Examining Life Satisfaction of Adults with Visual Impairments: A Social and Ecological Perspective of Disability

Mirko Kunstek

DISSERTATION
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The committee for this doctoral dissertation proposal consisted of:

Committee Member Susan E. Mason, PhD ________________________

Committee Member Charles Auerbach, PhD _______________________

Outside Reader Joan Rosenberg, PhD ____ ________________________

Advisor Ann A. Abbott, PhD_ ___________________________________

Chapter One: Dissertation Overview

Introduction

This study examined the factors that were predictive of the level of satisfaction with life of individuals with visual impairments. The following factors were examined as they relate to life satisfaction: general demographics, accessibility to services, acquired versus congenital visual impairment, social support, and adjustment to disability. This was a quantitative study. Quantitative research "is a means for testing objective theories by examining the relationship among variables. These variables can be measured typically on instruments, so that numbered data can be analyzed using statistical procedures" (Creswell, 2014, p. 247). The quantitative methodology approach according to Creswell (2014) posits "Postpositivist knowledge claims" (p. 18), in which:

> 1. Knowledge is conjectural (and antifoundational)- absolute truth can never be found. Thus evidence, established in research is always imperfect and fallible. It is for this reason that researchers state that they do not prove a hypothesis; instead, they indicate a failure to reject the hypothesis.
> 2. Research is the process of making claims and then refining or abandoning some of them for other claims more strongly warranted. Most quantitative research, for example, starts with the test of a theory.
> 3. Data, evidence, and rational considerations shape knowledge. In practice, the researcher collects information on instruments based on measures completed by participants or by observations recorded by the researcher.
> 4. Research seeks to develop relevant, true statements, ones that can serve to explain the situation of concern or that describe the causal relationships of interest. In quantitative studies, researchers advance the relationship among variables and pose them in terms of questions and hypotheses.
> 5. Being objective is an essential aspect of competent inquiry; researchers must examine methods and conclusions for bias. For example, standards of validity and reliability are important in quantitative research. (Creswell, 2014, p. 7-8)

The data were collected using survey methodology which included the following standardized scales, 'The Satisfaction with Life Scale' (Diener, Emmons, Larsen, Griffin, 1985), 'The Medical Outcomes Study Social Support Survey' (Sherbourne & Stewart, 1991) and 'The Nottingham Adjustment Scale' (Dodds et al., 1993). The sample obtained was a national convenience sample with 203 participants and was obtained from members of Merican Council of the Blind, Inc. (ACB). Permission for administering the study was obtained from the National Executive President of ACB, Inc., Eric Bridges and the President of ACB of Greater New York, Inc., Lori Scharff. Janet Dickelman, the Convention Coordinator of ACB disseminated the survey and invited people to participate. The survey was disseminated using the ACB listserv and survey monkey in the summer of 2020. In addressing the issue of informed consent, the following measures were in place: the survey had no identifiers (no names), data were analyzed aggregately, each survey was a separate case, only the researcher had access to the survey and the results.

The data were analyzed by the use of STATA 16 using Multiple regression as a statistical approach as well as other statistical techniques. Multiple regression is “used to predict the value of dependent variable (also known as an outcome variable) based on the value of two or more independent variables (also known as predictor variables)” (Lund Research, 2018, “Multiple Regression” section). Furthermore, “Multiple regression also allows you to determine the overall fit (variance explained) of the model and the relative contribution of each of the independent variables to the overall variance explained” (Lund Research, 2018, “Multiple Regression” section).

The following components of the National Association of Social Workers (NASW) Code of Ethics were relevant to the research, ‘social justice’ and ‘dignity and worth of a person’, ‘self-determination’ and ‘empowerment’ (NASW, 2017).

