors, the role of participation as involvement in a life situation can not be underestimated. The call for participatory research is a clear reflection of the shift from medical to social theoretical models of disability. This in turn links disability research into an

intercultural framework where qualitative research places the participant at the centre of the research process as is the case in this study as data gathering is by interview.

3.4. Ethical Concerns

Dublin City University's Research Ethics Committee (REC) approved this study fulfilling its ethical regulations. Ethics in social research is described as a way to find the 'right' approach for a given research project (Martin 2007) and as Ireland does not have a national research ethics body, this matter is left to the institutions themselves. The REC of Dublin City University has three primary aims to certify ethically acceptable research (Dublin City University Research Ethics Committee 2008):

> (1) To protect the rights and wellbeing of human and animal participants in research studies or trials conducted by or involving DCU researchers.
> (2) To facilitate the conduct of ethically sound, legally amenable research at DCU in agreement with national and EU legislation.
> (3) To inform the Research Committee on the further development ethical policies and procedures at DCU.

All research requires full anonymity and confidentiality to human participants in any research project (Martin 2007; Israel and Hay 2006). In order to assure anonymity and confidentiality of participants, each participant was assigned a pseudonym (McCann and Clark 2003c) an Irish first name. The decision to assign Irish names was made in collaboration with one particular key informant. The motivation for choosing these names was to reflect the feeling of contentment expressed by participants to be living in Ireland.

In compliance with the university's ethical requirements a 'Plain Language Statement' of the research objectives and an 'Informed Consent Form' were offered to the participants (see Appendix A). It contained the central research questions to be

covered and the research goals. At the outset a Braille conversion of the forms was considered. However, as the majority of the service users were at that time not adept at reading Braille this option was ruled out. Therefore, it was agreed that these documents would be explained verbally, which was carried out at the beginning of each interview.

3.5. Data Gathering: interview as research method

The methodology for this research is based in grounded theory and matches the chosen specific research technique of the semi-structured interview. Bingham and Moore (1959: 4) describe interviews as a "conversation with a purpose".

The task of the interview is to extract in collaboration with the interviewee meanings in and about their lived experience of the phenomena under research scrutiny. The interviewer has a definite purpose and in the case of the semi-structured interview format is equipped with a set of questions thematically clustered prior to the scheduled meeting. The objective of the semi-structured interview is to achieve as Geertz (1973: 5) says:

> Not an experimental science in search of law but an interpretive one in search of meaning.

Geertz (1974: 6) borrows the notion of "thick description" from Gilbert Ryle to denote the goal of qualitative analysis. In addition, interviewing is recommended as the most fitting and frequently employed method of data collection in grounded theory research (Charmaz 2006; Goulding 2002; Backman and Kyngas 1999) which is the method of analysis.

Interviews are distinguished by their chosen format ranging from fully structured to unstructured style. Fully structured interviews are composed of fixed questions in a prearranged order whereas, despite the semi-structured interview having predetermined questions, the order will depend on the interviewer's perception of the most appropriate flow of questioning at the time of interview (Robson 2002). The unstructured interview on the other hand is the most flexible; Robson (2002: 270) says it selects:

> A general area of interest and concern, but lets the conversation develop within this area. It can also be completely informal.

As this is a qualitative study a semi-structured interview is the most appropriate format as Lofland and Lofland (1995: 273) point out:

> Face to face interviews offer the possibility of modifying one's line of inquiry, following up interesting responses and investigating underlying motives.

Thus, for this small scale study the semi-structured in depth interview design is deemed the most appropriate interview style to adopt. It matches the overall research strategy and research questions which aim to document in the participants' lived experiences in their own words.

Furthermore, it links very well with the chosen methodology of grounded theory. A semi-structured interview style facilitates an interaction between interviewer and interviewee. It is as Holstein and Gubrium (1995) recognise a meaning making process that is actively constructed by both participants and so lends itself to a constructivist grounded theory perspective (Charmaz 2000; 2006). The semi-structured interview format encourages an interactive process of engagement and for this reason it is most apt for this study. Finally, the qualitative nature of this research

is reflected in the production of theories from the data collection in the interview from the participant's own words which "relate to feelings, processes, actions and meanings" (Barnes and Mercer 2003: 9).

3.6. Sampling Strategy

> Purposive sampling allows us to choose a case because it illustrates some feature or process in which we are interested.
> (Silverman 2001: 104).

This sampling method is considered most useful as it allows the researcher to choose participants who have the most depth of experience of the research topic in question namely the visually impaired migrant. Furthermore, as the reality that the size of this group of people in Ireland is particularly small in number means the study was dictated by the number of people available to be interviewed. This group represent a particular minority voice in Ireland today. Miles and Huberman (1994: 27) consider purposive sampling as "the most commonly used sampling strategy particularly in applied research." Denzin and Lincoln (1994: 202) acknowledge that:

> Many qualitative researchers employ… purposive, and not random, sampling methods. They seek out groups and individuals where…the processes being studied are most likely to occur.

This is the case of this current study where the participants were approached directly or secured through a third party within the NCBI.

Furthermore, as Patton (2007) acknowledges purposive sampling allows researchers to focus and select "information rich" cases that manifest the phenomenon intensely. Patton (2007: 1) describes "information rich cases" as:

> Those from which one can learn a great deal about issues of central importance to the purpose of the inquiry thus the term purposive sampling.

Moreover Patton (2007) recognizes that the sampling strategy is the central distinguishing feature between quantitative and qualitative research methods stating that:

> What would be "bias" in statistical sampling, and therefore a weakness, becomes intended focus in qualitative sampling, and therefore a strength. Studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations (Patton 2007: 2).

Considering this study aims to address a small sub section of society this strategy is ideal. This study's principal concern is to yield in-depth meanings from a small group of participants for that reason choosing purposive sampling is the most useful strategy to follow. In order to justify the particular case selection, clear criteria that strengthen that sample, must be outlined (Creswell, 1998). The specific criteria which underpin this are detailed in the next section.

3.7. Selecting and Approaching Participants for interview

Frankel and Devers (2000b: 266) note that researchers often cannot approach participants directly and "have to negotiate access by securing permission from 'gatekeepers'". Frankel and Devers (2000b: 266) identify gatekeepers as:

> Organizational officials in charge of research or specific departments the researcher wishes to study, or individuals who have control over subjects of interest, such as children and their parents, students and their teachers or educational administrators.

This was the case in this study. Participants for this study were identified in collaboration with these gatekeepers. In this case, there was reliance on gatekeepers for developing confidence with people who worked personally with migrant service users. The main group of participants were the service users who attended the centre or were in contact with an NCBI community resource worker. In total, 16 service

users were interviewed. The second main group of research participants are the professionals who provide services for visually impaired. In total, 6 service provider professionals were interviewed. All of the participants were candidly willing to contribute their views on the issue of provision of services for migrants and two of the participants had a special interest in the issue.

3.7.1. Selecting participants for interviews: service users

For this study 16 migrant service users were selected by purposive sampling. Of this participant group 10 represent individual service users from a migrant background. The remaining 6 participants are service users interviewed on the behalf on their children. The decision to interview only over 18's was based on ethical considerations as speaking with children with a visual impairment who may also have a language barrier would be too challenging for both the interviewee and interviewer. Furthermore, it is advised that qualitative research projects attempt to say 'a lot about a little' and the addition of a participant group of children would stretch the focus of this current study. Instead interviews were carried out with the migrant parents of children with a visual impairment. 5 interviews in total were conducted with migrant parents and one with a sibling of a visually impaired child.

A diverse range of nationalities are represented and there is no limit on the length of time living in Ireland. The time scale ranges from 2-3 years living in Ireland to up to one participant who has lived in Ireland for 30 years. As it is a study on a small amount of participants imposing the restriction of length of stay would limit the breadth of the research.

The sight loss experienced by the participants ranges from fully blind to mild sight loss. As this is a small-scale study and, in addition, as the participant group is also a

particularly small group in Irish society, the question to what degree of sight loss the participant possessed was not a major indicator on whether they would be included or excluded. In Ireland, as O'Brien et al. (2006: 367) note in order to be deemed legally blind an individual:

> [M]ust be shown by an ophthalmologist to have a (1) visual acuity of 6/60 or less in the better eye or (2) a visual field restricted to 20 degrees or less.

A factor to be considered is whether the individual was born with sight difficulties or whether their eye condition was acquired. Neither individual is excluded for the purposes of this research project as the determining factor for inclusion in this study is that all of the participants are registered blind with the NCBI.

3.8. The professional role of service providers

There are 6 participants in total in this group and all of the service provider participants in this study work for the NCBI. Individuals who represented three professions within the field of visual impairment were selected namely, community resource workers, mobility officers and management. These professional roles were selected on the basis of the contact such professionals may have working with migrant service users. Firstly, the community resource workers as 'frontline' staff tend to be the first point of contact for the service user with the organization. Secondly, the mobility officer has a unique role in relation to the visually impaired as the nature of their profession means working side by side with the service user. Thirdly, participants representing the management section were selected to gain insights into how the organization managed their migrant service user component and the staff working with them.

Two community resource workers were interviewed for this study as community resource workers are the 'frontline' workers in the organization. They are generally the first contact the service user has with the organization. They work with people in their homes enabling them to lead more independent lives. Their insights have the potential to provide a rich source of information into how the visually impaired migrant's process of adaptation to their visual disability in their new home environment, Ireland, progresses.

Two mobility officers were interviewed for this study as their role is to train visually impaired people to orientate themselves independently and safely. The main task is teaching them how to manoeuvre and negotiate their environment with the aid of a long cane on a one-to-one basis with the visually impaired individual. This close physical and emotional proximity which calls for developing a secure relationship of trust is of interest from an intercultural perspective, in terms of gender roles, space, and physical contact. Such issues raise the question of how mobility officers manage to work with service users from different cultures. Also, it is of interest to see how incorporating migrant service users into their Irish service user profile impacted upon them. As mobility officers are in a unique relationship with visually impaired migrant service users, valuable insights could be gained from documenting their experiences. All these reasons make the mobility officer a most suitable research participant for this study.

Finally, two research service provider participants represent management in this study as they play a key role in relation to supervising staff that care for visually impaired service users. This group is also included for their influence within the organization at policy-making level.

3.9. Preparation for the interview: interview guide

The nature of a successful topic guide is for it to provide flexible direction to the overall fieldwork process. Ritchie and Lewis (2003: 115) explain the benefits of preparing a topic guide prior to interviewing as it:

> [H]elps to ensure that relevant issues are covered systematically and with some uniformity, while still allowing flexibility to pursue the detail that is salient to each individual participant.

It can act as an aid to help the interviewer be as comprehensive as possible and not overlook certain issues. However, Ritchie and Lewis, (2003: 115) recognise that it:

> [S]hould be seen as a mechanism for steering the discussion in an interview or focus group but not as an exact prescription.

This matches the semi-structured interview style used in this research project where the interview guide was informed by preliminary informal meetings with professionals in the field. Following the recommendation by Lofland and Lofland (1984: 57), the topic guide opens with a face-sheet used for evidencing factual data. including name, age, gender, nationality and language. As there are two groups of participants, service users and service providers so it follows that there are two interview topic guides. The topic guide's core for the service user interview was clustered into ten 'interview themes' with space for note taking. The themes are (1) adaptation (2) support, (3) family, (4) culture (5) services for the visually impaired, (6) migration motivation, (7) language, (8) employment, (9)education, (10) attitudes towards disability and discrimination. The service user topic guide is presented in Appendix C. For the service provider 2 central themes guided the interview: (1) professional role (2) working with migrant service users (Appendix D).

3.10. Formal Interview Process

Walker (1985) makes a particular practical proposal regarding the actual conduct of the interview. He notes the significance of the physical positioning of the interviewer and interviewee. For instance, sitting side-by-side is considered to encourage more interaction co-operation rather than confrontation between the interviewer and interviewee. This physical positioning during the interview complements the collaborative meaning making process intrinsic to qualitative research and is particularly important in disability and intercultural research which aims to reduce the sense of "them" and "us" and enabling participant and researcher to consider "telling stories together" (Ferguson et al. 1992b: 299). The decision about the setting for the interview was made in collaboration with each participant. The objective was to facilitate and arrange the interview in a location most suitable for the participant taking into account accessibility issues. Most of the interviews with visually impaired participants were conducted in either the participants' homes or at the NCBI Training Centre. There were two exceptions where one was held in a classroom in Dublin City University and the other at the interviewer's home. In each case the decision was made for logistical and practical purposes. In the case of the service provider participant interviews, these were carried out in their places of work, a local pub and at the Interfaith Centre in Dublin City University.

In total, 22 semi-structured interviews were conducted and transcribed verbatim. Each interview was taped using a digital recorder (with the exception of the first interview which was recorded on a traditional tape recorder). Digital recording was selected as it facilitates easy uploading of data onto a PC, lessens the tedium of the transcription process and allows for data duplication and back-up. Moreover, the sound quality compared with traditional tape recorders is preferable, as this study records the voices of participants whose first language is not English and this factor

is most significant. Initially, the strategy of combining note taking with tape recording was explored. Nevertheless, having consulted with visually impaired individuals in the initial stages of the study, who felt that the sound of the pencil or pen and page turning throughout the process could be distracting, the decision was made to write up notes after the process instead to facilitate smooth communication. Rapley (2004) recommends recording as a means of facilitating communication between interviewer and interviewee as note taking may distract the interviewer from the interaction and hinder data retrieval.

Each interview participant with a visual impairment was invited to take the device into their own hands prior to the interview so they were fully aware that the recording was taking place and for general interest, how the recording would be uploaded onto the computer and their words transcribed and coded, was explained. The intention from the outset was to create a collaborative environment and feedback from the participants was positive towards this approach.

Prior to commencing each interview, the nature of the research and the purpose of the interview was explained to each participant in plain language and that throughout the interview at any time if they did not comprehend any question these would be explained. Moreover, any questions or concerns regarding confidentiality were addressed at this stage but were also again reiterated at the end of each interview process. Prior to commencing each interview there was clarification around the role of the topic guide, functioning mostly as an aide memoir and also permission was asked to make occasional notes. As the interviews progressed and there was less reliance on the interview guide for direction during the process as each interview

took on its own shape. As Holstein and Gubrium (1995: 76) point out the use of a topic is not rigid as it:

> [M]ay vary from one interview to the next, becoming the crux of the interview conversation on some occasions and virtually abandoned on others as the respondent (with the interviewer) stakes and develops narrative territory.

This certainly corresponds with the interviewing process for this study. It was with the less vocal participants that there was greater reliance on the topic guide, while with the more talkative participant there was a tendency for a more collaborative development of the narrative territory referred to by Holstein and Gubrium (1995).

The length of each interview ranged from the shortest lasting 40 minutes to the longest at just over 3 hours. The shortest was conducted in both English and the native language of the participant, French. Originally it was agreed that the interview would be conducted in English; however, only a few minutes into the interview it became apparent that the participant was struggling with communicating so it was suggested continuing in French. The interview aided by a dictionary on two occasions and several attempts by the participant to resume the interview in English.

One interview with the parents of a service user was held in the presence of an informal interpreter, a community resource worker who works with this family who is from the same home country. The interview participants, despite speaking reasonable English, felt more at ease to conduct the interview in their native language. In fact the interview would not have been agreed to, had the known professional to them, and facilitated it. This was for both practical reasons in terms

of easier communication, but mostly because this individual already knew their 'story' so they felt comfortable sharing it in the presence of the community resource

worker. Thus, this interview could not have taken place with a professional interpreter as it was less to do with the language barrier than their request for a familiar person to mediate such language issues.

Following the interview, each participant was thanked for their time and assured their anonymity would be protected. Although some participants did not have an issue with this, others sought assurances that their identity would be protected. Finally, the participants were reminded of the research goals of the study and it was suggested that if they felt they had anything else they wished to add to the interview at a later date they could do so. This proved unnecessary as, due to the flexible in-depth nature of the interview, each participant had the opportunity to voice their views to 'saturation point' and not until all themes had been covered and probed did the interview close. There was one case where once the interview had ended and the tape recorder was switched off the participant began discussing a topic of interest that had not previously been explored. Permission was given to switch back on the device and recommence the interview, proceeding for a further 20 minutes.

Creswell (1998) recommends a guideline of sample size of 20-30 for a grounded theory study. Therefore, the total of 22 interviews conducted in this study fits this suggested standard sample size. Glaser and Strauss (1967: 65) were the first to develop the concept of "theoretical saturation" classifying it as the point at which:

> [N]o additional data are being found whereby the (researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated.

Empirically confident that saturation of categories in the final interviews was achieved the interviewing phase came to a natural end and was followed by completion of remaining transcripts.

Transcription has the advantage of preserving participants' accounts in their own words and consequently their own unique expression of these words. However, compared with note-taking it does generate a substantial amount of text to be analysed. Although transcription is laborious Denscombe (2007: 196) recognises its worth stating:

> Personally transcribing the interview recordings is invaluable in bringing the researcher close to the data and the talk to life again' so subsequently is a 'real asset to using interview for qualitative data.

In personally transcribing the interviews richer insights in data analysis were gained and paved path for analysis.

3.11. Applying grounded theory in this study

This research project adopts a grounded theory approach to study its chosen phenomenon which was first introduced by Glaser and Strauss in 1967 and has its original basis on positivist assumptions, where an external reality is explored objectively by the researcher. This research does not employ constant comparison techniques refined by Strauss and Corbin (1998: 220) who describe grounded theory as:

> A detailed grounding of systematically and intensively analysed data…by constant comparison, data are extensively collected and coded… thus producing a well structured theory.

Instead of adopting a method of constant comparison throughout the analysis interviews were instead conducted first and analyzed individually; then subsequent emergent concepts were compared.

Strauss and Corbin (1990: 19) identify the tasks of qualitative research which is to:

> Uncover and understand what lies behind any phenomenon about which little is yet known.

As the case of the visually impaired migrant in Ireland has previously been undocumented this qualitative method of analysis matches the research goal. Data is grounded in and generated from the real lived experiences of the participants social world and not in the abstract and therefore is suitable for qualitative approach to data analysis (Seale, 1998).

Additionally, many scholars shifted the understanding of grounded theory to view the researcher as having a subjective rather than objective role in play in the research (Charmaz 2006; Dey 2004; Seale 2004). Strauss and Corbin (1998: 13) consider analysis as 'the interplay between researchers and data'. Charmaz (2006: 179) recognizes this as interaction:

> Your grounded theory journey relies on interaction-emanating from your worldview, standpoints and situations arising in the research sites developing between you and your ideas then returning back to the field – or another field and moving on to conversation with your discipline and substantive fields. To interact at all, we make sense of our situations, appraise what occurs in them and draw on language and culture to create meanings and frame actions. In short, interaction is interpretive.

Charmaz (2000) proposes a constructivist grounded theory that discovers and constructs the lived experience of a particular social world. She critiques Strauss and Corbin's (1998) as "didactic and prescriptive rather than emergent and interactive". Charmaz's (2006) constructivist approach to grounded theory is used in this study as

it provides a flexible tool to analyse data as "tools to use rather than recipes to follow" (Charmaz, 2006: 4).

Grounded theory is particularly useful for both disability health and intercultural studies research. It has been used in medical contexts such as Glaser's hospital study on dying (1967) and Charmaz's (2000) research on chronic illness and Hartley and Muhit (2003) work on visual impairment. Intercultural scholars Ting-Toomey (1983) and Gudykunst (1989) have explored the advantages of qualitative research methods in the study of intercultural communication; Sheridan (2005) has applied qualitative methods to her study of Vietnamese migrants in Ireland and Dunne (2008) has also adopted qualitative methods in relation to his study of the host receptivity to international students in an Irish university. Qualitative research methods are therefore an appropriate approach in both fields of academic inquiry and so it is particularly suited to this interdisciplinary study on visually impaired migrants in Ireland.

In this study I applied Charmaz's (2006) approach to grounded theory. The flexible nature of her approach to applying grounded theory methods to the research process appealed to me as I felt that strict compliance with the process of analysis immediately following each interview restrictive and in addition felt that the note taking and research entries at this time gave sufficient scope to mould the next interview as recommended by Charmaz (2006). Moreover, given the unavailability of research participants due to hospital appointments and work schedules it was essential that I set clear timeframes to conduct interviews. This meant that immediate analysis following an interview was often not feasible. Furthermore, considering the sensitive and often upsetting nature of the interview content allowing space in

between directly analysing an interview transcript was advisable as the activity of transcription (Charmaz 2006) acknowledges is often an intense experience where researcher relives emotions of the interview. Allowing space between an interview and directly transcribing it facilitated a more subjective perspective as I was not overwhelmed by the intensity of the experience and could examine the data with renewed rigour.

3.11.1. Evaluating grounded theory studies: Charmaz's (2006) criteria

The task of evaluating grounded theory research, be it the process or outcome, has created much debate however no agreed set of criteria have been established. Bearing in mind the range of approaches which have been advocated this is to be expected. For example it has been argued by Smith and Biley (1997) that conventional scientific methods are inappropriate for evaluating grounded theory while Jeon (2004), Lomborg and Kirkevold (2003), and Strauss and Corbin (1999) each consider the issue of rigour and quality in grounded theory, both in terms of the process and the outcomes. The approach to grounded theory adopted in this study is Charmaz (2006).

Charmaz (2006: 182-183) asserts four criteria to evaluate grounded theory research: 1) Credibility, 2) Originality, 3) Resonance and 3) Usefulness. Underlying each of these criteria specific questions are assigned. In Chapter 10 these questions will be applied to evaluate the current study.

Credibility

- Have you reached intimate familiarity with the setting or topic?
- Do your data sufficiently support your claims?
- Have you made systematic comparisons between categories?

- Is there a strong logical argument linking data, argument and analysis?

Originality

- Are your categories fresh?
- Do you offer new insights?
- What is the social and theoretical significance of your work?
- How does it challenge current ideas and concepts?

Resonance

- Do the categories portray the fullness of the studied experience?
- Do the findings make sense to those people central to the phenomenon?
- Do the findings offer those people deeper insights about their lives and worlds?

Usefulness

- How can your analysis be applied in every day settings?
- Does it suggest any generic processes?
- Can the analysis spark further research?
- How does it contribute to knowledge?

3.12. Applying grounded theory in this study: Charmaz's (2006) coding process

At the core of grounded theory is the coding process. This study applies Charmaz (2006: 3) approach to grounded theory which states that coding "distils data, sorts them, and gives us a handle for making comparisons with other segments of data". Charmaz (2006) traces this process through three principal actions. The first action of the process is "initial coding", also referred to as "open coding" as the researcher is encouraged to remain open in thinking. This first coding action involves, line by-line or incident by-incident coding. At the outset the data line by-line which encouraged deep immersion in the minutiae of the data which facilitated openness to ideas and diverse topics. Subsequently, an incident by-incident method of naming chunks of data occurred. Charmaz (2006: 48) advocates spontaneously coding "data as actions". The use of the gerund is encouraged in naming the sections of data as a

strategy for best capturing the active nature of the data, for example; *concealing disability*. In this case, the use of the gerund communicates an action in progress and in a perhaps unresolved state. This stage of the process also encourages generating *in vivo* codes which are direct phrases from the data; an example from this study is "arriving on their last legs". The in vivo code allows the researcher to preserve the view of the research participant in their own words and also the potential for inspiring ideas for category names. It also quickly communicates an idea and in this case refers to migrant service users accessing the services for visually impaired when their situation is desperate.

In addition, in vivo coding facilitates a transition to the next action in the process which is categorising (Strauss and Corbin 1998) or focused coding (Charmaz 2006). Categorising involves creating concepts that derive from the data and is comparable with the action Charmaz terms "focused coding". This action in the case of this study began on the second examination of the data thus overlapping with the initial coding process. Nevertheless, there is a clear distinction between the two coding actions as focused coding requires the researcher to make decisions about "which initial codes make the most analytic sense to categorise your data incisively and completely" (Charmaz 2006: 57).

Phenomena are represented by categories and phenomena represent significant critical thoughts that originate from the data (Strauss and Corbin 1998). The third action of the coding process is axial coding which aims of to "produce concepts to fit the data" (Strauss 1987: 28). It involves "intense analysis done around one category at a time in terms of the paradigm items" (Strauss 1987: 32). This category creates the "axis" around which additional coding and category construction occurs

subsequently, perhaps producing the core category for generating theory. Another feature of the coding process is theoretical coding. According to Charmaz, (2006: 63):

> Theoretical codes specify possible relationships between categories you have developed in your focused [substantive] coding.

Exploring the relationships between categories which have originated from the data is encouraged in theoretical coding. At this point it is comparable with axial coding which delves into the finer contextual properties of the code, so that, as Glaser (1992: 84) observes:

> In grounded theory…when the analyst sorts by theoretical coding everything fits, as the world is socially integrated and grounded theory simply catches this integration through emergence.

Thus, the purpose in contrast with the first action, open coding, is to depict a big picture of the code within the category. The aim is to develop properties of categories until no new properties surface, thus concluding the coding process when theoretical saturation is reached (Charmaz 2006).

This final action may involve returning to the field to verify instances in the data with the research participants and or contacting new participants if necessary. In the case of this study given the practical limitations returning to the field was not feasible. Thus, theoretical coding is a fundamental stage in theory construction and Locke (2001: 59) pinpoints the essential objective of grounded theory as it acknowledges its:

> [P]ragmatist philosophical heritage in insisting that a good theory is one that will be practically useful in the course of daily events, not only to social scientists, but also to laymen. In a sense, a test of a good theory is whether or not it works ‘on the ground’.

For this study, is it critical that the theory derived from the data is applicable for the improvement of services for visually impaired migrants and service providers in Ireland and that it directly makes sense to both groups.

3.13. Memo Writing

According to Lempert (2007: 245) memo writing is "the methodological link, the distillation process, through which the researcher transforms data into theory."

Without delay following coding the next action is memo writing (see example in Appendix F). This action connects the coding process and the first draft of analysis as memos help connect empirical reality with an analytic approach (Denzin and Lincoln 2003). Memos are written while coding, thus allowing the researcher to pause to reflect on a certain piece of data so that in essence, memos are "informal analytical notes".

In addition, following the intensity of close data examination, memo writing:

> Provides a space to become actively engaged in your materials, to develop your ideas and to fine tune your subsequent data gathering. (Charmaz 2006: 72)

Memos written during the coding process allow the researcher to note spur-of-the-moment thoughts, ideas and feelings about the data. These notes provide useful insights later in the research process as they represent the original fledgling analysis which can later be fleshed out and act as a springboard for the writing process.

Memos are flexible in nature; as such they can be both textual and can also take the form of diagrams or tables to note emerging points of comparison (Charmaz 2006).

Charmaz (2006) encourages the researcher to develop two types of memos. This is comparable with the first two stages of the coding process. Initial memo writing is more open in nature, capturing fleeting thoughts and ideas, whereas advanced memo writing is more complex in nature and urges the researcher to identify beliefs within the field, draw comparisons between and within categories and ultimately place the memo within a framework of a developing argument. The use of the memo function within the qualitative software programme Atlas.ti facilitated this action during this study. In addition, memos present the possibility to justify research analysis choices to other researchers as, Denscombe (2007: 295) observe memos to be:

> Permanent and tangible record of the researcher's decision-making, which in principle at least, other researchers could inspect.

Thus, memos enhance accountability in the research process.

3.14. Coding Applied in this Study: using CAQDAS

Charmaz (2006: 46) recognises coding as the:

> Pivotal link between collecting data and developing an emergent theory to explain these data.

This section of the methodology chapter outlines how the coding process was applied in this study supported by Charmaz's (2006) guidelines. For the process of data analysis I received training in software programme Atlas.ti at the University of Surrey from one of the creators of Atlas Christina Silver. The Atlas.ti software programme was developed in 1993 from a grounded theory base and is most typically employed in research where data is interpreted through the coding of themes with the aim of expanding existing theories (Lewins and Silver 2005). Barry (1998) advocates its suitability in small scale studies such as the current study. This

is dispute among scholars about using CAQDAS. While Bringer et al. (2004: 251-2) highlight the "level of transparency that is so labour intensive that it is rarely, if ever, seen in manual methods", Coffey, Holbrook & Atkinson (1996) consider adopting CAQDAS as prompting researchers towards pursuing a prescribed orthodoxy. Lee and Fielding (1996) argue that risk of a new orthodoxy is exaggerated. The software facilitates the researcher in organizing large quantities of data and coding into manageable thematic codes. The software provides an option to generate output reports in hard copy this enables the researcher to visualise the process which is systematic tool for viewing diverse and divergent comparative perspectives of the research at different stages of the data analysis. I found this aspect especially useful as visualizing complex data chunks in particular in code family network views facilitated a clearer picture of emergent key categories.

Lewins and Silver (2007: 10) recognises the main advantage of using software as "the access you have to whole data files" and that "whatever tools are used, 'live' contact to source data is always easy, increasing the researcher's 'closeness'". In addition, another benefit of using software is the speed at which the researcher can retrieve data and in many ways for example its relationship with other pieces of data, quotation, and memo quantities. I found the code manger tool particularly helpful in category building as codes could easily be swapped from one family to the next from the phases of focused to theoretical coding. In total 2,320 codes were created (Appendix E). From these codes 46 key categories were identified. Table 2 presents a list of the key categories created with their code and quotation occurrences. Three core categories were distilled from this list: cultural perceptions of disability, home and host support and cultural barriers. These core categories inform data analysis chapters 4-7.

Table 2 List of Key Categories created with their code and quotation occurrences

Key Category	Codes	Quotations
Accepting visual impairment	34	31
Adaptation to visual impairment	58	54
Adaptation to host environment	6	7
Age	4	5
Blind community	33	28
Communication development	26	26
Concealing disability	26	24
Connecting with home community in Ireland	20	20
Connecting with Irish	15	14
Coping with disability	34	33
Cultural perception of disability	36	37
Denying disability	12	11
Diagnosis experience	25	24
Disability- shame	11	9
Double outsiders	17	17
Economic climate	7	7
Education	47	43
Exclude or include disabled	32	27
Expectations	7	6
Family	53	44
Feeling accepted	18	17
Freak status	9	10
Friendships	2	2
Gender issues	13	13
Giving back	17	18
Home	25	24
Home v host V.I attitudes	33	41
Identity	66	66
Identity renegotiation	30	30
Language barrier- isolation	9	9
Language barrier debilitates	49	48
Language barrier to service provision	7	7
Language barrier- shame	5	5
Loosening home ties	8	8
Migrant- shame	4	4
Migration motivation	11	8
Overcoming cultural barriers	3	3
Peer support	42	41
Quality of life	9	8
Race and racism	51	41

Key Category	Codes	Quotations
Religion	21	19
Revealing disability	6	6
Service provider role	38	36
Service providers migrant issues	34	35
Stigma	10	12
Strengthening host ties	7	7

An example of the coding process is presented in Appendix F. The coding process occurred in three phases; opening coding, focused coding and theoretical coding; memo writing took place most significantly during the focused and theoretical stages.

3.14.1. First Phase: Open Coding

During the coding process in Atlas.ti I followed Charmaz (2006: 49) *code for coding*:

- Remain open
- Stay close to the data
- Keep your codes simple and precise
- Construct short codes
- Preserve actions
- Compare data with data
- Move quickly through the data

A combination of line- by-line and incident- by-incident informed the interpretation and naming of these codes. During the preliminary stage of open coding the purpose was to remain as close to the real lived experiences of the visually impaired migrant participants and the service providers working with them. Charmaz (2006: 48) advises that:

> The openness of initial coding should spark your thinking and allow new ideas to emerge.

At this early stage I moved through the data quickly and tried not to over think naming of codes as Charmaz (2006: 48) recommends "speed and spontaneity" in the initial phase.

As previously stated in section 3.13 it is recommended that data is coded in gerunds at this stage; as this part of speech reflects "strong sense of action and sequence" (Charmaz 2006: 49). Often I felt that my codes were less imaginatively constructed at this stage as many began with "feeling" or "being". I spoke with researchers who had experience in grounded theory study and was reassured that this was characteristic of the initial coding process and that the next phase, focused coding would allow for more creatively named codes. This supports the view that initial coding should not be concerned with theoretical construction but rather facilitate what I feel is comparable with a brain storming activity. The subsequent phase as Charmaz (2006: 48) recognizes allows the researcher to play with codes to "reword them to improve the fit". Some phrases or expressions instantly grab attention and in this case the raw data is preserved though in vivo codes. Charmaz (2006: 55) recognizes the potential of in vivo codes to comprehend "implicit meanings and actions but also to make comparisons between data and with your emerging categories". In vivo codes may provide opportunity for creative category names. In this study the mobility officer, Fionn offered the term "cultural perception of health" which I selected as an in vivo code during the focused coding phase. This code was elevated to the category level and later during the final phase of theoretical coding prioritized as one of three key categories.

This fast paced first phase of coding characterized by line-by-line and incident-by-incident facilitated familiarization with all of the data for the first time as a unit.

Charmaz (2006: 51) advocates line-by-line coding as by its nature it ensures the researcher builds his/her "analysis step-by-step from the ground up without taking off on any theoretical flights of fancy". Moreover, it sets the scene for comparison, the second phase of focused coding.

3.14.2. Phase Two: Focused Coding

During this phase I returned to the data to review the initial coding process to make sense of the experiences related in a more telescoped manner. This phase involved renaming and or collapsing codes which were created during the initial phase. 46 main categories emerged as the most significant for this study as presented in Table 2.

3.14.3. Phase Three: Theoretical Coding

Theoretical coding involved a detailed examination of the 46 main categories. This process entailed a cross examination of initial codes and categories to identify the most critically relevant research findings for this study. Ultimately three key categories were identified; cultural perceptions of disability, support networks and cultural barriers. These three key categories inform the three data analysis Chapters 5, 6 and 7 and are presented at the start of each chapter.

3.15. Reflection on the Research Process

Researchers assert that to ensure ethical qualitative research, self reflexivity is a valuable and moreover necessary component in the researcher-participant interface (Ganga and Scott 2006; Borkert and De Tona 2006; Sultana 2007; Yardley 2000, Seale 1999). Charmaz (2005: 510) emphasizes the prerequisite for any research is that researchers recognize that the absence of bias is implausible as "no analysis is

neutral-despite research analyst's claims of neutrality" thus nor are they "passive receptacles into which data are poured". This is because as Denscombe, (2007: 68) notes:

> Making sense of what is observed during fieldwork observation is a process that relies on what the researcher already knows and believes, and it is not voyage of discovery which starts with a clean sheet.

Therefore, throughout the research process, reflexivity was at the forefront in particular during the interview process of which a vital element was writing field notes prior to and shortly after each interview. The purpose of the notes was to record the range of my emotions on the interview process pre, during and post interview and this process of note taking developed into a research diary. Lincoln and Guba (1985) advocate the research diary as a means of monitoring the entire research process through regular diary entries. Admittedly the frequency of my entries was most intense during the interview process itself and later to a lesser degree during the coding process.

Writing in the research diary provided me with an outlet to express my thoughts and sometimes conflicting values and opinions compared with the research participants which naturally I could not engage in during the interviews. As such I found it a very useful space to record sometimes upsetting emotions raised during interviews so that it was cathartic process especially following often intensely emotional interviews.

During the interview process I had chosen to emphasize my role as a student researcher and not as an educator. Dunne (2008) in his study on international students at Dublin City University similarly deflected attention from his role as a lecturer at the university in order to facilitate data gathering as he recognises that:

> If students perceived me as a member of staff it could complicate power relations and create difficulty in building rapport. As a result they might withhold information – for example they might avoid criticizing staff or the overall institution – which would create a barrier to me gaining a deep understanding of their experiences.

In much the same way, I felt that if I were to highlight my role within the NCBI, during interviews with both service users and service providers, it may restrict communication and consequently, not yield participants' full views on their experiences particularly as I was not a migrant or visually impaired.

3.16. Ethical Issues for the Researcher

Despite the ethical regulations that research participants should sign the consent form, all the participants involved in the study did not feel it necessary to do so. In the majority of cases this was because a mutual rapport had been developed between the interviewer and the interviewee. In three cases however participants felt uncomfortable with the concept of signing a legal document. Martin (2007) experienced a similar concern as she explains participants felt "disempowered...when faced with a legalistic document" (Martin 2007: 324) that she asked them to sign prior to the interview. The unwillingness to sign the consent form was in each case connected with cultural beliefs surrounding suspicion of legal documents. In her research with the Vietnamese community in Ireland Sheridan (2005) experienced comparable ethical issues in her research where signing documents arouse suspicion amongst participants owing to their Communist cultural background. Sheridan and Storch (2009) also address this issue. Asking potential participants to sign a consent form can question the trust that has previously been developed between the researcher and the interviewee (Roth 2004).

The most significant element in the relationship between the researcher and participant is trust which could potentially be broken should it have been insisted that all participants sign the legal document (Gerson and Horowitz, 2002).Being a known person to participants from the Centre, facilitated uncovering the real lived experiences of the visually impaired migrants and was the first time many of the participants had spoken about their feelings on the sensitive topic of experiencing sight loss away from their home country.

The relationship between the researcher and participant requires the researcher to develop and use his or her awareness of cues and/or signals by which the interviewee is indicating distress. While some may assert that this detracts from the quality of the data (Morse and Field, 1985), others argue that is contributes to the depth of the data (Cowles 1988; Wilde 1992). If the researcher indicates recognition of the interviewee's emotional response the interviewee may feel that it is safe to reveal further information, which he or she may have felt was an "unacceptable" response or feeling (Cowles 1988).

As participants became distressed during emotional moments in some interviews the recording was frequently paused and the participant assured they could stop the interview. Yet on no occasion following an emotional exchange did any of the participants wish to discontinue the interview. McCosker (1995) acknowledges that the interview experience on sensitive topics can cause a sense of emotional exhaustion not only for interviewee but also for the researcher. In one case, I liaised with an NCBI counsellor to assist a service user following our interview. It had been the first time she had spoken about her psychological distress following her sight loss. For the researcher too, being overwhelmed by the nature of the interviewees

experience can be extreme (McCosker 1995). Cowles (1988) reported that she could undertake no more than one or two a week. 2-3 interviews were scheduled during the course of this research.

3.17. Limitations of the research

There were 6 critical limitations in this study. In the concluding section of this study, Chapter 10 these limitations are addressed as potential recommendations for future research. The limitations are as follows:

1. Interviews were not conducted with visually impaired migrant children and instead interviews with their parents and in one case a sibling of a service user took place.
2. The scope of this study is not sufficiently broad to include the views of Irish visually impaired service users to explore their views on sharing services with migrants and examine their views on different cultural attitudes to disability.
3. Owing to time and financial restrictions the geographical range of the interviews scheduled had to be limited to areas which could be accessed by Dublin public transport. Therefore, no interviews were carried out beyond the Greater Dublin area, with the exception of one interview which took place in County Wicklow.
4. Language proved to be a barrier to communication in two interviews. In one case the parents of a service user were not proficient in English and when asked by their community resource worker, who is a native speaker of their language, to participate they agreed on condition that she would interpret the interview questions for them.

5. Creating rapport with participants was challenging in the case of participants who did not attend the centre.
6. The emotional nature of the interviews was sometimes challenging. All of the interviews conducted were of a sensitive nature and often participants became emotional during the course of the interview. In each incidence when a participant became upset and or was crying, immediately they were asked would they like to stop the interview, take a break or simply have a glass of water. Of the 16 service users that were interviewed more than half cried at one point or more during the interview. However, when asked if they would like to pause or terminate the interview all of the participants declined this offer, wishing to continue. Nonetheless, one interview was extremely sensitive nature and throughout the interview the participant was in great emotional turmoil. On the participants' request, following the interview I linked the participant in with counselling services offered at the NCBI.

CHAPTER 4: Research Participants Profiles

Appeals to the past are among the commonest strategies in interpretations of the present (Said 1993: 1)

4.1. Introduction

This chapter introduces the research participants of this study, to facilitate a clear understanding of the idiosyncrasies of the specific details of the research participants, both service user and service providers. This chapter draws on the three core categories; cultural perceptions of disability, home and host support networks and cultural barriers. These three core categories were distilled from the 46 key categories which emerged from the data as outlined in Chapter 3. Special emphasis in this chapter is placed on delineating the profile of service user participants This chapter recognises the particularly diverse nature of the service user participant group in terms of variations in both experiences of sight loss and migration. The overall aim of this chapter is to set the foundations for in-depth analysis which follow in the subsequent data analysis chapters, by firstly establishing the research participants' relationship with visual impairment and the host country, Ireland. Therefore, in order to grasp the complexities of this group, including personal factors such as age, gender and country of origin, several key aspects of their profile in relation to their visual impairment are illuminated as:

1. Diagnosis at birth or acquired
2. Diagnosis in home or host country
3. Migration motivation dependant on migrant status
4. Support networks
5. English language proficiency

Three features of the profiles of the service provider participants are also presented; age, professional role and nationality. Most emphasis is placed on outlining the

professional role of the service providers where professions are represented: community resource workers, mobility trainers and managerial staff.

4.2. Profile of Service Users' Visual Impairment

This section presents the personal details of the service user participants. All participants names have been replaced with pseudonyms as outlined in the methodological discussion in Chapter 3. In particular three personal details are purposely selected for the service user profile; gender, age and continent, respectively. The reason for the inclusion of these particular features of the service users' profile is primarily to highlight the diversity in the service user participant group. In addition fleshing out the specific personal features, facilitates comparative analysis which stems directly from these personal profile features. Each of the headings in Table 3 is addressed in turn.