The Social Model of Disability

The study used ‘the social model of disability’ as a framework to examine the broad problem of persons with visual impairments. A frequently used alternative, the biomedical model, neglects to address the whole person and views disability as a problem to be fixed. In the biomedical model the social and environmental aspects of a person with a disability are not theoretically attributed. By disregarding the social and environmental aspects of a person with a disability, strengths and skills are given less attention. Persons with a disability end up being excluded from opportunities that could potentially benefit their lives. The biomedical model therefore is not adequate to account for the scope and intricacies of disability. This study recognizes that disability is not just a personal issue. It is also a social, societal, economic and political issue. The breadth of the influence of disability affects us all.

According to the World Health Organization (2011):

> the United Nations Convention on the Rights of People with Disabilities (CRPD)" (2006) (p. 3), "acknowledges that disability is "an evolving concept", that "results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others". Defining disability as an interaction means that "disability" is not an attribute of the person. (p. 4)

It is essential to consider disability as a multifaceted construct. Disability can be seen through the biopsychosocial lens, which incorporates medical, social, and environmental factors. The disability model, integrating the biomedical and biopsychosocial models, allows a more comprehensive picture of a person or group of people with disabilities.

In further examining disability, a discourse of the social and environmental barriers present in the lives of people with disabilities is needed. The scope of the barriers that persons with a disability experience is broad. When considering issues such as general healthcare, education, employment access, and accessibility to benefits, the literature supports evidence that inequity is present for these individuals. The lack of inclusivity creates barriers that become ingrained in the societal schema and misinformation about disability further exacerbates the inequity. What society believes directly manifests in the form of barriers and inequity that persons with disabilities must navigate on a daily basis. Consider the social construct of disability:

> Disability is a social problem concerned with the effects of hostile physical and social environments upon impaired individuals, or even a societal one concerned with the way society treats this particular minority group. As such, the base for social work activity with disabled people needs to be broadened" (Oliver et al., 2012, p. 3).

Disability is multifaceted and is integrated into society in a holistic and pervasive manner. A comprehensive treatment of disability must be viewed as the interaction of society and the person. A holistic approach is needed to understand disability as part of 'a web of society'. Any part of society or the person (person with a disability) cannot be taken in isolation. When society changes or is modified there is an appreciable or equivalent effect on the person and vice versa. The intermediary is the social worker. Their effectiveness depends on comprehending the different facets of disability and relating to the needs and experiences of people with disabilities and society (Oliver et al., 2012).

Compatibility of Study with NASW Code of Ethics

The NASW Code of Ethics values of social justice, dignity and worth of the person, empowerment, and self-determination are directly related to the framework of this study. The value of social justice pertains to the issue of disparity in accessibility for persons with disabilities. Dignity and worth of the person are necessary for a more comprehensive understanding of disability. The ethical value of empowerment is crucial in our understanding of how the lives of visually impaired individuals can be improved (NASW, 2021).

This study followed in the spirit of the NASW Code of Ethics (2021). In researching visual impairment in adults, all the stated tenets of the NASW Code of Ethics are represented in the literature. When considering access to resources and opportunities for adults with visual impairment, the discrepancies are marked. The social work values of social justice and dignity and worth of the person are key to understanding the significance of these discrepancies. The NASW Code of Ethics expects social work professionals to be aware of injustices and take action towards ameliorating them in any form manifested. The pursuit of social change with and on the behalf of vulnerable and oppressed individuals and groups of people (NASW, 2017) is key to this study.

Another key to understanding the discrepancies that affect the blind and visually impaired community is 'dignity and worth of the person'. The operative word 'dignity' is the value that guides how social workers treat individuals and groups of people. Social workers are duty bound to empower people in their lives and facilitate the "opportunity to change and address their needs" (NASW, 2017, Ethical Principles, paragraph 4, sentence 3). Another social work ethical principle is self-determination. The NASW code of ethics (2017) states the following: "Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs." (Ethical Principles, paragraph 4, sentences 2-3) This infers there is a reciprocal relationship between the clinician and the client. Therefore, the goal for the client/clinician dyad is for the client to have self-determination in their life course and to maximize their potential. In actual terms this includes self-advocacy and self-sufficiency and has the potential to improve the quality of life of disabled individuals.

In examining the social work values of social justice and dignity and worth of the person common themes arise. These values focus on the treatment of persons with a disability and stand out as factors that indicate levels of equity and accessibility in society. For instance, the value of social justice mandates social work professionals to confront discrimination in the societal context. Issues such as inequity in education, employment, access to healthcare services and access to benefits are issues that are prevalent for persons with a disability. On a broader level, the legislation proposed by the government stops short of ensuring that laws such as the Americans with Disabilities Act (ADA) are implemented equally across the country. Although the ADA is federal law, there is no adequate mechanism that can oversee the consistent administration of the ADA. In cases in which persons with a disability are discriminated against because of their disability, it is difficult to prove. In these cases, the employers, healthcare professionals and other personnel state other reasons why the person(s) did not get hired, receive adequate healthcare services, or had obstacles placed before them and did not receive access to educational opportunities.

In examining the social work value of empowerment, self-sufficiency and independence must be considered. People with disabilities require self-sufficiency and independence to take part in society's mainstream (Oliver et al., 2012). In addition, the perspective of people with disabilities has changed towards ability, not disability.

Implications of Study

This study can potentially increase the knowledge base relevant to people with disabilities, particularly individuals with visual impairments. The knowledge gained can provide helping professionals with an improved practice/treatment methodology, a greater awareness of visually impaired clients' issues, and the obstacles they face on a daily basis. Assisting the visually impaired community can be improved with a greater knowledge of the real needs in the environment that they must navigate, such as attaining employment, education, and health care services.

Legislators can use the knowledge gained from this study to help target the needs of the visually impaired community and tailor policy that can ameliorate their satisfaction with life and overall quality of life. In respect to macro perspective issues; high unemployment, lack of access to health care services, and lower educational attainment can be improved. If successful in addressing these issues, persons with a disability will gain greater control of their lives and futures. Creating laws that favor equity, accessibility of resources and services and overall prosperity would be of mutual benefit both to the visually impaired and mainstream society. When persons with a disability are included into the mainstream of society, all citizens benefit.

Anticipated Contributions to Social Work Knowledge

Finding what factors affect the life satisfaction of visually impaired adults can reveal what specific changes to governmental policy are needed to improve the lives of the visually impaired community. The results of policy change have the possibility of benefiting the visually impaired community by ameliorating their economic situation, improving access to educational opportunities, and subsequently the availability of jobs. The changes to policy would not be complete without addressing accessibility to services/resources as an essential part of the issues faced by visually impaired individuals.

Prior to acquiring any professional counseling experience, I had the great fortune of working at the Access and Technology Center at Hunter College. The center served students with disabilities by maintaining and advocating for ADA guidelines and granting accommodations to students with disabilities. The center also had assistive technology software and hardware which disabled students could access to do their coursework. My role at the center was to refer students to appropriate services, peer counseling and tutoring social sciences. Overall, I observed the students at the center have access to their designated accommodations. On occasion, students with disabilities experienced opposition from professors who did not abide with the ADA. Staff members at the center would then act as advocates for the students. It quickly became evident to me that students with disabilities experienced obstacles in their pursuit towards attaining an education in their chosen field. One such obstacle that students with disabilities are confronted with is the negative attitudes towards disability. Some individuals believe that people with disabilities are not as capable and that the assistance students with disabilities receive gives an unfair advantage. The obstacles visually impaired students face regularly defy the understanding of a person without a disability. The difference in the frame of reference for a visually impaired individual and an individual with sight is significant. For example, when a student with sight is preparing a research paper and accessing a library database, the act of performing research is straight forward. The links on the library web page that access articles can be accessed by a sighted person. The situation is different for an individual with a visual impairment. The same links to the articles are far more difficult to access and take more time to find.