Table 3 Visual Impairment Profile of Service User Participants

Name	Gender	Age	Continent of Origin	V.I at birth	Diagnosis in Ireland	Sight loss in Ireland	Other dis-abilities
Caitriona	Female	Under 5	European	Yes	Yes	Yes	Yes
Aoife	Female	Under 10	European	Yes	Yes	Yes	Yes
Niamh	Female	Under 5	African	Yes	Yes	Yes	No
Paddy	Male	Mid teens	European	Yes	No	Stabilized prior to arrival	Yes
Cillian	Male	Late teens	Asian	Yes	No	Yes	No
Gearoid	Male	Early teens	Asian	Yes	No	Yes	No
Grainne	Female	50s	Asian	Yes	No	Yes	No
Eileen	Female	Under 10	Asian	Yes	No	Yes	No
Seamus	Male	60s	African	Yes	No	Stabilized prior to arrival	No
Deirdre	Female	30s	European	No	Yes	Yes	Yes
Sean	Male	30s	Asian	No	Yes	Yes	No
Mary	Female	30s	African	No	Yes	Yes	No
Liam	Male	40s	African	No	Yes	Yes	No

Name	Gender	Age	Continent of Origin	V.I at birth	Diagnosis in Ireland	Sight loss in Ireland	Other dis-abilities
Ronan	Male	30s	African	No	Yes	Yes	No
Ciara	Female	20s	African	No	No	Yes	No
Sheila	Female	40s	African	No	No	Yes	No

The service user gender profile is reasonably evenly distributed between male and female. There are nine female service user participants, namely, Aoife, Ciara, Deirdre, Eileen, Grainne, Caitriona, Niamh, Mary and Sheila to seven male service users, namely; Gearoid, Cillian, Liam, Seamus, Paddy, Ronan and Sean.

The age profile of the service user participants is wide, ranging from the youngest being under 5 years old to the eldest being over 60 years old. 6 of the service users in this group, namely; Caitriona, Aoife, Niamh, Paddy, Gearoid and Eileen are under eighteen years old. These are the youngest service users in the whole 16 service user participant group. For this reason they are represented by one or both of their parents or in one case by a service user's older sister. Each is well placed to speak on behalf of the service user's diagnosis experiences. In contrast, the other two service users who were born with a visual impairment are the eldest service users in the study. Of the 7 service user participants who acquired their visual impairment four are in their 30s, namely; Deirdre, Sean, Mary and Ronan. Two of the service users are in their 40s and one in their 20s.

Three continents of origin are represented in the service user participant profile they are; African, Asian and European. As outlined, in Chapter 3's methodology discussion, specific country names have been replaced by continent names of origin in order to ensure anonymity of the research participants. There are 7 African service users: Ciara, Liam, Niamh, Mary, Seamus, Ronan and Sheila. The 5 service users

Eileen, Gearoid, Grainne, Cillian and Sean are Asian and 4 are European, namely, Aoife, Deirdre, Caitriona and Paddy.

4.2.1. Visual impairment at birth or acquired

The following section separates the service user participants into two groups according to whether they were born with or acquired their visual impairment. Profile features which will be outlined in each group include; diagnosis in Ireland and sight loss in Ireland. The purpose for doing so is to facilitate comparative analysis of service user's process of adaptation, both to living with disability and living in a new host environment. In the case of an individual who was born with a visual impairment and an adult who acquires impairment later in life the process of adaptation is distinct (Flavo 1991). However, as previously noted in Chapter 2 the focus of this study does not extend to a comparative examination of adaptation to visual impairment from a congenital or acquired perspective but rather addresses the issue of cultural perceptions and the barriers they pose for migrants' adaptation in general to visual impairment in the host environment.

This section presents the profile of service users who received a diagnosis of visual impairment at birth. Table 4 outlines two distinct features in relation to the service users' diagnosis which are whether the diagnosis took place in the home or host country and the feedback on this experience. In addition, whether sight loss deterioration was experienced in Ireland, is included, so as to account for the service users, who perhaps did not experience sight loss until arrival in Ireland, the consequence of which may translate to the level of engagement with home and host countries' services. To facilitate transparency of comparison the service users' age

and country of origin are also included in this table. The final field in this table charts whether the service user was born with additional impairments.

Table 4 Profile of Service User Participants Diagnosed with Visual Impairment at Birth

Name	Age	Continent of origin	Diagnosis in Ireland	Diagnosis Feedback	Sight loss deterioration in Ireland	Other Impairments
Caitriona	Under 5	European	Yes	Positive	Yes	Yes
Niamh	Under 5	African	Yes	Positive	Yes	No
Aoife	Under 10	European	Yes	Positive	Yes	Yes
Paddy	Mid teens	European	No	Negative	Stabilized prior to arrival	Yes
Cillian	Late teens	Asian	No	Negative	Yes	No
Gearoid	Early teens	Asian	No	Negative	Yes	No
Grainne	50s	Asian	No	Negative	Yes	No
Eileen	Under 10	Asian	No	Negative	Yes	No
Seamus	60s	African	No	No comment	Stabilized prior to arrival	No

Although the additional impairments are not the focus of this study it is deemed essential to acknowledge them. The reason for this is that the diagnosis of visual impairment is adjunct with the service users' medical condition which clusters assorted impairments.

4.2.2. Diagnosis in Ireland

9 of the 16 service user participants in this study were born with a visual impairment, as outlined in Table 4. Feedback in relation to their diagnosis experience is also recorded here. 6 of the service user participants, Paddy, Cillian, Gearoid, Grainne,

Eileen and Seamus, received their initial diagnosis in their home country. 2 of the service users, namely, Caitriona and Niamh were born in Ireland and received their diagnosis soon afterwards. Both Caitriona's mother and Niamh's parents relate positive feedback of their child's diagnosis experience in Ireland.

Although Aoife was not born in Ireland, she arrived to the country within the first year of her birth with her parents. Following an unsatisfactory diagnosis experience in her home country, as will be discussed in Chapter 5, the specifics of her condition and severity of her vision loss was diagnosed in Ireland. Therefore, feedback in relation to her mother's experience of her diagnosis is recorded as positive in Ireland.

Of the remaining 6 service users who were born with a visual impairment, 5 relate a negative experience of diagnosis, namely; Eileen, Gearoid, Grainne, Cillian, and Paddy. One service user, Seamus makes no comment either positive or negative in relation to diagnosis, as he reports having no recollection of being given any details from his parents at the time. It is noteworthy that each of the service users who relate a negative experience of diagnosis received their preliminary diagnosis in their home country. Only one of the service users', Aoife's mother reports a positive experience of her child's diagnosis in Ireland.

4.2.3. Sight deterioration in Ireland

7 of the 9 service user participants who were born with their visual impairment note that their sight deteriorated in Ireland as outlined in Table 5. These service user participants are: Caitriona, Aoife, Niamh, Cillian, Gearoid, Grainne, Eileen. Two of the service user participants, namely, Paddy and Seamus's condition had stabilized prior to arrival in Ireland. Seamus in particular relates living with his visual impairment at its current level for over fifty years. This feature of the service user

profile is significant in relation to their process of adaptation to their visual impairment. For example, Seamus reports feeling well adapted to his visual impairment prior to migrating to Ireland, whereas the other service users in this group are at present growing up with the impairment. With the exception of Grainne, who, although she reports that her sight deteriorated in a gradual process since moving to Ireland, has been living in Ireland for over half of her life.

3 of the 9 service users who were diagnosed at birth with a visual impairment, namely, Aoife, Caitriona and Paddy were also at the same time diagnosed with other impairments related to their genetic conditions. All 3 of these service users are children; two are under 5 years of age and one is in his mid teens. 6 of this group, namely, Aoife, Eileen, Gearoid, Grainne, Cillian and Seamus therefore were solely diagnosed with a visual impairment at birth.

4.2.4. Acquired visual impairment

7 of the service user participants in this study, namely, Deirdre, Sean, Mary, Liam, Ronan, Ciara and Sheila, acquired their visual impairment. Deirdre, Liam, Mary, Ronan and Sean received their diagnosis in Ireland. Correspondingly, each relates a positive experience of diagnosis in Ireland. The remaining two service users in this group, Ciara and Sheila received their diagnosis in their home country and respectively relate negative feedback on the experience.

All of the service users presented in Table 5 acquired their visual impairment. Deirdre, Liam, Mary, Ronan and Sean received their diagnosis in Ireland. Correspondingly, each relates a positive experience of diagnosis in Ireland.

Table 5 Service User Participants who Acquired Visual Impairment

Name	Age	Continent of origin	Diagnosis in Ireland	Diagnosis Feedback	Disability progression in Ireland	Other disabilities
Deirdre	30s	European	Yes	Positive	Yes	Yes
Sean	30s	Asian	Yes	Positive	Yes	No
Mary	30s	African	Yes	Positive	Yes	No
Liam	40s	African	Yes	Positive	Yes	No
Ronan	30s	African	Yes	Positive	Yes	No
Ciara	20s	African	No	No comment	Yes	No
Sheila	40s	African	No	Negative	Yes	No

The remaining two service users in this group, Ciara and Sheila received their diagnosis in their home country and relate negative feedback on the experience. Everyone in this group, apart from Ciara, received their diagnosis as adults. Ciara acquired her visual impairment in her pre-teens. However, her sight has deteriorated since the initial diagnosis in her home country, most significantly during the period of the last seven years since her arrival in Ireland. Sheila also acquired, and was diagnosed with a visual impairment in her home country and Sean and Sheila are now 'fully blind'. 4 of the service users have been diagnosed with degenerative conditions; as such the expected outcome is that they will progressively lose their sight to a state of blindness. Deirdre is an exceptional case, as her visual impairment is related to her diabetic condition. She experienced severe sight loss as her condition developed but has since recovered her vision almost completely. Sight deterioration since living in Ireland is noted by all service user participants in this subgroup, regardless of being diagnosed in home or host country.

4.3. Migration Profile of Service Users

The purpose of this section is to outline the migration profile of the service user participants so as to distinguish between the various migration experiences. The key factor highlighted is the migrant participants' legal status in the context of migration motivation. 12 key features of their migration profile to Ireland are highlighted and presented in turn. They are:

1. Length of stay at time of interview
2. Motivation for migration
3. Working in Ireland prior to sight loss
4. Currently working in Ireland
5. Motivation to return/remain to/in home/host country
6. Host language competency on arrival
7. Current host language competency
8. Arrived with family
9. Support networks within home community in Ireland on arrival
10. Support networks with home community in Ireland developed or weakened since arrival
11. Support networks established with host community in Ireland through services for visually impaired
12. Support networks developed with host community through work and/or personal contacts.

For the purposes of manageability, these key features are separated into three tables and are now discussed in turn. The first table, Table 6, outlines the migration profile of the 16 service user participant group in the context of their migration motivation. The first feature outlined in Table 6 is the number of years each of the service users have been living in Ireland. The length of time ranges widely between a few years to Grainne who has been living in Ireland for thirty five years. The rest of the headings will be discussed individually.

Table 6 Migration Profile of Service Users: Motivation Factors

Name	Year of Arrival to Ireland	Migration motivation	Working in Ireland prior to own or child's sight loss	Currently working in Ireland	Motivation to remain
Aoife	2005	Economic	Yes	No	Health
Ciara	2002	Seeking asylum	No	No	Health
Deirdre	2002	Work contract	Yes	No	Health
Eileen's father / Eileen	2001/2004	Economic	Yes	Yes	Health
Gearoid's family / Gearoid	1992/1995	Work contract	Yes	Yes	Health
Grainne	1974	Economic	Yes	Yes	Health
Cillian	2000	Work contract	Yes	Yes	Health
Liam	1999	Economic	Yes	No	Health
Caitriona's parents / Caitriona	2004/2006	Economic	Yes	No	Health
Niamh	2006	Seeking asylum	No	No	Health and Safety
Mary	2000	Economic	Yes	Yes	Independence from family
Seamus	2003	Seeking asylum	No	No	Health and safety
Paddy's father / Paddy	2003/2007	Economic	Yes	No	Health
Ronan	2005	Joining family	No	No	Health
Sean	1999	Economic	Yes	No	Health
Sheila	2004	Joining family / Health	No	No	Health

4.3.1. Migrant Legal Status

A migrant's legal status is the key distinguishing feature in his/her migration experience as rights and entitlements are assigned according to how the host state recognises the individual migrant. Therefore, from the outset in analysing the migrant service user's experiences of adaptation to their visual impairment in Ireland, it is essential to bear in mind their migrant legal status. This is because the challenges they face in adapting may stem directly from the power granted or denied them from their status recognition. Different migrant statuses determine access to the host labour market and social welfare support so impact facilitating or hindering adaptation to the new environment and in turn impact overall adaptation to visual impairment. This section presents the different migrant statuses of the service user participants. Migrant legal status as a factor in migrant's adaptation to visual impairment in Ireland is analysed in Chapter 7.2.

Four migrant experiences are delineated; professionals invited to work; migrant job seekers; migrant reuniting with family and asylum seekers. These groups are identified from the personal profile data which emerged from the in depth qualitative interviews. The order in which the groups are presented expresses the range of variation in migration experience. Therefore, the migrant skilled worker who was invited to participate in the booming Irish economy, from the outset has increased economic, social and emotional advantage over the asylum seeker who is denied a work permit and full social benefits.

Invite to Work- The Professionals

In this study 5 migrant research participants had secured work contracts prior to arrival in Ireland. Deirdre was alerted to the position in Ireland by members of her ethnic community though the job was for an Irish company. Deirdre's experiences are presented in Case Study 1 in Section 4.6.1. In contrast with Deirdre, Mary secured her role in an international company based in Ireland, through a prior contact within the Irish community. In the case of the other participants in this group, Cillan and Gearoid; both of their fathers were recruited to work in Ireland by the Irish government overseas recruitment scheme during the time of its booming economic climate. For all five of these participants, proficiency in the English language was a prerequisite for the post. For this reason four of these participants were requested to take English language exams, which they all passed, prior to arrival in Ireland. The one exception was Mary who is a native English speaker so she was not requested to take the language exam.

This group of migrants were sought to fill a shortage in specialised roles in Ireland. As they were actively recruited they were in a position of power to plan and prepare for their migration experience. For example prior to arrival there was the possibility to acquire proficiency in English language, familiarise themselves with Irish social services and connect with home and host social networks on arrival. Most significantly, this group owing to their professional roles have the most economic resources among the migrant groups in this study. Directly related to their status as a skilled professional labour force, invited to work in Ireland, this group is in the best

position for potential successful adaptation to the host society. This is because their professional work permit status facilitates and encourages socialization within the host work environment and creation of a supportive social network.

Seeking Work- Service Workers and Labourers

In this study 7 service users, arrived in Ireland seeking employment, essentially 'pulled' toward a new country by social, economic and political forces. Bochner et al. (2001: 23) note:

> The majority of migrants are powerfully motivated by economic factors and habitually move from poorer to more affluent countries.

Aoife's parents, Eileen's father, Caitriona's parents, Grainne, Liam and Paddy's father all found work within the service and construction sector during the first few months of their arrival in Ireland. Since EU accession on May 1st 2004 migrants from the new accession states were granted access to the Irish labour market. Unlike the EU citizens in this group, the South Asian job seekers Sean and Grainne were hired to work in their ethnic community's service sector. None of these participants had strong English language skills on arrival, with the exception of Liam who spoke English; however, because of his distinctive accent he often struggled to be understood. The chief priority for this group of migrants is to fulfil personal economic improvement. Sean explains that economic recession in this home country pushed him to seek a living in Ireland.

However, in recent times as Ireland's economy experienced recession this group of economic migrants' jobs were at risk. In fact, all of the individuals in this group had

lost their jobs at the time of this interview. Due to the nature of their work contracts compared with the professional group, their job security was from the start fundamentally weaker. Several of the participants in this migrant group link losing their job with decreasing language skills which in turn is connected with undoing progress made in their integration process. Prior to losing their jobs all of these participants had connected with services for visually impaired in Ireland. Owing to participants' home countries' poor perception of disability compared with the potential for visual impairment to be accepted in Ireland despite reduced economic resources this group choose to remain in Ireland. The contrast in cultural perceptions of disability between home and host country is the driving motivator factor in the decision to remain in Ireland.

Reuniting with Family

Another common migration motivation is family reunification. In this study 2 of the service user participants, Ronan and Sheila cite family reunification as the chief motivating factor in migrating to Ireland. Both participants experienced sight loss prior to arriving in Ireland. Ronan migrated to Ireland to reunite with his wife and child, who arrived in Ireland two years prior to his arrival. Case Study 3 in Chapter 4.6.3 provides an account of Ronan's experience of life in his home country and in Ireland.

Sheila cites two motivating factors which are intrinsically linked; they are in order to reunite with her family and for health reasons. These factors are interlinked as it is her sister who informs her about the services for visually impaired in Ireland. As Sheila's

sister had already migrated to Ireland, on her strong recommendation, she joined her sister to live in Ireland. Both Ronan and Sheila had refugee status in Ireland; as such they were granted permission to work and access to social services. At the time of arrival both participants had not received either a clear diagnosis of their eye condition or rehabilitative care in their home country. Owing to their refugee status they could access services for visually impaired in Ireland which would facilitate adaptation to both their visual impairment and life in Ireland.

Seeking Asylum

Owing to their asylum seeker status, the situation of the 3 remaining service users, namely; Ciara, Niamh's family and Seamus is in stark contrast with the three other migrant groups presented. Whereas, the other three groups have been pulled into Irish society, the asylum seeker has been pushed out of their home country. As Bochner et al. (2001: 25) acknowledge:

> On the most fundamental level refugees have generally been exposed to pre-migration trauma including civil war, genocide, famine, imprisonment and torture. Their relocation is involuntary as they are unwillingly displaced from their home countries and 'pushed' into alien environments.

This was the case for these 3 service users, as each was forced to migrate due to political instability in their home countries and so pushed to seek asylum in Ireland.

The marked difference between the migration experience of the asylum seeker and the first and second migrant groups in this study is that the Irish state does not grant work permits or extend full social welfare rights to asylum seekers.

Furthermore, in contrast with the three groups presented, asylum seekers are likely to be involuntarily separated from family members thus lacking support on arrival in the new socio-cultural environment. Given the pre-migration trauma often endured and the haste with which people seeking asylum may leave their home countries, pre migratory planning such as acquiring necessary English language and social skills of the host society could not be foreseen and so are usually absent. Due the fundamental nature of seeking asylum, this group of migrants are in the most vulnerable economic and social position of all sixteen migrant participants outlined in this study. Essentially, asylum seekers are at the mercy of the host state to decide their fate. The restrictive legislative barriers of the Irish Immigration Act 1999 clearly impact the individual's potential to adapt as the asylum seeker is rendered powerless to participate in Irish society, thus denying him/her the opportunity to even attempt to integrate. The process of asylum is a waiting game which can turn very dangerous when the migrant's citizenship is not the only status in question but also most critically his/her health status is in jeopardy.

4.3.2. Motivation to remain or return

All of the 16 service users detail their aspiration to remain in Ireland. Moreover, of this group 15 identify health as the chief motivation for the decision to remain in Ireland. The issue of health is complex as it acts as an equally strong push and pull factor. Distinct cultural perceptions of disability causation and societal attitudes towards people with impairment may motivate service users to remain in Ireland. In practical terms, higher quality service provision and future health benefits experienced in Ireland compared with home country experience is also key in the

decision to remain. Aoife's parents, Eileen's father, Caitriona's parents and Paddy's father all state that in spite of each of them losing their jobs their intention is to remain in Ireland. Owing to comparatively poor treatment of people with impairments in their home countries, they are motivated to seek a better life for their children in Ireland. Two of the fathers of the service users, namely, Gearoid's father and Cillian's father despite the economic downturn, have maintained their professional roles in Ireland. Moreover, renewal of their employment contracts has been offered. And yet both express the desire to return to their home country to reunite with their wider family circle. Indeed, both families report that preparation for permanent return to their home countries is in motion.

However, neither Gearoid nor Cillian will be returning to their home countries with their families. This is because their motivation to remain in Ireland is based on the quality of services for and cultural attitude towards visual impairment in Ireland a factor explored in-depth in Chapter 5. Deirdre, Grainne, Liam and Sean each cite higher quality services for visually impaired and an overall feeling of acceptance of their impairment in Ireland in comparison with their home countries at the heart of their motivations to remain. A distinct motivating factor is expressed by service user, Mary. She states that she is motivated to remain in Ireland as she fears that returning to her supportive yet overprotective parents in her home country's childhood home, she risks losing her independence greatly. Two other service users, namely, Niamh and Seamus, identify security issues in their home country as a motivating factor, along with health as reasons to remain in Ireland as indicated in the five table headings below.

4.3.3. Language and support

The second table charting the service users' migration profile outlines the specific features which relate to their competency in the host language on arrival compared with their current competency. Table 7 outlines whether service users arrived with their family, support networks within home community in Ireland on arrival, whether networks remained the same, developed or weakened.

Table 7 Migration Profile of Service Users: Language and Support

Name	Host language knowledge on arrival	Current host language Working Knowledge	Arrived with Family	Support within home community in Ireland on arrival	Home community ties in Ireland
Aoife/Aoife's mother	No	Yes	Yes	Yes	Strengthened
Ciara	No	Yes	Yes	No	Strengthened
Deirdre	Yes	Yes	No	Yes	Loosened
Eileen/Eileen' s father	No	Yes	Yes	Yes	Strengthened
Gearoid/Gearoid's sister	No	Yes	Yes	Yes	Loosened
Grainne	No	Yes	No	Yes	Loosened
Cillian	No	Yes	Yes	Yes	No change
Liam	Yes*	Yes	No	No	Strengthened
Caitriona/ Caitriona's mother	Yes	Yes	Yes	No	No change
Niamh/Niamh parents	Yes*	Yes	Yes	No	Strengthened
Mary	Yes~	Yes	No	No	Loosened
Seamus	No	No	No	No	Strengthened
Paddy/Paddy's parents	No	Yes	Yes	No	Loosened
Ronan	Yes*	Yes	No	Yes	No change
Sean	No	Yes	No	Yes	No change
Sheila	Yes*	Yes	Yes	Yes	Loosened

*** Distinct accent in English ~ Native English speaker**

4.3.4. Language Competency

9 of the service users namely, Aoife's mother, Ciara, Eileen's father, Gearoid's sister, Cillian, Seamus, Paddy's parents and Sean state that they did not have prior knowledge of English on arrival in Ireland. Each of these with the exception of Seamus has now achieved a working knowledge of the host language. At the time of interview Seamus had just enrolled in an English language course.

The remaining 7 service users, Deirdre, Liam, Caitriona's mother, Niamh's parents, Mary, Ronan and Sheila all spoke English on arrival; Mary is a native English speaker. Liam, Niamh's parents, Sheila and Ronan each articulate their spoken English with a distinctive African cadence which sometimes causes comprehension difficulty, while they all report that grasping Irish accents was difficult at first too. Paddy's parents note that their English language competencies have weakened since losing their jobs and contact with native English speakers greatly reduced. The issue of the language barrier is examined in Chapter 7 in connection with the concept of shame, distress, isolation, increased vulnerability and overall inhibiting awareness and engagement with host visual impairment services.

4.4. Support from Home Community on Arrival

8 of the service users migrated to Ireland with one or more of their family. Ciara and Sheila arrived here with their sibling. The remaining 6, Aoife, Eileen, Gearoid, Cillian, Caitriona, Niamh and Paddy each arrived in Ireland with parents and siblings. 9 of the service users, namely, Aoife's mother, Deirdre, Eileen's father, Gearoid's

sister, Grainne, Cillian, Ronan, Sean and Sheila had support from their home community in Ireland on arrival. Aoife's family and Sean both had friends living in Ireland and Grainne's brother had been living in Ireland for several years; Ronan was reunited with his wife and young son after two years absence.

Thus, 7 of the service users had no support networks within their own home community in Ireland on arrival. They are: Ciara, Liam, Caitriona's parents, Niamh's parents, Seamus and Paddy's parents. Of this group Liam and Seamus neither arrived with nor was greeted by family or friends in Ireland. Support networks emerged as a key category from the data and home and host support networks are examined in detail in Chapter 5.

4.4.1. Home community ties in Ireland

Since arriving in Ireland, service user participants have noted that their social ties with people from their own home community who also currently reside in Ireland are:

1. Similar to when they first arrived
2. Strengthened
3. Weakened

The number of service users who relate that their ties with their home community have strengthened since they first arrived is the exact equivalent to the proportion of service users who relate a loosening of ties that is, 6 service users in each group. Those who identify a strengthening of ties are; Aoife's mother, Ciara, Eileen, Liam, Niamh's parents and Seamus. In contrast, service users Deirdre, Gearoid, Grainne, Mary and Sheila and Paddy's parents disclose that ties with their home community have loosened significantly since arrival in Ireland. 4 of the service user participants

state that the social ties formed on arrival have remained the same, they are; Cillian, Caitriona's mother, Ronan and Sean. The concept of strengthening or loosing social ties within the visually impaired migrant's home community in Ireland is discussed in Chapter 6.5 and 6.9.

4.4.2. Host country support

Table 8 outlines the host country's support feature of the service user's profile. It presents the support received by the service user migrant from the host country in relation to provision of services is for the visually impaired. Other avenues of support accessed by the service users are through their daily life experiences in the Irish education system, workplace and personal contacts.

Table 8 Migration Profile of Service Users: Language and Support

Name	Current Host Support Established through services for visually impaired in Ireland	Host Support Established through work, school or personal contacts
Aoife	Yes	School
Ciara	Yes	School
Deirdre	Yes	Work
Eileen	Yes	School
Gearoid	Yes	School
Grainne	Yes	Work
Cillian	Yes	School
Liam	Yes	None
Caitriona	Yes	School
Niamh	Yes	School
Mary	Yes	Personal contact
Seamus	Yes	None
Paddy	Yes	School
Ronan	Yes	Personal contact
Sean	Yes	Work
Sheila	Yes	None

All of the service users are currently connected with services for the visually impaired in Ireland, as presented in Table 8. Additional support from the host country has been established through work, school and personal channels. The majority have established host country links through Irish schools as 8 of the service users, Aoife, Ciara, Eileen, Gearoid, Cillian, Caitriona, Niamh and Paddy show. Moreover, for example, Aoife's mother created the link with the services for visually impaired through the support established with the school system. Deirdre, Grainne and Sean specifically relate the support received from work colleagues. Personal contacts were an important channel of support for Mary and Ronan. In Mary's case, she had a strong friendship with a member of the host community prior to arrival who offered her great support on arrival and whose friendship continues to be the mainstay of her social life in Ireland. Ronan developed friendship with host country members through shared religious practice. In contrast, Liam and Sheila report having established no host support through work, school or personal contacts. The impact of host support for the participants' adaptation to visual impairment is examined in Chapter 6.

4.5. The Service Providers

Three features of service provider research participant group profile are outlined in Table 9: professional role, nationality and age.

Table 9 Service Provider Research Participants

Name	Professional Role	Nationality	Age
Dermot	Manager	Irish	40s
Darragh	Manager	Irish	30s
Fionn	Mobility Officer	African	40s
Sorcha	Mobility Officer	European	30s

Clodagh	Community Resource Worker	Irish	40s
Tara	Community Resource Worker	European	30s

The key feature is the professional role of each service provider and can be subdivided into three strands with two service providers in each.

Three professional roles are represented by the service provider research participants with two representatives at management level in the organization, namely, Dermot and Darragh. Clodagh and Tara are frontline community resource workers and the final two Fionn and Sorcha work in the specific area of mobility training. It is noteworthy, that 3 of the 6, namely, Fionn, Sorcha and Tara hence half of this demographic, are non-Irish. For the purposes of anonymity, as proposed in the Chapter 3's methodological discussion, national identity is concealed by again simply assuming the participant's home continent's name. Each of these service provider participants has experience working with migrant service users in Ireland and for this reason, their views provide an invaluable insight into service provision, from the three professional angles, management, mobility and community resource work for visually impaired migrants in Ireland.

4.6. Case Studies

In this section four case studies of the service user participants are presented. The aim is highlight the variations in migration experience related to the service user's migrant status.

4.6.1. Case Study 1: The Professional – Deirdre

Deirdre was born in Eastern Europe. She was an only child who excelled academically at university in her chosen medical related field. After university, due to an economic crisis and lack of employment in her field of expertise in her home country, she gained a work visa to work abroad. In 2002, Deirdre in her early 30s, was working in another part of Europe when one of her colleagues from her home community who was working in Ireland contacted her about a vacancy at the company where she was working. Deirdre applied, took the prerequisite English language exam for the post and not long afterwards was accepted for the job on a working visa contract. In her words she arrived in Ireland with "*contract, permit and everything, all the legal things in place*" including being proficient in English. In fact she says her employers were surprised that she had such a strong command of English. Deirdre found meeting Irish people was 'very easy when you work' together it is 'natural'. On arrival her friends were waiting for her and had even prepared her room at their house. For the first two years she shared a house in West Dublin with her home country friends, "*good friends we finished university together".* Through her job she met Irish people which she said 'make her adaptation easier' as Deirdre says as a professional in Ireland "*you don't live isolated in a home community all the time, you are with Irish people*".

One year after arriving in Ireland Deirdre started to feel unwell. Connected with another medical condition she gradually began to experience significant sight loss. At this time she began to reduce her work hours. Until that time she had been working fulltime and when possible covering over-time work shifts as she says "*when you're*

here you want to work so most of time you work work work". Eventually, Deirdre had to resign from her job due to her health condition. This meant she spent most of her time at home. As her health deteriorated so too did her friendships with her host community. Since her host community friends migrated to Ireland to improve their economic circumstances they began to view Deirdre as a liability. This was an extremely challenging time for Deirdre, as in her words "*they just eh keep on eh their lives…they don't give me any help*". She considered at this time returning home. However, the medical treatment which was vital to her condition was not available in her home country. Therefore for fundamental survival she had no choice but to stay where she was made to feel progressively more unwelcome by her own home community friends. She was very worried as at this time as she was unable to look after herself. The physical pain she felt from her health condition was compounded by the emotional torture inflicted on her by her own home community friends. Not only did they not support her but they criticised her for increasing their household bills by having the heating on while they were at work. Directly related to her health condition Deirdre had extra waste disposal which her home community house mates complained meant bin collection would be more frequent hence more expensive. As a result of her "*changed status*", her home community friends now perceived Deirdre as "*a burden*" Their relationship with her altered radically, in her own words, "*from being a friend I was bit of an enemy at this moment*". Consequently, the pressure she endured from this group aggravated her already fragile physical and emotional state to the point where she became depressed contemplating suicide as her only option.

In her first week in Ireland she met and became friends with an Irish man at a work function. During her most challenging moments when she was rejected by her home community friends at the time of her critically poor health, he was the person who supported her throughout. In her words, she recognises that "*he helps me all the way is possible he help me he took me places he everythin*g". He was the one to bring her to the National Council for the Blind (NCBI). Without his support she is unsure she would have survived alone. In possession of a social security number Deirdre was entitled to access social services for visually impaired in Ireland, unlike asylum seekers who are denied this right. For Deirdre, attending the NCBI training centre was a route "*out of home, to learn something to meet people…to have a new beginning"*. Deirdre found a new sense of security and shared experience at the centre with the other visually impaired trainees. She felt that she had a better opportunity to be accepted as a person with disability in Ireland than in her home country. This is because she comments that people with disabilities in her home country are "*segregated*" whereas in Ireland they are "*much more integrated into society"*. As her health condition improved Deirdre was determined to retrain so as to 'give back' to other people with disabilities in the Irish community. For Deirdre, the key is to accept her disability and to recognise that 'still there is a place for you and you can play a good role'.

4.6.2. Case Study 2: The Job Seeker

Aoife was born in Eastern Europe. While at playschool aged 3 Aoife's teacher noticed and informed her parents that she had trouble seeing; Aoife's vision problems affected her concentration and ability to mix with her classmates. When Aoife's mother took

her to their GP she was simply told that Aoife did not see well and was given glasses. No further medical tests were carried out, and as a result she did not receive a clear medical diagnosis of her condition. In addition to her vision problem Aoife experienced other medical problems which were also not explained fully or more significantly in relation to one another.

In Aoife's home country the medical model approach towards disability persists as such common practice is to segregate people with disabilities from society. For example parents with children with disabilities are encouraged to place them in institutions. As special needs schools are scarce and privately owned they are often beyond the financial resources of ordinary working families.

Aoife's parents began to observe that her sight problems were worsening, and as the time came for her to start primary education were worried about how she would cope in mainstream education. At this time, they were also struggling financially to support themselves as their country's economy was in decline. Following the EU enlargement on May 1st 2004 which opened the borders for migrants from the new accession states, some friends of Aoife's parents decided to migrate to Ireland in search of improved economic circumstances. Through their encouragement and assurance that they would find better paid jobs to support their daughter, Aoife's parents also decided to leave their home country.

Life in Ireland

When Aoife and her parents arrived in Ireland in 2005, they were welcomed by their home country friends who supported them settling into Irish society. For example, they assisted them in finding accommodation, job seeking and locating a school for Aoife. Despite, their "*no good English"* within three months, both of Aoife's parents had found work in the Irish service sector. Aoife now aged 4, started at a primary school in West Dublin. It was here that the severity of her eye condition was detected. Aoife's mother struggled to communicate in a meeting with the school principal about Aoife's visual impairment. The school principal decided to liaise with the National Council for the Blind (NCBI) for Aoife's parents.

Coincidentally at the NCBI at this time, there was a frontline staff member who was from their home country. This service provider was assigned Aoife's case. As Aoife and her parents struggled with speaking English this service provider advocated on their behalf, mediating between doctors, teachers and other service providers. Most critically, this home country service provider mediated a meeting between Aoife, her parents and medical professionals where Aoife was diagnosed with a rare medical condition which affected her vision and other bodily functions. This was the first time that Aoife had received a professional medical diagnosis. As Aoife's mother commented in her home country they "*know she see less but no nobody knows that it's that much problem here everybody explain you, have to learning Braille like that, cos I don't know about that*". Receiving a medical diagnosis meant that Aoife's parents could for the first time, plan for her future, bearing in mind the particular restrictions of her medical condition.

Since Aoife's diagnosis, her parents have enrolled her at the NCBI resource centre in Clondalkin where teachers trained in assisting children with vision difficulties work with her. Initially the language barrier prevented Aoife adjust to the centre, as her mother notes "*she was very shy don't talking because it was different language she don't play with children, every day she cry*". Gradually through the support of her teachers, Aoife began to settle and make friends as her mother says "she playing with children and she's no alone and she's happy now". Since the time of their arrival during the economic boom years, recession has hit Ireland hard. At the time of interview, Aoife's mother had recently lost her job in the service sector. Feelings of homesickness were strong in Aoife's mother's words, "*I miss my family really and this is worse*". In spite of testing economic and emotional challenges Aoife's mother was determined to remain in Ireland for the sake of her daughter's wellbeing. In her words:

I know Aoife have good here and that for me is very important, the first thing is that she have good, everybody care about her. In our home country I think, I don't know she was 5 I think she have to go to normal school I don't know, but will be harder for her I think and for me and she's happy, everybody care I feel like everybody care for Aoife, you know, they ask me what will be for the best for her the thinking, not just put her somewhere and don't care for her.

As EU citizens, Aoife's parents are entitled to access social welfare to enable them to care for their daughter. Crucially, Aoife is eligible for support from host services for visually impaired. In contrast with their home country's attitude towards people with disabilities Aoife's parents feel their daughter has the opportunity to be accepted by society. Through connection with Irish services for visually impaired Aoife has the opportunity to adapt to her visual impairment, in doing so ultimately boosting her

overall opportunity to integrate into Irish society through socializing with Irish children and improving her English language skills.

4.6.3. Case Study 3: The Family Member

Ronan is from West Africa. In the early 2000's his home country experienced violent civil conflict and became an unsafe environment for his family to live. Ronan described living in his home country as a "*life of fear*" where every day was filled with anxiety about whether he and his family would be "*killed or kidnapped*". In 2003, Ronan arranged for his wife and child to leave the country and seek asylum in Ireland. He remained behind as unfortunately at this time, due to his progressive sight loss he had lost his job and their savings did not cover his travel costs. Following their departure Ronan experienced deterioration in his vision and he sought medical attention. However, in his words, "*you can go see a doctor in my home country he will not break it down for you*". Ronan's eye condition was not diagnosed, nor the severity of his condition explained. As a result, his eye condition remained untreated. In his home country there are no public services for visually impaired people as disability in general is perceived as a "*curse from God*" which ought to be endured. People with visual impairment in his home country are considered in Ronan's words "*not useful to society*". There is an intolerant attitude towards people with visual impairment as Ronan experienced "*no words of encouragement*" but instead repeatedly told that he was "*totally finished… blind man what is wrong with you stay at home if you can't do anything*".

As his sight loss progressed, Ronan separated from his family, in the face of societal rejection due to his visual impairment and moreover in the midst of the wider context of civil unrest became clinically depressed and contemplated suicide. To sum up his emotions at this time prior to arrival in Ireland he remarked that he simply felt "*what about this life*".

Life in Ireland

Ronan's wife and child were granted refugee status in Ireland in late 2004. Refugee status enabled Ronan's wife to request family reunification permitting Ronan's entry to live in Ireland in 2005. Ronan's wife had registered with a GP in Dublin and soon after arriving Ronan also registered. Following a medical examination the GP referred him to a local hospital ophthalmologist. For the first time, Ronan received a diagnosis for his eye condition. For the first time in years Ronan felt "*safe*". This feeling of security he relates to the dual experience of not living a "*life of fear"* caused by his home country's civil unrest and its attitude towards him as a person with disability.

Refugee status in Ireland has offered Ronan and his family the opportunity to start their lives again. In connecting with services for visually impaired in Ireland Ronan discovered that "*if you tell anybody you have problem with your eye they will assist you*". This was a new experience for Ronan as in his home country he had tried to conceal his visual impairment as a defensive mechanism against harsh societal criticism. At the rehabilitative centre he learnt that "*having vision problem doesn't mean your life is over for you*". At the time of the interview Ronan had begun his first mobility training classes to regain the ability to travel independently. He was also

learning IT skills which he never thought as a visually impaired person would be accessible to him. On arrival Ronan spoke English but often found it difficult to comprehend an Irish accent.

Since arriving in Ireland Ronan and his family have joined Catholic Church services where they have made friends with many Irish people. Ronan remarks that "*most of the people from his home country are Catholics but coming here many of them move to Pentecostal churches*". Maintaining his Catholic practices in Ireland he believes is great way to meet Irish people at church. In fact, Ronan asked an Irish friend he met there to be the godfather of one of his children. Through friendships he has made at the NCBI his ability to communicate fluently has improved significantly and in his own words Ronan says he feels "*his integration is 100%*". Ronan is determined to participate in Irish society he says:

> *I can contribute because now I'm trying to get myself filled up with skills, that I can deliver to people that are close to me and to serve the country.*

Ronan now prides himself on his communication and people skills and expressed an interest in applying for telephone receptionist roles in Ireland. In Ireland Ronan has learnt by example to accept his visual impairment and at the time of interview expressed renewed:

> *hope that you can do a whole of things for yourself you know that even when you have problems with your sight that's not the end of the world because you see people that have problems that are doing really good things.*

4.6.4. Case Study 4: The Asylum Seeker

Life in Home Country

Ciara was born in south central Africa during a violent civil war. Her family lived in a small country town. Her family had a reasonably comfortable lifestyle and her father supported his family through his steady job in a local business and her mother was a housewife. At the age of nine while at school she began to experience increasing difficulty with her vision. At first her mother did not believe she had an eye problem but eventually she brought her to the doctor who confirmed that she was losing her sight but "*can't tell why*" She was fortunate that in the capital city there was a recently opened special school for children with vision problems and so her parents enrolled her there. In the beginning she was scared and cried a lot. Despite it being a difficult time for Ciara, she soon began to feel most at home in this special school where her struggle to see was assisted by her teachers. She felt understood and made friends with other children who shared her difficulties with vision. Her sight loss was a very gradual process and by secondary school had stabilised. She found that reading Braille gave her headaches so did not pursue it so her literacy skills suffered. As her sight loss at this point did not impact her mobility she did not learn cane skills.

In essence this school provided a protective environment; however, as it was not equipped with the appropriate assistive technology for teaching visually impaired students the standard of education was limited. In addition the school did not have the resources to have separate classes according to age groups so all students of varying school and visual ability were taught together. During this time, there were fragile

periods of peace but civil unrest was worsening Ciara's parents had for some time wanted to leave the country but thought Ciara was too young and vulnerable due to her sight problems. By the time Ciara was in her late teens and her sister Kathleen in her twenties the war had intensified. Ciara's parents felt there was no alternative but to arrange for them to leave the country and seek asylum seek in Ireland. They did not have enough savings to go themselves so prioritised their children's safety. Ciara's parents wished for their daughter's safety and for Ciara to be able to finish school.

Life in Ireland

Ciara arrived safely in Ireland aged 17 accompanied by her older sister Kathleen in 2002. Immediately on arrival they lodged their asylum application. They did not know where they were going to be sent and did not know anybody else living in Ireland. After two weeks in a reception centre in Dublin, they were relocated under the Dispersal Scheme to an accommodation centre in Drogheda. Currently, state allowances for asylum seekers are minimal; as an adult Kathleen received €19.10 per week and Ciara received the child rate of € 9.60 per week. Neither Ciara nor her sister spoke English as it was not taught at their school in their home country. At this time Ciara still had some remaining working sight but as in her home country her education needs would have been most suitably met at a special school for visually impaired. However, owing to her asylum seeker status Ciara was not entitled to attend the special needs services offered by the Irish state. Instead she attended an Irish national mainstream secondary school.

Ciara in her own words described her English on arrival in Ireland as "*zero, zero"*. She describes it as a very difficult time. In the Irish classroom she found coping with her sight problem while not being able to communicate a frightening experience. At times she said she "*wanted to run away*". Yet this was where they had run to seek refuge. At first she felt "*lost*" but with the teachers' help her English began to improve. Nevertheless, she had a hard time mixing with Irish students and felt excluded as she chose not join them in their drinking or smoking social habits. She missed her family, especially her mother and worried about their safety. She managed to take the Leaving Certificate examinations the next year but struggled due to her combined difficulties with language and sight loss. She described the exam experience as "*hard because of her vision*" which was not accommodated for in school or the exams. Ciara was fully aware that she ought to attend a school which catered for children with vision problems but she was prevented in doing so as she was "*waiting for the response*" After leaving school as she awaited a response from the Minister for Justice about her asylum case, she was not entitled to a work permit nor access to further education or access to services for visual impairment as she says "*I couldn't do anything*" Unable to participate in Irish society, Ciara spent a lot of time at home alone. She had to wait 6 years before her case was approved, during which time her eye health deteriorated considerably. In 2004 her sister brought her to the National Council for the Blind but was told they could not offer her a place at its rehabilitative training centre as she did not have a social security number. As her sight worsened she became more housebound as she was feeling gradually more insecure about leaving the house due to her sight loss. Once Ciara's asylum application was

she could access services for visually impaired where she received her first proper professional rehabilitative training. In this environment she learnt independent living skills and also met with other visually impaired people with whom she could share the challenging experiences of living with sight loss. At the centre IT skills are taught. Despite never having used a computer prior to her arrival as they "*don't have those supports*" in her home country Ciara excelled in her IT class. At the time of the interview she had just been accepted on a computer networking post secondary education course. Even though Ciara has lived in Ireland for six years it is only since her asylum case has been accepted that she can truly integrate into Irish society and in turn now learn to adapt to her visual impairment. As she says until the moment that she got the response there was "*nothing*" she could do but wait as it doesn't "*depend on you it depend upon the government*"

4.7. Chapter Conclusion

This chapter has presented the outline of the research participants profile with special attention given to the service user profile. The service user profile was presented in three interlinked parts, they are; personal, visual impairment and migration profiles. The service users' visual impairment profile for the purposes of analysis in the subsequent chapters, were distinguished firstly on the basis of whether the individual was born with or acquired the visual impairment. A key feature outlined was the experience of diagnosis and whether it took place in the home or host country. The migration profile of the service users was outlined and twelve critical features were identified, including motivations for migration language competency and the

existence of support from home and host communities in Ireland. A brief overview of the professional roles of the service providers was also presented.

The overall aim of this chapter has been to provide a point of reference to facilitate an accessible understanding of the complexities of the research participants. As such it represents a bridge between the preceding discussion of methodology and the following chapters of in-depth analysis and consequently may be consulted throughout the thesis.

CHAPTER 5: Cultural Perceptions of Disability for Visually Impaired Migrant in Ireland and their Consequences

People's perception of health and illness is culturally variable, highly context-specific, dynamic and subject to change. (Bilton et al. 2002: 358)

Under all that we think, lives all we believe like the ultimate veil of our spirits (Machado 1973: 75)

5.1. Introduction

This chapter presents the findings which emerged from the data connected with the core category of cultural perceptions of disability. Cultural perceptions of disability are found in this study to determine the expectations a migrant service user may have for the host country service provision. The extent to which a service user engages with services for visually impaired in the host country is influenced by their own cultural perception of disability. In turn, the cultural perception of disability in the host country, Ireland may influence a migrant service user's decision to remain in Ireland. This chapter draws chiefly on one of the core categories which were discussed in Chapter 3. This core category is called cultural perceptions of disability. 32 key categories are connected to this core category and are outlined in Table 10. Each of the headings in this chapter relates to the model presented in Figure 6 in Chapter 9 drawn from the grounded theory analysis in this study.

Cultural perceptions of disability are examined from three perspectives; the moral, medical and social. In this study it emerged that the cultural perception towards disability held by the migrant and the host community can influence adaptation from the outset of the process in two key ways.

Table 10 Core category Cultural Perceptions of Disability and its related key categories

Cultural Perception of Disability	
Accepting visual impairment	Blind community
Adaptation to visual impairment	Concealing disability
Adaptation to host environment	Connecting with home community in Ireland
Connecting with Irish	Diagnosis experience
Coping with disability	Disability- shame
Cultural perception of disability	Double outsiders
Denying disability	Economic climate
Education	Expectations
Exclude or include disabled	Family
Feeling accepted	Home
Freak status	Home v host V.I attitudes
Friendships	Migrant- shame
Identity	Migration motivation
Identity renegotiation	Quality of life
Religion	Service providers migrant issues
Revealing disability	Stigma

Cultural Perceptions of disability can influence expectations and engagement with host services. For example, moral and medical perspective towards disability in home country results in low expectation of visual impairment services in host country.

Secondly, cultural perceptions of disability in Ireland can influence migrants' decisions to stay. For example, the social model perspective of disability in Ireland results in an attitude of inclusion towards visually impaired individuals and encouragement to engage with rehabilitation services. A positive experience of inclusion motivates visually impaired migrant to remain in Ireland. Each of the chapter's following headings relates to the model presented in Figure 6 in Chapter 9, drawn from grounded theory analysis.

5.2. Impact of Cultural Context of Disability Causation

Following medical diagnosis of impairment, specifically visual impairment, depending on the culture in which the individual is born or acquires their disability, the reception towards themselves and their impairment will vary (Bilton et al: 2002). In this study three distinct general cultural understandings of disability emerge. Firstly, the perception that disability is a 'curse' from God or the gods, hence people are encouraged to 'stay away' from the person. Secondly, corresponding with a medical definition of disability individuals with physical and or mental impairments are segregated from society. Thirdly, disability is 'integrated' into a culture's social structure. The way in which a society considers disability will affect whether or to what extent a person is positively or negatively labelled, mocked or encouraged and ultimately 'integrated' into or 'pulled out of' that society.

Understanding cultural belief systems facilitates a deeper understanding of societal attitudes towards disability. In this study the cultural understanding of disability often presented itself as one of the most challenging psychological barriers for the participants to surmount. Participants in this study demonstrate that the cultural understanding of the causation of disability is intrinsically linked with how persons with disabilities are treated in society.

5.3. The Moral Model: Cultural Perception of Disability as a 'Curse from God': Blamed and Shamed- No Support: Hinders Adaptation

> Suffering, misfortune, disease and accident, are all 'caused' mystically, as far as some African peoples are concerned. To combat the misfortune or

> ailment the cause must also be found, and either counteracted, uprooted or punished. (Mbiti 1969: 170)

This study demonstrates that this cultural perception of suffering in this case disability is still prevalent today.

> In the oracle bone inscriptions, the word "curse" (sui) generally signified illness inflicted by direct ancestors or other spirits of the dead.
>
> (von Glahn 2004: 99)

These views represent traditional African and Asian understanding of illness which perceives impairment as a 'curse' and which also emerge in the data in this study. The concept of disability being a curse is rooted in a culture's belief system, that disability is a punishment from God or the gods due to former misdemeanours in a past life (Omigbodun 2001). This cultural perception of disability may have detrimental consequences on how the individual with a disability and their family are treated within that society. For example, a society that firmly believes that disability is a punishment is unlikely to ensure the individual with a disability is supported or indeed given the opportunity for rehabilitation in order to contribute to that society.

Two service users reveal the influence that perceiving disability as a 'curse' has on how people with impairments are treated. Sheila explains that in her home country impairment is synonymous with being 'cursed', as she states:

> *Being blind or handicapped they will say it's a curse.*

The societal response is thus to shun the cursed individual, as Sheila remarks:

> *That person has been cursed, stay away from that person.*

Accordingly, the individual and their family dealing with disability are not merely judged for the causation of disability, but, in addition, a societal strategy of avoidance is adopted towards them.

Secondly Niamh's father echoes this notion of equating blindness with being cursed:

In our home country if you born blind you cursed.

Furthermore, Niamh's father sheds light on the motivation for a societal strategy of avoidance towards people with impairments as directly following the above statement he simply states:

Nothing can be done for you.

The fact that 'nothing can be done for you' is one natural impulse for adopting a strategy of avoidance. In addition, it confirms that a culture which perceives disability as a 'curse' believes the power rests with God, not humankind, to decide an individual's fate. Therefore, humankind should not interfere with the work of God but instead the 'cursed' individual is to be excluded from society lest his wrongdoing contaminate the rest of the community.

Consequently, the statement 'nothing can be done for you' also refers to the lack of service provision and/or support to help someone with impairment. This lack of support is directly related to the cultural moral model perception that impairment is a 'curse'. This short statement by Niamh's father emanates a remarkable sense of hopelessness felt on behalf of an individual who, owing to their impairment, is culturally perceived as 'cursed'. Thus, the fate of an individual with a disability

within a culture which perceives their disability as a ‘curse’ is determined by this cultural perception. The belief that impairment is caused by an individual or an individual’s family’s past life behaviour is the motivation for exclusion by their society.

Furthermore, the cause of disability is attributed to evil behaviour in a past life; thus, it is not an entirely adequate response to simply ostracize the individual with a disability and their family and label them ‘cursed’. Subsequent culpability must be directed towards the individual and their family. Hence, the impairment, or, as it is culturally perceived, the ‘curse’ bestowed by God or the gods on the individual is merited. The service user participant, Deirdre highlights this point:

> *They say you somehow deserve this situation anyway, for example, in your past life probably you did something, probably your parents they you something wrong so that’s why you suffering now.*

This statement by Deirdre is distinct from the three examples quoted previously. It is distinct because it explicitly conveys the cultural perception of disability causation as entirely the fault of the individual or a member of their family. For this reason, responsibility is solely with the individual. In essence, the impairment and the individual who possesses it are considered outside society.

Blaming an individual for their impairment has consequences for their self-perception, inducing strong feelings of guilt for a past misdemeanour of which they can rationally possess no knowledge, let alone experience, of committing. The reality for an individual with impairment from a culture which believes their impairment is of their own making, results in intrinsically double ‘suffering’. Their impairment in

itself presents practical challenges in their lives; for example, lack of, or severely reduced vision limits the individual's independent travel. In addition to the practical challenges posed by visual impairment cross-culturally, an individual with impairment in a culture which perceives disability as a 'curse' must cope with distinct psychological challenges posed by its very own culture.

Within a culture which perceives disability as a 'curse' the individual with a disability, in this study visual impairment, is to expect negative behaviour from their society as this is an unswerving consequence of the negative cultural perception of disability. Groce and Zola (1993: 1049) recognize that:

> The culturally perceived cause of a chronic illness or disability is significant in all cultures studied to date. The reason why an illness or disability is believed to have occurred in a particular individual and/or family will play a significant role in determining family and community attitudes toward the individual…and help determine the amount of resources a family and community invest in an individual.

Consequently, little sympathy and/or support would be extended towards people with impairments in a culture that perceives disability as committing a transgression in a 'past life' (Omigbodun et al. 2001). In turn, people with impairments living in a culture orientated to support this belief, and who are seeking to rehabilitate a visual impairment, would not be encouraged to do so.

For example, visually impaired individuals, by pursuing mobility training to equip themselves with the skills to be independent would not be encouraged or supported. Indeed, such an activity could be considered an act of insubordination against the natural order if due 'suffering' was attempted to be cured and not plainly endured. A

culture whose belief system perceives disability as a ‘curse’ and the person with a disability ‘cursed’ would consider rehabilitation futile, where nothing can be done. In such a society ‘normal’ members of society, would be encouraged to ‘stay away’.

As discussed in Chapter 1, Goffman (1963) claimed that the existence of a stigmatizing feature caused the non-stigmatized others to avoid the stigmatized person. For some ethnic groups that consider disability a curse from the God or Gods, avoidance is merely the first response. Owing to the individual with a disability being believed to represent condemnation from God or Gods for past wrongdoings, they and their family are targeted “throughout the community by prolonged public and private discussions about what wrongs the family may have committed” (Groce and Zola, 1993: 1049). The service user participants in this study expose the authority of cultural perceptions of disability which dictate the path in life open to people with impairments. The negative attitude towards disability embedded in their home cultural belief system influences this perspective.

5.4. Medical Model Cultural Perception that Disability is Purely a Medical Problem: Exclusion from Society: Hinders Adaptation

Culturally, disability is viewed primarily from a medical perspective. As discussed in Chapter 1, the medical model approach to disability was first outlined by the World Health Organization (WHO) in 1980 as a personal tragedy. The potential for rehabilitation and subsequent societal contribution is limited in this cultural understanding of disability. Segregation of the person with impairment from society is the preferred approach if a cure is not an option, which, in the case of severe visual

impairment and blindness, most frequently is not. The interview extracts in this chapter are telling of the situation of parents who, due to the cultural perception of disability as a medical problem within their home society, are encouraged or often coerced into housing their children with impairments in institutions.

A service user participant, Caitriona's mother speaks of the pressure she felt to place her daughter in an institution:

> *The doctor was like pushing me you have to put her in there you have to put her in there.*

During the interview the pressure she felt was perceptible in her voice, particularly as she emphasized the word 'pushing' in her statement and the reiteration of the phrase 'put her in there'. The way in which she uttered this statement appeared as though she were imitating the expression and tone of voice of the doctor. Directly following this statement, Caitriona's mother was quite exasperated. Her frustration was audible in the pitch of her voice as she said:

> *They don't give you other options.*

The immense pressure experienced by Caitriona's mother to place her daughter in an institution was heightened by the reality that in her home country culture disability is perceived as an entirely medical issue; as institutionalization is the norm no alternative avenues for her child were explored. Leder (1990: 148) posits that medicine:

> Silences the patient and makes her/his subjective voice become inessential to the medical encounter.

Silencing the voice of the individual with a disability and the family is a consequence of the cultural attitude of perceiving disability as solely a medical issue.

The prospective benefits of social interaction with other individuals with disabilities, in this case visual impairment, are not contemplated or explored in a society that opts to institutionalize not educate people with impairments. Therefore, engaging individuals with professionals in the field of rehabilitation are not considered. The reason for this is that in some cases, services for specific disabilities and impairments do not exist, or, if they are present in society, they do not accommodate specific impairment rehabilitative training. In the case of sight loss, mobility training to regain independence is one example and the lack of such service provision is a direct result of the society's cultural attitude towards disability.

It is also significant to acknowledge economic factors in a society's decision to provide rehabilitative services. The cultural attitude towards disability is intensified in a society which is struggling economically. The Federal Ministry for Education (1981) in Nigeria for example, reported that citizens felt that people with disabilities were already "downtrodden and out" and investing in improving their situation would be squandering national funds. Prioritizing service provision for people with impairments is neglected in a society which views disability, as solely a medical issue. This view persists as the most common perspective today as the organization AbleChildAfrica found in their consultation with African families of children with disabilities (AbleChildAfrica 2010). If a society chooses not to accept the person with impairment, but segregates them, then a direct emotional impact can be to associate

shame with disability. As the mother of a service user describes, the action of not providing a service to support the child, sends the message that the child is worthless. Thus, for a parent to choose to place the child in an institution is, essentially an act of abandonment, as Catriona's mother states:

> *There is no services in my home country for disabled child your choice is to put the child in…which you kind of say I don't want that child anymore.*

Despite being coerced into a decision to institutionalize her child, by the fact that she is given no alternative, Caitriona's mother's statement illustrates that she takes responsibility for this decision. As she says:

> *Your choice is to put the child in.*

However Caitriona's mother ultimately chooses not to put her in an institution and instead she returns to Ireland. Overall, the main negative criticism by research participants towards a home country's attitude towards disability is that a person with a disability is separated from the rest of society.

Service users when asked about their home culture's attitude towards disability seldom commented on their home country's cultural perceptions and behaviours in isolation from their experience of living with a disability or family member's disability in Ireland. A culture which perceives disability as entirely a medical issue is not concerned with rehabilitating and integrating an individual into society. Instead, people with impairments are separated from 'normal' members of society and placed in institutions. It follows that in a society where people with impairments are fundamentally invisible, as their co-existence with the rest of the community is

discouraged, the majority of that community will not have experience of this excluded sub-group. The service user Deirdre recognizes the division between people with impairments and those without in her home country:

> *I still don't see people like that and communicate with them, I told you they are not mixed with the other people that much.*

The critical point is that people with impairments, are not mixed with the other people in her home country's culture, and because of this, interaction between people with impairments and people without, is rare. It is also noteworthy that this service user does not view herself as 'people like that', in spite of her own impairment.

Having lost her sight in Ireland, Deirdre developed close connections with other visually impaired people in the Irish community. However, she did not access services or socialise with visually impaired people in her home country. Thus, the experience related above, about not communicating with people with impairments, refers to a time when she had not lost her sight and was living in her home country.

In contrast, to a society that advocates segregating people with impairments, migrants in this research view Ireland as adopting an integrative approach. One service user, Gearoid's sister explicitly says:

> *People who are disabled are living in the community, you know, in their homes.*

However, in her home country this is not the case as people with impairments, similar to Deirdre's are not mixed with the rest of society. Consequently, a person with impairment who lives in the community is strange in the home country.

Thus, owing to their difference, people with impairments would be conspicuous in a society whose attitude is to separate them. Gearoid's sister describes the reaction towards her brother, in their home country, as inquisitive and bordering on interference. As she reflects on the attitude towards her brother in her home country, her irritation with this attitude was perceptible in her tone of voice, as she remarks:

> *But over there they would say why what happened more conscious, even though why are they worried, we should be worried so that kind of attitude comes into it, which we don't like, it's not their problem.*

In a culture where the general practice is to segregate a child with impairment, mere existence within the community sparks sharp inquiry. Therefore, if the family has not conformed to this societal norm, it faces relentless questioning about the circumstances of the disabled family member's condition, from other members of the community. There is a sense of the community intruding into what Gearoid's sister feels is a family matter. For this study the most significant impact of the medical approach to disability is to inhibit the individual's potential to adapt to their visual impairment, as access to vital rehabilitation services which have been demonstrated to positively contribute to the integration of people with impairments into society is denied (Florian 1982; Thurston 2010). A further consequence of holding a medical perspective towards disability is to assume that the host society will hold the same cultural attitude; thus, a migrant may be reluctant to engage with services for fear of similar treatment such as institutionalization. This is a key finding in this study of visually impaired migrants in Ireland.

5.5. Cultural Perception of Disability Influences Diagnosis Experience

5.5.1. Diagnosis at birth

9 of the 16 service user participants in this study were born with a visual impairment as outlined in Chapter 4, Table 2. The experience of diagnosis of a visual impairment or blindness can be traumatic for the individual or family member. In the case of an individual being diagnosed with a visual impairment at birth the responsibility for caring for the child rests with the family or child's guardian. At this very early stage, the child is plainly not cognizant of their visual impairment; it is the child's family or guardians that are dealing with and processing the diagnostic information. This is a critical time for decision-making regarding the welfare of the child. As disability is often a new experience for a family, the feeling of vulnerability and shock may be experienced. Therefore, if the individual and their family do not receive a clear explanation of the eye condition at the time, appropriate support to assist in adapting to disability cannot be extended. The critical point is that lack of clear diagnosis can be indicative of the cultural perception of disability. Hence, as discussed in the earlier section of this chapter, a moral model approach to disability will be unlikely to consider the relevance of providing a clear medical diagnosis; the medical model approach to disability on the other hand would purely consider medical treatment not social rehabilitation.

5.5.2. Acquired Disability

7 of the service user participants in this study acquired their visual impairment as outlined in Chapter 4, Table 3. All the service users who acquired their visual impairment, despite being diagnosed in their home country or Ireland, noted that their

sight deteriorated in Ireland. Everyone in this group, apart from Ciara received their diagnosis as adults. Ciara acquired her visual impairment in her pre-teens. However, her sight has deteriorated since the initial diagnosis in her home country, most significantly during the last seven years since her arrival in Ireland. 5 received their diagnosis in Ireland. 2 of them, Sean and Sheila, are now 'fully blind'. 4 have been diagnosed with degenerative conditions; as such, the expected outcome is that they will progressively lose their sight, to a state of blindness. Deirdre is an exceptional case, as her visual impairment is related to her medical condition. She experienced severe sight loss, as her condition developed, but has since recovered her vision almost completely.

5.5.3. Unclear Medical Diagnosis Explanation in Home Country: Delays Acceptance: Hinders Adaptation

In Chapter 4 Table 4 shows the service users positive or negative views on the medical explanation received at the point of the diagnosis of visual impairment. It also shows whether the diagnosis was received in the service user's home country or Ireland. Unclear explanation of medical diagnosis is considered to harm the ability of an individual and a family to accept disability. The process of acceptance of disability is associated with acceptance and engagement with rehabilitation services which is connected with improved adaptation outcomes (Gill 1997; Livneh and Antonak 1997; Thurston 2010).

Seamus's condition is genetic and was diagnosed at birth in his home country. He was not given a clear diagnosis of his eye condition:

I have had the illness since birth that is all I know that's what she tell me.

In total, 3 service users disclose no criticism either positive or negative on the medical explanation of their diagnosis in their home country at birth; they have no recollection of any precise medical explanation, nor were they subsequently informed by their parents. 7 service user participants namely, Paddy's parents, Aoife's mother, Gearoid's sister, Breda's father, Sheila, Ronan and Grainne give negative criticism of the medical explanation of diagnosis provided. With one exception, all negative criticism is aimed at medical explanations given in the service user's home countries. The exception is Grainne, whose criticism of her diagnosis is connected with the experience of being taken by her mother to a medium. More than fifty years ago at the time of her birth, attending a medium as part of Buddhist culture to seek medical advice was a popular practice specifically amongst the 'uneducated' as Grainne describes her mother.

The power rested in what the medium communicated concerning her condition; on this basis the decision was taken that she should not have the operation that had been initially advised by doctors at the time. Grainne says:

> *I had to have an operation as soon as possible before I was three but my mother being a devout Buddhist went to a medium and asked them should she go for the operation…she tell my mother not to do it or I will die…decision was not to have the operation.*

This decision was to have repercussions hindering Grainne's adaptation to her sight loss for the rest of her life. A subsequent impact of her mother's decision was also to drive a wedge, in later years, between mother and daughter. The animosity generated in their relationship was a direct result of a clash in understanding of a culturally-

rooted religious approach to diagnosis. This clash in viewpoint triggered Grainne's decision to migrate to Ireland. Apart from this case, the lack of clarity or careful explanation of the eye conditions and the nature of their seriousness are the key criticisms made by service user participants.

Naming a disabling condition is a crucial component to understanding, treating and coping with it. 6 of the study's participants demonstrated frustration, during the interviews, about the vague diagnosis they received, in their home countries. This was expressed in their statements and observed in their behaviours. Gearoid's sister, plainly states that neither she nor her family, were satisfied with the service received, regarding diagnosis of her brother's condition in their home country. Their family was:

> *Not happy with how they make diagnosis at home not clear to us.*

Paddy's father expresses a similar grievance in relation to his son's eye condition not being explained clearly. Moreover, the serious nature of the condition itself is not broached, in any way. He states:

> *At that time, at home, don't make it clear about his eye problem that, he even, have a serious problem.*

Again, such a statement is accompanied by a sigh of frustration, towards the service received in the home country as it was to directly hinder his son's adaptation.

Breda's father, Sheila, Ronan and Aoife's mother are 4 of the service users all of whom had a negative diagnostic experience in their home country, draw comparison with the positive experience they had in Ireland. Breda's father and Sheila specifically

refer to receiving a name for their eye condition in Ireland and not in their home country. Breda's father describes how in his home country he is told his daughter simply does not see very well, whereas in Ireland, her condition is given a name. He says:

> *Just say she can't see so good don't know exact name for it til we come here.*

As Breda's father utters the latter part of this statement which refers to Ireland, a clear lift in his voice was audible. Similarly, Sheila's eye condition went undiagnosed until she came to live in Ireland. She states:

> *I started losing my sight in 2003, no diagnosis… here they tell me I have glaucoma.*

For Sheila there is a sense of ownership of her eye condition.

In order to commence the journey of adjustment and adaptation to their condition, individuals and their families, essentially, need to know the symptoms of their condition. Hence, clear explanation of their condition is vital. The language employed by medical professionals may facilitate or obstruct the individual's process of comprehension of the symptoms of a condition. One service user participant, Ronan specifically highlights the obstacle presented by professionals adopting ambiguous language in diagnosing his eye problem, in his home country. He explains:

> *You see you can go see a doctor in Africa he will not break it down for you actually what is the problem.*

Ronan seeks a clear explanation in simple language and he draws a comparison between his experiences with medical professionals in Ireland:

> *But if you come here they will spell it out in the language you want it to be.*

Aoife's mother also distinguishes between the diagnostic experience for her daughter, in her home country and Ireland. The difference is based on whether the condition is explained or not, as she says:

> *Nobody explain me biggest problem and here everything explained.*

It is a vulnerable time and patients and their families look for clear and candid explanations of their condition and future prognosis. Without a clear explanation, of their own or their child's eye condition, the likely outcome is confusion and a sense of isolation which hinders adaptation (Radley 1994; Bau 1999)

Following her daughter's negative diagnostic experience, in her home country, Aoife's mother felt bereft without help coping with her child's condition.

> *I feel like lost in my country… I feel alone.*

There is evidence of a sense of abandonment; this in turn, is echoed by all the service users, who relate negative feedback on medical explanation given at the time of diagnosis in their home countries. The impact of having a condition fully and clearly explained cannot be overstated for the individual and their families' emotional wellbeing, practical future health planning and overall adaptation. This is a key

finding in this study on migrants experiencing of adapting to their visual impairment in Ireland.

5.5.4. External Labelling: Hinders Adaptation

Embedded in the concept of cultural perceptions towards disability is the theory of external labelling. This theory focuses on the processes by which some people label other members of society as deviant and people's labels rather than actions are considered important (Clarke et al. 2000).

Labelling a person due to their impairment has considerable consequences on, their overall sense of self and adaptation. In contrast a positive attitude towards disability recognizes the impairment, as one aspect of an individual, rather than a single defining characteristic. The service user participants in this study describe being labelled, based on their visual impairment and blindness. In addition, the consequences of the statuses assigned to them by the perspectives of those around them are addressed. 2 of the service user participants refer to being labelled based their visual impairment, in their home country. Both of these service users compare the way they are treated in Ireland to their home countries, in relation to negative labelling. Cillian compares the difference between being labelled 'blind' in his home country, and not being labelled by his impairment, in Ireland. He states:

> *When I came here… I never heard a person call me blind, or anything you know it's great you know!*

He does not directly state that 'blind', is to be perceived as a negative label. Nevertheless, the fact that he is not called 'blind' in Ireland instils happiness and a

sense of acceptance which facilitates his process of adaptation (Gill 1997; Livenh and Antonak 1997; Thurston 2010).

During the interview as he articulated these final words his voice audibly lifted. The positive emotion displayed by not being labelled blind facilitates his process of adaptation to his visual impairment and subsequently his adaptation to living in a new culture, Ireland. Moreover, the fact that he does not experience labelling in the same way, or indeed at all, in relation to his impairment, as he did in his home country contradicts his expectation and is a strong inducement to remain in Ireland.

In his home country, Cillian is labelled because of his impairment, whereas in Ireland he is not. As he says:

> *In Ireland from my experience you wouldn't really hear somebody saying ah you blind person, but they in my home country do, I think they need more education on these things.*

His comment that his home country needs to be educated demonstrates that his attitude reflects an Irish understanding of integrating persons with disabilities. In this view he is distancing himself from his home cultural perception of disability and advocates that his home country learn to respect people with impairments not label them by their impairments.

> *I am not blind I'm just vision impaired.*

He adamantly rejects the label 'blind' as he has working sight and prefers to refer to himself as 'vision impaired'.

Another service user participant, Ronan, remembers being labelled 'blind man', in his home country. On arrival in Ireland he expected to be labelled in the same way. When he did not experience the same labelling, it elicited sentiments of deep acceptance from people at the Irish school of his presence in Ireland and his impairment, as part of his whole personhood. He explains:

> *In my home country they called me blind man, blind man can't do nothing, him see, he's blind that's it…it's totally different here, they don't say you blind guy, no, not like that, just accept me as you know.*

In this interview extract, the concept of labelling an individual due to their impairment results in the person being directly addressed, by the name of the impairment and identified by the stigmatized state. In his home country, the cultural perception of disability, as a negative trait, defines Ronan. Thus, he is a man who is blind; no further character details are required, not even his name. The difference in Ireland is that he is called by his first name. This difference is notable as it facilitates a sense of acceptance of who the person is, including their vision impairment, as well as providing a strong sense of self which facilitates his adaptation (Gill 1997; Livenh and Antonak 1997; Thurston 2010).

5.5.5. Stigma: lowers self esteem: hinders adaptation

Mocking an individual due to their disability is a concept that is a result of a negative attitude towards a stigmatized identity, in this case visual impairment. Mocking an individual based on their inability to see, has strong negative repercussions for the individual's self esteem and accordingly, their process of adaptation and transition

from sight to blindness. For the visually impaired migrant in Ireland, if they have experienced their impairment as a catalyst for mocking and harassment behaviour in their home country, they expect to be treated similarly in the host country, Ireland. There is relief if this treatment is not commonplace in this new environment. One service user, Cillian remarks that he expected bullying because of his visual impairment and he is pleased when he is not:

> *I never got any hassle from them, you know, I was kind of happy then, I was kind of expecting something like that, but I didn't, you know, I didn't get anything, so thought that's very good.*

Ronan also highlights this issue as he acknowledges:

> *Nobody kind of mock at you because you cannot see properly… they put you through.*

The lack of mocking behaviour can assist the individual in dispelling past negative treatment. Also it acts as a disincentive for future prospects of returning to their home country because of negative attitudes towards disability. The positive repercussion of not being mocked or harassed is feeling encouraged to participate in the life of the community.

An opportunity unfolds and this counteracts examples given in the data, where service users, such as Sheila, describe blind people as 'not being counted' in their home countries. Here Ronan's expression 'to be put through' is interpreted, as being counted. The gateway into society has been opened to professionals with expertise in working with specific impairments, such as in Ireland at the NCBI, are trained to support and enable people, to lead independent active lives.

As Ronan says:

> *Yea a lot of progress in my life, so now I sleep, I sleep like a new born baby. Cos before when I sleep I don't sleep cos, I'm just thinking no place to just come in her, makes life much more easy for me, come in here and meet different kind of people that want to put you straight in life, make you feel you can do it, can do a lot of things with your life. You know having vision problem doesn't mean your life is over for you.*

The power of encouragement over a mocking attitude is immense in changing the outlook of a visually impaired person, who perhaps had grown up with, and become used to, being negatively regarded in their home country.

This negative behaviour is the consequence of stigma (Goffman 1963). Sheila locates the principal difference between behaviour towards people with impairment in Ireland and her home country with the presence or absence of stigma, as she says:

> *Here they are looked after, they are people, they are respectable people but back home they are not, ah that's the difference.*

The appreciation of individuals with impairments means they will be 'looked after' through service provision, as opposed to being stigmatized.

5.5.6. Staring at impairment: feeling unwanted: hinders adaptation

Two motivations for staring emerge in the data, and are dependent upon the cultural perception of disability within a community. For a community, which resolutely believes that disability is a curse, the stare or gaze is directed at both the individual with a disability and their family. This represents the stare of disgust embedded in the

belief that disability is a punishment and the person, or their family, has committed evil and immoral deeds in their past lives; hence the community is disgusted.

In the home culture it would be unusual to be seen in public with a child with disability as it is not part of the society's cultural norms to do so, as Caitriona's mother says:

> *People stare at you, like what's that in the buggy, you know, kind of like ha something strange, like why you out on the street.*

A community whose cultural perception of disability is rooted in the medical model of disability does not consider social engagement with the individual with impairment and their family; instead it advocates segregation. The motivation for staring is distinct: the stare is one of curiosity and disbelief. This is because seeing a person with impairment, would be a rarity as the medical profession encourage and 'push' parents, to institutionalize children with impairments, immediately subsequent to diagnosis, therefore inhibiting potential for adaptation to their condition.

5.5.7. Smiling at impairment: feeling accepted: facilitates adaptation

In contrast to staring, it emerged from the data that a simple smile could be felt to reflect the positive attitude towards disability in a community. 3 of the parents in this study specifically compare the impact of staring or smiling at their visually impaired child. It made them feel as if they fitted in and provided an overall sense of wellbeing.

Caitriona's mother compares the experience of her child being stared at in her home country with the Irish attitude to smile at her child; she relates how a passer-by's compliment towards her child made her 'feel good':

I don't have this experience in here that somebody would stare or more people actually…an old lady came to me look in the buggy and say look at the beautiful boy ah makes me feel good.

This attitude portrays an underlying acceptance of the child.

Paddy's father is hesitant to equate smiling or not, as suggestive behaviours and attitudes towards disability. Yet he does so nonetheless, despite displaying awkwardness during the interview, as he shifted in his chair, appearing embarrassed to make such a connection. Nevertheless, he says:

Maybe it is going to sound silly, but people are smiling more to us than it was in, in our home country. I had experience of being treated badly and people looking at us with contempt…an aggressive attitude.

He has experienced negative behaviour towards his child and his voice softened as he related the experience of someone smiling at his child. Such smiling reflects an encounter with a positive attitude towards people with impairments in Irish society and as this data demonstrates, is a visual cue to parents of disabled children, that their child is welcome in society (Livenh and Antonak 1997).

5.6. Moral Model Cultural: no expectation of service provision: delays connection with visual impairment services

Community resource worker Clodagh considers service user's belief systems as an obstacle in engaging with services for their visual impairment. In particular, she refers to peoples' views surrounding disability causation:

People who think of disability as a curse from God, is it some sort of evil eye on you is it punishment… It's more difficult if you have the baggage of superstition, or you know certain beliefs around certain things to deal with those things, will hold anyone back if you believe in those things, if

> *your community shuns you or if you cannot let on that you have a disability, because you don't want to lose face and it is harder for some peoples more than others when it comes to disability, you know to get help.*

The phrase 'baggage of superstition', is pertinent to understanding the influence of cultural perceptions of disability on migrant service user's expectations and engagement with the services in Ireland.

This study interprets the word 'baggage' to convey an intrinsically linked two fold connotation. Firstly, that the migrant has carried this cultural perception (superstition) that disability is god-given and it is like luggage brought from the home country to the host country. Secondly, that the cultural perception itself, the superstition that disability is god-given, is in itself a heavy weight to carry. The 'baggage of superstition' understood in both senses will hold one back from accessing support. Understanding that the cultural perception of disability is the root cause of a migrant's expectation of service provision in this study and how swiftly they access it, is critical in aiding migrant service users access the service more effectively to facilitate their adaptation (Gill 1997; Livenh and Antonak 1997; 2007).

5.7. Cultural Perception of Disability: delays connection with visual impairment services: hinders adaptation

A consequence of a migrant's cultural perception of disability is that as Ronan says 'nothing' can be done for individuals with disabilities. For that reason, visually impaired migrants in this study have not always attempted to access services, as from experience in their own cultural background such services do not exist. This expectation influences the timeframe in which the migrant accesses the service. As

this belief system teaches that disability is a 'curse', potential service users may be slower to access rehabilitative services. The mobility officer Fionn acknowledges the connection between peoples' belief systems regarding disability causation and slower engagement with services. He states:

> *Maybe it's from god if I am losing my sight …There are many I mean it's sounding funny but people eh for some reason becoming too religious you know and believe in maybe that what's happening to them is maybe because their past deeds you know.. Yea and that you just think that happens to you you know*.

Fionn has had experience working with migrants who access the service much later due to this belief that sight loss is related to their past deeds. This key interpretation supports service user Ronan's statement, about expecting nothing.

Fionn, associates the time in which a service user reacts to the severity of the sight loss and accesses the service with the service user's cultural perception of health and disability. As he says, the person's home country's perception of health will shape their reactions to their sight loss:

> *When do they do something, you know, react to something, you know and when you do not react to something, it's cultural perception of health…you know where you come from and what shaped you when you come in.*

For this reason, a migrant may contact the service when their sight loss has dramatically deteriorated as Fionn explains:

> *Maybe I come when I'm on my last legs when in fact if maybe I done it maybe four months ago, it be a different story.*

A migrant service user's cultural perception of disability influences accessing services and this is delayed until the penultimate moment, which has critical effects upon the rehabilitation process; the outcome for a migrant user's sight reduction, and, or, rehabilitation hinges on the timeframe in which professional assistance is accessed. A migrant's cultural perceptions of disability can be the basis for the expectations they have for service provision in the host country, Ireland, and the extent to which they engage with the Irish services for visually impaired. Coming from a society where no social support or rehabilitative programmes are established the individual experiencing this cultural perception of disability will carry this perception as part of the migration process. From this cultural standpoint there is no support; consequently it is unlikely the migrant will expect support in the host country.

For example, on discovering the seriousness of his sight loss, following migration to Ireland Ronan believed his life was over. He says:

> *I was thinking everything about my life is over… I'm just thinking no place…because there were no words of encouragement from anywhere sometimes you feel what about this life you know anyway there is nothing I can do…why would it be different here.*

This extract demonstrates despair, where the first part indicates his hopelessness for the future following his sight loss where the lack of expectation for support is the trigger for his hopelessness. The second part demonstrates that the lack of service provision influences the outlook that there is 'no place'. The third part of this extract illustrates the impact the lack of encouragement to establish a purpose in life has on his spirit to survive. The expectation that is embedded in his cultural perception of

disability is that his impairment and his potential societal participation are not within his control. The expectation is that the same will be true in Ireland.

The response from the service providers in this study who work with migrant service users confirms this lack of expectation of a service for visually impaired in Ireland is based on cultural perceptions of disability. The consequence is that migrants, when they discover that services for visually impaired exist, that there is a 'place' for them, are surprised. It is in a sense a revelatory experience. Community resource worker, Clodagh regularly witnesses migrant service users' surprise on discovering services exist and says:

> *I think people are just so glad for anyone to listen to them, for anyone to offer some help or hope, they'll take it from anywhere you know…I think some people are overwhelmed by the fact that there is a service because it depends on where you are coming from, you know there are people coming from countries where there is no such thing as social welfare or services for anything.*

Clodagh recognises the significance of the context of a service user's cultural background which will dictate their expectation for assistance in Ireland. During the interview Clodagh stressed the line "overwhelmed by the fact that there is a service". The influence that the cultural perception of disability in a migrant's home country has on their expectation for support in the host country, Ireland is clear. Moreover, this extract demonstrates the joy and relief felt in finding a channel to express feelings and needs about visual impairment, as she says, "they are just so glad for anyone to listen to them". It is this positive experience, whose basis is rooted in the local cultural perception of disability which will ultimately impact visually impaired

migrants' overall experience of living in Ireland and in turn their decision to stay or return to their home country.

5.8. Host Cultural Perception of Disability: increased opportunities for visual impairment: facilitates adaptation: motivates decision to remain

A culture which views disability through a medical lens expects people with disabilities to be segregated from the wider society. Rehabilitative services may exist but they are not a societal priority. Where the medical model of disability is upheld, education services also tend to group people with disabilities according to their age not their specific disability. Therefore, the special needs of each individual tend to be neglected. Furthermore, as the expectation would be to institutionalize people with disabilities, accessing support to do otherwise may prove extremely challenging.

Migrants in this study who have grown up with this cultural perception of disability bring this expectation with them when they migrate to Ireland. One service user, Caitriona's mother, fought to achieve support for her child in her home country where disability is culturally perceived as a medical issue; as her child cannot be cured she is not deemed a worthwhile investment to support. During the interview her words were communicated with immense astonishment that the services in Ireland comparatively caused much less hardship to access. Indeed, this astonishment demonstrates that her innate expectation was that she would be battling with the Irish system. She says:

> *So it's really different than in my home country cos in my home country who you do not ask for you won't get help…You need to fight for everything every little thing otherwise you will not get it you will not get anything...here I feel like it's coming to me than like I'm asking for*

something…just from my side it's just one word and it's coming everything around.

There is incredulity that she is not expected to hound the system for assistance. As such, this section has so far demonstrated the influence of cultural perception of disability from a medically focused viewpoint of disability on migrant service user's expectation of service provision in Ireland. The following section discusses how cultural perceptions of disability in Ireland can influence migrants' decision to stay.

5.9. Motivation to remain in host country: associated with increased opportunities for visually impaired in Ireland

The Irish cultural perception of disability is associated with the social model approach to understanding disability. Instead of viewing a person with impairment as either 'cursed', as is rooted in a moral model approach or a victim to their tragic circumstances as facilitated by the medical model, the social approach to disability identifies 'possibilities for changing society' and 'empowering people' (Oliver 2004). The impact of this contrasting approach to understanding disability can be overwhelming for service users who come from a cultural background that views disability through a moral or medical lens. It may be so immense that, consequently, the distinct Irish cultural perception of their visual impairment or that of their child may be the most critical motivating reason to remain in Ireland.