Imagine for one moment you could not use your sight in performing daily tasks. How would you manage to do them successfully? Now imagine that you had additional obstacles preventing you from doing your daily routine. How would you navigate the kitchen to make a meal? How would you cross the street safely? It soon becomes clear that for visually impaired individuals to be successful in society, people in general must change their attitudes and perceptions. First, it is likely for a person to acquire a disability in their lifetime. Second, everyone has abilities and skills. Third, everyone has the need to be accepted and respected. Fourth, for society to work properly we have to cooperate with other human beings.

The glaring inequities and systematic discrimination that individuals who were visually impaired experienced is in part why I chose to research the visually impaired community and their satisfaction of life or quality of life for my dissertation. In my work with individuals who were visually impaired, I observed the difficulties this community faces and the obstacles they navigate. Most of all, I have observed how resilient and determined persons who were visually impaired are in achieving their goals. This community wants to work, have an education and live a happy life. For those reasons, this dissertation research study is needed for visually impaired individuals and society.

The visually impaired community faces discrimination on a regular basis. In my professional experience working with people with disabilities, I have seen individuals who are credentialed professionals struggle to attain a job in their field. In one instance, a person with full credentials in Mathematics Education actively looked for a job position for more than eight years. She finally received a job position as a math tutor at a community college. After a great deal of aggravation testing her resolve, she is doing what she loves - teaching students mathematics. She would be teaching in a university had it not been for the pervasive inequality in opportunity faced by visually impaired individuals. This is not an isolated case. Individuals who were visually impaired and educated in their field are systematically excluded from the opportunity of working in their chosen vocation. Visually impaired individuals are eager to work and contribute to society yet despite their apparent talents and skills, there is a marked gap in visually impaired people who are employed versus unemployed or underemployed. The visually impaired community would be vastly improved in all aspects of their lives if there is a shift in the societal perspective. By acknowledging people with disabilities’ strengths and abilities and treating them with dignity, a more equitable and functional society can result.

Chapter Two: The Study Problem

This study was designed to identify factors that influence the satisfaction with life of individuals with visual impairments.

Who Is Affected and How

According to the Center for Disease Control and Prevention (CDC)'s National Health Interview Survey, in 2017, approximately 27 million "adults age 18 and over" in the United States reported having visual difficulty. More women (16.383 million) than men (10.516 million) reported visual difficulty (CDC, 2017, Table A-6A, p.4).

Environmental obstacles that prevent persons with a disability from fully participating in the mainstream of society are pervasive (WHO, 2011). According to WHO's Summary World Report on Disability, examples of obstacles include: "inadequate policies and standards; negative attitudes; lack of provision of services; problems with service delivery; inadequate funding; lack of accessibility; lack of consultation and involvement; and lack of data and evidence" (WHO, 2011, pp. 9-10). These obstacles influence the level of inclusion of individuals with a disability and manifest as poor health, diminished educational attainment, higher unemployment, increased levels of poverty, lower autonomy and decreased involvement in daily activities (WHO, 2011)

Individuals with disabilities have worse wellbeing outcomes in comparison to the general population (WHO, 2011). When considering susceptibility of avoidable diseases, people with disabilities fare worse than the general public. The Summary Report on Disability (2011) also states persons with disabilities represent higher levels of perilous behavior (i.e., smoking, poor diet, physical inactivity) and increased peril of violent assaults. The lack of professional assistance towards the reintegration of individuals with a disability may result in less than adequate well-being, as in worsening of medical condition(s), activities of daily living, decreased inclusion in community activity and a decline in overall life satisfaction (WHO, 2011).