A service user, Niamh's father, whose cultural perception of disability is rooted in the moral model of disability, compares the situation of people with disability in his home country and Ireland:

> *Chances are cut short, it is just really nothing that they can achieve, but in this country there is a good chance for them children that have certain disabilities.*

The future prospects are bleak for someone with a visual impairment in his home country as he says the majority are homeless. Therefore, there is a strong motivation for Niamh's parents to remain in Ireland. This echoes service user Ronan's feeling that there is 'no place' for people with disability. Thus, in their home countries the likelihood is to find people with disabilities begging on the streets. As Niamh's father says:

> *You ninety nine percent are on the street begging that's it…We have chosen this place to be our home…our daughter is safe here… I've passed our home country I don't want to go back to there.*

Niamh's father identifies Ireland as home now as his daughter is 'safe' here. Moreover, having connected with Irish services for his daughter's visual impairment, he does not wish to return to his home country and jeopardize her adaptation process to her disability.

Two other service users, Ronan and Sheila consider that in their home country visually impaired people are found on the streets begging. Firstly Sheila says:

> *Totally nothing if you become blind in my home country…they end up in the street begging.*

Ronan echoes this:

> *Just sitting on the streets begging you have nothing.*

Such cultural perceptions of disability can influence a migrant's decision to stay in Ireland and subsequently consider it home. The motivation to remain in Ireland is rooted in its social model approach to disability which offers increased opportunities and potential to successfully adapt to their visual impairment.

5.10. Motivation to remain in host country: associated with improved quality of life: improved adaptation

Aoife's mother, despite herself and her husband losing their jobs in Ireland, chose not to return to their home country because Aoife has a better quality of care in Ireland. Based on her home country's medical approach to disability, as well as a poor diagnostic experience, she was dissatisfied with the experience in her home country. Moreover, it was her positive experience with engaging with services in Ireland which prompted her decision to remain.

> *I think it's better than like in my home country, like somebody ask me yea, that's why I'm here yea, because my daughter for me is very important, it's first thing that's why I'm here, not now no money, you know we both lost jobs. It's just life, I feel my daughter has good here, and…That's why I am here you know money is important but it's not the best.*

Her daughter is better cared for in Ireland and consequently has a better quality of life and this is the reason for choosing to stay.

Another service user parent, Caitriona's mother, having weighed up the options of returning home or remaining in Ireland also cites her daughter's wellbeing as the motivating factor for staying:

> *We didn't know what to do should we stay here should we go to our home city…So we start to see it like what's the options for us in here with*

Caitriona, what's the options for us in our home city in our home country,, so it's the only thing we have to stay in here.

This decision is based on comparing the service available in her home country which is dictated by a medical understanding of disability in contrast to Irish service provision which focuses on integrating people with disabilities into society. The decision to remain is grounded in the perceived higher quality of life.

5.11. Motivation to remain in Ireland: associated with quality of education services

Eileen's father compared the situation for his visually impaired daughter in their home country and Ireland. Eileen is fully engaged with education services for visually impaired in Ireland. In their home country, special needs schools do not exist, reflecting the cultural perception of disability. The provision of specialist services in Ireland prompted Eileen's father to remain in Ireland:

Eileen future very good, for Ireland, my country, no good for future for Eileen. Here specialist school or something very good…no chance for her at home.

Additionally, a young service user, Cillian whose family plan is to return to their home country is adamant that he will not be returning with them.

CILLIAN: Well I won't be moving anyway my parents will in 5 years or so you know
EM: Home is Ireland?
CILLIAN: Yea it is yea I think it's em like more facilities for visually impaired people.

On the practical level, he recognizes that services for people with sight loss are of a higher standard in Ireland. For this reason, when his family returns to their home country as they wish to reunite with their extended family, he will remain in Ireland.

Similarly, Paddy's father remarks that attending the special needs school is instrumental in his son's adaptation:

> *School is just everything. Since he started attending school it is like his second home. It gives him a purpose.*

This 'purpose' is not possible for his son in their home country, thus hinders his adaptation, so motivating them to remain in Ireland.

5.12. Motivation to remain associated with acceptance towards visual impairment in Ireland: facilitates adaptation

The positive attitude towards disability as experienced by the service users in this study subsequently impacts the decision of some migrants to remain in Ireland. In the earlier section discussing the outcomes of mocking individuals with impairment, Cillian compares the experience of being harassed because of his visual impairment or not. In Ireland he is not antagonized because of his impairment, nor is he labelled. Instead, he feels accepted. Owing to this feeling of acceptance, his overall wellbeing is improved, quality of life enhanced, future prospects brightened and adaptation facilitated. As a result, even when his family will as anticipated, return to their home country, the positive attitude towards his impairment in Ireland motivates his decision to remain. Moreover, Cillian now considers Ireland home. Identifying Ireland as home is intimately linked with his level of acceptance in Ireland through increased 'facilities

for visually impaired people'. By providing services that cater for his needs, the cultural perception of disability transmits a message of acceptance which will enable the adaptation process to his visual impairment.(Gill 1997; Livenh and Antonak 1997; Thurston 2010).

Service user Paddy's father sums up the reason for choosing to stay in Ireland as associated with the care his son receives in contrast to the negative cultural perception of disability in his home country:

> *In our home country disabled kids are worth less, here, they exist… That is the reason why we stay in Ireland. Just to have ordinary, peaceful life…in general society here is more tolerant.*

In their home country Paddy's father has experienced intolerant behaviour towards his son based on impairment. Thus, the fact that their child is well-adjusted and accepted in Irish society determines their decision to remain in Ireland. This interview extract reveals the force of cultural perception of disability to influence the quality of life of the individual and their family. Thus, by choosing to live in Ireland Paddy, according to his father, has the opportunity to 'exist'. Paddy not only exists but has the opportunity to integrate into Irish society and his adaptation process to his disability is facilitated in Irish society through connection with host services for visually impaired. Another service user, Deirdre speaks about the impact of connecting with services for the visually impaired had on her life. She equates the experience with starting anew:

> *Start to take me out of home, to learn something to meet people….to have a new beginning.*

This new beginning for migrant service users is made possible due to the cultural perception of disability that these visually impaired migrants have encountered in Ireland. This perception of disability encourages service users to question and even reject their own deeply held cultural beliefs surrounding disability. Sheila states:

They are wrong they are not cursed they can still do something.

This demonstrates the power of cultural perceptions of disability to enable or disable an individual to seek assistance and expect more from themselves, in that they can make a valuable contribution to society.

5.13. Chapter Conclusion

This chapter has discussed the dominant impact cultural perceptions of disability have on an individuals' quality of life, expectations of service provision in Ireland and engagement with the service. Subsequently, the contrast of home cultural perceptions of disability, based on the moral or medical model, with Irish cultural perceptions of disability will in due course influence decisions to remain living in Ireland. This decision is deeply rooted in the cultural 'baggage' of home country views of disability and home country experiences of attitudes and services for visually impaired in their home countries. Migrants in this study are relieved of this 'baggage' as different views on disability are encountered. Cultural understanding of the causation of disability strongly influences a medical explanation of a condition as discussed at the beginning of this chapter. The service user participants in this study expose the authority of cultural perceptions of disability to dictate the path in life open to peoples with disabilities. The negative attitude towards disability embedded in their cultural

belief system impacts on their process of adaptation to their disability, so potentially encouraging them to remain in Ireland where disability is viewed more positively.

CHAPTER 6: Support Networks Influences for a migrant's adaptation to visual impairment

If you have knowledge let others light their candles from it (Fuller1855)

6.1. Introduction

The focus of this chapter is on the support factors which facilitate or hinder the research participants' adaptation process to visual impairment in Ireland. In this study home and host support networks which may facilitate or inhibit adaptation emerged as central categories derived from the data.

Table 11 Core category Home and host support and its related key categories

Home and Host Support	
Accepting visual impairment	Expectations
Adaptation to visual impairment	Family
Adaptation to host environment	Feeling accepted
Blind community	Friendships
Concealing disability	Giving back
Connecting with home community in Ireland	Home v host V.I attitudes
Coping with disability	Migration motivation
Cultural perception of disability	Migrant- shame
Connecting with Irish	Peer support
Denying disability	Quality of life
Disability- shame	Race and racism
Double outsiders	Religion
Economic climate	Revealing disability
Education	Service provider role
Exclude or include disabled	Service providers migrant issues
Loosening home ties	Stigma
Language barrier- isolation	Strengthening host ties

This chapter is informed by the core category called home and host support networks. This second core category was generated from a distillation of the 46 key categories. 34 key categories are related to this core category and are presented in Table 11. Each of the headings in this chapter relates to the model presented in Figure 6 in Chapter 9 drawn from grounded theory analysis.

6.2. Home Family Support on Arrival: counteracts loneliness: and pre-existing knowledge provides connection with host services: facilitates adaptation

9 service user participants, namely, Aoife, Ciara, Eileen, Gearoid, Cillian, Caitriona, Niamh, Paddy and Sheila, as outlined in Table 6 in Chapter 4, arrived in Ireland with the support of family members. In this study the most significant sources of support, particularly in the preliminary stages of migration are family and friendship connections. Similarly, during the preliminary stages of diagnosis of visual impairment and realization of sight loss, emotional and practical support from close ties is central to the adaptation process to sight loss (Lin et al: 1999). Lin et al. (1999) identify three layers of support which form a "nested support system" the outer which constitutes being part of the community; secondly participation in interpersonal ties and thirdly the innermost layer comprising an individual's intimate ties based on mutual trust and confiding (Weiss 1974; Lin et al 1999; Thoits 1995; Krokavcova et al. 2008). The reason is that during times of transition, such as migration, and moreover, the most vulnerable time of sight loss, which triggers emotional distress, support from family and close ties, can alleviate a sense of alienation (Bisschop et al. 2004)

Affective family support is identified as alleviating feelings of loneliness and homesickness. Feelings of homesickness are reduced as people are surrounded by their most intimate ties, as Gearoid's sister says:

> *It's ok we don't miss home… cos the families are here it's easier for Gearoid more support for him.*

In Gearoid's sister's family's case, they were not only supported as a unit migrating together, but also had the support of an established network of extended family in the host community.

An established home support network assists the individual in their fundamental survival on arrival in host country in relation to seeking accommodation, employment and education. This practical support from home community can aid initial adjustment to a new cultural environment. Mobility officer, Fionn differentiates between a migrant service users' speed of adaptation process due to several factors, emphasising the significance of whether a service user is familiar with host country or not:

> *The difference of eh, already existing knowledge…who is settled and who is not settled.*

On arrival in Ireland, Eileen's family connected with pre-existing home country support networks among extended family and friends. Eileen's father was able to access existing knowledge from his friends to facilitate connection with a school for his children:

> *Home friends' community coming to long long time em he daughter and son going to school I go to my friends house how to recognise a good school here… He told me the school, the teacher the principal I'll give you the address I'm going to the school and meet the teacher and the*

principal and going to just organize for them and after daughter and son, now I know everything, which place the school, the place and the city centre…Yea I know places so now…Easy, little bit easy for me, now I know everything.

At the school recommended by his home country friends, Eileen's visual impairment was detected as requiring special needs support and so she was linked in with host services for the visually impaired. Eileen's experience of host services support is discussed in the subsequent section on host V.I services role in facilitating adaptation.

Unlike Eileen's family who arrived to Ireland together, Deirdre arrived alone to Ireland. However, similarly she had a pre-existing established support network through work-related connections with home community colleagues already in Ireland prior to her migration. Most significantly, Deirdre signed a work contract prior to migrating and arranged shared accommodation with fellow home community work colleagues in Ireland.

I had a job like prepared in advance for me, not just go somewhere and start looking for a job, just know, what I'll do and everything was arranged before that… I have friends which was my colleagues, working her for sometimes…they told me that there is a job for me, in here and they contacted me with the employer and he called me on the phone, I send my documents and I come here to work… They wait me and preparing my room for me to come… good friends from the university yea, we finished together… The neighbours were from my home country too…Big network.

Through her network of home country friends Deirdre started working and considered that she began to integrate with Irish people.

Very easy when you work with Irish people…Just come natural. With Irish clients also…in the, eh, place of work…Cos all the time you meet you have to communicate with Irish people.

In her workplace Deirdre later met her Irish partner and the support he provided her in accessing host services for visually impaired is discussed in section 6.7.4.

Another service user Sheila also found great support from an established home country network in her case from her sister. However, Sheila is also an exceptional case, as she is the only adult participant to migrate following severe sight loss. Sheila's sister having migrated to Ireland a few years previously returned to their home country to bring her back to Ireland with her. This decision to bring Sheila to Ireland was motivated by Sheila's increasing sight loss. Sheila's sister had knowledge of the higher quality care for visually impaired people in Ireland compared with their home country. Sheila recognises that were it not for her sister's support she could not have left her home country and sought professional support to assist her rehabilitation and re-entry into society:

> *My sister was already here in Ireland she was working here so when she heard about my situation losing my sight she went back home to visit and she decided let's go back to Ireland…she bring me and take care of me help me link with NCBI.*

Sheila's sister's positive experience of living in the host environment was decisive to her migration. Furthermore, her practical support facilitated her connection with rehabilitative services and the emotional support of her sister has assisted her process of adaptation to her visual impairment.

Through a home community support network Sean, like Deirdre arrived to Ireland to work. In Ireland he connected with a childhood friend from his home community, and began working in his business in Ireland. Sean also shared accommodation with this

friend for the first year in Ireland and this friendship provides the foundation for Sean's support in the host community especially during the difficult and vulnerable period of sight loss:

> *My friend bring me to the doctor, he let me stay, when my sight getting worse he see me at my worst, it's ok he's my friend.*

This friendship has endured throughout Sean's residence in the host culture and has been his main emotional and instrumental support during all stages of his migration and most significantly his process of accepting his sight loss.

Established home community support networks on arrival facilitated the initial transition into Irish society for these migrant service user participants. The critical pre-*existing knowledge* which is made available to newcomers, Eileen, Deirdre and Sheila assists in their adaptation. For Eileen and Sheila their established home community support networks enable them to connect with vital host support services for visually impaired. For Deirdre, the pre-existing connections within her home community facilitate adaptation to Irish society through accessing the workplace. From an intercultural perspective, Kim (1998; 2001) and Berry (2001) note a pre-existing network in the host community prior to migration can be beneficial to overall successful integration to living in the host country.

6.2.1. Home Country Support: assists visually impaired during asylum process: facilitates survival

Similarly to Sheila, Ciara's sole source of support on arrival in Ireland was her older sister. There are however, three distinctions in their situations. Firstly, Ciara was significantly younger than Sheila at the time of arrival. As Ciara was not yet eighteen

her sister assumed the role of her guardian. Furthermore, Ciara's sister was as unfamiliar with the new host environment as Ciara, it also being her first time in Ireland. The most significant difference between the two service users is that Ciara and her sister arrived to the host country as asylum seekers. Owing to her asylum seeker status, she was unable to access the host country's services for the visually impaired, so subsequently she relied more intensely on her sister's support for her fundamental survival:

> *I arrive with my older sister just me and her…she really help me in every way, I would be lost without her…I'm living with her still now she's married.*

Ciara was a minor when she arrived in Ireland, without her sister's support her adaptation to living with her progressive sight loss in new cultural environment would have been greatly reduced. It is difficult to comment whether Ciara's process of adaptation to visual impairment in Ireland was facilitated through her sister's support. It is more appropriate to state that it was an impasse but without her support she would have struggled for basic survival.

6.3. No pre-existing home support networks on arrival: increases isolation: hinders adaptation

Two of the service user participants, Liam and Seamus arrived in Ireland alone with no pre-existing support networks in place in Ireland. They may be considered the most vulnerable, as the lack of support can prove isolating (Radley 1994; Baus 1999). For instance, Liam identifies holiday seasons customarily associated with family gatherings and unity as particularly lonely:

Here at Christmas time, you will be alone.

He lowered his head and mumbled this during the interview.

In the case of Liam and Seamus the circumstances of their visual impairment differ. Liam was unaware of his visual impairment on arrival in Ireland while Seamus, in contrast, had been living with his visual impairment since childhood. Both are planning to assist the migration of other family members from their respective home countries. Due to his asylum seeker status, Seamus has been unable to access social services to facilitate adaptation to his progressive sight loss for the last six years. He lives alone and finds the separation from his wife and children while living with visual impairment in a different cultural environment the most challenging aspect of his situation, as he says:

It's really hard…without the family it's worse problem.

They both share the same reality that their sight loss most significantly deteriorated while living in Ireland. A positive note was that by the time of significant sight loss, they both had developed support networks within their home community in Ireland. In fact, the most significant sources of support for each service user were with home community churches in Ireland and Irish services for the visually impaired. These channels of support will be discussed next in 6.3.1 and also in 6.7.5.

6.3.1. Home religious community support: alleviates isolation for lone migrants: facilitates adaptation

As discussed previously, Liam and Seamus migrated without support ties; nonetheless they share a source of support in common, that is, their home religious community in

Ireland. Both of the individuals live alone and Seamus, due to his poorer vision is particularly vulnerable and isolated. It is important to state that at the point of interview, although Seamus had established contact with an NCBI community resource worker, he had yet to attend the Rehabilitative Training Centre. Moreover, due to a rise in the intake at the Centre he was not successful in achieving a space in the year of the interview. In his case, he stresses the significance of the practical support he receives from his nearby religious community. Ethnic religious organizations may act like extended family in particular for lone migrants who are separated from their family in host country (Hirschman 2004).

In fact, for Seamus, his basic everyday survival relies heavily on the support from the religious community; for example, members of his home community prepare and deliver his meals to his home:

> *Because me no cook, very important, yes, because everyday the food, everyday, because this moment, me, I can't cook, I have problem for my eyes.*

The home religious community also provides Seamus with practical support with coping with sight loss in Irish society. This can take the form of informal interpreting with the services for the visually impaired as well as the informal translation of forms in relation to his migrant status and applying for the family reunification scheme.

> *My friend from the religious community he help with English talking with person from NCBI…help prepare dossier to put it in for the visa.*

In Liam's case, the support at his home community church offers him valuable friendship; in fact he recognises the friendships fostered in this environment as the single genuine friendships he has in Ireland. He says:

> *In church make me feel well, because if I do not have them as my friends, I do not have any.*

Liam's home church friendships increase his sense of well being.

Eileen's father identified, in the opening section of this chapter, as arriving in Ireland with family, also acknowledges the remarkable support he receives from his home community network at the mosque his family attend. He has made many friendships through this channel:

> *I find a place…meet friends in the mosque, I sometimes go to city centre another place …where my community go, a lot, a lot of people together to pray together every Friday, you know, especially not like Christian who go to Sunday church.*

Niamh's father says that when Niamh was born in Ireland, the only visitors his wife received in hospital were members of her home community church in Ireland:

> *The only people that come round are the church members of the church that she goes to….my wife had big big problems with Niamh when she was alone it wasn't easy for her to carry that because most of her she spent several months in hospital.*

Niamh was born severely visually impaired; her mother was alone in Ireland as her husband was still in their home country. During this challenging time the home church members provided support coping with her daughter's sight loss in the host country..

Thus, the home religious community is a great source of support for the visually impaired migrants in this study who migrated alone to the host country. When support from family is absent, the home religious community helps, much in the same way as a supportive family would. Seamus relies most heavily on the support from his home religious community for his fundamental survival while coping with his sight loss in a new cultural environment. Liam feels that without his home religious community he would have no friends and the support Niamh's mother received helped her cope with Niamh's visual impairment during the challenging time of separation from her husband.

6.4. Over-reliance on home community support: social isolation and poor independent life skills: hinders adaptation

In Section 6.2 on home community support from pre-existing networks and 6.3.1 on home religious community in the host country were identified as facilitators in adaptation due to their potential to alleviate alienation and connect visually impaired migrants with host services. Nevertheless, in this study the over-reliance on these same home support networks is found to hinder adaptation (Kim 1988; 2001). Over-reliance on host support networks for visually impaired migrant can contribute to social isolation and poor independent life skills. Mobility officer Fionn recognises the dilemma for family members who want to ensure the safety of their visually impaired relative but cautions against overprotection as it will hinder adaptation:

> *When you live with family they take over, you know, they start making you a cup of tea, you know, because you, they are too frightened, that you might scald yourself, probably, so suddenly, they also kill your own*

> *morals, kill your own fire, yea and eventually, you are just there, everybody is too cuddling and loving doesn't help.*

For instance, Ciara still lives with her sister who continues to support her eight years after arriving in Ireland. Ciara's strong reliance on her sister has provided her with emotional and instrumental support in Ciara's initial adjustment to living in an unfamiliar cultural setting. However, eight years later the lack of informational support may impede her increased integration into the host society and act as barrier to enabling her to lead an independent life, which the host country services advocate.

In fact, aside from her sister, her connections within her own home cultural community are limited. She cites one home country friend and she feels she has little in common with Irish people of her own age:

> *When I was in school it was hard, I don't smoke, I don't take alcohol… I don't have much friends, as well, I like to just stay at home sometimes lonely.*

It appears the over-reliance on her sister's support has impeded Ciara's confidence to connect with the outside world. This is coupled with the impact of her inability to access services for visually impaired for a full six years after arrival, due to her asylum seeker status. Once her application for asylum was approved Ciara eventually connected with host services for the visually impaired.

6.5. Unsupportive home community family and friends: exclusion: hinders initial adaptation

The most intimate ties of family and close friends are relied on most significantly in times of crisis (Lin et al. 1999). In this study crisis points are most acute during the

process of adaptation to visual impairment, particularly, the realization or "point of impact" of sight loss (Thurston 2010). Unsupportive behaviour from home community family and friends is considered the trigger for the most damaging psychological distress for the individuals in this study. The visually impaired migrant has the expectation that the home culture will be supportive and if this expectation is violated (Burgoon 1982) the individual may be extremely disappointed and experience feelings of depression (Lin et al. 1999). Unsupportive behaviour from closest home culture ties, while the individual is coping with sight loss in a new cultural environment, impacts on mental health. Deirdre recounts the sense of abandonment she felt when her home community friends, with whom she shared accommodation, began to ostracize her following her sight loss; owing to her visual impairment she was unable to work and remained at home. Deirdre's home community friends did not support her, as they were busy with their own lives and considered her an extra responsibility:

> *They just eh keep on eh their lives…they didn't give me any help… they see me every day… they see this, every day, they just eh distance themselves they just didn't want this extra weight on their shoulders too.*

Deirdre's home community friends witness her sight difficulties as they all live together, yet they do not offer their support. Instead they retreat from her leaving her to cope with the challenges of sight loss alone. Furthermore, they make life more difficult for her by labelling her a burden:

> *Even they was complaining, because I was a burden for this house, because for example, why they're working, I stay at home and eh put on the heating, for example, which costs money.*

Being labelled a burden has a negative impact on successful adaptation (Liachowitz 1988; Radley 1994). As Deirdre is perceived to be a drain on communal resources she is resented by her fellow house-mates and her presence in the house is unwanted. This sense of feeling unaccepted is one that Liam experienced from the host community by being stigmatized on racial grounds. In Deirdre's case she is being stigmatized because of her acquired disability by people who, prior to her sight loss, she considered to be her close friends. The fact that the stigmatizing behaviour was carried out by trusted friends, compounds her psychological distress.

The specific medical condition, to which her visual impairment is attributed, requires the use of an increased amount of waste disposable. Deirdre's home community friends explicitly target this waste connected to her disability:

> *These bags from the medical condition, your waste is much, much more, so it's you have to do something, we can't pay for your waste, for example, from being a friend I was bit of enemy at this moment.*

It appears that as her sight loss deteriorated so too did her bond with her home community friends. Moreover, as she is separated from her family the challenge of coping with sight loss while being alienated by her closest ties in the host environment is compounded. The challenge of coping with sight loss for Deirdre is heightened as she is separated from her family:

> *In a way it's more difficult when you, when you your real friends are not with you and your family, you're really on your own this is really very difficult.*

She emphasises the support of *real* friends, so highlights the issue that not all friendships and family ties are genuine and as such can be unsupportive. Indeed, when expectations of support are violated the outcomes may cause more emotional distress (Burgoon 1982). Grainne another service user, when asked if she is supported by her closet home community ties, in her case her older brother living in Ireland, sobbed as she said:

> *Definitely not in fact totally different to supportive…You see you don't get any family support…being criticized not encouraged…you think big brother he's going to look after you not at all just being bullied because you have a disability.*

Grainne echoes Deirdre's feelings of being neglected by her home culture. During a process of transition from sight to sight loss in a foreign cultural environment the withdrawal of support from the closet ties within their home community inhibits the individual's initial adaptation to deterioration of sight in the host environment in this study.

6.5.1. Weakening ties with unsupportive home community: increases integration into host community: facilitates adaptation

Following the unsupportive behaviour Grainne and Deirdre experienced from their home community, they both weakened ties with their home communities. The experience of being stigmatized due to their disability drives the process of distancing themselves from the instigators of the stigmatizing behaviour.

> *It's funny for example I feel much more stigmatized by my own home community.*

Grainne has the same experience of feeling unaccepted in her home community in Ireland:

> *My home country people are quite old fashioned and they don't have the same kind of upbringing as the Irish so the Irish would have you know em they are not very fond of showing affection and they eh criticize you instead of encouraging you so basically you know if you have a disability you know you be ashamed of yourself so then you get bullied.*

Community resource worker, Clodagh is surprised to discover that those who stigmatize migrant visually impaired children are not Irish children but children from their same home country:

> *It's particularly hard for young children, you know, em, for anybody for any young child at school and children being cruel, you know, maybe a bit of bullying taking place, or people or kids are cruel, but it is difficult for any young child to cope with, if you're from another em country, another colour another creed, whatever, it's not so much even the national kids that would be causing difficult, it would be people from their own community that would create eh would stigmatize them… dealing with their own community and the community's view on disability.*

The lack of support for visually impaired migrant children reported to Clodagh correlates with Grainne and Deirdre's experiences of being stigmatized by their own home communities. Stigma, as discussed in Chapter 2, has damaging effects for self-esteem (Goffman 1963).

Both women associate the stigma experienced with the migration motivation of members of their home community as Deirdre says:

> *People coming here to earn money and nothing else matters that much.*

Grainne's experience of her home community echoes that of Deirdre's as she acknowledges:

> *They're money mad. You know I don't find that, you know, that most of my home community are what you call genuine you know when I mean genuine money you know comes before anything like, I have cut, if off I have cut off, a lot of home community friends.*

Deirdre considers that one of the key differences between the host and home communities is that the home community in Ireland is much smaller therefore mostly represents a sector of society driven by economic motivations:

> *Here Irish society is a big society and there's everything there you see its restricted type of community this one.*

Deirdre compares how she feels accepted by Irish people regardless of her visual impairment:

> *They see she's not like us, she's something rubbish, uf, for Irish community I was nobody before, so they take me for what I am now, so I'm not stigmatized here in this sense, if you understand me.*

Overall, host community acceptance drives these migrant women to sever ties with their home community, contributes to their positive process of adaptation to their visual impairment and ultimately motivates them to remain in Ireland.

Subsequently, host community ties are strengthened through establishing permanent links with the host community. It is noteworthy that both women have established long term relationships with Irish partners who provided them with the emotional

support that their own home community denied them during their very challenging health circumstances. This means of support is discussed further in section 6.7.4.

6.6. Support from host services for the visually impaired: provides space for social interaction alleviates isolation of visual impairment: facilitates adaptation

Less contact with host community networks than with ethnic community networks are common amongst migrants (Veerstegh 2000; Bochner, McLoed and Lin 1977). Despite this, developing social connections in the host community are fundamental for a migrant's successful adaptation to the new environment (Kim, 1998, 2001). Granovetter (1973) highlighted the significance in not underestimating the significance of developing of weak social ties. For this study this means developing vital connections with the host community's services for the visually impaired. To varying degrees and periods of duration in contact, all of the visually impaired migrants and their families that are represented in this study are currently connected with host community services for the visually impaired.

Host services for the visually impaired, principally, the NCBI and St. Josephs' School for the Visually Impaired are recognized as the most critical sources of support received by visually impaired migrants and their families in Ireland. The main focus of support provided by NCBI Training Centre is rehabilitation; the goal is to enable service users to lead independent lives. St. Joseph's School provides primary school education for visually impaired students. Although the main goal at the Centre is rehabilitative, the potential to provide a space for social interaction amongst visually

impaired people is recognized and welcomed, as Darragh a management service provider states:

> *The NCBI would classify the training centre as a rehabilitative centre, which it is, but it is also bigger than that and lately in the last couple of years, it has become a place, where people come for social interaction and I think that is perfectly ok. I think there are people who without the training centre would sit at home, every day on their own and be isolated and not have the opportunities to meet other visually impaired people, to take part in the classes, see some of the aids, that are available to be informed to be empowered to make you know, sort of take action, take responsibility for their own actions.*

Service user participants, such as Ciara, Deirdre, Ronan, Sean and Sheila voice a similar view that were it not for the social outlet provided at the Centre they would be confined to their homes. Moreover, some of them are already deeply aware of this state having experienced extreme isolation in their home communities.

Sheila recounts how when she lost her sight in her home country she hid in her bedroom:

> *I never went out, I never allowed anybody in my bedroom.*

Owing to the cultural perception of disability in her country, there is a lack of service provision for visually impaired individuals, as discussed in Chapter 5. In addition, as a blind woman she is a perceived as an easy target for abuse. Due to visual impairment and lack of familiarity with new cultural environment Sheila relates that she was also isolated in Ireland:

> *I never did anything; I just was inside the house.*

This behaviour is similar to the staying in her bedroom in her country of origin. Subsequently, she relates her first experience meeting her NCBI support worker:

> *She came to me one day and said would you like to go out and socialise with other people… I like meeting people and I like making friends so she introduced me…there was so nice people there, the staff including the people the blind themselves, they were so nice they welcomed me first day I got there, they welcomed me, they made friends with me.*

Connecting and being welcomed into the community of visually impaired people at the Centre provided Sheila with the interpersonal support she had been craving.

As highlighted in Chapter 5, several of the service user participants, such as Ronan, experienced aggressive behaviour from their home community, attributable to their visual impairment. However, the support and space for social interaction with other individuals with visual impairment had transformative consequences for him as Ronan had resigned himself to a very limited existence, prior to accessing services for visually impaired:

> *Since I discovered the NCBI, now I can say I am one of the happiest persons on earth, cos I was thinking everything about my life is over.*

Consequently, when such negative perception, attitude and behaviour towards their impairment in their home community does not transfer to their experience in Ireland, a migrant service user in this study may be described as experiencing feelings of gratitude and elation.

Another service user, Paddy's father compares the accessibility of support services for their child in their home country where Paddy is considered a second class child due to his disability as discussed in Chapter 5 and in Ireland:

> *You need to have connections, the service is not as accessible there, you have to know someone to be able to access a service, here it's so different they really support us.*

He highlights corruption in service provision in his home country potentially related to the medical model approach to disability as discussed in Chapter 5.

Mobility officer, Fionn recognises the influence of providing a space for social interaction to alleviate alienation of sight loss experience and increase inclusion:

> *If you feel as individual ah that might have thought totally excluded you know physically, emotionally you know and all that and suddenly there is something to make you feel you know included…if you can relate to people there…especially if you are losing your sight this is the end of the world*

Consequently, connecting with host support services for visually impaired provides an inclusive space for social interaction with other visually impaired people. This social interaction can facilitate adaptation to visual impairment through alleviating the alienating experience of sight loss and motivate individuals to follow positive example of fellow trainees at the Rehabilitation Centre. In sections 6.7- 7.1 the benefits of accessing peer support from similar others is explored in relation to impact on adaptation to visual impairment for a migrant in this study.

6.7. Peer support: provides empathetic understanding: facilitates adaptation

This study finds that the most cherished support givers may be from similar others, that is, individuals who themselves have successfully faced the same stressful circumstances that the individual is currently facing (Thoits 1986; Smart 2001). In the case of this study, similar others refer to those who have experienced sight loss in

two categories: firstly, all individuals who experience visual impairment and secondly, individuals with visual impairment from a migrant background. This study finds that the best support mechanisms for visually impaired migrants are others with most similar sight loss and migration pattern and home country background. Fionn, the mobility officer recognizes that:

> *Sharing of ideas is one of the biggest things, you know, you realize I'm not alone, you know, I think it's a really big thing, people suddenly, when the walls are collapsing on you, suddenly you had sight before…it might make you emotionally, you know, maybe to cope better.*

Evoking the image of the walls collapsing on the individual due to losing their sight is very powerful. This is the crumbling effect of a world entirely changed, rebuilding life from the debris from sight to sight loss. Moreover, the challenge is to rebuild his/her life as a visually impaired person in a new country. As discussed in Chapter 5, the most negative consequence of the cultural perception of disability is that individuals feel they have nothing to contribute and that there is nothing for them. Several of the service users in this study, disclosed having suicidal feelings following their sight loss. For instance, Deirdre was bitterly hurt when her friends distanced themselves from her following her sight loss, as she confides:

> *It really was so difficult, this period that I was really thinking, seriously to commit suicide.*

The individuals in this study who had the least amount of home country support were most vulnerable and prone to severe emotional strain. In contrast, locating support within an environment, where other people are in the similar process of coping, creates a nurturing space for developing a new identity as a person with a visual

impairment. As Fionn says, sharing the experiences of loss and anxiety with someone who can offer genuine empathy may potentially heal the hurt feelings and ease feelings of isolation. Following her rapid sight loss, Deirdre, was confined to her house as she was unable to travel independently. Once connected with the services for the visually impaired at the Training Centre, she identifies the enabling power of being with others who share similar sight problems:

> *I met a lot of people there with similar problems and you see other ways, if you don't see you think you're the only one person with that problem in the world, but after you see there are a lot of people like you and they are alive and some even happy, so there is hope.*

Witnessing other people with similar sight problems coping well and being content is a source of support and most significantly provides optimism for the future. In addition, positive role models may be identified within the visually impaired community, who provide immense collective pride for the group due to their achievements and successful adaptation progress, for example mastering Braille and long cane skills. The potential of positive role models to inspire other visually impaired individuals to lead independent lives is found to positively influence both their own adaptation process and enable similar others follow their example.

6.7.1. Peer host family support: provides empathetic understanding: facilitates adaptation

It is noteworthy that for migrant parents who do not have the support of older generations for example, grandparents often miss the much needed emotional and instrumental support of childcare, especially when their child has special needs. Consequently, migrant parents of children with visual impairments are heavily reliant

on other sources of support, most significantly host community support services. For parents of children with visual impairment, school support services facilitate parent groups for parents of children with disabilities to meet and provide a confidential forum for discussion. This provides a valuable source of support as one service user, Aoife's mother relates:

> *It help better, there was a few meetings…the children playing together, we talking, it was very nice, very good for someone else to tell you, you know, I have similar problems with my child.*

Being with other parents of children with visual impairments offers parents the opportunity to share their experiences and receive empathetic support. Most significantly, it relieves the sense of alienation felt when coping with the impact of their child's visual impairment alone.

Beyond the organized channels of support, Paddy's parents recounts the supportive gesture of an Irish mother of a child at their son's school. They were pleasantly surprised when she stopped them at a local petrol station and invited Paddy to her house during the summer school break, to play with their daughter. Paddy's father says this invitation made them feel supported:

> *The mum from the school was there as well and she invited Paddy over when the summer holidays come. We exchange the numbers…We were surprised…She wanted Paddy to visit her daughter so they can play together…Feel like you know they understand our situation was nice support.*

Sharing experiences with other families can alleviate the sense of alienation associated with coping with a child's disability for the parents and most significantly connects their children with others who can empathize with their

sight loss challenges. This empathetic understanding can facilitate acceptance and adaptation to visual impairment.

6.7.2. Host school system and the workplace: provides esteem support: facilitates adaptation

8 of the service user participants as presented in Table 7 in Chapter 4, accessed support for their child with visual impairment, through the Irish school system. School provides the perfect setting for children to receive esteem support (Cobb 1976). Aoife's mother says:

> *They knows Aoife that she sees less and they know that like talking to her, they know she maybe don't see her, so she explain like, "Hi Aoife I am talking to you" and say name…children with school that know her, know she has problem they just be careful for her and very nice for me, it was end of the year and everybody go holiday and she was last day everybody was like oh Aoife big hugs and kisses very nice, like I think Aoife good at school and care about her, this is very, very, nice for me.*

This channel of support generates positive well being for both parent and child and is connected with esteem support as the gesture of support is displayed in a public environment, the school.

The host country workplace is also identified in this study as a source of esteem support. Three of the service users, Deirdre, Mary and Sean, developed support networks in the Irish workplace. Deirdre acknowledges the support from work colleagues following her sight loss:

> *From the first day make friends because at work, you work mainly with Irish people. You don't live isolated in home community, all the time, you are with Irish people, they good to me later when I am not well.*

Additionally, Mary identified her Irish workplace as being responsible for sending her for initial eye examinations. Following her sight deterioration her employer supplied her with assistive technology so that her work performance would not be impeded. She remarks:

> *They say they will accommodate any disability, anything no matter, they will accommodate the staff you have to say what it is, if you're comfortable saying what it is and em well we need your documentation, so for their own insurance purposes, they need to know exactly what my condition is, so that was the first time I went to an eye specialist because they insisted on it… I'm really glad they did that was good support for me.*

Mary is still employed at her workplace; the company have invested in assistive technology to enable her to continue to carry out her job.

Sean worked for several years in Ireland prior to losing his sight. At first he worked in a home community company in Ireland and later in an Irish company. Following diagnosis of his eye condition, his workplace was very supportive and facilitated his extended absences from his job, due to his eye surgeries, so providing Sean with esteem support (Cobb 1976). As Sean says:

> *They ring me see how I'm doing after the operations… they say no problem Sean no problem take your time you come back when you're ready.*

The support provided by their workplaces alleviates stress associated with coping with sight loss. Unfortunately, since losing their sight both Deirdre and Sean are no longer employed in their former workplaces for safety precautions. However, as a result of the support extended towards them from their workplaces in the initial stages of their sight loss they were each aided in their adjustment to their visual impairment.

Deirdre and Sean have been motivated to return to the education system for retraining in their specific areas of expertise. At the time of interview Sean was in his first year of third level education in Ireland. Deirdre was in her second year of a diploma course choosing to retrain in social care with the intention of working with individuals with disabilities. The ambition to regain independence and make a contribution to Irish society drives them.

Support within the school and work setting is instrumental in the provision of esteem support which visually impaired migrants require for the adaptation process.

6.7.3. Host friendship support: facilitates adaptation

Mary arrived in Ireland alone but accessed support from the host community through personal contacts as she had fostered a pen pal friendship with an Irish individual for several years prior to arriving in Ireland:

> *I had a very good pen friend in Ireland… he must be my oldest friend in Ireland now still very good friends and he's got married since so they would be my closest friends so generally spend Saturday nights with them, they're a great support, especially good to me, now with my sight and everything.*

Ten years after arriving in Ireland, she counts this friendship, as her main socializing outlet and it continues to be a great source of support since her progressive sight loss.

6.7.4. Host partner support: provides connection to host V.I services: facilitates adaptation to visual impairment

Two of the participants, Deirdre and Grainne have Irish partners. Both of these migrant women experienced unsupportive behaviour from their own home community in Ireland as a result of their visual impairment. The bond Deirdre and

Grainne have formed with their partners since arriving in Ireland has assisted them greatly in their adaptation process. Following her sight loss, Deirdre relied heavily on her Irish partner for basic survival as she says:

> *Thanks God he was there… I mean, he helps me, all the way is possible, he help me, he took me places - he everything.*

For both Deirdre and Grainne it was their Irish partner who found out about the services for visually impaired. Due to her visual impairment Deirdre could not travel independently so her partner accompanied her. She says:

> *I don't know if I find the place by myself, I don't know anything about it, he knew where to go he bring me I can't walk by myself*

Grainne also found support from her Irish partner as she says:

> *He look out for me, when my brother abandon me, later, he help me find the NCBI.*

Forming connections within the host community is considered one the most significant routes for long term successful adaptation to a new society (Kim 1998; 2001) and is also a finding in this study of visually impaired migrants in Ireland.

6.7.5. Host religious community support: provides connection with host V.I services: facilitates adaptation

This study also identifies a host religious community as providing a positive source of support for visually impaired migrants in this study. The local religious community setting may provide migrants who share the same religious faith as the local population, with a channel in which to maintain their cultural religious beliefs and establish support networks within the Irish community. The support and friendships

developed in this host community environment will have consequences for the migrant's process of integration into Irish society. In the case of one service user participant, Ronan, it was through attending Irish Catholic church services that he developed a host culture support network in Ireland. He and his wife chose Irish godparents for their children:

> *I don't go to black churches because they are not Catholic, sorry, I go to Catholic church, here you meet more Irish people, makes it easy for me and my family worship at the Catholic Church and you get to meet Irish people this way. You know the godparents for my children, they are Irish.*

Indeed it was through this network among his Irish church friends that he heard about the NCBI Training Centre. He expresses gratitude towards them for introducing him to the rehabilitative program:

> *I am very thankful to them, I don't know about NCBI my child's godfather he tell me about this place and bring me here.*

The host community church evidently provides a valuable source of support for this service user, facilitating his overall process of adaptation to his sight loss by connecting with Irish services for visually impaired.

6.8. Unsupportive host behaviour: racism: hinders adaptation

The most unsupportive behaviour experienced by the research participants in this study is racist behaviour. The issue of racism is discussed in relation to the negative impact on the individual's adaptation to their sight loss. The strongest and most frequent references to racist incidents in Ireland are related by the service user Liam.

He reports numerous occasions, when people on the streets and on public transport shout abuse at him, referring to his migrant status:

> *They say go back to your own country, what you doing here?*

He recognises the situation as unsafe:

> *I will not be the one to look for the trouble, keep head down I know that this is trouble, this is trouble coming, so I will not be the one to go and explode it I am quiet.*

The effect of this abuse is to further strengthen his bonds with his home country community and create a barrier between himself and the host community.

In fact, when he is on public transport, he chooses to place his leg across his seat, so that a host country passenger cannot sit beside him:

> *If they don't want to sit down, I will now put my leg on that space… that let them know that I don't want anybody to come near to me.*

Liam uses his leg as a physical barrier between himself and a potential host country passenger. This is his mechanism of taking control on public transport and is his signal of refusal to be judged on the basis of the colour of his skin, even if it may not be understood by other passengers. Liam also discloses a more direct attack from people in his neighbourhood:

> *You have to watch your step, cos you don't know, if they will mess now, this eh, em, eh, let me say, early last year, at my gate, when I was just about to open the gate …they were throwing egg on me.*

When asked did he report the incident he began to smile, appearing bemused by the question, as he states:

> *I don't report it but who would I report…The Garda?* (Laughs) *I don't maybe it happening there, I don't know, maybe it is happening over there, throwing eggs to people and they take for a fool, for not knowing this.*

It is noteworthy that he is unsure about behaviours in the host community, querying whether the unprovoked action of throwing eggs at a neighbour is common and moreover acceptable behaviour within the host environment. Therefore, he chooses not to report the incident to the Garda Síochána, from whom he feels unwelcome. Furthermore, he believes that in reporting the incident he risks being further taunted by the host community for potentially not knowing the rules of its society. This is an example of where esteem support (Cobb 1976) is denied, the consequence of which is the development of negative self-esteem. This negative self esteem is rooted in the perception of his migrant status as a stigmatized identity (Goffman 1963). The impact is to widen the distance between Liam and the host community and encourage the strengthening of home community ties in Ireland. His natural impulse is to remain with the security of the familiar home community strengthens his home culture values; this has consequences on the perception of his visual impairment adaptation to his sight loss, due to his fears of being stigmatized by his home community because of his visual impairment.

It is therefore significant that, despite attending the Centre, Liam has developed one of the weakest connections with the host community in this group of all the migrant service users in this study. The lack of development of weak ties (Granovetter 1973), in this case with the visually impaired community will have damaging effects for the individual's adaptation to their visual impairment, as the lack of development of strong connections within this specialized community will subsequently influence

their rehabilitation. It seems that Liam has developed a lack of trust in the host community as a whole and the only bonding connection he makes at the Centre is with a fellow migrant of African cultural origin, Sheila. He says:

I like to stay on my own; maybe I talk with Sheila that's all.

It is noteworthy that Sheila socializes indiscriminately with everyone at the Centre. She does not report racist experiences in the host community and has very strong 'weak ties' within the visually impaired community. A key finding is that the strengthening of Liam's home community network ties reaffirms home community values and this has powerful consequences for his adaptation to his visual impairment.

As discussed in Chapter 5, Liam's home culture has a poor perception of disability, and consequently does not value the potential societal contribution to be made by visually impaired individuals. His home country friends do not encourage him to attend the rehabilitative Centre:

They ask why you going there, you stay home, we can come by to see you.

This attitude in itself can be debilitating and is incompatible with the work being carried out at the Centre, where trainees are taught skills to lead independent and socially constructive lives. The participation in rehabilitative services shapes quality of life and encourages successful adaptation to visual impairment (Horowitz et al. 1994; Smart 2001). In practical terms, his home community's unsupportive attitude towards rehabilitation can lead to hazardous consequences as at the time of interview Liam had been refusing to participate with the mobility officer in long cane skills. The motivation for his absolute rejection of learning cane skills is rooted in the cultural

perception of disability in his home country, that there is no space in society so there is no reason to equip himself with the skills necessary for societal participation. In addition, most significantly he feared derision by members of his home community for carrying a visible symbol of blindness: the long white cane.

It is significant to note that several of the participants refer to the initial feelings of embarrassment in carrying the long cane as they would be easily recognisable as a visually impaired individual. In Liam's case his refusal to learn long cane skills is similarly connected to shame in being recognised as someone with a visual impairment. Nevertheless, as discussed in Chapter 5 it is most strongly rooted in the poor perception of people with impairments in his home culture. This group of people, his home community friends are the single group of friends he identifies in Ireland; as such they are his sole source of emotional support. He is anxious not to isolate himself from them, as he fears being left alone to cope with his progressive visual impairment in a country where he feels unwanted because of racist encounters.

A few weeks after the interview for this study, Liam was physically assaulted near his home. The attack left him badly injured and emotionally disturbed. At the time of the incident he was not carrying a long cane. It is hypothetical to suggest that if he had been carrying a white cane, he may not have tripped as he dismounted the bus and not drawn attention to himself. Indeed as the social model attitude towards disability is the predominant approach to disability in Ireland as seen in Chapter 1 he may not have been harmed due to his disability. His visual impairment may have protected him against the attack. Nevertheless, this is simply speculation.

During a later interview with a member of the management staff the issue of the attack on Liam was raised. The manager, Darragh disclosed how the attack impacted the whole group at the Training Centre, as he says:

> *It shook him um but it also really upset us as a group. It shook everyone in the training centre, staff and trainees, in general, work as a team.*

This team mentality is corroborated by staff and trainees; individuals such as Sheila consider the ties they have formed at the Centre as similar to family:

> *When we come into the training centre, we treat ourselves as one family…look after one another.*

This sentiment is echoed by Fionn, the mobility officer who says:

> *We are like one big family here, a team working together.*

The manager, Darragh recognises that a positive outcome from the attack on Liam was that it prompted trainees at the Centre, to support each other and unify the group:

> *One of the sort of nice things that came out of that, if there is a nice thing is, is that groups of trainees have started going into town together and that there was a bit of solidarity people …they felt good about it.*

Thus, the impact of the racist incident on the whole group was to strengthen ties. As the interview with Liam was held prior to the racist attack it is not possible to gauge whether the supportive response from the community at the Training Centre motivated him to strengthen ties or whether the racist attack from host members simply further weakened his potential to integrate. It is however encouraging that Liam reported the incident immediately to the Centre manager and after a week's absence returned to the Centre.

6.9. Loosening unsupportive home ties and strengthening supportive host ties: links with visual impairment services: facilitates adaptation

Of the 6 participants who report strengthening ties with their home community on arrival in the host country, namely, Aoife, Ciara, Eileen, Liam, Niamh and Seamus, 4 developed support from the host school system. They are Aoife, Ciara, Eileen and Niamh. Each of them with the exception of Ciara is still in the host school system and reports positive experiences as detailed in the earlier section in this chapter. Ciara attended school for two years and completed her Leaving Certificate examinations. Since leaving school she has not maintained contact with other students or staff but she recognises the support she received from some teachers while she attended. She relies heavily on the support from her sister and one home country friend.

Two of the service users, Liam and Seamus have developed no meaningful ties with the host community. Although both arrived in the host country alone, they have strengthened ties within the home community through their home religious communities. Liam is connected with host services for visually impaired; nonetheless his engagement with rehabilitation services remains low as he resists learning low cane skills and integrating with host community members. This has negative consequences for their adaptation process to living with their visual impairment in a foreign cultural environment, as they have distanced themselves from integrating into Irish society and in doing so reduced their rehabilitative opportunities.

6 of the participants report loosening ties with their home community. Each of them, namely, Deirdre, Gearoid, Grainne, Mary, Paddy and Sheila justify their choice to

distance themselves from their home community due to cultural perceptions of disability as detailed in Chapter 5. The motivation for loosening ties with the home community is associated with experiences of being perceived as a burden because of their disability. For example, in the earlier section of this chapter, on home community support, the service user Deirdre's experience of rejection by her home community friends was discussed. Owing to the nature of her medical condition she could not travel back to her home country, as she says:

> *I wanted to go back even for a short while but because of the type of medical condition… I couldn't go.*

Fortunately, Deirdre had developed strong ties within the host community in particular through a relationship with a host country partner. Both Deirdre and Grainne who also has an Irish partner no longer maintain contact with individuals from their respective home communities. Thus, they have not simply loosened ties with their home community but have severed them completely. This caused tremendous emotional strain especially at the crisis point of realization of visual impairment. Grainne continues to suffer psychologically from the lack of her older brother's support. The fact that support is denied from the most binding of social ties, of family is the most painful form of unsupportive behaviour (Lin et al. 1989). This study finds that severing these ties with their respective home communities is a crucial measure in both Grainne and Deirdre's overall adaptation process to their visual impairment and a further repercussion is to ensure more successful integration into Irish society.

Sheila has not experienced direct stigmatizing from her home community in Ireland but she carries the memory of her home country's cultural perception of disability with her as she loses her sight. In Ireland, Sheila distances herself from members of her home community and she is adamant that she will have no contact with them, as she says:

> *There is a community in Ireland…they always come together and celebrate independence day…but I'll tell you I've never been to one of them…I just don't want to get involved with them …I've never been to one, I never intend to go to one…like as I told you at the beginning, back home being blind, they always look at you and say look at her, she's blind, I always have that feeling, to say if I go there, what is she doing in Ireland, why did she come to Ireland, to do what, she can't work, she can't do anything, so why is she in Ireland, that's just a thought that comes to my mind …I think they will say, ah look at her, she can't do anything, she's blind.*

She chooses not to socialise with her home community as she fears they will judge her on the basis of her disability status as a blind person. In essence, that they will, as she has preserved the knowledge of the cultural perception of disability of her home country; so too her home community will have carried the belief system that a blind person cannot contribute to society. Moreover, she predicts that due to this belief they will question why she is living in Ireland if she cannot work. It seems she has employed this distancing tactic as a defence mechanism to protect the new identity she is developing for herself in her new home as a visually impaired migrant.

6.10. Chapter Conclusion

The potential of support systems to shape the pattern of adaptation is one of the most significant tools in adjustment to the complexities of living with visual impairment as a migrant. The most well adjusted individuals living in the host community and with

visual impairment have found a balance between reliance on home community support and the development of weak ties within the host environment. Developing weak ties for this study's participants involves connecting with host services for the visually impaired. An obstacle identified in accessing and developing strong relations within this special community are cultural perceptions of disability carried from the home country and reaffirmed through connections within the host country. However when connection with this environment is eventually made, the potential to relate and share their experience of visual impairment with similar others facilitates a powerful combination of instrumental, emotional and informational support. The strengthening, weakening or indeed severing of ties with home and host communities has consequences for the overall adaptation to both coping with sight loss and living in a new cultural environment. The impact depends on the closeness of the ties in relation to emotional, instrumental and informational support. In fact the loosening of ties within the home community, if they do not support an individual's changed status can facilitate deeper connections within the host community leading to more successful integration of a changed identity within a new home setting.

CHAPTER 7: Cultural Barriers to Accessing Services and Providing Services

Culture affects the way people approach health services, how they use them, what they expect from them, how and where they look for them and ultimately how they interact with the health service providers.(Minervino and Martin 2007: 190)

7.1. Introduction

The focus of this chapter is on cultural barriers to adaptation to visual impairment for a migrant in Ireland. In this study three key cultural barriers were identified (1) barrier of asylum seeker status, (2) language barrier and (3) barrier of cultural perception of gender.

Table 12 Core category Cultural Barriers and its related key categories

Cultural Barriers	
Accepting visual impairment	Home
Adaptation to visual impairment	Identity renegotiation
Adaptation to host environment	Language barrier- isolation
Age	Language barrier debilitates
Communication development	Language barrier to service provision
Coping with disability	Loosening home ties
Cultural perception of disability	Migrant- shame
Denying disability	Migration motivation
Diagnosis experience	Overcoming cultural barriers
Disability- shame	Peer support
Double outsiders	Quality of life
Economic climate	Race and racism
Education	Religion
Exclude or include disabled	Revealing disability
Expectations	Service provider role
Family	Service providers migrant issues
Feeling accepted	Stigma
Freak status	Strengthening host ties
Gender issues	Giving back

These three cultural barriers will be examined in relation to how each challenge both the service user in accessing and engaging with services for visually impaired and service providers' ability to provide these services. This chapter is informed by the third core category cultural barriers. This core category is connected to 40 key categories and they are presented in Table 5. Each of the headings in this chapter relates to the model presented in Figure 6 in Chapter 9 drawn from the grounded theory analysis in this study.

7.2. Consequences of Migrant Legal Status for adapting to visual impairment for migrant

Factors beyond that of bodily functional limitations are believed to create 'socio-cultural barriers' for an individual's adaptation to disability (Nagi 1991). An individual's specific migrant status may cause the first barrier to adapting to their visual impairment in Ireland. This is related to their migration motivation dependant on their migrant legal status as presented in Table 6 and discussed in Chapter 4.3.1. Migrant legal status is highlighted as a key determinant in individual's potential to integrate into Irish society and consequently hinder or facilitate adaptation to visual impairment. Four motivations for migration were identified by the service user participants in this study: 1) invited to work 2) seeking work 3) reuniting with family and 4) seeking asylum. Owing to their migrant status, as either EU citizens, invited professionals with working visas and refugee status participants in the first three groups were entitled to access services for the visually impaired in Ireland. Thus the way in which the Irish state categorised their migrant status permitted them to work facilitated their process of adaptation to visual impairment.

The case however, for asylum seeker is more complex, especially those with disabilities in this instance, visual impairment. Ciara and Seamus arrived in Ireland seeking asylum. Niamh's mother arrived in Ireland pregnant with her seeking asylum. Despite being born in Ireland, Niamh was not eligible to access services for visually impaired until her mother had achieved refugee status 3 years after arrival. As highlighted in Chapter 4 Ciara and Seamus's sight loss was progressing on arrival in Ireland. Neither Ciara nor Seamus spoke English.

Asylum seeker status is identified as a barrier to adaptation to visual impairment for a migrant in Ireland in this study for three reasons: (1) prioritising coping with an asylum application instead of a disability (2) as owing to their asylum seeker status such visually impaired migrants are not eligible to access Irish social services (3) prolonged waiting time for asylum case approval negative impact on migrant integration

In order to remain in Ireland it is logical that a migrant should prioritise his/her asylum application; however, in the meantime if appropriate professional rehabilitation is postponed or owing to asylum seeker status denied the process of adaptation to visual impairment will suffer. Nevertheless, unless an individual has received refugee status he or she will not be entitled to access support to help cope with sight loss. Community resource worker Clodagh appreciates that migrants who are coping with sight loss while attempting to resolve their entitlement issues related to their migrant status experience an additional burden:

> *I think that's one of the big problems for people because they have so much on their plate, in terms of dealing with sight loss and other issues around, they're trying to gain status, it depends how the people come to the country.*

This interview extract draws attention to the issue of the status situation of the migrant on arrival in Ireland. In the case where the migrant has been invited to work in Ireland their situation may be much more manageable, even though the individual may be coping with sight loss, they do not have the added anxiety of applying for asylum. Irish migration laws do not allow for asylum seekers to claim benefits or access as in this case, services for disability rehabilitation and training. Therefore, the asylum seeker who is coping with sight loss must often manage without the support of disability professionals.

Niamh's mother was pregnant with Niamh when she arrived alone in Ireland. In her home country in West Africa due to violent family disputes she feared for her and her unborn baby's safety. Unfortunately at that time her husband did not have the economic resources to accompany her. Immediately on arrival she applied for asylum status. Two months after arriving, she gave birth to Niamh, who was born with a severe visually impairment. Coping alone with her visually impaired child in a foreign country was hard. These challenging circumstances were further complicated by her asylum status. Linking in with services for visual impairment took second place to her focus on securing her husband's successful asylum application in Ireland:

> *It was so tough at the start with Niamh, alone in a foreign country, I spend my time trying to help my husband come over, don't know what to do about Niamh and her blindness, wait til he is with us.*

Service user Seamus at the time of interview had been living in Ireland six years. He fled his home country as his personal safely was at risk due to political unrest. His application at the time of interview had just been approved. While he waited for his refugee status approval he relied on support from his religious community in Ireland:

> *My mosque help me, I don't know what to do without them, cos I no see good and I waiting to hear from system here about my application.*

The mosque and his co-nationals supported him during this period when he was ineligible for Irish social support.

Ciara also arrived in Ireland as an asylum seeker and she too experienced a prolonged wait for application approval. Owing to her asylum seeker status she could not access social support in the host country so instead she attended a mainstream school despite being unable to see properly:

> *Hard because eh with my vision… I couldn't go to I went to a normal school…but I should go to a, a…a special school but because I was waiting for the, the what's that?....my appeal in the Minister of Justice em I was waiting for the response, whether I could eh…stay in Ireland…This took I think it was, I got the response in one year now, one year this January…I think six years… I couldn't do anything…for the education like, for college um work, em, stuff like that…I just wait ah…You have to wait we are still working on your case bla bla…*

Ciara was required to wait six years before she could access services for the visually impaired in Ireland. During this time her sight deteriorated and she was denied the opportunity to avail of essential rehabilitative support such as mobility training.

> *Woo when I start mobility training so hard you know and I know I should be doing this before now but couldn't.*

While she waited to receive a response on her application for asylum she became frustrated because her visual impairment needs were not catered for at a 'normal school'. However she was powerless in the system to decide when or if she will be deemed eligible for migrant status and so gain access to the Irish social services:

> *Only you can do is wait be eh patient it is not in your hands it is eh in the hands of the government.*

Ciara's advice to other asylum seekers, especially those with health problems is to develop patience, as the decision lies outside their control. Manager Darragh confirmed that the NCBI cannot extend rehabilitative support to asylum seekers:

> *We are technically not allowed to offer assistance to people who come to us and have you no eh you know no social security eh what's it called? P.P.S number.*

Thus asylum seeker status disarms individual's rights to access services for the visually impaired in Ireland. Currently, the Irish Citizen's Information Bureau states that asylum seekers are entitled to welfare and health care support while their application is being processed (ICIB 2011). Even so, entitlement does not extend to accessing special needs support. As a result of asylum seeker status the vital course of rehabilitation will be delayed and subsequent adaptation to their visual impairment hindered as the visually impaired asylum seeker is sidelined and socially excluded in Irish society. Ciara worn down by the waiting process says she rarely left the house after she left secondary school. Under Irish asylum regulations she could not apply for a job or third level education most critically she could not access services for visually impaired in Ireland. As her sight loss progressed she became more anxious for her safety as she gradually became less able to travel independently.

I prefer to stay at home it's safer eh where would I go eh you know cos I don't see good maybe have accident

This study demonstrates that visually impaired migrants who are awaiting asylum approval in Ireland are a particularly vulnerable group in the Irish immigration system. The legislative restrictions imposed by the Irish state on asylum seekers hinders not only the potential to integrate into Irish society but in so doing crucially obstructs for asylum seekers with specific health concerns, in the case of this specific study, visual impairment the right to vital rehabilitative support services.

7.3. Language barrier hinders connection with services for visual impairment: hinders adaptation

One of the key factors contributing to successful adaptation for migrants to new cultural environments is proficiency in the host country's language (Kim 1998; 2001). However, when language presents a barrier to communication a migrant may feel isolated and excluded from society. Moreover, when a migrant has a disability the potential of hindering their adaptation is compounded (Albrecht et al. 2009).

The language barrier is identified as one of the most critical barriers in this study in relation to accessing health care specifically rehabilitative services for visually impaired members of society (Minervero and Martin 2007). In relation to the language barrier this chapter is interested in understanding how competency in the host language can help or hinder first and foremost a migrant's potential to adapt to their visual impairment in Ireland. Secondly, the migrant's competency in the host language is addressed in relation to how service providers can enable their rehabilitation. The key finding is that the stronger the migrant's English language

skills are, the more likely they are (1) to connect with services for visually impaired and (2) the sooner they are to connect. Through connecting and engaging with services for the visually impaired their potential of successful adaptation to their visual impairment is enabled.

9 of the service user participants report lack of competency in the English language prior to arrival in Ireland as outlined in Table 6 in Chapter 4. Each of these participants acknowledges how the inability to communicate in the host language hindered their adaptation or in the case of parent participants that of their child's to their disability in Ireland. The language barrier is identified as causing shame, distress, isolation, lack of awareness about services and increased vulnerability for visually impaired migrants. Consequently, adaptation to their visual impairment is hindered. In addition, the language barrier is identified as impeding service providers' ability to help migrant service users, in particular for mobility officers whose role relies on clear communication.

7.3.1. Language barrier causes shame: hinders adaptation

A concept associated with the inability to communicate sufficiently in English is the feeling of shame. The shame associated with weak English language skills then acts as a barrier to communicating with the host community; consequently, accessing information about host services for visual impairment is hindered. Two participants identify shame associated with their poor English language skills preventing them create connections with the host community. Sean says:

> *I was bit ashamed to meet people at that time because I found it very hard to communicate with them because I haven't got that strong English…I was afraid to speak with them.*

Sean's lack of proficiency in English embarrasses him and as a result he is afraid to communicate with Irish people which blocks his connection with services for visually impaired:

> *It take me a long time to know about this place, NCBI, I think because my English no so good, I afraid to ask, find out.*

Sean is an affable individual and through contact with neighbours in the community he persisted with learning English:

> *I found it very very nice the way when you ask somebody 'could you give me a hand'…before got that feeling of kind of frustration how I going to cope here in Ireland because you know the language as well as the weather, so slowly, slowly I got pick up myself and go talk with people, the neighbours they help me.*

Ciara also felt ashamed about her lack of ability speaking English:

> *No English zero zero…not a word…Wooa my first day in school was like run away from the class so embarrassed…I should be in special school but I didn't know about it couldn't ask.*

Similarly to Sean, Ciara attributes her setback in connecting with services for the visually impaired as being due to a combination of her weak English language skills and her asylum status and she says:

> *I was lost…it was really hard but my teacher he helped me, he helped me a lot.*

Following help from her teachers at the mainstream school she improved her language skills.

Negotiating a visually impaired child's education is a challenge which may be complicated when there is a language barrier. Owing to shame felt about their poor English language skills, Paddy's parents initially chose not to attend school parent teacher meetings:

> *We don't want to go to these meetings cos we can't understand, what's the point?*

The barrier posed by language hinders the potential for Paddy's parents to gain valuable insights into their son's progress at school which in turn may enable them to further assist him in managing his disability.

The school detected their embarrassment about not speaking English fluently and that this was dissuading Paddy's parents from attending meetings; the school organized for an interpreter to be present at large meetings and now Paddy's parents, encouraged by efforts to include them, feel comfortable to attend smaller meetings independently:

> *I know, say it's a big meeting now the school will get an interpreter for us but like if only a small one we'll go ourselves, it's good for Paddy that we go.*

In collaboration with Paddy's special needs school his parents have developed confidence to resolve language difficulties and consequently this positively influence his adaptation to his disability as well as facilitating the entire family's integration into the local community.

7.3.2. Language barrier causes distress: hinders adaptation

The lack of host language skills and incapacity to understand can create feelings of helplessness among migrants which subsequently amplify distressed feelings of anxiety (Kim 2001; Berry 2004). This study demonstrates that the potential for distress is compounded when a migrant has a visual impairment and is simultaneously struggling with learning a new language in a foreign environment. Additionally, visually impaired migrants are often also learning Braille and cannot communicate their needs and seek assistance as they cope with this dual load. Cillian remembers how difficult it was for him to cope in primary school, when he first arrived in Ireland:

> *In eh school yea I couldn't communicate with anyone didn't know any English…To be honest it was hell. Couldn't speak ah awful. It was tough…learning English and Braille with it definitely a lot to cope with.*

Despite finding it difficult to adjust to his visual impairment while learning English and Braille, Cillian recognises it would have been more challenging to learn English in secondary school:

> *I wouldn't like to learn English in secondary school, to be honest, there's loads of people looking at you.*

Similarly, Aoife's mother highlights the distress for her daughter adjusting to her visual impairment in Ireland when she started school and could not speak English:

> *When she first went to school she was very shy, don't talking because it was different language, she don't play with children, every day she cry, hard cos she no see well too.*

It is noteworthy; however, that Cillian's smooth connection with the school for visually impaired when he arrived in Ireland was due to his father's strong English language skills enabling him to research his son's education options prior to migration. Unlike Cillian, Aoife's mother did not speak English and had no prior knowledge of Irish services for the visually impaired. Thus, her process of connecting with the services was not immediate, as at first Aoife attended a mainstream school, as she was unaware of the school for visually impaired children.

Fear associated with lack of language ability combined with visual impairment can aggravate an already stressful situation. Grainne recognises the fear she felt when she first arrived simultaneously coping with her sight loss and inability to communicate:

> *When you don't speak the lingo it's quite frightening a person coping with your eyesight, you know, all those years when I first came here, I mean, I , my English wasn't very good, couldn't go looking for information, cos I wouldn't understand every single thing, you know.*

The language barrier combined with her visual impairment is the basis for her fear and prevents her seeking rehabilitative assistance in an unfamiliar environment. As a result her sight deteriorates. The distress caused by the lack of English language skills for these participants is more acute as the social barrier in communication combined with the physical barrier of disability work in concert to generate relentless isolation, often resulting in the progression of further sight loss.

7.3.3. Language barrier hinders awareness about services

Owing to a lack of an ability to communicate with the host community a migrant may not be able to access information; moreover, it is even more challenging when the

person is experiencing sight loss. For example, Grainne identifies the language barrier as an obstacle for other members from her cultural community in connecting with services for visually impaired in Ireland:

> *I actually feel that the reason, why you are not getting a lot of people from my country is, you know, first, because they don't know the lingo, second they don't know anything about you, they thought you know they might have to pay and things like that it might cost them and things like that.*

Grainne makes two points here. Firstly, to begin with the inability to speak English prevents this cultural group finding out about the service and secondly, owing to this language barrier, they are uninformed about whether the service is costly or not. There is an underlying assumption that it is not a free service, which is in fact untrue, but because they cannot speak English they do not clarify this; hence, they do not connect with services. The inability to communicate in English poses barriers to access and use of health services and may deter outreach to medical and public health assistance (Jang et al. 1998). Grainne identifies a particular woman from her country with a visual impairment who does not speak English:

> *Like I know somebody who has a mother, whose eyesight is bad and she wouldn't go into the NCBI for help because, first and foremost, there is a language problem…she doesn't speak a word of English, so she even if she look for help from you, you all wouldn't be able to tell her what to do or translate her language you know what I mean.*

Community resource worker Tara supports this view and identifies the language barrier as the distinguishing feature when working with migrants, as opposed to Irish service users:

> *There is a difference because what happens like first the language barrier ok, so they have no access, lack of knowledge about the system, how it works, where to go, how to get things going.*

Furthermore, Tara identifies the issue of informing people about services when there is a language barrier:

> *We send leaflets to all the GP centres, the leaflets are available but if you have a language barrier you not able to access those information, you know, so even if the leaflet is there you don't know what it is.*

Thus, due to the language barrier, migrants with a visual impairment may not be aware that services for the visually impaired exist in their new environment therefore they do not access them or if they do succeed in making contact, it is usually after a considerable length of time. Mobility officer Sorcha has experienced cases where migrant service users have been coping with sight loss alone, for an extended length of time without knowledge of the service:

> *I know a lot of people are saying I'm blind since 10 years and I've never heard of the NCBI…you know I met people who are saying it took them a long time to hear about the NCBI…most of them newcomers to Ireland don't speak English…that's sad.*

As a result of not accessing the service or delay in accessing service due to language barrier the potential for the migrant to successfully adapt to their visual impairment is significantly reduced.

7.3.4. Language barrier causes isolation: hinders adaptation

Difficulty in English language communication is a significant factor in frustrating interaction with members of the host society and so hinders the process of cross-cultural adaptation (Kim 1988; 2001). Accordingly, migrants with a language barrier

may find themselves socially isolated within their new environment as interaction with members of the host community is impeded (Kim 1988; 2001). Social isolation is a critical factor in hindering a migrant's adaptation to their visual impairment as such problems in communicating in English can cause separation (Berry 1980; Berry et al. 2002), as migrants may choose to avoid contact with members of the host country, feeling ashamed of their weak language skills and helpless to understand an Irish person. For example, in this study Liam attributes his feelings of isolation and consequent lack of knowledge about services for the visually impaired to his difficulty in communicating with Irish people:

> *I found it very hard when I come over to Ireland to speak or to reflect um, I wish to go somewhere else…feel alone…don't know anything about this NCBI for a long time.*

Due to the language barrier, Liam feels alienated which delays finding out about services for the visually impaired in Ireland.

Community resource worker Clodagh acknowledges that a language barrier presents migrant service users with an added challenge in the process of adapting to their visual impairment, as the inability to communicate in English can cause them to experience isolation:

> *I think it is particularly difficult for people from other countries, who don't have that maybe backup… they are isolated, if there is a language barrier.*

As a result of the barrier in communication posed by lack of proficiency in English, migrants may remain within their own home community. Within this environment they can take advantage of institutional completeness (Breton 1964) that does not

involve English language skills, for example attend shared religious services. However, unlike in Britain where there are, for example, organizations that cater for specific ethnic groups, such as, the Asian Blind Association, all service provisions for visually impaired are run by Irish service providers. Thus, in order to access these services migrants must initiate contact with the host community. However, language difficulties can result in migrants deciding to ignore their problems (Carballo and Siem 2006). For that reason, the isolation caused by the language barrier will critically impact upon a migrant's adaptation to their visual impairment, if they avoid contact with the host services for visual impairment.

7.3.5. Language barrier increases vulnerability: hinders adaptation

The inability for a person to express themselves in the host language can lead to feelings of vulnerability (Kim, 1998; 2001). In the case of a visually impaired migrant who is struggling to cope with sight loss, the added anxiety of the language barrier disadvantages their process of adaptation to their disability, so feelings of vulnerability may intensify. The key concern for enabling a person with visual impairment to adjust to their sight loss is safety. Community resource worker Clodagh recognises that the issue of safety is critical regardless of a service user's nationality:

> *The issue around personal safety and being identifiable as a vulnerable target is a big issue across the board for everyone who has a visual impairment.*

Nevertheless, owing to the language barrier, Clodagh considers migrant service users to be especially vulnerable:

> *But particularly if you're a non national you know, who is additionally identifiable, you know, got language barrier and that's a big issue for them…there are people in that situation and it must be horrific for them to have to live with that level of stress.*

Feelings of vulnerability deepen due to the language barrier causing significant stress and debilitating confidence to reach out for assistance. As a result migrants with a visual impairment may avoid contact with services for visually impaired which will reduce successful adaptation outcomes.

Two of the service users identify the inability to communicate in English as a kind of disability in itself. Deirdre says:

> *Two times disabled that way cos you have this language community barrier and your disabled liveliness barrier also ah it makes your life more difficult.*

This phrase is poignant as it captures the concept of coping with the language barrier as a disability in itself; thus, coupled with the migrant's visual impairment, disability may be experienced on two counts. It is significant to note that Deirdre had prior knowledge of English on arrival; therefore, she is speculating about the difficulty posed by a language barrier as it is not an issue for her. Similarly, Sheila echoes this idea and also specifies the particular challenge of visual impairment for someone who does not speak English:

> *They've never ever spoken English and when they come in, they find it very, very difficult, first of all, they have to concentrate on their blindness, second, they have to mind how am I going to make friends, cos by making friends you have to know their language, there is no way you are going to communicate with somebody by using your hands when you can't see, you have to know their language.*

Sheila highlights the particular challenge for a person with a visual impairment who does not speak English which is specific to their inability to see, as unlike a sighted migrant they cannot rely on sign language and reading facial gestures to communicate with the local community. Sheila has developed a strong sympathetic feeling towards her visually impaired peers who struggle with increased vulnerability due to language difficulties while at the same time coping with sight loss.

7.3.6. Language barrier impedes mobility training: hinders adaptation

The most central task in mobility training involves teaching a visually impaired person to orientate themselves to travel independently using a long white cane. The nature of the role requires the mobility officer to work in close physical proximity with the service user, in order to ensure safety and emotional and practical support.

Clear verbal communication is essential to successfully fulfil this task as non-verbal communication is incomprehensible (Fitzgerald and Parkes 1998). The task is complicated when a service user and mobility officer do not share the same language. Mobility officer Fionn recognises that language difficulties impede critical communication:

> *When I say stop, I don't mean walk slowly, I really mean stop…if our language communication, there is a problem…but it is maybe, you know, how long or how quicker it takes someone to decode, maybe what you have just said, might make things a little bit of challenging…in mobility clarity is a must.*

Furthermore, the language barrier increases the potential for misunderstanding essential mobility skills. Fionn identifies this as a key issue:

> *If there is a misunderstanding hopefully, it wouldn't end up in catastrophic things, it could lead to one day saying, "Why are you using the cane like that?" "Oh you told me to hold it like that!" But possibly that's not what I said, probably how you received it…could be dangerous.*

The inability for clear communication between service user and provider can produce hazardous outcomes for the visually impaired migrant. As a result the process of adaptation to their visual impairment may be influenced by slow growth and development of confidence to travel independently.

7.3.7. Language barrier drives service providers to provide extra language support

The issue of service providers for visually impaired, acting as translators and interpreters during the interviews was raised with the service providers themselves. All of the 6 service providers interviewed identified the lack of proficiency in English as the principal barrier to enabling migrant service users' to successfully adapt to their visual impairment. Community resource worker, Clodagh identifies the struggle for visually impaired migrants who have a language barrier to manage official procedures:

> *When it comes to dealing with bureaucracy, official paperwork, you don't have some handle on the manual or if someone in your family doesn't have English, it's a big disadvantage, em, it's hard enough for ourselves to deal with paperwork in the normal run of our lives, you know, it's quite daunting and challenging you know, when you have difficulty around the language, you know, it's hard and with the sight loss.*

She recognises that bureaucratic matters are challenging even for sighted people but for an individual with a visual impairment and an inability to communicate in English it is much more complex.

Despite the role of a community resource worker not including translation or interpreting training or skills, given the nature of the close relationship, often built between service user and provider, Clodagh admits that she often feels compelled to perform this duty too:

> *I suppose I'm seen as someone, who can perhaps help fill out the forms, get the information make the applications, so em we kind of help with the language end of things, you know which is not necessarily, we're not here as translators, that's not necessarily our role but em it is a supportive thing for our clients service users…trying to get to the the information you know, when someone doesn't really understand or there is nobody in the family who can interpret for them.*

Clodagh realizes that providing a translation service is not part of her job; however, when there is no one else available to assist the migrant service user she mediates as a means of support for her client.

Community resource worker Tara has been referred certain service users as they share the same mother tongue:

> *She was referred to me from another colleague, from a different area but because of the language she came to me.*

Similarly Tara echoes her colleague Clodagh's experience of acting as an interpreter for migrant service users:

> *I was going to with the families to the hospitals for the appointments which had nothing to do with the visual impairment…I was trying to get the hospital maybe to get the person I didn't like, I didn't feel competent enough to be translating medical things I wouldn't have that language skills to do that comfortably so the family was aware that I was kinda doing that on my own level it's not professional…I was trying to get hospital to provide a translation and interpreter, which they supposed to do…if we gave enough notice it worked but another time a family rang*

> *and said there was no one there because they forgot or whatever…it's frustrating.*

Due to the language barrier migrant service users can rely heavily on their community resource workers to facilitate communication even when it is not directly related to their visual impairment. This can hinder adaptation to visual impairment for a migrant as it reduces the time spent on issues related to the migrant's visual impairment and creates sometimes unhealthy dependence on the service provider. It is also important to recognise that service providers who are identifiable as being knowledgeable in other languages and cultures are not exploited.

As Chamba et al. (1998) and Ahmed et al. (1998) reveal the 'specialist worker' approach may result in overloading and the 'dumping' of all minority cases on this provider. Service providers who work with migrants with a language barrier may experience increased levels of stress (Bernard et al. 2006). For this reason, combined with the lack of resources, Irish services for the visually impaired may be reluctant to engage with migrants. The manager Darragh identifies the issue of the language barrier as a stumbling block in the willingness to provide services to migrants:

> *I probably say for instance his first language was Japanese, I don't think would could have catered for that and I would have been a lot more reluctant to take him into the service.*

Darragh is referring to an incident where a non-English speaking visually impaired migrant contacted the services. As a member of the rehabilitation team coincidentally spoke the migrant's first language this individual was accepted at the Centre. Darragh gives the example of Japanese, as nobody at the Centre is familiar with this language, he would be less willing to offer assistance. Thus, the language barrier would hinder

adaptation to visual impairment from both migrant service user and service provider perspectives.

7.3.8. Reducing language barrier: facilitate adaptation

In order to reduce the language barrier which can hinder a migrant's adaptation to visual impairment and the service provider's ability to facilitate this process the onus is on both service user and provider to create smoother communication.

Darragh identifies the need for both service user and provider to improve their communication skills:

> *We do need to work on our listening skills, just as much as they have to work on their English language skills.*

Service user, Deirdre recognises that forming connections within the host community as a means of facilitating her adaptation process:

> *I prefer to get more Irish people and to speak in English so it will make my adaptation easier.*

The potential for successful adaptation to visual impairment is increased through connection with the host community, as exposure to English facilitates learning the language and connecting and successfully engaging with services for the visually impaired in Ireland (Lee and Miller 2002).

Reliance on inexperienced individuals who are already professionally overstretched in their own field of expertise can cause distress to service providers which may hamper offering the optimum level of specialised care and thus hinder adaptation to visual impairment for migrant service users. Mobility officer Sorcha recognises the need to

link in with professional language support as that is not the role of the rehabilitative centre:

> *We are a rehabilitation centre, not an English school but linking in with other training centres would be good.*

Ideally in cases where a service user cannot speak English a professionally qualified and trained translator or interpreter would bridge the language barrier. However, in reality, particularly in economically challenging times, this may be perceived as a luxury service. Mobility officer Fionn recognises the need for culturally competent services; however he is also acutely aware that this, may, in the current global recession not be possible:

> *Need to provide targeted services… but interpreters we might need everyday…but in the credit crunch it might not be feasible.*

Fionn asserts a valid point that owing to financial restraints interpreters may not be an option, in which case as Darragh suggests the responsibility must remain with both service user and provider to ensure that communication flows so that adaptation to visual impairment is facilitated as best as possible. Currently, the NCBI does not have a field on their service user database that provides information on the individual's first language. However, this is identified as being a useful tool to develop better understanding between service user and provider as Sorcha says;

> *There's no mention of language no none…I suppose if a person needed help with their language to know in advance would be helpful. Eh yes absolutely, now that I think of it would have helped me with the case of that migrant trainee…Absolutely.*

Thus, in order to facilitate adaptation to visual impairment, prior knowledge of migrant service users' English language skills and first language could be useful for service providers so that they could be linked in with appropriate assistance and alleviate potential stress and linguistic misunderstandings for both service user and provider.

7.4. Cultural perception of gender: causes barrier to providing services

4 of the service providers in this study identify cultural perceptions of gender creating a barrier to providing service to migrants. This refers to where either the gender of the service user or service provider poses a challenge to culturally perceived appropriate gender conduct. Allen et al. (2006: 206) recognise that:

> women may confront challenges related to quite different gender role norms in their new cultural setting as compared to their home culture.

Considering that one of the chief services provided for visually impaired is mobility training, which involves working in close physical contact with the service user, the potential for issues associated with gender are magnified.

Two community resource workers express the difficulties they encountered working with service users whose cultural perception of gender inhibited service provision. Clodagh recognises gender poses practical difficulties in providing services to migrant service users:

> *In terms of difficulties that sight loss presents you for migrants could say…the difficulties are practical functional and em I think that the*

> *challenges for someone like me or my work would be around gender issues.*

The practical difficulty Clodagh observes for migrant service users is their cultural perception of gender which disapproves of close contact between the sexes, which in turn poses a barrier to service provision by a female provider:

> *Gender issues about what you, who you can associate with you…depending on their religious background, me, being a woman em, where people are coming from culturally or religiously, em and their view of women and because my job is very it's quite hands on, anybody working with people with visual impairment, it is hands on...the very nature of it is.*

Ponchillia and Ponchillia (1996: 79) recognise the challenge posed for service providers working with visually impaired migrants who have distinct cultural perception of gender:

> Traditional male and female roles differ among cultural groups, and these variations if unknown or ignored by the rehabilitation teacher, could complicate the relationship between teacher and learner. For example, some people, such as women from the Middle East, might be uncomfortable touching or being touched by a member of the opposite sex during a lesson on sighted guide technique.

Clodagh admits to having direct experience of service users not engaging with her due to their cultural perception of gender conduct:

> *I've had cases where people don't put themselves forward, they don't take up the service that is offered because for those issues, em, it, it isn't and it's nothing to do with us as female mobility instructors, as such, it's eh deeper than that, people link their own wives or sisters you know, so it's nothing to do with us providing the service, there are other issues that can't be addressed because it's deeper culturally, so people who might be more independent and avail of living skills or mobility em training cannot because of those issues.*

Based on deeply embedded cultural belief systems engagement with critical services for visual impairment is impeded. Thus, in such cases the overall potential for effective learning of independent life skills and adaptation to visual impairment is significantly reduced. This can be a frustrating situation for service providers as they feel it is beyond their control to enable people to engage with them as the issues are strongly rooted.

Tara has also experienced issues related to gender specifically associated with teaching long cane skills to migrant service users:

> *What was interesting there was like people from Muslim community and if the man had a vision impairment, you had to be very careful how you deal with those issues you know… if you teach the person with visual impairment or if you teach them how to use the cane, sometimes it requires physical contact…You know to be able to kind of show them…sometimes you need to hold their hand on the cane, to make sure they kind of follow you, the movement of the cane, so those issues, it was kind of, I learnt a lot.*

Both Clodagh and Tara were cautious when discussing this topic during the interviews. Clearly they felt uneasy during these sensitive exchanges with their migrant service users related to the distinct cultural perceptions of gender. Neither community resource worker had, at the time of the interview, received professional training in cultural awareness. Therefore, when issues related to gender arose they dealt with them in the moment, to the best of their ability, drawing on their own personal experiences.

Cultural perception of appropriate gender conduct was also a barrier for mobility officers Sorcha and Fionn performing their rehabilitative tasks. The impact is to cause

a setback to service provision and ultimately hinder adaptation to visual impairment. Sorcha says:

> *No way he will work with me, he's a man and I'm a woman, not right where he comes from, he won't listen to me, so anyway I try find someone else…he has to wait, a long wait.*

Fionn encounters the same issue when assigned young girls as their community's cultural perception of gender appropriate behaviour forbids physical contact between strangers of the opposite sex:

> *Working with young Muslim girls and at the end we had to cancel the service because they, that not how things are in the community, I was as a man she was a girl…they want a female…but the resources could not be there and they was aware of that so it means we have to go back to the waiting list, you know, somebody else closes another case.*

These examples reveal the profound impact of cultural perception of gender to act as a barrier to providing services for visually impaired. It also raises questions in relation to the power of culture taking precedence over visual impairment.

7.5. Mutual cultural awareness: facilitates adaptation to visual impairment in new culture

Acculturation is the perceived goal in intercultural adaptation; it is a bidirectional process which involves two groups mutually influencing one another (Berry 2006). Encouraging cultural sensitivity and awareness of different cultural attitudes among service providers and users can facilitate the adaptation to visual impairment for migrants. Community resource worker Clodagh recognises the need for sensitivity when working with migrants:

> *I'm always very sensitive and aware of those issues before I go out and try to be as respectful…because I would have lived elsewhere and I would have mixed with people from different communities… it is about awareness em how we understand other people how they live their customs you know so I would have been aware and I would have used my own experience and knowledge and anything I don't know I'll always ask them.*

Having experience living in other cultures has positively impacted Clodagh's recognition to endeavour to respect difference. Moreover, when she is unsure of how to behave with service users from distinct cultural backgrounds she asks them directly. The result is to create the potential for the migrant service user to engage with the services in a manner which is culturally appropriate for them.

It is noteworthy that Clodagh is quite exceptional in her knowledge of distinct cultures. For this reason, her colleagues often consult with her for her 'expert' advice on dealing with cultural issues. Tara mentions that when she was unsure of how to behave with a migrant service user who presented a challenge in relation to gender issues, she asked Clodagh's opinion:

> *Umm at first thought this is a difficult case, not sure how to deal with it new to me so I spoke with someone, you know I know she knows a lot about these things.*

Sharing information and knowledge between service providers is a great support; however, it is important that the perceived 'expert' is not overloaded, nor that their opinion is never challenged. Another mobility officer Sorcha recognises the need to firstly be informed prior to meeting service users about cultural issues:

> *Need to be aware of these things; before you go to their house…It would be valuable to include cultural background.*

For instance, in the case of cultural perception of gender acting as a barrier to service provision, the availability of prior knowledge of a preference in gender of provider could be organized in advance; the issue of cancelling service and returning to the waiting list would be avoided, so facilitating a smoother adaptation process to visual impairment for a migrant.

None of the service providers interviewed have received cultural awareness training. Sorcha recognises that it would have been helpful if she had:

> *I would have loved some cultural training, I would have loved that…You know sometimes we talk about that stuff or changes needed but not followed up, you understand what I mean.*

Sorcha acknowledges that the topic of cultural training has arisen; however, at the time of interview it was not prioritised.

7.6. Chapter Conclusion

This chapter has presented the study's findings in relation to three cultural barriers which may hinder a migrant's adaptation to visual impairment and a service provider's ability to provide services for them. The first barrier which blocks the path towards adaptation to disability for a migrant is their migrant status, specifically whether they are asylum seekers. This factor is identified as a barrier as during the asylum application process asylum seekers are not entitled to access services for the visually impaired; rehabilitative training is denied, reducing their potential for successful adaptation to their disability. The second factor that hinders adaptation to visual impairment for a migrant in this study is the language barrier. Four concepts associated with the language barrier for migrant service users were identified; it

impedes shame, distress, lack of service awareness and increased vulnerability. Two concepts associated with the language barrier for service providers were identified; impedes mobility training and drives service providers to provide language support. Improving language skills and listening skills for both service user and provider and linking in with professional language support services were identified as factors which would reduce the language barrier and, consequently, enable improved adaptation to visual impairment for migrant service users.

Cultural perception of gender was identified as the third barrier in accessing and providing services for visually impaired migrants. Due to perceived culturally inappropriate physical proximity between genders, service providers report that migrants choose not to engage with rehabilitative support where close contact between service user and provider, for example, in long cane skills is intrinsic to the training experience. In answer to the challenges posed by working with service users from distinct cultural backgrounds, the development of cultural sensitivity and awareness through sharing knowledge, attending professional cultural training workshops and being permitted access to cultural and linguistic service user information, prior to commencing training, were identified as positive measures to ensure that visually impaired migrants can access the services and service providers can engage with them to facilitate successful adaptation to visual impairment in Ireland.

CHAPTER 8: Intercultural Theories and Studies Relevant for this Study

Diversity is a fact of life, whether it is the 'spice of life' or a significant irritant to people, is the fundamental psychological, social, cultural and political issue of our times. *(Berry 2000: 1)*

8.1. Introduction: Defining Culture

> A society's culture consists of whatever it is one has to know or believes in order to operate in a manner acceptable to its members. Culture, being what people have to learn as distinct from their biological heritage, must consist of the end product learning; knowledge, in a most general, if relative, sense of the term. By this definition, we should note that culture is not a material phenomenon; it does not consist of things, people or behaviour, or emotions. It is rather an organization of these things. It is the forms of things that people have in mind, their models of perceiving, relating, and otherwise interpreting. (Goodenough 1964: 36)

Goodenough's (1964) definition of culture emphasises culture being shared learning which is compatible with this study. In relation to disability, perceived acceptable behaviour and attitudes are revealed to vary cross-culturally. The models of perceiving disability discussed in the review of disability literature in Chapter 2 are thus influenced by the shared learning of culture. In this way, this definition of culture implies that culture can be learnt, as newcomers to Ireland can learn new cultural practices, as for example the visually impaired migrants and in turn Irish people, as represented by the services providers for visual impairment in this study.

The focus of this chapter is to present the literature in the field of Intercultural Studies that is considered most relevant to the current study which demonstrates that disability models do not pay attention to intercultural issues nor do intercultural models pay attention to disability issues. Key intercultural theories are reviewed in connection with their significance for understanding the central categories in the investigation

into the lived experiences of the visually impaired migrants and their service providers in Ireland. In Chapter 9 the study's findings are interpreted in relation to these selected theories.

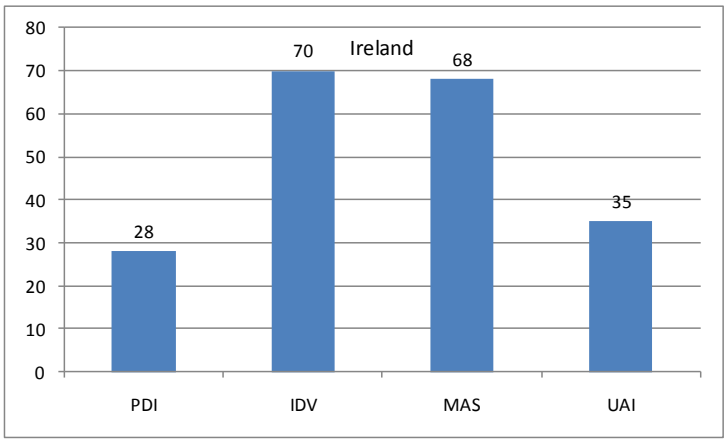
The theories are presented in three divisions of the cross cultural experience; universal, societal and individual. There are four universal; Hofstede's (2001) cultural dimensions; Berry's (2006) six cultural variables, culture shock theory (Oberg 1960; Kim 1988; 2001) and (Gudykunst 1988; 1993; 1998).Three societal intercultural theories are presented; Push and Pull Model of Migration; theory of institutional completeness (Breton 1964) and the theory of strength of weak ties (Granovetter 1974). The final group encompasses theories related to individual cross cultural experience. They are; culture learning approach (Ward and Searle 1991); expectancy violations theory (Burgoon 1978); the developmental model of intercultural sensitivity (Bennett 1986; 1993); social identity theory (Tajfel 1978); acculturation strategies (Berry 1980; 1997; 2008). The final two theories are related to cross-cultural adaptation model which link the individual with the society; ethnic group strength (1998; 2001) and host language acquisition. These theories are presented in the context of the case of a migrant's journey to adapt to their visual impairment in Ireland.

8.2. Universal Intercultural Theories: Hofstede's Cultural Dimensions

Benedict (1887-1948) and Mead (1901-1978) universalised the concept of cultural dimensions in the early 20th century. The concept is based on the notion that despite encountering comparable challenges, each cultural group distinguishes itself from

others in the approach in which it deals with their social dilemmas (Hofstede 2001). For Hofstede (2001), an aspect of a culture is a dimension that is measurable in relation to other cultures and his own research yielded cultural differences across four measurable dimensions: Power Distance, Uncertainty Avoidance, Individualism /Collectivism and Masculinity/Femininity (1980; 2001) across national cultures.

Figure 4 Chart of Ireland's Cultural Dimensions Scores



Power Distance: The cultural dimension power distance relates to "the different solutions to the basic problem of human inequality" (Hofstede 2001: 29). For example, in a high power distance culture, rehabilitation services for visually impaired may not exist, whereas in low power countries such as Ireland and the UK provisions for people with disabilities will be made. For example, migrants come from countries in Africa, Asia and Europe which can have quite high PDI and authority can also relate to a moral or medical perspective of disability. Also, it might be difficult to access such services, which according to Hofstede's power distance

index (PDI) Ireland scores a low PDI therefore social provision for less powerful members of society exist. Ireland' scores are demonstrated in Figure 4. This study demonstrates that the impact individuals' low expectation of how inequalities are treated may result in for example, the lack of rehabilitation services for visually impaired members of society as discussed in Chapter 6. This is demonstrated in Chapter 6's discussion of the low expectation of service provision which translates into slow engagement of migrants with services for visually impaired. Furthermore, the potential for successful adaptation to visual impairment is boosted through accessing these services.

Essentially, the PDI evaluates the degree to which it is expected and accepted that power will be unequally distributed (Hofstede 1980; 1984; 2001). Hofstede (2001: 97) recognises that a:

> [S]ocietal norm is meant to be a value system shared by a majority …it contains both values as the desirable and values as the desired and is only at some distance followed by reality.

According to Hofstede (2001: 97) high power distance countries will implement more "coercive and referent power" as opposed to in low power distance countries who rely on more "reward, legitimate and expert power". As social norms vary cross-culturally, Hofstede (2001: 100) highlights the significance of this reality, for providing support for individual members of divergent cultures:

> [P]roviding psychoanalytic help to a person from another type of society…is a risky affair. It demands that the helper be aware of his or her own cultural biases versus the culture of the client.

This has relevance for this study for the way in which service providers assist and counsel migrant service users from diverse cultural backgrounds, as discussed in Chapter 8.

Uncertainty-avoidance:

> The borderline between defending ourselves against uncertainties and accepting them is fluid…different societies have adapted to uncertainty in different ways…ways of coping with uncertainty belong to the cultural heritages of societies, and are transferred and reinforced through basic institutions such as the family, the school and the state (Hofstede 2001: 146)

A society's tolerance of uncertainty is the focus of this cultural dimension (1980; 1984; 2001). In this study attitudes towards visual impairment are culturally embedded. The concept of uncertainty avoidance corresponds with this study's findings that tolerance of an individual's visual impairment depends on their cultural upbringing. Consequently society may deem the individual as deviant and take an exclusionary approach or in contrast deem them as just another member of society. An example of a society viewing an individual with visual impairment as deviant is outlined in Chapter 5's discussion of cultural perception of disability rooted in belief systems that view the disability causation to be connected to past transgression.

Societies which score a low uncertainty avoidance index (UAI) are fundamentally more open to diversity in all forms as the "stronger a culture's tendency to avoid uncertainty, the greater its need for rules" (Hofstede 2001: 147). This 'intolerance of ambiguity', Hofstede (2001) recognises may result in racial discrimination. This is relevant for this study in Chapter 7's discussion of a migrant service user's experience of racism in the host society. High UAI has been called alienation (Dean 1961) and

alienation as a concept is viewed as having three distinguishing features: "powerlessness, normlessness and social isolation" (Dean 1961: 754). In this study visually impaired migrants who are simultaneously coping with the dual process of adaptation are considered more susceptible to high alienation status when they are in denial of both visual impairment and new cultural system. Additionally, high UAI appears to link to a medical model view of disability as discussed in Chapter 2.

Individualism – Collectivism: According to Hofstede (2001: 209) individualism as opposed to collectivism illustrates:

> The relationship between the individual and the collectivity that prevails in a given society…for example, in nuclear families, extended families, or tribes. In some cultures individualism is seen as a blessing and source of well-being; in others, it is seen as alienating.

In social interaction, members of individualistic cultures, learn to value independence and personal accomplishment, whereas in collectivist cultures, they are encouraged to appreciate an apparently harmonious cooperation (Gudykunst 1988; 1993; 1996; Gudykunst and Nishida 1986). In this study an individualist or collectivist perspective will impact the way in which a migrant service user will choose to seek or expect assistance in the host country or not. A collective understanding of care may create barriers in service provision in the case where an individual's whole family unit is the decision maker for rehabilitation choices. Bearing this dual perspective in mind will enable service providers to better understand the motivations of individuals from distinct cultural backgrounds in acceptance or rejection of assistance.

Collectivist culture members tend to apply distinct value benchmarks for members of their in-groups and members of out-groups (Gudykunst and Ting-Toomey 1988). This notion has relevance for this study where a visually impaired migrant may be viewed as an out-group within their own cultural community as discussed in Chapters 6 and 7. Collectivist societies are considered to be shame cultures, whereas individual societies are guilt cultures (Benedict 1946/1774). Hofstede (2001: 229) distinguishes between the two orientations recognising that in collectivist cultures that:

> Not only the culprit him-or herself but also his or her in-group mates are made to feel ashamed when a misdeed has been committed. Shame is social in nature, whereas guilt is individual.

The concept of shame is important in this study in relation to primarily impacting migrant service user's poor self perception within their own cultural community when belief of disability causation is associated with a family's past misdemeanour, as discussed in Chapter 2 and examined in Chapter 5.3. Furthermore, shame for the visually impaired migrant may act as a barrier to seeking assistance within the host community when associated with language barrier as outlined in Chapter 7.3.1.

Masculinity and Femininity:

> The duality of the sexes is the fundamental fact with which different societies cope in different ways; the issue is what implications the biological differences between the sexes should have the emotional and social roles of the genders. (Hofstede 2001: 279)

The cultural dimension of masculinity and femininity addresses gender roles in society and the allocation of social as opposed to biological roles in society. In relation to this study it has application for the way in which service providers handle working relations with individuals who perceive gender roles differently to the

professional service providers. There may be cultural clashes when men are culturally perceived as superior to women and do not feel comfortable being trained in orientation and mobility for a female instructor. The impact of cultural differences for service provision may result in willingness or unwillingness to engage with assistance from for example, a female service provider as outlined in Chapter 7.4.

8.2.1. Berry's Six Cultural Variables

John Berry has elaborated on Hofstede's cultural dimensions identifying six cultural variables in cross cultural communication which are, diversity, equality, conformity, wealth, space and time (Berry 2006: 31-32). In relation to the current study the cultural variable space is most pertinent as it discusses the use of body contact in interpersonal communication. The way in which individuals perceive space in social interactions is rooted in their cultural upbringing.

In the context of service provision for visually impaired individuals, mobility officers are required to work in close physical contact with service users in order, for example to demonstrate long cane skills. When cultures perceive space differently from one another in the case of a migrant service user and Irish service provider cultural misunderstandings may develop. A finding of this study emphasises the significance that being cognizant of these differences may potentially prevent cultural misunderstandings which hinder a migrant's adaptation to their visual impairment.

8.2.2. Culture Shock Theory

The concept of culture shock (Oberg 1960) refers to the experience of cross-cultural adaptation. The cause of culture shock in Oberg's view is:

> [P]recipitated by the anxiety that results from losing all our familiar signs and symbols of social intercourse. These signs or cues include the thousand and one ways in which we orient ourselves to the situations of daily life. (Oberg 1960: 177)

In his perspective culture shock is a necessary malevolence to be overcome though Kim (1988; 2001) in contrast does not view the process in this way. Instead, she emphasises the positive and valuable potential of the culture shock phenomenon in instigating personal growth. Through cross-cultural experience individuals are faced with the challenge of learning about a new cultural environment and at once learning more about themselves generates a transformative experience (Kim 1988; 2001).

In relation to this study the negative impact of culture shock, for example provoking feelings of frustration in communication may hinder an individual's ability to access services for visual impairment. However, once services are engaged with, the positive outcomes in relation to their adaptation to both their disability and to living in a new cultural environment are enhanced as discussed in Chapter 6. This shift from negative attitude of culture shock phenomenon parallels the theoretical framework in Disability Studies from the medical stance of tragedy and loss associated with impairment to positive perspective towards identity transformation.

8.2.3. Anxiety and Uncertainty Management Theory

Reducing uncertainty about the unfamiliar is the main objective in intercultural communication (Berger and Calabrese 1975) and Anxiety and Uncertainty Management theory focuses on communication in a new cultural setting (Gudykunst 1988; 1993; 1998). According to Gudykunst and Hammer (1984a) uncertainty reductions and managing anxiety are instrumental in enabling a stranger's adaptation

to a new cultural environment, thus in the case of this study can also facilitate a more successful adaptation to sight loss for a migrant.

This study recognises that anxiety for both visually impaired migrants and service providers can be reduced through mutual cultural awareness. Additionally, English language acquisition and linking in with language support services also controls anxiety associated with intercultural communication as discussed in Chapter 8.

8.3. Societal Intercultural Theories

8.3.1. Push and Pull Model of International Migration

> On the most fundamental level refugees have generally been exposed to pre-migration trauma including civil war, genocide, famine, imprisonment and torture. Their relocation is involuntary as they are unwillingly displaced from their home countries and 'pushed' into alien environments. This process differs significantly from the experiences of sojourners and migrants who voluntarily relocate, either temporarily or more permanently, because they are drawn or 'pulled' towards the countries of resettlement. (Bochner et al. 2001: 25)

Migration motivation is the primary factor in a cross cultural adaptation process as the journey towards integration into a new cultural environment takes a distinct path, dependant on migrant status on arrival, as presented in Chapter 5's discussion of migration motivations and Chapter 7.2 respectively. Several models of migration adaptation identify motivational factors as important deciders of both the migration and cross-cultural adaptation processes (Berry 1997; Kim, 2001; Rumbaut 1991; Ward, Bochner, and Furnham 2001). Sociologists recognize social, political and structural factors that encourage individuals to move from one country to another (Richmond, 1993). The push and pull model of international migration (Bierbrauer and Pedersen 1996; Richmond, 1993) accounts for migration motivations. According

to this model, there is a clear differentiation between refugees and voluntary migrants. Refugees, for example, are considered as migrants who are "pushed" by alleged threats to their well-being. The reason individuals become refugees depends on a range of factors though "above all they included wars, especially civil wars" (Roberts 1998: 378).

In contrast, voluntary migrants are viewed as "pulled" by anticipation of an enhanced future with improved economic prospects (Rumbaut 1991). Although motivations for migration may vary from economic, educational, political or social reasons, migrants all are impelled by an aspiration for a better quality of life (Furnham and Bochner 1986). In this study four chief motivations for migration have been identified as outlined in Chapter 5. The case of an asylum seeker is identified as the most challenging in adapting to a new cultural environment and most significantly for the focus of this study the adaptation to visual impairment is most seriously at risk.

Fanning (2007: 4) emphasizes the inimitable situation of an individual in the asylum process:

> The asylum process is often described as a state of limbo, a place where lives are on hold. It is one where people can experience extreme isolation, unnecessary poverty, neglect and cruelty that exacerbates, what for some, have been profound levels of pre-migratory trauma. By any standards this limbo amounts to an unpromising starting place for new lives in a new place.

This study portrays how this 'state of limbo' is intensified when the asylum seeker is simultaneously experiencing sight loss and cannot access vital support services.

The sense of alienation of the migration experience is heightened when a migrant's orientation in a new environment is coupled with sight loss as discussed in Chapters 6, 7 and 8. Furthermore, an added migration push factor is identified as the disability factor where an individual is "pushed" out by a cultural perception of visual impairment as discussed in relation to moral, medical models of disability and stigma and "pulled" into Irish society by the inclusive perception of disability. Thus as a result of increased opportunities for visually impaired, acceptance of disability and better quality of life participants in this study are motivated to remain in Ireland as is discussed in Chapter 5.11-14.

8.3.2. Institutional Completeness

The theoretical concept of "institutional completeness" was developed by Breton in 1964 and it addresses the extent to which a migrant connects with "formal institutions" in the host country. Breton (1964) recognises the influence of three communities in the migrant's integration process; the native community, the ethnic community and other ethnic communities. For a migrant, for example whose ethnic community does not have formal institutions in the host country he/she will "establish all his institutional affiliations in the native community since his ethnic group has little or no organization of its own" (Breton 1964, 194). In contrast, a migrant who can access formal ethnic institutional support, for example, through a religious organization will be less likely to engage with host country religious or other social services. The concept of institutional completeness correlates with Berry's (1980 1997; 2008) four strategies of acculturation. For instance, Berry's separation strategy corresponds with the institutional completeness in its most extreme form as

"whenever the ethnic community could perform all the services required by its members" migrants would "never have to make use of native institutions for the satisfaction of any of their needs" (Breton 1964: 194); hence, they separate themselves from the majority community. Support services during the period of transition from one country to another, for instance, schools, health and social services, and the community in general play a pivotal role in assisting and supporting migrants to adjust and integrate into the host society (Breton 1964).

In relation to this study, applying the theory of institutional completeness is a useful tool in assessing successful integration of visually impaired migrants into Irish society. The significance of support networks both within the individual's own home community and the development of supportive alliances within the host community are addressed in Chapter 6. Through analysis of the data under the chief categories pertaining to support, accessing rehabilitative assistance from Irish services for the visually impaired is identified as the most beneficial mechanism to nurture adaptation to visual impairment. Within this host community environment which specifically caters for the needs of the visually impaired, a migrant has the opportunity to engage with and receive empathetic support from 'similar others'. This opportunity is denied if the migrant over-relies on support from the home community which cannot provide the specialist care critical to visual impairment. This is because currently in Ireland no formal ethnic institutions for the visually impaired exist.

However, due to cultural perceptions and barriers, discussed in Chapter 5 and 7, migrants still may not access services despite their own community being ill-equipped

to manage their visual difficulties. Ethnic religious institutions for example in the case of this study are identified as being both a help and a hindrance to long term adaptation to visual impairment for the migrant. Connection with ethnic religious organizations may assist in initial stages of adjustment providing a safe haven where migrants can communicate easily in their mother tongue. Nevertheless, the long term consequences of overdependence on ethnic institutional support may limit the individual's adaptation process into the host environment. Furthermore, in the case of a visually impaired migrant, as no special needs education system or rehabilitation services exist in ethnic communities in Ireland, not engaging with the host community alienates them from the opportunity of fully adapting to their new identity as a visually impaired individual.

8.3.3. The Strength of Weak Ties

Granovetter's (1973) emphasizes the power of less developed social networks in facilitating intercultural adaptation. Granovetter (1973) defines the strength of a social tie as the "combination of the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie" (Granovetter 1973: 1361). The development of weak ties refers to connecting with members of the community who are not part of the individual's intimate friendship and family circles, essentially social groups on the margins of their own inner enclave. In the case of migrants, however, it refers to developing relations with the host community and with relevance to this study it involves both visually impaired migrants and host service providers mutual engagement. According to Granovetter (1973: 1369), "weaker interracial ties can be seen to be more effective in bridging

social distance". This concept correlates with the findings in this research study that the potential for visually impaired migrants to be informed about services for visually impaired is increased through weak ties, such as through host country institutions as for example, school, work and religious settings. Hagan (1998: 65) notes the risk for the migrant who does not associate outside his own ethnic enclave:

> Migrants can become so tightly encapsulated in social networks based on strong ties to coethnics, that they lose some of the advantages associated with developing weak ties with residents outside the community.

The advantage in the development of weak ties within the host country is the potential to cultivate what Cobb (1976) terms, "esteem support" is enhanced. Cobb (1976: 301) defines esteem support as:

> Information that one is valued and esteemed is most effectively proclaimed in public. It leads the individual to esteem himself and reaffirms his sense of personal worth.

This is relevant to this study, as when disability is culturally negatively perceived as discussed in Chapter 2, esteem support is denied and the individual's ability to adapt to their visual impairment is hindered. However, conversely when it is supported the individual reaps positive adaptive benefits as discussed in Chapters 6.2 and 6-7.5.

8.4. Individual Intercultural Theories

8.4.1. Culture learning approach

Cultural empathy is the optimum goal of intercultural communication. For Masgoret and Ward (2006) culture specific skills are an important feature of adaptation. In relation to how the migrant and host community orientate themselves, Ward and

Searle (1991) classified five key traits: extraversion, openness, agreeableness, conscientiousness and cultural empathy in facilitating adaptation. The culture learning approach is relevant for this study because it recognises the responsibility of both the newcomer, in the case of this study, the visually impaired migrant and the host community, the service provider in learning and applying culture specific skills to facilitate successful adaptation as evident in Chapter 7.

8.4.2. Expectancy Violations Theory

Expectancy Violations Theory was formulated in 1978 by Burgoon and is concerned with the role of expectations in communication and reactions to violations of expectations (Burgoon 1978; 1983; 1986; 1992; Burgoon and Hale 1984). Burgoon, Stern and Dillman (1995) expanded the theory to discuss the whole adaptation process developing interaction adaptation with the theory of expectancy violations at its core. Six major assumptions of expectancy violations theory were emphasized:

1. Other people's behaviour influences individuals' communication expectations
2. Distraction and alarm are caused by violations of these expectations
3. Communicator's reaction impacts interpretation of unclear communication
4. Communicator's reaction impacts behaviour assessment
5. Three factors determine violation valences (a) behaviour assessment, (b) whether the behaviour is more or less favourable than the expectation, and (c) the scope of the violation.

Therefore, a positive violation transpires when the behaviour is more favourable than the expectation. However a negative violation transpires when the behaviour is not as favourable (Burgoon, Stern and Dillman 1995).

Particular relevance of this theory for this study is found in Chapter 5's cultural perceptions of disability, Chapter 6's focus on the support networks and finally Chapter 7's discussion on cultural barriers. Often migrant service users carry the expectation that their visual impairment will be treated in a similar manner to that of their home country that is in a hostile way; thus they expect a similar reaction in Ireland.

In Chapter 6 the issue of support in relation to coping with sight loss was addressed. When the expectation of support is violated the repercussions for the migrant's well-being can be particularly unfavourable, even more so when the unsupportive behaviour is from close family and/or friends. When there is an expectation that visual impairment will be negatively perceived and it transpires that this is not the case, migrants in this study are overwhelmed. Furthermore, in this study it is shown that several participants did not expect services for the visually impaired to exist in Ireland at all. This view is also supported by service providers for visually impaired so that expectations are violated for both service user and service provider. For the migrant service user who does not expect visual impairment to be socially accepted and rehabilitation is offered, expectations are positively violated, as the behaviour towards them is more favourable than expected. As a result migrant service users are fuelled

with extra determination to successfully adapt to both their disability and to the country which is assisting them in their adaptation.

For service providers, their professional expectations are negatively violated as the expectation is that service users will have awareness about the services and be willing to engage. Expectations are thus negatively violated when migrants are slow to engage with services and also when, due to cultural barriers posed by gender issues, may not engage with the services at all. Nevertheless, it is significant to point out that service providers report expectations being positively violated as well. In relation to migrant service users who do engage with services, if they had no negative expectation of how their visual impairment would be perceived in Ireland, they are often more determined and focused in their rehabilitative training. The determination to rehabilitate, re-enter and contribute to the host society facilitates service providers' ability to assist them in achieving this goal.

In relation to racial discrimination which is discussed in Chapter 6.8 when an expectation of support from the host community is violated by the experience of discrimination, negative outcomes for the psychological well being of the individual are generated. Finally, this theory has relevance for the issue of gender addressed in Chapter 7.4. Expectation of being offered a choice of male or female service provider may be negatively violated when Irish services provide what is culturally perceived as inappropriate gender behaviour by a migrant Thus, adaptation to visual impairment is hindered as discussed in Chapter 7's discussion of cultural barriers to migrant service user accessing and engaging with services for visually impaired in Ireland.

8.4.3. The Developmental Model of Intercultural Sensitivity

Bennett (1986; 1993) created the developmental model of intercultural sensitivity (DMIS) which identified six stages of developing sensitivity to cultural difference. The hypothesis of the model is that as the individual's experience of cultural difference becomes more refined, aptitude in intercultural relations potentially expands. The six stages of DMIS are divided into two principal categories, firstly ethnocentric and secondly ethnorelative. The three ethnocentric stages; denial, defence and minimisation locate the individual's own culture at the heart of their lived experience, whereas during the ethnorelative stages; acceptance, adaptation and integration, the individual's own culture is viewed within the context of other cultures (Bennett 1986). This model correlates with Thurston's (2010) model of adaptation to visual impairment as the stages of adjustment relate firstly to how the individual experiences the impairment within themselves prior to focusing on re-integration into the exterior environment. In essence, ethnocentric stages can be considered as the individual avoiding cultural difference while in contrast the ethnorelative stages demonstrate the individual seeking cultural difference. The underlying assumption is that the individual's orientation towards intercultural sensitivity is infused by social encounters which are based in group membership (Tajfel and Turner 1986).

In this study visually impaired migrants are in a dual process of development of adaptation to changed status. During the ethnocentric stages, individuals use their "own set of standards and customs to judge all people" (Bennett 1993: 26). This concept is relevant for this study as visually impaired migrants during these stages, for example judging the host community by their own society's standards may not expect

Irish people to view their disability positively; therefore, they neither seek nor engage with rehabilitation services. Isolation is acute during the ethnocentric stages, and is compounded for an individual who is simultaneously coping with sight loss. Conscious separation by the intentional erection of physical or social barriers to create distance from cultural difference may be adopted as a strategy, to avoid contact with the host community (Bennett 1986: 35). In relation to this study the avoidance of social situations due to poor host language skills will hinder the individual's adaptation to visual impairment and life in a new cultural environment as discussed in Chapter 8.

The ethnorelative orientation is based on:

> [T]he assumption that cultures can only be understood relative to one another and that particular behavior can only be understood within a cultural context. (Bennett 1993: 46)

This concept is relevant for this study for both migrant service user's development of sensitivity towards Irish behaviour, for example in relation to gender and correspondingly for host community service providers understanding of the context of cultural differences between themselves and service users.

The compulsion to deny one's identity is most forceful for asylum seekers who recognise the negative label and attempt to reject it as Galvin (2000: 207) notes:

> Individuals begin to deny their status as asylum seekers and refugees when the experience of exile fails to live up to expectations; when the status itself is viewed as a barrier in interacting with the host society, and when there is genuine fear for their own safety.

The motivation to deny their identity becomes more complex when an asylum seeker is also attempting to conceal a visual impairment, as discussed in Chapter 7 and 8.

In the ethnorelative stages the focus is on expanding cultural perspectives not assimilating one culture into another and involves the development of cultural empathy (Bennett 1986; 1993). Exposure to a variety of cultural worldviews offers the potential to develop a "pluralistic" perspective as "part of their normal selves" (Bennett 1993: 55).

This prospect is revealed by service providers in this study who are required to manage an increasingly culturally diverse service user groups. This study finds that developing a pluralistic cultural attitude is beneficial for service provision in an increasingly diverse user environment. The final stage of the model treats the integration of different features of an individual's cultural identity into a complete picture. With respect to visually impaired migrants this concept correlates with their adaptation of their visual impairment into the other aspects of their identity as discussed in the review of the Disability Studies literature in Chapter 2.

8.4.4. Social Identity Theory

Tajfel and Turner developed the theory of social identity in 1978 and this theory proposes that the concept of social identity is fundamental to understanding intercultural relationships. For Tajfel (1978: 63), social identity is:

> That part of an individual's self concept which derives from his knowledge of his membership in a social group (or groups), together with the value and emotional significance attached to that membership.

The study of cultural identity concerns cultural (or ethnic) differences; nevertheless, there is an acknowledgment of other aspects of individuals' identities that influence inter-group activities, as discussed by Hofstede (1994), Berry et al. (2002) and Kim (2001). Social identity theory is relevant for this study as it identifies the significance of self-conception of being a member of an individual ethnic community whilst also being nested within the extended identity of a host community. For the visually impaired migrant the emphasis which is attached to a particular social identity may influence the extent to which they engage with host community services, as discussed in Chapter 6.

Another feature of social identity theory is the assumption that individuals are essentially motivated to attain a positive social identity, hence, to view themselves in a positive rather than negative light. When an aspect of an individual's identity is culturally perceived to be spoiled (Goffman 1963), as discussed in Chapter 2, the challenge is to overcome this. In the case of an individual who is experiencing progressive sight loss and within whose culture visual impairment is viewed negatively, the opportunity to achieve a positive social image is hindered, as discussed in Chapter 6. In contrast, in societies which perceive visual impairment as one aspect of identity and rehabilitative assistance is offered to aid re-integration into society, the potential for positive self identity is restored. The same applies when an individual's cultural identity is negatively viewed as in the case of migrants who experience racial discrimination in the host country, where positively valuing their ethnic identity is damaged. Discrimination is related to negatively impacting individual by increasing stress, lowering self-esteem and overall poorer adjustment (Ward, Bochner and

Furnham, 2001), as discussed in Chapter 6.5 and 6.8. Overall, in this study positive or negative social identity status influences an individual's fundamental processes of adaptation to visual impairment in a new home.

8.4.5. Acculturation strategies

Berry (2006: 27) defines acculturation as the:

> Process of cultural and psychological change, that results from the continuing contact between people of different cultural backgrounds.

This definition is most suitable for this study as it recognises the on-going nature of acculturation which impacts both members engaged in the interaction. In addition, dominance of one group above another is not an expected precondition for acculturation (Berry 2006). This component of the acculturation process is significant for this study as it could appear that the optimum goal is to engage both the migrant service user in learning cultural skills to facilitate adaptation to visual impairment and for service providers to progress this process by providing a culturally balanced service. Berry identifies four acculturation strategies; 'assimilation', 'separation', 'integration', and 'marginalization' (Berry 1980; 1997; 2008) where the 'swallowing up' of one culture by another is the concept of assimilation (Ward et al. 2001:28). In contrast, an organic relationship between the minority community and the host country involving a continuous process of collaborative adjustment is the goal of integration (Berry 1987; 1997; 2006).

Berry et al. (1987) claim that individuals who choose the integration acculturation strategy experience better mental health. Acculturation is the bidirectional nature of

adaptation as two groups reciprocally influence each other (Berry 1987; 1997; 2006) Fostering mutual responsibility is central to facilitating the adaptation process for visually impaired migrant in Ireland. As outlined in Chapter 7 mutual cultural awareness is advocated for improving the adaptation process of the visually impaired migrant as each group, both migrant service users and host service providers' behaviours impact on each other. During the process of acculturation feelings of stress may be experienced and Berry (1987) links acculturative stress with lowered health levels:

> The concept of acculturative stress refers to one kind of stress, that in which the stressors are identified as having their source in the process of acculturation; in addition, there is often a particular set of stress behaviours, which occurs during acculturation, such as lowered mental health status (specifically confusion, anxiety, depression), feelings of marginality and alienation, heightened psychosomatic symptom level, and identity confusion. (Berry 1987: 492)

For the visually impaired migrant the acculturative stress experienced is compounded by the stress of sight loss; hence increasing alienation and identity uncertainty as discussed in Chapter 8.

8.4.6. Linking the Individual with Society: Cross-Cultural Adaptation Models

> Cross-cultural adaptation…is a personal journey that ultimately leads to a transcendence of cultural categories in individual consciousness. (Kim 2001:195)

Kim's integrative theory of cross-cultural adaptation (1998; 2001) highlights three chief context conditions significant to the adaptation process; host receptivity, host conformity pressure and ethnic group strength. With relevance to this study host

receptivity specifically relates to how Irish service providers receive visually impaired migrants either positively or negatively. As receptivity towards visually impaired migrants within the Irish social system is dependent on their migrant status, therefore, poor receptivity is noted when a migrant is seeking asylum, as access to critical rehabilitation services is denied, as discussed in Chapter 6.4 and Chapter 7.2. However, for voluntary migrants host receptivity by visual impairment services is positive, as discussed in chapter 6's discussion of support networks which facilitates adaptation to visual impairment. Kim (1998; 2001) correlates positive host receptivity as a key factor in individual's successful migration. This study corresponds with this perspective as the positive reception of host community towards migrant service users facilitates greater engagement with services for visually impaired which leads to greater potential for adaptation to visual impairment. The opposite response to positive host receptivity is racial discrimination which incurs a sense of helplessness (Fernando, 1984); the impact of racial discrimination for visually impaired migrants is discussed in Chapter 6.8.

Host conformity pressure in this study relates to the extent of the demand on the visually impaired migrant to conform to Irish societal norms. This is relevant to this study in relation to the pressure felt by migrants to, for example as outlined in Chapter 7.4, to let go of deeply rooted beliefs regarding gender in order to engage with mobility officers. In addition, it impacts the extent to which the host service providers require migrant service users to conform to Irish practices. In Chapter 7.4 service providers discussed the challenge posed by the cultural barrier of gender in mobility training, given the physical nature of the task. Little pressure from the host service

providers was forced upon migrant service users. In fact, there is more of a tendency from the migrant community to pressurize the host services to conform to their cultural norms. Consequently, lack of host conformity pressure in the area of provision of mobility training may result in hindering migrant service user's adaptation to their visual impairment. Finally, in relation to host language acquisition, host conformity pressure to learn English is considered a positive measure in this study, as improved host language skills will minimize cultural misunderstandings, hence facilitating clearer communication, which is essential in mobility training.

The process of cross cultural adaptation involves both acculturation and de-culturation which Kim (2001) defines as the process of "unlearning" or "losing of something old". This is relevant for this study, as in Chapter 7.5 it is proposed that the onus lies with both the migrant service user as well as the service provider to facilitate engaging with the services in the case of gender conflict. This period of adjustment to distinct cultural values Kim refers to as "temporary personality disintegration" which may be distressful as the "capabilities of the individual are not adequate to the demands of the environment" (Kim 2001: 55). Withdrawal, hostility, denial and self-deception may be felt (Kim 2001). This period also corresponds with Bennett's later ethnocentric stages of intercultural sensitivity development (Bennett 1986; 1993). In this study, as the migrant is simultaneously experiencing a period of adjustment to sight loss and to a new culture, feelings of distress are compounded due to a language barrier as discussed in Chapter 7.3.2.

8.4.7. Ethnic Group Strength

One of the key environmental conditions for adaptation that Kim (1998; 2001) identifies is ethnic group strength which refers to:

> Relative status and power that membership in an ethnic group accords, the degree of prestige and ethnic group enjoys in a given society or community, the degree to which the group is institutionalized and the degree to which group is engaged in ethnic politics. (Kim 2001: 155)

In relation to this study currently the most relevant aspect of ethnic group strength is the extent to which the visually impaired migrant can access support within their own ethnic enclave. The potential to receive support within the ethnic group may act as a barrier to developing weak ties (Granovetter 1973). As a result, engagement with vital services for visually impaired is restricted due to over reliance on home ties as discussed in Chapter 6.4.

Nevertheless, the fact that in Ireland the sole providers of rehabilitative assistance for visually impaired are Irish services, the lack of ethnic organizations offers no alternative for the migrants than to engage with the host community. In doing so, the positive prospects for adaptation to visual impairment and additionally to their new cultural environment are boosted. The strength of an individual's ethnic group and the strength of an ethnic group's information, emotional, and material support system is a factor in the individual's intercultural adaptation process. The concept of ethnic group strength is comparable to Breton's institutional completeness (Breton 1964).

Boyd (1989: 652) acknowledges the central role of ethnic support in the entire migration process:

> Ethnic associations and ethnic enclaves have multiple roles in the migratory/settlement/integrative process. Ethnic based associations which focus around some activity such as sports, religion or recreation act as conduits for information and help.

The depth of the role played by ethnic support networks is critical in this study to the individuals' adaptation process to visual impairment in the host society. Castles and Miller (2003) believes ethnic social networks have a double edged nature. Firstly, they may initially provide shelter in an unknown environment thus shielding newcomers from the negative impact of culture shock. However, over-dependence on home community social networks may ultimately disadvantage migrants and hamper successful adaptation (Kim, 1988: 2001). Despite the disadvantages to integration outlined Begley et al. (1999: 77)'s study examining the case of asylum seekers in Ireland from a health perspective found that asylum seekers themselves identified fellow asylum seekers as "the most accessible and helpful medium of such support". Reliance on home ties for support is most viable option as participants in their study highlight that "this involves no costs and has all the advantages that empathy derived from a shared experience brings".

While family networks may benefit migrants during the initial transitory stage of migration, failure to establish networks beyond the family circles may disadvantage migrants (Kim 1988; 2001; Gurak and Caces 1992).

For this reason Gurak and Caces **(**1992: 165) suggest that:

> While most networks may originate as tightly knit kin networks, the underlying needs for diverse resources (aid with legal systems, better employment, improved housing, schooling options etc) should predispose

> migrants to open up their networks and involve specialized elements in them.

Nevertheless, the impact of the denial of support from those closest in the home community to a visually impaired migrant during the period of transition from sight to sight loss can cause severe psychological distress in relation to cultural perceptions of disability, support networks and cultural barriers as discussed in Chapters 5, 6 and 7, respectively. In contrast, the support offered in accessing information about education for example is instrumental to a migrant's integration process, both to their disability and into Irish society.

In this study religious organizations also play a strong supportive role for a visually impaired migrant. Home community religious organizations may extend assistance to help migrants adjust to their new cultural environment as Hirschman (2004: 1207) states that:

> With smaller and less proximate families in present times, churches and temples can sometimes fill the void. Members in many religious bodies, similar to members of a family, do not expect immediate reciprocity as a basis for friendship and social exchange.

The void may be particularly deep for a migrant who is *simultaneously* coping with sight loss. Therefore, the reliance on support from a community which shares common cultural values may be especially comforting. Moreover, in the case of asylum seekers who are living in 'limbo' with limited financial resources and moreover for those with a visual impairment who cannot access host support services the religious organization can provide fundamental survival support. ,As Hirschman (2004: 1208) notes religious communities can provide:

> A combination of culturally attuned spiritual comfort, and material assistance heightens the attractions of membership and participation in churches for new migrants.

The danger is that the migrant will not venture beyond this safe haven to seek professional rehabilitative assistance from host services and thus jeopardize their adaptation process (Kim 1988: 2001). On a positive note, religious leaders are identified as figures of respect and power within the home community and may be useful contact points between host service providers and 'hard to reach' visually impaired migrants as discussed in Chapter 7.

8.4.8. Host language acquisition

> The significant role that English language acquisition plays in supporting the adjustment of refugees to living in this country, and particularly in buffering the refugee against psychological distress, cannot be emphasized enough. (O' Regan 2000: 195)

Learning the host language is vital to a successful intercultural adaptation process for all migrants. Ward and Kennedy (1994), and Ward et al. (2001) explore the role that language learning plays in migrants' acculturation, in their new cultural environment. Nash et al. (2006) study on immigrant civic engagement identified language barrier as the fundamental obstacle in preventing immigrants access specialised services. The language barrier is most critical in this study in relation to accessing health care. Minervero and Martin (2007: 190) note:

> When health services are accessed and used, language can be the most impeding barrier for non-English speakers or persons with limited English language proficiency.

This study identifies the language barrier as a major obstacle for both service user and provider in the development of successful adaptation and assisting the adaptation process to visual impairment as clear communication is essential in tasks such as mobility training (Fitzgerald and Parkes 1998).

Host language acquisition is hindered when migrant communities cluster together and adopt a strategy of separation (Berry 2008). Lee and Miller (2002) identify strong ethnic group association with weaker host language skills:

> In a region where a high percentage of individuals are from the same birthplace, and hence, many will speak the same minority language as the immigrant, the costs of not knowing the dominant language, or the benefits of learning the dominant language, are presumably decreased. The effects arise from the ability to communicate in consumer, labour market and social activities in the immigrant's mother tongue. Moreover, since second language skills improve with experience using the language, improvements in English language skills are retarded by using the mother tongue. (Lee and Miller 2001: 9)

The delay or indeed absence of intention to learn the host language for visually impaired migrants, creates a language barrier between the migrant and the host community as discussed in Chapters 7.3-7.3.7 and it will negatively influence the process of adaptation to visual impairment. Due to a language barrier migrants often decide to ignore their health problems (Carballo and Siem 2006) as discussed in Chapters 2 and 7. The inability to communicate in English poses barriers to access and use of health services and may deter outreach to medical and public health assistance (Jang et al. 1998). In contrast, language ability is positively related to adaptation and the more competent an individual is in the host culture language, the less he or she experiences fewer difficulties (Ward and Kennedy 1994).

8.4.9. Cultural competent service provision strategies: linking disability and cultural competence

The ECRE Task Force and Integration 1999 has observed that:

> Health providers should seek to develop culturally sensitive services and shift from a diagnostic orientated framework to an integrated approach to health; listening, asking questions, and taking time seem to be very simple practices that are seldom implemented.

Health is defined in inclusive manner by the World Health Organization (2004):

> Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity.

This definition adopted by the World Health Organization represents a broad spectrum understanding of health and challenges public health practitioners not to merely focus on physical health but also to adopt a holistic perspective

Culturally competent service (CCS) provision has been advocated by a wide variety of scholars and practitioners in the field of Intercultural Studies (Cross et al. 1989; Minervino and Martin 2007) and more recently in Disability Studies (Ahmed et al. 1998; Chamba et al. 1998; Bau 1999). Cross et al (1989: 18) in relation to the provision of culturally competent services for emotionally disturbed minority children in the United States, view CCS as involving:

> Systems, agencies, practitioners with the capacity to respond to the unique needs of populations where cultures are different than that which might be called "dominant"…The word "culture" is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word "competence" is used because it implies having the capacity to function in a particular

> way…within the context of culturally integrated patterns of behaviour as defined by the group.

A holistic attitude is advocated by this approach encompassing the individual, cultural and organisational facets of institutions and systems that commit to activate the process of developing cultural competence. Scott et al (2001) in their study of patients with retinal disease found that referral to appropriate health care professionals and support groups alleviated emotional distress and contributed to improved health status.

Minervino and Martin (2007: 194) in their study on need for culturally competent services in a culturally diverse Irish social context, recognise that cultural meditation is a skill required in cultural competence:

> Cultural Mediation is needed when the different cultural background of service providers and minority ethnic users might bring about misunderstandings or conflict. The cultural mediator's job is to create a space for dialogue between service provider and the client with a different cultural background who may have recently arrived in the country.

In this study it is demonstrated that the breakdown in communication due to cultural misunderstandings can hinder access and engagement with services for the visually impaired. This is because culturally competent service provision is not in place and workers rely on ad hoc personal experiences as discussed in Chapter 7. This demonstrates the relevance of the intercultural in relation to disability. These two disciplines thus come together in this research on visually impaired and blind migrants.

In addition Chamba, Ahmad and Jones (1998) and Ahmed et al (1998) reveal that the "specialist worker" approach may result in overstraining and the "dumping of all minority cases on that worker has been found in this study's discussion in Chapter 8. Service provision that is not culturally competent may also neglect to provide vital information in other languages than English. Flynn (2002) in his study of service provision for minority disabled children in the UK suggests that the absence of translated or accessible material contributes to low awareness and engagement of services. Again in this study translation was an issue in relation to Chapter 8's discussion of language barrier in hindering the provision of services for migrants. In the case of visually impaired migrant there is the added complexity of providing services in visually accessible format such as large print or Braille.

Cultural mediation is advocated as discussed in Chapter 7.5 for its potential as Minervino and Martin (2007: 194-5) acknowledge that it:

> empowers users by providing them with a means to voice their own needs and concerns. It should be used together with other resources such as counseling, training and capacity building to enable minority ethnic clients to manage their own health and exercise their own choices.

This understanding of cultural mediation also correlates with the perspective of the independent living movement as discussed in Chapter 2.

8.4.10. Discussion: linking disciplines

This study links the disciplines of Intercultural Studies and Disability Studies in relation to visually impaired migrant in Ireland. Bau (1999: 292) in his pioneering study on the provision of culturally competent services for the visually impaired

ethnic minorities in the United States recognises the similarity in objectives of practitioners in both fields:

> To bridge the gaps between cultures entails openness, observation, listening, learning and redefining one's viewpoints. These strategies are the same ones that professionals use in working with disabilities.

Mutual learning between both the disability service provider and intercultural mediator/trainer is encouraged. In the case of migrant service users, the opportunity to share distinct cultural experiences and values is promoted rather than silenced. For example, in the case of gender causing a barrier to engagement with services, Ponchillia and Ponchillia, (1996: 79) recognise the importance of cultural awareness so as to facilitate service provision for visually impaired:

> Traditional male and female roles differ among cultural groups, and these variations, if unknown to or ignored by the rehabilitation teacher, could complicate the relationship between teacher and learner. For example, some people, such as women from the Middle East, might be uncomfortable touching or being touched by a member of the opposite sex during a lesson on sighted guide technique.

In sum, the significance of cultural awareness both on the part of the service user and the service provider to be cognizant of the cultural practices of the host society cannot be overstated in relation to the potential successful adaptation to visual impairment by the migrants in this study and the service provider's capacity to facilitate the process.

CHAPTER 9: Discussion of Study's Findings

To bridge the gaps between cultures entails openness, observation, listening, learning, and redefining one's viewpoints. These strategies are the same ones that professionals use in working with disabilities. (Bau 1999: 292)

This chapter firstly presents a brief reiteration of the research questions is presented. Secondly, the study's findings are collated into the inhibitors and facilitators to visual impairment for migrant in Ireland. These findings are examined within the theoretical frameworks in Disability Studies and Intercultural Studies as outlined in Chapter 2 and 8. The current study's findings are related to empirical studies which have investigated disability adaptation and specifically adaptation to sight loss and integration in Ireland. Finally, having compared this current study's findings with earlier research the overall contribution of this study is evaluated in relation to Charmaz's guide (2006).

9.1. Research questions

As stated in 1.2 this study has been driven by four key research questions which are:

1. What are the experiences of visually impaired migrants living in Ireland today?
2. What factors facilitate or hinder their adaptation to their visual impairment in Ireland?
3. What are the experiences of service providers working with visually impaired migrants in Ireland?
4. What factors facilitate or hinder their ability to enable visually impaired migrants adaptation to their visual impairment in Ireland?

The first two questions relate directly to the experiences of the visually migrants living in Ireland. Given that the study's primary focus is to give voice to the lived

experiences of this minority group in Irish society answering these questions is the thesis's main concern. The second two questions relate to the experiences of the professionals who support visually impaired migrants in Ireland. The purpose in asking these research questions is to find answers as to how visually impaired migrants can best adapt to their visual impairment in Ireland. The following section of this chapter collates the findings which emerged from the data analysis of qualitative interviews with the 16 service users and the 6 service provider interviews.

9.2. Collating the Findings: Inhibitors and Facilitators to adaptation to visual impairment for migrants in Ireland

In endeavouring to answer these research questions eight inhibitors and seven facilitators to adaptation to visual impairment for migrants in Ireland emerged from the data which was analysed in Chapters 4, 5, 6 and 7. Disability models which were detailed in Chapter 2 and Intercultural theories outlined in Chapter 8 provide the theoretical framework for discussion. Each inhibitor and facilitator will be examined bearing in mind the theories most relevant to the specifics of the finding and related to empirical studies which have unearthed similar findings. To facilitate discussion each barrier and facilitator will be examined separately in relation to each key category.

9.2.1. Home Cultural Perceptions of disability was found to delay connection with host services

This study finds that migrant service users can be slow to connect with vital rehabilitative services because of their lack of expectations of societal acceptance and service provision due to their home cultural perceptions of disability. In the context of adapting to visual impairment in the host country, this study found that the migrant

carries their moral or medical model home cultural perception that his/her impairment will be negatively perceived. Thus, the migrant in this study does not expect societal acceptance and service provision. The idea that migrants carry their own cultural attitudes towards healthcare has been documented (Anderson et al 1995; Westbrook, Legge and Pennay 1993; Carballo and Mboup 2005). As Carballo and Mboup (2005) comment in their report for the International Organization for Migration and Health "migrants carry with them the health "footprints" of the countries and social environments they come from". This statement strongly supports the findings in this study.

In this study negative perceptions of disability in participants' home countries are found to be based on cultural beliefs. Two service providers; community resource worker Clodagh and mobility officer Fionn report that cultural beliefs related to cause of sight loss result in delayed connection with services as migrants believe 'nothing can be done' for them. Hence the process of adaptation is inhibited by the delay in which it takes for him/her to engage with professional support.

The most extreme perception of disability found in this study is that it is a curse from God. Two migrant service user participants in this study, Sheila and Niamh's father reported that in their African home countries disability is perceived as a curse from God for past misdemeanors as analyzed in detail in Chapter 5.3. In these participants' home countries there is 'nothing' for them; no formal or informal support is available.

Another service user, Deirdre from Eastern Europe (Case Study 1 in Section 4.6.1) recounts being told by member of her home community that her condition is a result of past transgressions and that she deserves to be suffering with sight loss.

Disability scholar Vohn (1993) supports this view that people with disabilities repeatedly identify "societal attitudes as the most potent and negative stressor in their lives". Negative perceptions of disability present individuals with impairments with a major barrier to adaptation and are found to inflict an additional constraint for coping with the impairment (Florian 1982; 1987). Based on the cultural perception of disability, Sheila, Ronan and Niamh's father relate that the future for someone who loses their sight in their home countries is one of desolation. Visually impaired people left unassisted are forced to beg on the streets. As Niamh's father explains:

Ninety nine percent are on the street begging that's it

Perceiving disability as a curse is supported by the moral model of disability. This study finds that this negative cultural perception towards disability hinders adaptation to visual impairment. This finding is supported by empirical research in disability studies that demonstrate the link between cultural perceptions of disability rooted in a moral model approach with reduced adaptation potential for the individual (Buscaglia 1975; Vash 1981; Evans et al. 1989; Wagner and Oliver 1994). The process of acceptance of disability is associated with acceptance and engagement with rehabilitation services which is connected with improved adaptation outcomes (Gill 1997; Livneh and Antonak 1997; Thurston 2010). The moral model approach to disability does not accept people with impairments in society and rejects the

usefulness of rehabilitation. This study finds that one of the factors that contributed to migrants' delay in connecting with host services for visually impaired is rooted in their home cultural moral understanding of disability.

A less extreme approach to disability is grounded in the medical understanding that physical impairment is a personal tragedy to be 'cured' as outlined in Chapter 2.3.1. Following this perspective however, should curing the impairment not be an option, individuals with impairments are segregated from society in institutions. In the case of progressive visual impairment a cure is often not medically feasible. In this study three participants; Paddy's father, Aoife's mother and Caitriona's mother expressed their concern for their children's well being in their home country because of the cultural attitude held towards segregating people with disabilities from society. As Caitriona's mother says:

> *No services in my home country for disabled child your choice is to put the child in.*

Seven of the migrant research participants in this study give negative feedback on their visual impairment diagnosis experience. Each of these participants experienced sight loss deterioration in their home country. They all expressed concern about the ambiguous nature of the diagnosis for his/her eye condition. However as this medical perspective towards disability is held as normative practice in these participants' home countries they do not question its authority. In order for individuals and their families to begin the journey of adjustment and adaptation to his/her or their child's condition, it is vital that comprehensible diagnosis of specific symptoms and restrictions be clearly communicated. This study finds that the poor diagnosis

experience is related to the cultural perception of disability in participants' home countries.

Lack of clear diagnosis of eye condition, access to rehabilitation services and overall societal stigmatization of visually impaired members of society damages an individual's self-esteem. This finding is supported by Goffman's (1963) research exploring the relationship of stigma and reduced self esteem of individuals who are excluded from society because of their identity differences. In relation to adapting to visual impairment the process is greatly hindered for the individual when he/she is forced to endure societal exclusion when he/she most needs support. Given that a migrant may not expect assistance or acceptance in the host country he/she is not actively seeking it; thus migrant service users can be slower to connect with host services for visually impaired.

Overall this study demonstrates the existence of the moral and medical models of disability as 'cultural baggage' for visually impaired migrants in Ireland today. In the concluding chapter recommendations are made to attempt to address these cultural perceptions of disability so that preventable time delays in connecting migrants with vital specialized services are avoided in the future.

9.2.2. Lack of Home Support reduces potential to connect with services for visually impaired

This study finds that the visually impaired migrant who lacks support from his/her closest ties is in a particularly vulnerable position in Ireland. The sense of isolation is compounded as he/she ***simultaneously*** copes with stress of adjusting to sight loss and

immigrant life; the potential to adapt to visual impairment in the host country is hindered by lack of emotional and practical support from home ties Furthermore, the presence of home ties provides migrant with pre-existing knowledge about the host country, in the context of this study this relates to information about host services for visually impaired.

In this study as outlined in Table 7 in Chapter 4, two of the research participants, Liam and Seamus arrived alone in Ireland; moreover, on arrival in Ireland they knew nobody. Seamus was in an exceptionally weak position as his sight loss was more progressive; he also had the added social disadvantage of asylum seeker status. Seamus had been living in Ireland six years before his refugee status was recognised. During this protracted waiting period he has been separated from his family; hence emotional support during the simultaneous stress of sight loss as a migrant was absent. For Seamus, coping alone as a visually impaired individual separated from his family causes him the most distress, as he highlights:

> *No family here, can't help me this is the worst…can't cook can't leave house alone*

The finding that lack of home support isolates a migrant in the host country in general is supported in the literature in Intercultural Studies related to integration, specifically in the work of Kim (1988; 2001). As outlined in Chapter 2.4.5 support from family to cope with health problems has been found by Lin et al (1999) to ease stress and combat depression. This finding is supported in this current study. In relation to the individual coping with sight loss affective support from family has been found to help alleviate anxiety of transition for sight to sight loss (Reinhardt 2001; Thurston 2010).

Reinhardt's (2001) large scale longitudinal study with recently impaired elderly highlights the value of reliable family support in protecting against social isolation. The significance of pre-existing support from migrant's home community on arrival in host country to assist in settling into new socio-cultural environment is vital (Kim 1988; 2001). Boyd (1989: 652) recognises (as outlined in Chapter 8.4.7) the key role ethnic enclaves play in acting as "conduits for information and help". In the context of this study the presence of home support in Ireland is found to facilitate connection with special education and services for visually impaired whereas the absence of familial support for visually impaired delays connection with host serves and thus heightens susceptibility to social isolation. This study finds that at the time of interview Seamus was the participant that was most isolated and least well adapted to living with his visual impairment of all the migrant service users in the study. Adaptation to disability is associated with social participation (Charmaz 1995; Gill 1997; Salick and Auerbach 2006). Seamus is unable to negotiate his environment independently, as he has not learnt the necessary adaptive skills; social isolation results. One of the factors that contribute to his isolation is the lack of emotional and practical support from his family which inhibits his ability to cope with his sight loss in new socio-cultural environment. Another major factor was his asylum seeker status which is examined later in this chapter**.**

In all of the focus groups in Begley et al.'s (1999) study of health consequences for asylum seekers in Ireland emotional support was identified as a prerequisite to cross-cultural adaptation. Attempting to adjust to a new socio-cultural environment without former social support was found to contribute to feelings of depression (Begley et al.

1999). This study supports this finding that asylum seekers without home support networks in Ireland are most susceptible to depression due to lack of emotional support. The potential for asylum seeker to feel depressed is more acute this study asserts should he/she be ***simultaneously*** coping with adapting to sight loss alone.

In short, lack of home support in the host society is a barrier to adaptation to visual impairment for migrant as emotional and informational support channels are absent.

9.2.3. Migrant's dealing with sight loss at great risk of losing home community support

This study found that migrants who were perceived due to his/her visual disability as a financial burden by his/her own ethnic group were ostracized from the home community in Ireland. This study finds that this outcome originates in the cultural perception of disability in the participants' home country. Just as the visually impaired migrant carries his/her home perception of disability the notion of 'cultural baggage' as analysed in Chapter 5.6 and in the first finding discussed at the beginning of this chapter 9.2.3 so too do the rest of his/her home community.

In this study it emerged from the analysis of the qualitative interview data that two participants Deirdre and Grainne experienced discrimination in Ireland from members of their own ethnic community due to their visual impairment though the motivations for the intolerant behaviour were distinct.

9.2.4. Absence of Family Support in Host Country Due to Home Moral Model Cultural Perception of Disability

Grainne is bullied by her brother because of her low vision which she relates to her home country's attitude that disability symbolizes a transgression in her past life. The role of supportive older brother in the new socio-cultural environment is not merited as her status as a person with disability overrides her position in the family as younger sibling warranting protection; she is in her words to be "*criticised not encouraged*". Grainne's brother abandons her when she most needs emotional and practical support to simultaneously cope with sight loss while in unfamiliar socio-cultural surroundings. His behaviour is supported by a moral model perspective of disability. Alone in Ireland coping with sight loss, a language barrier and most significantly without the support of her brother Grainne contemplated suicide. This study finds that the absence of support from a home community has a detrimental impact of the psycho-social adaptation to visual impairment for a migrant.

9.2.5. Withdrawal of Home Support in Host Country Due to Economic Factor Based on Home Medical Model Cultural Perception of Disability

This study finds that the withdrawal of support from a migrant's home community while he/she is coping with sight loss weakens the process of adaptation to visual impairment. In this study Deirdre experienced psychological harassment from her home community friends with whom she shared accommodation in Dublin. In contrast with Grainne, the persecution Deirdre suffered from her home community friends was motivated by her home country's medical model understanding of disability. Following her progressive sight loss, Deirdre was forced to resign from her

skilled job in Ireland. Instead of providing sympathy and support, her home community friends who were motivated to migrate to Ireland for personal economic advancement not only did not support her but firstly distanced themselves and ultimately labelled her a burden for the household (Chapter 4.6.1 presents Deirdre's case and Chapter 6.5 analyses Deirdre's discrimination experiences in detail).

This discriminatory behaviour can be seen to be supported by a medical perspective of disability. The medical model of disability as detailed in Chapter 2. 3.1**,** locates the challenge of disability within the individual, as such outside of society. Oliver (1990) argues that the medical perspective of disability focuses exclusively on individuals' limitations not factors within society which impose restrictions on individual's potential to participate. This finding is supported by Liachowitz (1988)'s research that demonstrated the link between negative societal behaviour towards members of society with "*role failure*"; with the inability to carry out socially valued positions in the labour market. Furthermore, failure to contribute economically results in being perceived as a burden.

Karlsson et al (1998) and Horowitz et al (2003) found that the harmful impact of sight loss on functional ability and social activities has been shown to increase individuals' risk for depression and poorer perceived life quality; family support is fundamental in combating social isolation and depression. In this study, both Grainne and Deirdre were psychologically damaged by their home ties' rejection of them; both on several occasions seriously contemplated suicide.

This study highlights the acute vulnerability of a migrant whose home community reject them as a burden as he/she run the real risk of suffering mental health difficulties in addition to simultaneously coping with sight loss and immigrant life.

9.2.6. Over-reliance on home support-independent life skills suppressed results in social isolation contributes to delay connecting with host services for visually impaired

This study finds that over-reliance on home support can greatly influence the health of visually impaired migrant. In the case of the visually impaired migrant it is critical for their visual health and social rehabilitation that he/she connects with specialized services for visually impaired in the host country. Engaging with expert rehabilitative services to learn new skills that compensate for sight loss is demonstrated to facilitate greater adaptation to visual impairment (Boerner et al. 2006).

In Ireland, unlike the UK where some ethnic minority groups have set up their own services for visually impaired as for example the Asian Blind Association, distinct cultural services for people with disabilities do not exist. This means that everyone in Ireland with a visual impairment must access host services to facilitate adaptation to his/her visual impairment. Failure to do so results in poor adaptation to visual impairment. Over-reliance on support from family in the host society is intensified for a migrant with a visual impairment as he/she struggles to cope simultaneously with sight loss and the new socio-cultural environment. The impact of over-reliance on home support this study finds is to reduce the opportunity to connect with host services for visually impaired and so hinder adaptation to visual impairment.

Gurak and Caces **(**1992) and Kim (1988; 2001) identify an immigrant's over-reliance on support of his/her home community as an obstacle to integration. Gurak and Caces (1992: 165) highlight the need for migrants to "open up their networks to involve specialized elements". Wierzbicki (2004) also suggests that migrants who maintain strong ties exclusively with groups of co-ethnics may be socially disadvantaged. This current study adds to these findings that failure to open host networks has influence on migrants' health; in the context of this study's participants it directly impacts his/her visual health.

One service user, Ciara (Case Study 4; presented in Chapter 4.6.4) arrived with her sister seeking asylum in Ireland. Owing to the combined challenge of coping with sight loss and life as an asylum seeker she became heavily dependent on her sister for "*everything*". Relying on her sister as her exclusive source of support in Ireland prevented Ciara from developing independent living skills crucial to adapting to her visual impairment.

Mobility officer, Fionn criticises the dynamic between family and visually impaired individual where independent living skills are not encouraged. Over-dependence on family support he recognises merely serves to suppress an individual's development of independent living skills which can "*kill your own fire"*. Consequently the capacity to adapt to visual impairment which is dependent on integration through social participation is hindered. The integral relationship between effective adaptation to visual impairment for a migrant in Ireland and his/her societal (re)integration is a key point in this study.

9.2.7. Racism impacts migrants perception of service provision

This study finds that racism reduces trust in the host community which in turn reduces the level of engagement with host services for visually impaired and hence hinders adaptation to visual impairment.

In this study one of the research participants, Liam relates frequent racist verbal and physical abuse. During the course of Liam's interview he relates incidents of racist verbal abuse on Dublin public transport, city centre streets and racist attacks outside his house. Excluding Seamus, the participant who arrived alone seeking asylum in Ireland and had just prior to the interview connected with NCBI, Liam is the least connected with host services. In Chapter 6.8 Liam's experiences of racism in Ireland are analysed. Although Liam attends the rehabilitative centre following a vicious racist attack, it was reported by service providers that he had become less receptive to mobility training and began to distance himself from his peers excluding a fellow African service user. The impact of the racist attack for Liam served to reverse the progress he had been making at the centre; hence, his overall adaptation to his sight loss was inhibited. Racial discrimination is found in this study to contribute to weakening of ties with the host community. This is a harmful backward step for migrant service users' potential to adapt to living with sight loss as a withdrawal from rehabilitative participation is proven to hinder ability to foster independent living skills. Furthermore, as Liam began to rely more on the support of his home community in Ireland his home cultural perception of disability was strengthened

which this study finds would make it more difficult in the future for Liam to seek support to live independently.

A fundamental factor in successful cross-cultural adaptation to a new socio-cultural environment encompassed in Kim's (1988; 2001) integrative theory is host receptivity towards newcomers (as outlined Chapter 8.4.6). Accordingly racial discrimination is a manifestation of negative host reception to newcomers to Ireland of extreme unsupportive host behaviour. It is the conflicting response to constructive host receptivity which incurs a sense of helplessness in the target of racist behaviour (Fernando 1984). In the recent ESRI (2009) study entitled "Adapting to Diversity: Irish Schools and Newcomer Students" it emerged that African pupils did not mix as well with Irish children compared with other for example children from Eastern Europe. In addition, according to the ESRI's (2009) study African children reported experiencing bullying more frequently. The link between discriminatory behaviour and tendency to 'stay amongst themselves' (ESRI 2009: 88) cannot be overemphasised.

In 2005 the ESRI conducted the first methodical research on migrants' views of racism in Ireland. It was a postal survey; participants were asylum seekers and work-permit holders. The study found that harassment on the street or on public transport was the most common form of racism in Ireland. This verdict concurs with studies carried out across Europe (EUMC 2006). Begley et al.'s (1999) study on the health situation of asylum seekers found that the majority of their participants were concerned with racial hostility towards them which contributed to existing feelings of

stress and anxiety so reducing self esteem for the victim. These findings support this current study's findings. This study additionally asserts that the sense of helplessness triggered by racist behaviour may provoke a more acute sense of alienation for migrant who experiences racist attack while also coping with sight loss.

9.2.8. Fear of racist attack contributes to social alienation which hinders adaptation to visual impairment

This study finds that fear of racist behaviour from the host society can prevent visually impaired migrants' societal participation which leads to social alienation which in turns negatively impacts his/her potential to adapt to visual impairment.

In addition, to Liam's account of racism, the impact of racial discrimination for visually impaired migrants is explored by service providers. For example, community resource worker, Tara describes the stress experienced by a Middle Eastern migrant service user she attempted to engage with who fears racial attack in his Dublin neighbourhood. Following his sight loss, he refused to leave his house to practice mobility training as he feared his vulnerable physical status as a visually impaired individual would make him an easier target for racist abuse.

This service user's fear of attack inhibited his rehabilitation programme which had negative consequences for his overall potential to adapt to living with sight loss. Tara described his situation as "*sad*" and "*desperate*". Without the necessary skills in orientation and mobility Tara expresses concern for his wellbeing as he became increasingly housebound. Another community resource worker Clodagh considering the *dual* challenge of coping with sight loss and fear of racism recognises the stress

induced as "*horrific*". Adaptation to visual impairment is dependent on social integration which, due to fear of racist attack, is inhibited for this visually impaired migrant.

This study recognises the additional distress for migrant service users who fear racial attack. Racism has been identified as a key societal barrier to successful integration of migrants into Irish society (Fanning 2002; 2009; 2011) This study further asserts that racist behaviour in Irish society presents a societal barrier for migrants' ability to adapt to his/her visual impairment as the real experience and fear of racist attack forces the visually individual impaired to retreat into reclusive state within ethnic enclaves. Fanning (2002) describes the asylum seekers as the 'most disempowered group in Irish society'. This study argues that the asylum seeker, and to a lesser extent economic migrants who are coping with sight loss and racial fear and attack face additional disempowerment.

9.2.9. Asylum Status debilitates the process of adaptation to visual impairment

This study finds that asylum status is a debilitating factor in migrant's adaptation to visual impairment in the host country. This is because asylum seekers cannot access services for, visually impaired, hence, negatively impacting adaptation to visual impairment. Chapter 4.6 delineates the research participants' different migrant statuses. Asylum seeker status is identified as the weakest social position of all migrant groups in this study. Ciara and Seamus are the asylum seeker participants in this study; both waited six years before their refugee status was approved by the Irish State. During this time they were not entitled to access specialized support services.

As Ciara's visual impairment needs are not met at the mainstream school in Dublin she struggles to keep up with her classmates. Her struggle in the classroom is compounded as on arrival as an asylum seeker she could not speak English. Ciara would have benefited from attending a special needs school where her visual impairment needs could have been supported. However, it was the time lapse between leaving school and attending the NCBI that was the most challenging for Ciara. During the interview Ciara found it difficult to articulate how she spent the five years after leaving school, simply saying "*I couldn't do anything*". As her sight loss progressed, unable to access support to learn skills to cope independently Ciara became increasingly housebound.

Similarly, Seamus waited six years before his refugee status was approved. Unlike Ciara, he arrived alone in Ireland so lacked important source of support from family. Unable to access support to learn independent life skills necessary to cope with sight loss Seamus also became housebound. Begley et al. (1999) found that the prolonged waiting time characteristic of the Irish asylum process contributed to reduced psychological health for asylum seekers in their study. The inability to work or access full social welfare entitlements resulted in feelings of social isolation, poor self-esteem and in some cases depression.

This current study concurs with the findings of Begley et al. (1999) and adds that the asylum seeker who is coping with the additional challenge of sight loss is at high risk of irreversible psychological and visual health outcomes. Lack of access to professional services to support their vision problems denies asylum seekers the

opportunity to learn skills to help them cope independently with their sight loss and integrate into society. Begley et al's (1999) study on the health consequences of the asylum seeker status recommends that Good Practice Guidelines in relation to the prioritization of women and children in the asylum process be implemented. This current study adds that people with disabilities also be prioritized to ensure in the case of this study that urgent health issues related to vision not be overlooked.

9.2.10. Awareness and level of connection with services greatly impacted by Host Language Skills

This study finds that lack of host language skills can result in reduced awareness and connection with services for visually impaired in host society. Consequently, delay in connection with rehabilitative services will negatively impact migrant's process of adaptation to visual impairment. As outlined in Table 7 in Chapter 4 in this study participants' with the least proficiency in the host language were the asylum seeker participants, Ciara and Seamus. Neither could speak English on arrival in Ireland. For example, to illustrate her language level Ciara describes her ability at that time as "*zero, zero*"

At school Ciara suffered due to her inability to express herself as she says:

I was scared I wanted to run away

Coping with sight loss while struggling with host language hindered her ability to communicate her special needs related to her sight loss.

Another participant, Sean identifies the shame associated with his poor language skills as an obstacle in seeking assistance to support his progressive sight loss. Sean identifies his weak language skills as a barrier in connecting with services which delays his process of adaptation:

> *It take me a long time to know about this place, NCBI, I think because my English no so good, I afraid to ask, find out*

From the service providers' perspective the language barrier is the key distinguishing feature between working with migrants and non migrant service users. As outlined in Chapter 7.3.2 mobility officer Sorcha associates the delay in migrants connecting with services for visually impaired with lack of awareness about the service due to language barrier. This delay in connecting with services obstructs the ability for visually impaired migrants to learn how to cope with living with sight loss in Ireland.

In the context of Intercultural Studies in relation to immigration research the impact of language barrier on poor integration outcomes for migrant are well documented (Bischoff et al. 2003; MacFarlane et al. 2009; De Maesschalck et al. 2011). Critically for this study, competency in the host language is fundamental to negotiating access to important services and is considered one of the most critical problems for all immigrant groups (Nash et al. 2006; Minervero and Martin 2007). This study supports these studies' findings and adds that the language barrier, in obstructing a migrant's connection with specialized support services, will negatively impact on the process of adaptation to visual impairment. The concluding chapter will discuss recommendations to prevent this delay in connection in the future.

9.2.11. Language barrier impedes clear communication essential to mobility training

This study finds that a language barrier causes an additional challenge for a migrant with visual impairment as visual cues in communication are removed. In the context of the relationship between service user and provider of services for visually impaired, clear communication is essential, especially delivery of key services such as mobility training (Fitzgerald and Parkes 1998). As one mobility officer participant in this study, Fionn asserts "*in mobility clarity is a must*". Clarity in communication is crucial to ensure that service user has fully grasped mobility instructions. The safety of the service user both during training practice and most significantly when he/she is negotiating the environment without trained professional support by his/her side depends upon clear communication during mobility training.

9.2.12. Differences in cultural perceptions of gender a key factor influencing success of mobility training

This study finds that cultural perception of gender can impede mobility training which is fundamental to adapting to living with sight loss. Considering that one of the chief services provided for visually impaired is mobility training, which involves working in close physical contact with the service user, the potential for issues associated with gender are magnified as two cultures come into an unique close proximity. A key concept in Kim's (2001) integrative theory to cross cultural adaptation is host conformity pressure. This refers to the perceived pressure placed on immigrant groups to conform to the host society's societal behaviours and rules. Host conformity pressure in this study relates to the extent of the demand on the visually impaired migrant to conform to Irish societal norms. This is relevant to this study in relation to

the pressure felt by migrants to, for example as outlined in Chapter 7.4, to let go of deeply rooted beliefs regarding gender in order to engage with mobility officers.

In addition, it impacts the extent to which the host service providers require migrant service users to conform to Irish practices. In Chapter 7.4 service providers discussed the challenge posed by the cultural barrier of gender in mobility training, given the physical nature of the task. Community resource workers Clodagh and Tara and mobility officer Fionn express concern about the obstacle posed by different cultural attitudes related to gender in engaging with migrant service users. Physical contact between service user and provider is integral to teaching independent orientation skills and techniques. Due to the physical nature of mobility training migrants whose cultural perception of gender may not consent to physical interaction between strangers of the opposite sex may therefore not wish to engage in mobility training with a trainer of the opposite sex.

The difficulty for service providers is catering for this cultural perception of gender as the host societal norm is to assign community resource workers according to regional location not gender. This means that migrants who decline support from service providers on the basis of gender must wait to be reassigned another staff member of the same sex as the migrant. The management service provider participants in this study have expressed concern that resources for services for visually impaired in Ireland due to current economic recession are overstretched and community resource workers caseloads have amplified. When a migrant declines support based on his/her home pressure to conform to gender practices, he or she delays the process of

adaptation to living with sight loss as his/her case goes 'back to the waiting list'. The service providers in this study express helplessness in the face of this cultural challenge and place little pressure on migrants' to conform to host norms. In the concluding chapter recommendations are made to address the issue of a cultural barrier posed by gender in adapting to sight loss for migrants in Ireland.

9.3. Adaptation Facilitators

In contrast to inhibitors, facilitators for the process of adaptation to visual impairment are also key findings in this study. They are detailed in the following sections.

9.3.1. Home Community Support on Arrival- provides ready-made connections with host services for visually impaired.

In this study it is found that support from family on arrival in Ireland facilitates migrant's connection with host services for visually impaired.

Pre-existing home social networks in the host society are found to assist newcomers during their transition from home to host country (Kim 1988; 2001; Berry 1980; 1997; 2008; Ryan et al. 2008). In the case of migrants who are *simultaneously* coping with sight loss and a new socio-cultural environment the presence of family with what mobility officer Fionn refers to as "*existing knowledge*" about services for visually impaired in Ireland is a great benefit. Fionn highlights this presence or absence of knowledge communicated by home ties as a factor in the speed in which a migrant activate his/her process of adaptation to visual impairment. This is because adaptation to visual impairment is intrinsically bound to social integration which cannot successfully take place without specialized rehabilitative training.

For example, on arrival in Ireland Eileen's family connected with pre-existing home country support networks among extended family and friends. Eileen's father was able to access existing knowledge about local schools from his friends. Soon after starting at the mainstream local school recommended by her family's home friends, the severity of Eileen's eye condition was detected and she was referred to host services for visually impaired. This study finds that access to home community's pre-existing knowledge about Irish support services helps visually impaired migrants in this study connect with specialized services to enable them cope with their sight loss.

9.3.2. Home Religious Support Safeguards against Social Isolation and Acts as Conduit for Connection with Host Services

This study finds that home religious support safeguards against combined social isolation of disability and immigrant status. In addition it finds that support from a religious community can act as a conduit to connection with services for visually impaired.

Support from a home religious community is found to reduce social isolation and a assist migrant's fundamental survival in simultaneously coping with sight loss and immigrant life in Ireland. In this study two migrant participants, Liam and Seamus identify their home religious community as their main source of support in Ireland. Without the support from their religious home community both express concern for their everyday survival in Ireland. Liam says if he did not have the support of his fellow home community churchgoers he would have "*no friends*" in Ireland. Liam, as outlined in the earlier section on inhibitors to adaptation to visual impairment, has experienced numerous racist incidents. Following racist abuse from the host

community he relies on the support of his religious home community to ease his anxiety. At the time of interview Liam was attending the rehabilitative training centre so was receiving specialised support to cope with his gradual sight loss. However, Liam did not develop significant ties at the centre choosing rather to rely on his religious community for emotional and practical support. For Liam similar to participants in Ugba's (2007: 178) study on the role of African Pentecostal churches in Ireland, religious affiliation in the host country can "compensate for the lack of recognition or the diminished social status that they experience in the larger society".

In Seamus's case, he relies on his home religious community for support in his basic everyday living needs. As Seamus arrived in Ireland as an asylum seeker he was not entitled to access host specialized services for visually impaired. During the six years he waited for his case to be approved, the members of his mosque supported him emotionally and practically to cope with his fundamental survival needs. Members of the mosque cook, clean and care for Seamus as due to his visual impairment he cannot carry out daily routine tasks independently. A friend he made at the mosque who speaks English helped him with his asylum application and subsequently to make contact with the NCBI. As Seamus has limited English language skills this friend acts as a translator in meetings regarding his future attendance at the rehabilitative training centre; as he says:

> *My friend from the mosque he help with English talking with person from NCBI introduce me.*

Ethnic religious organizations have been found to potentially act like extended family in particular for lone migrants who are separated from their family in host country (Hirschman 2004). In addition, Ubga's (2007: 177) study found that:

> Some members see the church as a place of refuge from the problems, hostilities and rejection they face in the wider society. For others, the church does not serve as a mere distraction from the harsh realities of living as strangers in a strange land but as a channel for receiving real solutions to various kinds of real problems.

Begley et al.'s (1999) study of psycho-social health impact of asylum status in Ireland also found that home community religious affiliation was identified as a means of accessing social support.

This study highlights the home religious community as a critical source of support, specifically for exceptionally vulnerable asylum seekers who are coping with the real problems of enduring the dual challenge of asylum seeker and disability status unsupported by professional services in Ireland. The concluding chapter will suggest ways in which this source of support from home religious communities may be harnessed to facilitate connection with services for visually impaired.

9.3.3. Independent Living Model of Disability Promotes Migrant's Adaptation to Visual Impairment

In this study it is found that the host cultural perception of disability grounded in the independent living model positively impacts migrant's adaptation to visual impairment. The reason for the positive impact on migrants' adaptation to visual impairment is because in contrast with his/her moral or medical home cultural

perception of disability, in Ireland for the first time, each of the migrant participants in this study experienced a sense of acceptance towards his/her disability status.

Feeling accepted and being integrated into society has been found to be fundamental to individuals' potential to adapt to living with disability (Gill 1997; Charmaz 1995; Salick and Auerbach 2006; Livenh and Antonak 2007). Three of the parents in this study specifically compare the impact of staring or smiling at their visually impaired child. It made them feel as if they fitted in and contributed to a general sense of wellbeing. This feeling of acceptance is amplified as these participants carry a cultural perception of disability which they articulate as analysed in Chapter 6 which is more commonly expressed in public staring not smiling at their disabled child. Their expectation of not being accepted is positively violated and so the feeling of acceptance is enhanced (Burgoon 1978; 1983; 1986; 1992; Burgoon and Hale 1984). The independent living model of disability advocates empowering individuals with disabilities to lead independent lives; which facilitates process of adapting to living with sight loss and integration into Irish society.

9.3.4. Host Services reduces social isolation through peer support

This study finds that connection with host services provides a migrant with hope in the face of a past negative perception of his/her disability in the home country. Connecting with host visual impairment services offers a space for social interaction for migrants who find themselves coping *simultaneously* with the dual isolating impact of disability and migrant status. In connecting with host services, and developing what Granovetter (1974) termed "weak ties" within Ireland visually

impaired migrants have access to a vital social outlet with a peer support network. The NCBI rehabilitative training centre is highlighted in this study as an important space for social interaction for migrants whose marginal societal position is at risk due to their double minority status. This social interaction eases the alienating experience of sight loss *intensified* by migrant status facilitating adaptation to visual impairment. The provision of rehabilitative services at the NCBI is in accordance with an independent living social model perspective of disability.

This study finds that accessing support from "similar others" (Thoits 1989) is the most valuable form of support in coping with sight loss. In this study this refers to the dual nature of the research participant therefore; similar others are those who ***share disability and migrant status.*** At the rehabilitative centre individuals have the opportunity to socialise with other people who are learning to cope with their sight loss. In addition, the NCBI provides a peer counselling service run by people who have lost their sight and can share their experiences of adapting to a changed status

Begley et al's (1999: 68) study on health consequences for asylum seekers in Ireland identified socialisation patterns as indicative of integration outcomes and acknowledge;

> informal association with Irish people is a vital pathway to fostering integration, satisfying social needs and breaking down barriers like prejudice.

In the context of immigration, Begley et al.'s (1999) asylum seeker participants also identified their peers as the most valuable source of support as they can empathize with one another in the face of the adversity of living as asylum seekers in Ireland.

Fostering connections within the host community is considered integral to successful integration (Breton 1964; Berry 1980; 1997; 2008 Kim 1988; 2001). For the visually impaired migrant this study finds that connection with host services for visually impaired is indispensable to his/her process of adaptation to visual impairment. Peer support from other visually impaired individuals provides empathetic understanding and alleviates social isolation for visually impaired migrants. Witnessing other people with similar sight problems managing and being content is an inspiring source of support. For Deirdre, most significantly socialising with peers provides optimism for the future, as she says:

> *I met a lot of people there with similar problems and you see other ways, if you don't see, you think you're the only one person with that problem in the world, but after you see there are a lot of people like you and they are alive and some even happy, so there is hope.*

In addition, this study finds that visually impaired migrants who connect with Irish people through host services for visually impaired increase their opportunity to adapt to their visual impairment in harmony with integrating with Irish people.

9.3.5. Host Partner Provides Connection with Host Services for Visually Impaired

In this study two migrant research participants, Grainne and Deirdre identify their Irish partner as their main source of support in coping with their visual impairment in the host country. As a result of psychological distress caused by their home community's rejection of them on the basis of their disability status, both women seek refuge in the support provided by relationships developed with Irish partners. In loosening ties with their home community and strengthening ties with the host are, as

has been theorized by Granovetter (1973), these women increase the opportunity to simultaneously adapt to their visual impairment and integrate into Irish society. A strategy of integration is associated with better mental health as acculturative stress is reduced through developing host country connections (Berry 1987; 1997; 2006; Kim 1988; 2001). In the context of immigrant integration Bhugra (2001) found that emotional support from close relatives or a partner can ease homesickness and loneliness in the new host environment. These close relationships must be resilient involving a good deal of trust and empathy in order to support the migrant (Bhugra 2001).

In the case of the visually impaired migrant developing host country connections is essential not merely for integration into Irish society but most significantly adaptation to his/her disability. For both Grainne and Deirdre it is the pre-existing knowledge of Irish services for visually impaired which facilitates their connection with the NCBI. The use of rehabilitative services enables a process of adaptation to sight loss (Boerner et al. 2006); consequently, Grainne and Deirdre through linking in with support services report developing an ability to adapt to visual impairment. Both women acknowledge that it was their Irish partner's existing knowledge of the host social services system that facilitated their connection with the NCBI. Moreover, they both believe that without their Irish partner's support they would not have connected with the service. The reason for this is based both on the severity of the womens' sight loss which impeded independent travel and lack of awareness about the service. As Deirdre says:

don't know if I find the place by myself, I don't know anything about it, he knew where to go he bring me I can't walk by myself.

9.3.6. Host School Support Facilitates connection with assistance for visual impairment

Cobb (1976) identified a society's public domains such as school and work settings as facilitating esteem support through identity recognition and encouragement. In this study the Irish school environment is found to assist visually impaired migrants adapt to their visual impairment through emotional and practical support which is based on the independent living understanding of disability promoted in Ireland. In addition the finding that migrant children in this study report positive adaptation to visual impairment and integration into Irish special needs schools contrasts with empirical studies which highlight immigration segregation in Irish mainstream schools (DES 2007 and ESRI 2009). In the framework of Cobb's support networks theory (1976) through the encouragement and acceptance of his/her visual impairment in the public domain of the school setting, the visually impaired migrant child is nurtured to successfully adapt to disability status.

In this study eight of the service user participants as presented in Table 7 in Chapter 4, accessed support for their child with visual impairment through the Irish school system. For all of the parents involved in this study the fact that they feel their children are accepted and cared for by Irish children and school staff generates a strong sense of well-being. The visually impaired migrant children in this study do not report experiences of social isolation in special needs schools. This finding contrasts greatly with research findings exploring experiences of migrant children in mainstream Irish schools. For example, two empirical studies, *Intercultural*

Education: Primary Challenges in Dublin 15, a 2007 report funded by the Social Inclusion Unit and the Department of Education and Science (DES), and *Adapting to Diversity: Irish Schools and Newcomer Children* by the Economic and Social Research Institute (2009) find that immigrant children are more socially isolated at school in particular non-white children were identified as least well integrated. In contrast to being labelled 'blind' in his home country school, in Ireland Cillian feels accepted at a school for the visually impaired. The fact that he is non-white is not cause for segregation at the special needs school; rather, his visual impairment status is cause for his inclusion facilitating his adaptation to his visual impairment and overall integration into Irish society. In Aoife's case for example, it was through the Irish mainstream school system that the severity of her eye condition was detected and she was linked in with special needs services. This was crucial for her process of adaptation to her visual impairment. This study finds that the Irish school setting provides both emotional support through instilling acceptance of disability and practical support in linking migrant children with visual impairment with appropriate support services to enable adaptation to visual impairment.

9.3.7. Host Religious Community Support- provides opportunity through established networks to connect with host V.I services

In this study one migrant research participant Ronan identifies the friendships he made at the Catholic Church her attends in Dublin as helping him integrate into Irish society, and, most significantly, in adapting to his visual impairment assisted him link with services for visually impaired. Breton (1964) theorizes that the more a migrant fulfils his/her institutional requirements in this context of religious and spiritual needs

in the native community the more completely he/she will integrate into the native society (Breton's concept of institutional completeness also corresponds with Berry's (1980 1997; 2008) four strategies of acculturation). Ronan acknowledges that by maintaining his Catholic faith in Ireland he and his family have direct access to socialisation with the Irish community which enhances their integration.

Ronan identifies membership of the Catholic Church as a valuable means of meeting Irish people. In turn, through the friendships he made with Irish people who had existing knowledge about services for visually impaired he was put in touch with the NCBI.

9.4. Summary of Barriers and Facilitators to Adaptation to Visual Impairment for a migrant in Ireland

This section presents a summary of the key findings grounded in the eleven barriers and eight facilitators to adaptation to visual impairment for a migrant in Ireland which emerged from the data in relation to the lived experiences of the research participants. They eleven barriers which emerged from the data as inhibiting a migrant's process of adaptation to visual impairment in Ireland are as follows:

1. Home Cultural Perceptions of disability was found to inhibit adaptation to visual impairment as it caused 1) poor diagnosis experience 2) societal exclusion 3) delay in connection with host services for visually impaired
2. Lack of Home Support reduces potential to connect with services for visually impaired
3. Migrant's dealing with sight loss at great risk of losing home community support

4. Absence of Family Support in Host Country Due to Home Moral Model Cultural Perception of Disability
5. Over-reliance on home support-independent life skills suppressed results in social isolation contributes to delay connecting with host services for visually impaired
6. Racism impacts migrants perception of service provision
7. Fear of racist attack contributes to social alienation which hinders adaptation to visual impairment
8. Asylum Status debilitates the process of adaptation to visual impairment
9. Awareness and level of connection with services greatly impacted by Host Language Skills
10. Language barrier impedes clear communication essential to mobility training
11. Differences in cultural perceptions of gender a key factor influencing success of mobility training

In this study seven facilitators which aid the adaptation to visual impairment for migrants in Ireland are identified as follows:

1. Home Community Support on Arrival- provides ready-made connections with host services for visually impaired
2. Home Religious Support Safeguards against Social Isolation and Acts as Conduit for Connection with Host Services
3. Independent Living Model of Disability Promotes Migrant's Adaptation to Visual Impairment

4. Host Services reduces social isolation through peer support
5. Host Partner Provides Connection with Host Services for Visually Impaired
6. Host School Support Facilitates connection with assistance for visual impairment
7. Host Religious Community Support- provides opportunity through established networks to connect with host visual impairment services.

9.4.1. Reducing Inhibitors

Two means to reduce inhibitors emerged from the data.

1. Linking with professional language services- reduces language barrier between service user and provider in order to enhance service provision experience. For example, when a migrant does not speak English well and the service provider does not speak his/her mother language a professional interpreter is recommended for communication. This is noted as particularly significant for mobility training when "clarity is a must" so that hazardous situations are avoided.
2. Providing cultural training for service users and providers- fosters mutual cultural awareness which would ease cultural misunderstandings, which impede connection and level of service engagement. It is significant to note that cultural awareness is not one sided but rather an exchange of cultural perspectives. This is noted as particularly significant in relation to different cultural perceptions of gender which may impede migrant adaptation.

9.5. Conclusion

This chapter has collated the analysis of this study's research findings with reference to the original questions guiding the research. By presenting both barriers and facilitators to a migrant's process of adaptation to visual impairment in Ireland, it has identified concrete issues which enable and disable the process and so identities issues which may stimulate further research. In addition, two means to reduce the impact of language and cultural barriers are recommended. The concluding chapter will present a holistic conceptual model of adaptation to visual impairment for a migrant in Ireland based on the research findings. In addition it will evaluate the overall contribution to knowledge of this study in accordance with external criteria and offer specific recommendations for future research.

CHAPTER 10: Conclusion

Cross-cultural differences in the interpretation of disability show that the lives of individuals with disability are limited not so much by their specific type of disability as by the social interpretation of that disability. If this is the case, then the issue of interpretation of disability moves from one of health to one of human rights (Groce 1999: 756.)

10.1. Introduction

This final chapter presents the concluding reflections on the whole study. It has five principal objectives which are:

1. Reflection on the whole study by succinctly reviewing each chapter.
2. Presentation of conceptual model of barriers and facilitators influencing adaptation to visual impairment for migrant in Ireland
3. Similar international findings are discussed in relation to the contribution of this study to existing research in the fields of both Intercultural Studies and Disability Studies.
4. Evaluates the research according to a set of externally-imposed criteria
5. Recommendations for future research

10.2. Review of Thesis Chapters

This study on the experiences of visually impaired migrants in Ireland and the service users which work with them is the first of its kind in Ireland. It examines the journey of adaptation to visual impairment in Ireland of sixteen migrant service users. In addition, six service providers describe their experiences and challenges of working with an increasingly culturally diverse user group. Given the nature of a small qualitative research sample group this study does not aim to be representative.

Instead, this study aims to raise awareness of the experiences of this minority group in Ireland in order to better facilitate their process of adaptation to sight loss in the host country. Qualitative interviews in depth interviews were conducted to collect data; the coding process was assisted with the software programme Atlas.ti which was created to facilitate grounded theory studies such as this. Following the introductory chapter of the thesis, the study is comprised of nine chapters including this concluding chapter. The next section of the study discussed the timing of the literature review within grounded theory studies and provided a justification for positioning the Disability Studies review of theories at the outset and the Intercultural Studies review of theories after the data analysis.

In *Chapter Two* disability models were reviewed in relation to their relevance for this study on the case of the visually impaired migrant in Ireland. The three main approaches to disability; moral, medical and social model of disability were discussed in connection with the power of cultural perceptions of disability, specifically for the participants of this study. In addition, theories of stigma and empirical studies related to disability adaptation were examined which are of relevance for later data analysis.

In *Chapter Three* the methodological approach of the entire thesis was discussed in detail. The natural history of the research was mapped from initial curiosity in the case of the visually impaired migrant in Ireland to the selection of participants and the inception of solid research questions. The rationale to pursue qualitative research method within a grounded theory framework was debated and the nature of qualitative research was discussed most specifically the semi-structured interview technique was

carefully explained. The concept of disability was viewed through an intercultural lens. The coding process which was assisted through training and application of Atlas.ti was thoroughly examined. In addition, the limitations of the study were acknowledged and ethical issues addressed. Finally, this chapter presents a reflection piece on the interview process with particular emphasis on the challenges of interviewing visually impaired migrants.

In *Chapter Four* the personal profiles of the all of the research participants are presented. This chapter linked the methodological section with the data analysis detailing the participants' personal information in relation to both disability and migrant status, for example length of time living with sight loss and migration motivations. In the case of the six service providers in this study this chapter outlines their profiles for example in relation to their professions.

Chapter Five is the first of three chapters of data analysis in this study. Chapters 5, 6, and 7 present the research findings extracted from the raw data, communicated through the categories and concepts which surfaced from the process of data analysis. As a chapter of analysis, Chapter 5 is rooted in the data on the subject of the cultural perceptions of disability. In essence, it is the backbone of the analysis of the thesis from which the foundations of the subsequent chapters of analysis are built. Cultural perceptions are identified as the driving force in the way in which an individual's impairment is subsequently accepted or rejected within society. This study found that the consequences of culturally constructive or destructive perception of visual impairment for the individual are far reaching. This echoes other studies findings in

the field of Disability Studies that poor cultural perception of disability can hinder adaptation to impairment.

In *Chapter Six* the influence of home and host support networks emerged as one of the strongest categories from the data. In this second chapter of analysis the impact of home support from for example, family and friends in the host country is explored in relation to its outcomes for the migrant service users' adaptation to their visual impairment. Cultural perceptions of disability connected to moral and medical model perspectives were identified as negatively impacting on migrants' process of adaptation to their visual impairment. The role of the host support networks in facilitating adaptation is also analysed; for example, support from work, school and religious institutions are discussed. Racial discrimination was identified as negatively impacting on migrant service users' adaptation to visual impairment in this study.

Chapter Seven, the final chapter of data analysis, draws together the experiences that emerged from the data of migrant service users accessing and engaging with host services for visually impaired and service providers' ability to provide them. Three cultural barriers; migrant status, language barrier and cultural perception of gender, which may hinder this process were highlighted.

Chapter Eight reviews Intercultural Studies theories, applicable to the process of adaptation for the visually impaired migrant in Ireland and service providers who engage with them. The theories are presented in three levels in accordance with their influence for the participants' adaptation process, on (1) cross cultural (2) societal (3) individual level.

Chapter Nine highlights the factors related to (1) cultural perceptions of disability (2) home and host support networks (3) cultural barriers which can facilitate or hinder a migrant's adaptation to their visual impairment in the host environment. Eleven barriers and seven facilitators to the process of adaptation to visual impairment for a migrant in Ireland are identified. Each factor is analysed in detail in relation to theoretical frameworks and specific contributions of findings to knowledge outlined. These findings emerged from analysis of qualitative interviews which result the in formulation of a new conceptual model which is presented in this concluding chapter in the following section, 10.3.

10.3. Presentation of Conceptual Model of Adaptation to visual impairment for a migrant in Ireland

This section presents the new model of adaptation to visual impairment for a migrant in Ireland based on the findings which emerged from a grounded theory approach to the study of visually impaired migrants and their service providers in Ireland. Following Charmaz's (2006: 130) approach to grounded theory the aim has been to get "as close to the inside experience as we can get but realize that we cannot replicate the experiences of our research participants". Thus, a constructivist approach to grounded theory "acknowledges that the resulting theory is an interpretation".

The development of this model is a synthesis of the data collection and analysis process as presented in Chapters 4, 5, 6 and 7. Three core categories emerged from the coded data as the most integral research themes: cultural perceptions of disability, support networks and cultural barriers. Analysis of the adaptation journey, of the visually impaired migrant in Ireland pivots on these three key categories. Each key

category identifies factors which influence the migrant research participant's facility to adapt successfully or not to their visual impairment in Ireland. The findings of this study relate to the adaptation inhibitors and adaptation facilitators which emerged from the qualitative interview data.

Force field analysis is considered the most suitable means to illustrate this grounded theory model. Lewin (1997: 2001) described force field analysis as "a method of analysing causal relations and of building scientific constructs". Force field analysis demonstrates the push and pulls factors in a social context in order to assess progress in social phenomenon. For this reason it is a suitable method to adopt to highlight the inhibitors and facilitators of the adaptation process to visual impairment for a migrant in Ireland. Silverman (1999) considers that how we observe reality may be illustrated in the framework of a model. Oliver (1996: 41), however, is critical of models, as he believes that models cannot 'do the work' of social theory, nor can a model explain disability in its entirety. This current model of adaptation to visual impairment does not intend to capture disability in totality but rather is an interpretation based on the grounded theory approach which involved a sample of visually impaired migrants and their service providers in Ireland.

Therefore, the aim of this model correlates with Brett (2002: 827), who asserts "value, credibility and usefulness" of a model rests on placing the "lived experience" at the heart of the model. Additionally, like Brett (2002: 828) this study is cognizant that:

> A model may make little difference to the way in which we understand disability. An alternative model of disability will not make life suddenly

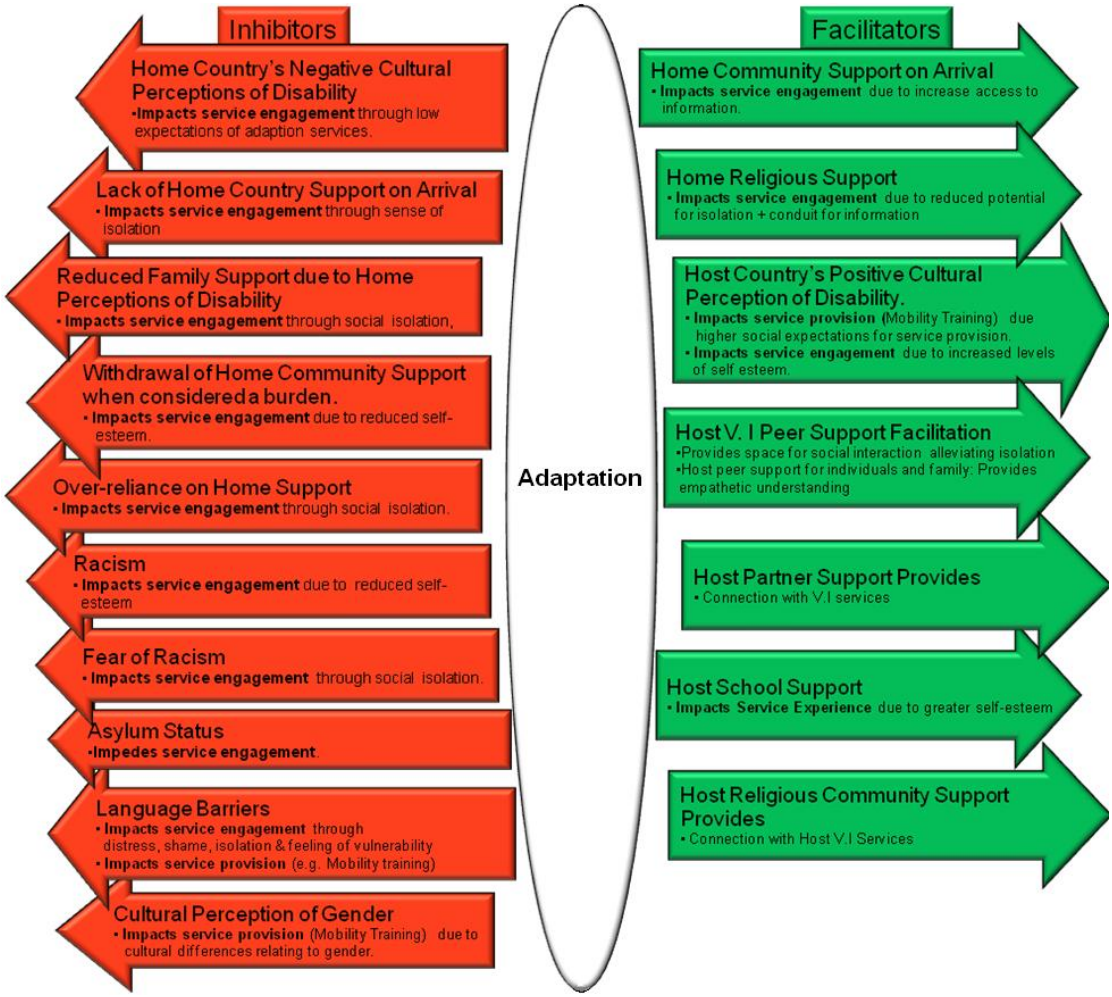
> easier for children and their parents, but may serve in the goal of understanding disability from the parent's perspective.

Brett's study is concerned with incorporating the perspective of parents of children with disability. She recognises that:

> In simple terms, a model could act as a starting point in an attempt to enable the various professionals involved in their child's life to have an enhanced comprehension of the aspects of disability encountered by parents.

In relation to this study, this model is presented as a starting point in considering the perspective of visually impaired migrant and their service providers in Ireland, in order to better understand their adaptation journey so that inhibitors can be identified and reduced. This study identifies eight inhibitors and seven facilitators for the process of adaptation to visual impairment for a migrant in Ireland as presented in Figure 5.

Figure 5 Force Field Analysis model of facilitators and inhibitors for migrant adaptation to visual impairment in Ireland



10.3.1. Similar research findings: current study's contribution to knowledge

This study, as it is the first of its kind in Ireland, contributes to knowledge in the area of both Disability Studies and Intercultural Studies in identifying key facilitators and barriers to adaptation to visual impairment for a migrant in Ireland. This study has

provided profound and hitherto undocumented experiences of visually impaired migrants in Ireland and the experiences and challenges for service providers working with them. In exploring how the interface between a migrant service user and service provider is negotiated this study provides valuable insights into how communication may be enhanced so as to facilitate adaptation process to visual impairment for a migrant in Ireland.

This study emphasises the value of qualitative inquiry for investigating individuals' perceptions and lived experiences, in addition to researching phenomena which have been relatively unexplored to date. Prioritizing the research participants' own words to support the presentation of theoretical categories facilitates genuine insights into the experiences of a group of individuals in Irish society whose voices had hitherto been unheard.

The case of the visually impaired migrant has been examined in some international studies. In the UK collaborative studies were conducted into visually impaired Black Ethnic Minorities initially in Birmingham and later across the UK (Morajaria-Keval and Johnson 2005; Scase and Johnson 2005). It was discovered that visual impairment services were relatively underused especially among Asian and Afro-Caribbean groups due to "low cultural relevance or sensitivity" and "low levels of knowledge among minority groups" (Scase and Johnson 2005: 440-1). In addition, the issue of the language barrier and lack of cultural competence between user and provider is identified as problematic. Similar findings have been identified in this study as discussed in Chapter 7.3-7.3.8 and 7.4-5.

The novelty of this current study is that it identifies the language barrier as posing an additional challenge for migrants with a visual impairment. This is because it is vital in the absence of visual cues clear communication is paramount in rehabilitative training specifically mobility training. This essential clear communication is impeded when there is a language barrier. Thus a language barrier between service user and provider negatively impacts the process of adaptation to sight loss for a migrant.

Scase and Johnson (2005: 441) suggest as a positive measure in enhancing service provision for migrants that "registers of blindness need to record ethnic origin". In this study community resource workers highlight the need for prior cultural knowledge about their clients. This is a key recommendation in this study as currently no such record exists in Ireland. Addressing issues of gender in relation to service provision for visually impaired people of Islamic faith has been welcomed by Ahmed (2007) in the UK. This study contributes to knowledge by addressing issues of gender relations as this subject emerged as posing a particularly challenging obstacle in relation to mobility training due to the unusual close proximity required between service user and provider. This study contributes to this area in relation to the cultural barrier posed by different cultural perceptions of gender and suggests fostering mutual cultural awareness, so as to ease cultural tensions and facilitate adaptation processes.

In relation to the adaptation process to sight loss Ganesh et al. (2007: 28) acknowledge the significance of "referral to appropriate support services" in successful adjustment to sight loss. This study concurs with this view as once individuals connect with specialised visual impairment services the process of

adaptation can commence. Furthermore, Ganesh et al (2007: 30) found that "the need to accept the reality of their disorder" is crucial to adjustment to sight loss for all individuals and this is facilitated through engagement with visual impairment services. This study found that adaptation is hindered due to cultural perceptions of disability with for example the moral and medical model approach to disability which delay connection to vital visual impairment services. Fostering mutual cultural understanding through intercultural training is recommended to facilitate better understanding of cultural differences which may inhibit individuals' ability to adapt to sight loss in Ireland.

Albrecht et al. (2008; 2009) examined the case of disabled migrants in Belgian society, though visual impairment is not specifically addressed in these studies. This study contributes new findings in relation to the specific concerns of visually impaired migrants and their service providers who support them in Ireland. Most significantly this study highlights the vulnerability of asylum seekers who are coping with sight loss in a new socio-cultural environment. Albrecht et al. (2009) recognises asylum seekers as "more vulnerable because they do not have the same access to health care and disability benefits as European citizens". The same is true for asylum seekers in Ireland as this study found. A reconsideration of asylum seeker health care is advocated in the case where an individual is experiencing deteriorating sight loss which may be controlled, treated and the individual rehabilitated in order to facilitate connection of this vulnerable group with vital visual impairment services in the host country.

Finally, in terms of specific findings the study has identified key factors which may inhibit or facilitate visually impaired migrant's process of adaptation to sight loss. These factors are related to the three core categories; 1) cultural perceptions of disability, 2) home and host support networks and 3) cultural barriers. These factors emerged from the grounded theory analysis of qualitative interviews with service users and providers. Eleven barriers and seven facilitators to a migrant's process of adaptation to sight loss in Ireland were identified. A summary of the study's findings is provided in Chapter 9.5. An unexpected finding was that home support would be removed from migrant following the onset of disability. Social exclusion and harassment by individuals' closest support ties during the time of health crisis of sight loss was found to cause deep psychological distress which hindered ability to emotionally and practically cope with sight loss in new socio-cultural environment. This extremely unsupportive home community behaviour was found to be related to moral and medical approaches to disability. In the case of the medical model approach the individual with disability is perceived as an economic burden due to inability to work.

The host society was also found to negatively impact migrants' ability to adapt to living with sight loss in Ireland. Host society's racist behaviour causes psychological distress significantly reducing a migrant's trust in host society. Consequently, due to reduced trust ties with host services for visually impaired are weakened which will negatively impact adaptation process should a service user disengage from rehabilitative services. The fear of racist attack was also reported to hinder migrants'

confidence to travel independently which hinders social integration which is central to adaptation to visual impairment and integration into new society.

The most critical determinant for successful adaptation to visual impairment for migrant is the independent living model approach to disability in Ireland. Emotional well-being enhanced by sense of acceptance of disability by Irish society and the practical support in accessing rehabilitative services is central to migrants' ability to adapt to sight loss. In addition, this study found that through connection with rehabilitative host services a migrant could link in with valuable peer support from "similar others": i.e. those also experiencing sight loss. Through connection with the host services this study also found that a migrant could *simultaneously,* adapt, to sight loss and integrate into Irish society.

This study's findings make a valuable input to theoretical models of adaptation to both the discipline of Disability Studies and Intercultural Studies by highlighting the need to include migrant status in models of adaptation to disability as a decisive factor in an individual's capacity to adapt to their disability in the host country. In addition, this study asserts that intercultural models of adaptation bear in mind the impact of migrants' disability status in shaping their ability to integrate into their new society.

10.3.2. Limitations of the research: recommendations for future research

This study has investigated the lived experiences of visually impaired migrants in Ireland. The chief focus has been to gain an insight into the experiences of this minority groups' process of adaptation to their visual impairment in Ireland and the

challenges for service providers working with them. Given that this is the first ever study into the experiences of visually impaired migrants in Ireland there is naturally much scope for further research. Moreover, given the diversity of issues which have emerged in the current study, the prospective for further research is vast. Embedded in this research agenda is the understanding that the main objective of the research is to promote intercultural understanding to better facilitate a migrant who is coping with the implications of disability and migrant status in Ireland.

This section of the thesis provides some recommendations for future research. These recommendations are connected with the limitations of the study as outlined in Chapter 3. 17.

Due to the scope of this study and ethical considerations of this study visually impaired migrant children were not interviewed but rather migrant parents of children with visual impairment advocated for them. It is recommended that future studies consider interviewing children where possible to give voice to their views of growing up in Ireland with a visual impairment and being from a migrant background. This study recommends that children's direct perspective would add a deeper understanding of their experiences of adapting to visual impairment. Without the filter of their parents there would be the opportunity to document how they simultaneously cope with sight loss in distinct socio-cultural environment in their own words.

In this study, service providers draw comparisons between Irish and migrant service users. It was not the objective of this study to record the opinions of the Irish service users. It is proposed that a comparative study into the experiences of each group

would provide valuable insights into attitudes towards service provision and comparative processes of adaptation to visual impairment.

This study due to time and financial restrictions did not extend its fieldwork, beyond County. Dublin; with the exception of one interview which was conducted in County Wicklow. For this reason, it cannot claim to be representative of all experiences of visually impaired migrants living in Ireland today. It is highly recommended that a nationwide study into the experiences of this minority group take place so as to record for example, the experiences of individuals in more remote parts of the country. In order to facilitate this research it is highly recommended that a field within the national organization the NCBI is created to query migrant status to include cultural and linguistic information.

Due to a language barrier communication occasionally proved challenging during the interview process. This echoes the same issue which arises for the service provider working with migrant service users who do not have a strong command of English. One of the interviews due to the sensitivity of the topic and compounded by financial restrictions was facilitated by a non professional interpreter who worked with the family. Without this community resource worker's assistance this interview could not have taken place. However, as she was involved with the family her perspective was perhaps somewhat coloured by being from the same country of origin. It is recommended where possible in future research when there is a language barrier between researcher and participant a professional interpreter is used.

Although creating a rapport with service users who did not attend the NCBI Rehabilitative Training Centre was sometimes more difficult, as this group were inclined due to lack of trust to cancel the interview, their presence in this research is vital. It is recommended that researchers are, where feasible, introduced to service users by service providers, most likely trusted persons such as front line members of staff. In this study this occurred with one exception, following this interview the participant was referred to professional counselling. In addition in relation to the impact of the research on the researcher, the need for professional support should the interview be excessively emotional in nature is identified in this study.

This study found that religious community support both from home and host community provided a valuable emotional and practical source of support for visually impaired migrant. This study recommends that this source of support be linked in with host services for visually impaired. In practical terms this would mean establishing connections between the host community resource worker and most significantly ethnic religious communities for example through a mosque or Pentecostal church. The aim would be to foster relations to inform newly arrived migrants about the possibility of connecting with specialised services where they can learn adaptive skills such as mobility training and gain valuable esteem support from professionals and peers.

With respect to further research this study advises that the role of a church or other religious organization providing support for migrants who are coping with disability be examined in more detail.

From an economic perspective this study carried out in-depth qualitative interviews with service users and providers just as the economic recession began to hit the Irish society. A key finding of this study was that despite some of the participants losing their jobs due to this recession they were motivated to remain in Ireland due to the sense of acceptance of their child's disability and higher quality of care. It is advisable that a follow up research be conducted to investigate whether this trend has or will continue considering the economic climate has worsened since the time of interview. Furthermore, it is advisable that Irish attitudes towards both disability and migrant status in the light of welfare support be examined to investigate whether social inclusive perspective towards disability is impacted by economic downturn.

The study's research findings give first hand insights into the hitherto undocumented case of the visually impaired migrant in Ireland and in doing do generate many more areas of research interest. Identity for example was a key topic in this study related both to migrant and disability status. For example, research into the role of self-esteem, disclosure of disability and the anxiety attached to that when individual is in a new socio-cultural environment with language and cultural barriers is recommended as area for future research.

Finally this study recommends that further research be conducted into migrants who are coping with disability in general. This study answered a call from Irish academics (Zappone 2001; Pierce 2005) not to neglect the case of the double minority in our society. Having completed this research it has become more apparent that research into the case of individuals who occupy multiple minority roles is undeveloped. This

study recommends that this study be implemented as a comparative tool with further studies into the lived experiences of other individuals who are coping simultaneously with disability as for example the deaf community who are migrants in Ireland.

10.3.3. Evaluation of the Study

This study adopted Charmaz' (2006) version of grounded theory. Following completion of the research Charmaz recommends evaluating the work on the basis of four criteria (i) Credibility, (ii) Originality, (iii) Resonance and (iv) Usefulness. In Chapter 3.11.1 explicit questions ascribed to these criteria were detailed. It is useful to now reflect on the findings according to these criteria.

(i) Credibility

Through a rigorous and detailed engagement with this minority group and the phenomena of simultaneously coping with disability and migrant status in Ireland an intimate familiarity with the topic of the experiences of visually impaired migrants has been reached. Qualitative data was thoroughly analysed presenting findings grounded represented by participants' own words. Key categories have been identified based upon logical argumentation which link data to analysis and in addition supporting information provided in Volume II's Appendices lend further transparency to the research process.

(ii) Originality

Given that this is the first time the situation of visually impaired migrants in Ireland has been examined the research is innovative in nature. As has been discussed, it contributes to knowledge by identifying several key facilitators and barriers to adaptation to visual impairment for migrant in Ireland. The conceptual model which is based on the study's research findings offers useful guidelines for service providers working with visually impaired migrants in Ireland to ensure a smoother transition from sight to sight loss. Furthermore, this study's findings challenge dominant understandings of migrant support networks. Asylum seekers with visual impairment are identified as the most vulnerable group in this study as prolonged delay in access to specialized services can severely damage the process of adaptation to sight loss. Recommendations are offered to reduce barriers to adapting to sight loss in Ireland.

(iii) Resonance

The key categories in this study portray the central areas of concern for the visually impaired migrants in Ireland and moreover these categories are interlinked. Cultural perceptions of disability are found to impact both the potential to accept and hence adapt to disability. Deeply rooted cultural perceptions of disability are carried from home to host country which can impact connection with host services. Consequently delay in connection with services can impede adaptation to disability and overall integration into Irish society. Participants themselves played a central role in guiding the research interview in order to fully capture their main concerns. My role as researcher was to attempt to remain objective so as to detect areas of special individual concern and probe further to offer deeper understanding about their lives.

This study reports on the concerns most pertinent to the people who took part so as to better understand their experiences and address the barriers faced in adapting to sight loss.

(iv) Usefulness

As discussed this study is the first of its kind in Ireland to address the situation of migrants who are coping with sight loss in Ireland. By identifying factors which can help or hinder the process of adaptation to visual impairment the aim is for the study to provide practical guidelines for service providers working with migrants. In addition the findings also make a valuable contribution to the broader disciplines of Disability and Intercultural Studies.

10.3.4. Reflexivity

This section provides a brief reflection on the impact of the study on me and the participants involved. In Chapter 3.15 the necessity for reflexivity in the research process is discussed.

The research process in its entirety has had a profound impact upon me as a social researcher, professionally as a teacher at the NCBI and to a lesser extent during my time lecturing at DCU. This research study grew from questions that arose from experiences of teaching intercultural studies class to a diverse group of visually impaired individuals at the NCBI. I believe that I have answered most if not all the original research questions and at the same time unearthed many more which provide motivation for further research. Meeting and hearing firsthand accounts of lived

experiences of sight loss for migrants during the interviewing process in particular, I found particularly rewarding and challenging at the same time. During the process, as my confidence in coping with sensitive subjects developed, I found that my interview skills were improving. Moreover, the progress I made with the interviews I felt was reflected in my ability to move through the data during the analysis stage at a quicker pace and ultimately construct a new conceptual model of adaptation to sight loss for a migrant in Ireland.

In the context of the impact upon my role as a teacher at the NCBI I feel that this research compliments the way in which I prepare and plan for my intercultural studies class bearing in mind the complex nature of language and cultural barriers for someone with little working sight. Following the research study I have liaised with NCBI staff to run intercultural workshops at the training centre. Intercultural training workshops aim to foster mutual cultural understanding between service users and providers as advocated by this study's research findings. During my time as a lecturer on intercultural studies undergraduate courses I found that my experiences of qualitative interviewing impacted my approach to setting assessments which involved fieldwork; moreover, I developed lecture plans to address the case of migrants coping with disability in Ireland to highlight the issue for my students.

The long term impact of the research on the participants involved is often difficult to gauge. Nevertheless, following each of the interviews the participants did express appreciation for my interest and concern in their experiences. Moreover, the majority of the service user participants mentioned that this had been one of the first occasions

they had experienced the opportunity to articulate their feelings of coping with sight loss in Ireland. In addition, the majority of the service providers who participated in the study expressed the value in adding a field to the service user database to include nationality with the aim of being informed of language and cultural barriers that may impede service provision prior to connecting with migrant service user.

10.4. Conclusion

The goal of this study has been to explore the experiences of visually impaired migrants so as to understand their process of adaptation to visual impairment in Ireland. Embedded in this is the aim to identify the means to facilitate the process of simultaneously coping with sight loss in a new socio-cultural environment. The challenge of integration and social cohesion is the challenge more than ever of our increasingly diverse society. This study concludes that the perceived cultural attitude of inclusion towards people with disabilities is the overriding factor in migrants' ability to adapt to their visual impairment. Cultural perceptions of disability are found to be carried from home to host country. Negative perceptions of disability in migrants' home country will influence the expectation of support and the way in which migrants access host services. This study has identified negative cultural perceptions of disability as rooted in moral and medical approaches as not only hindering individual's engagement with services but also the home community's engagement with the visually impaired migrant. Absence and withdrawal of support from migrants' home community is due to being perceived as an economic burden and is identified as connected with moral and medical approaches to disability. This

study highlights the positive supportive role of both home and host religious communities in assisting migrants to cope with sight loss in the new socio-cultural environment. This study concludes that it would be advisable for host specialised services to connect with ethnic religious organizations to provide information and awareness about rehabilitative services in Ireland. Furthermore, it is recommended that the opportunity of establishing links between host services and ethnic religious groups would be beneficial for developing intercultural communication regarding cultural difference, for example, gender relations.

Migrant status was raised as a determining factor in migrants' ability to adapt to visual impairment in Ireland. Given that asylum seekers are not entitled to full access to specialized support services, asylum seekers must endure a prolonged wait prior to eligibility to access services. This study asserts that the case of an asylum seeker who is coping *simultaneously* with the challenges of separation from family in a new socio-cultural environment while coping with sight loss places them in an extremely vulnerable health position. This study concludes that the case of migrants who are coping with asylum and disability status should be prioritised in the asylum process and access to specialised services be granted. Facilitating access and engagement with services will alleviate some of the immense stress felt by asylum seekers coping with sight loss and asylum status. This study concludes that to deny asylum seekers access to vital health care in the face of coping with disability is a denial of human rights.

The issue of a language barrier between service users and providers has been highlighted as a key challenge to migrants' successful process of adaptation to sight

loss in Ireland. This study concludes that the asylum seeker who is struggling with a visual impairment in a new socio-cultural environment is ill equipped to adapt without language support from the host country. This study recommends that asylum seekers have access to professional language support on arrival so as to communicate most specifically their needs in relation to health.

A language barrier is highlighted as posing a particularly severe challenge for a migrant coping with sight loss as clear communication is identified as fundamental in rehabilitation especially mobility training. This study recommends that a professional interpreter mediate communication between service user and provider to overcome a language barrier and ensure a migrant can safely pursue their goal of independent living.

Within the current economic climate of cuts to service provision, the National Council of Special Education (NCSE 2011) has witnessed Irish children with special needs including visual impairment directly impacted with withdrawal of vital care. Irish governmental attitudes of equality and inclusion towards people with disabilities are currently debateable. This study has demonstrated the tremendously positive impact an inclusive Independent living socially driven model of disability has for potential to adapt to visual impairment and additionally for a migrant to (re)integrate into society. The current cuts to provision of social support for society's most vulnerable threatens the positive work of disability organizations nationwide and it represents a backwards step in Irish social cohesion policy in general.

The study's research findings highlight the complex nature of the visually impaired migrant and in doing so aimed to bridge a gap between the disciplines of Disability and Intercultural Studies. By identifying the barriers and facilitators to a visually impaired migrant's process of adaptation in Ireland this study makes a valuable contribution to theoretical models of adaptation to both the discipline of Disability Studies and Intercultural Studies. Recognising and including migrant status in disability models of adaptation and disability status in intercultural models of adaptation as decisive factors in an individual's capacity to adapt to their disability in their host country represents a critical action in bridging the gap between the disciplines.

It has identified that similar obstacles of inequality face both individuals with disabilities, specifically in this study those coping with sight loss and individuals from a different cultural backgrounds. There are in fact, strong parallels in the terminology connected with both disciplines three key terms which are significant in this study are related; orientation, adaptation and integration. In essence, this study has demonstrated for the visually impaired migrant an overlap in these three terms, as adaptation to sight loss in Ireland is dependent upon independent physical and cultural orientation in society so as to integrate disability into their identity to participate in Irish society.

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