Educational attainment is lower for youth who have a disability. They begin school at a later age than students that do not have a disability. The decreased rate for educational achievement is exhibited at every age category and in both lower and higher socioeconomic statuses, with a higher rate within lower socioeconomic status. (WHO, 2011)

Individuals with a disability have elevated levels of joblessness. In addition, their salaries are lower despite having a vocation. The rate of employment for people who do not have a disability is nearly twice that of people with a disability (i.e., "75%" and "44%", respectively) (WHO, 2011, p. 11).

On a global level poverty is greater for individuals with a disability. The necessities that the general population takes for granted are not readily available to people with disabilities. Absence of essentials such as sustenance, adequate shelter, sufficient "clean water and sanitation", accessibility to "health care" and financial capital expenditure are seen at higher levels for individuals with disabilities. For people with disabilities that have "low-income" the situation is far more serious. Individuals that have low-income and a disability "are 50% more likely to experience catastrophic health expenditure" (WHO Summary World Report on Disability, 2011, p. 11).

Zhang et al., (2008) found that 8.2% of the United States population who self-reported as having a visual impairment did not have health insurance. Additionally, only 4% of Americans who did not have health insurance had the option to get vision insurance, as opposed to 74.7% who had private health insurance and "71.1%who had public health insurance. They also found that over 44% of U.S. individuals with a visual impairment with no health insurance were in the lower income brackets (Zhang et.al, 2008).

Background of Problem in American Society

Although people with disabilities have existed in America since the inception of the country, equality for individuals who have a disability has not. The move towards equality of persons with a disability has been long, difficult, and ardently fought for; and continues to present day. In her book “A Disability History of the United States”, Nielsen asserts:

> “When “disability” is considered synonymous with “deficiency” and “dependency,” it contrasts sharply with American ideals of independence and autonomy. Thus, disability has served as an effective weapon in contests over power and ideology. For example, at varying times, African Americans, immigrants, gays and lesbians, poor people, and women have been defined categorically as defective citizens incapable of full civic participation.” (2012, p. xii).

Nielsen goes on to state that:

> “In real life, however, just as in real democracy, all of us are dependent on others. All of us contribute to and benefit from the care of others – as taxpayers, as recipients of education, as the children of parents, as those who use public roads and transportation, as beneficiaries of publicly funded medical research, as those who do not participate in wage work during varying life stages, and so on. We are interdependent people.” (2012, p. xiii)

This researcher concurs with Nielsen’s conception that humankind is interconnected, that we are all part of the ‘web of society’, and disability is an integral part of humanity that can become part of anyone’s reality at any time. We run the risk of disrupting or destroying the ‘web of society’ when we neglect to acknowledge this essence of ourselves.

In striving towards the progression of equality for people with disabilities the belief that deficiency is the only criterion for understanding disability is in actuality a false and limited conceptualization. Disability is multifaceted and does not have a generic description or prescription for all individuals.

According to Oliver et al., what is needed for people with a disability to achieve full social integration is to achieve independent living. They identify twelve basic rights that are necessary to bring equal opportunity for disabled people: “information; counseling; housing; technical aids; personal assistance; transport; access; inclusive Education and Training; an adequate income; equal opportunities for Employment; advocacy (towards self-advocacy); appropriate and accessible health care provision” (2012, pp. 75-76).

The above basic rights as framed by Oliver et al. (2012) illuminate what is necessary to achieve independent living for people with disabilities. Information about what the rights and benefits that people with a disability are entitled to is needed for beginning the road towards self-sufficiency and empowerment. Counseling is required to guide recipients in navigating the services as well as assisting people who have a disability to integrate into the mainstream of society. Housing is essential to provide a stable environment in which safety, psychological and house design needs are met. Technical aids, when appropriate, permit the recipient to be further integrated into society and to be able to communicate with the outside world. Personal assistance allows the recipient to incorporate services for the recipient when necessary. Transportation provides access to the external environment. Access is especially important when obstacles such as physically inaccessible places of business or offices are present. Inclusive education and training are facets that permit recipients to attain upward mobility and more opportunities. Adequate income makes it possible for disabled people to be self-sufficient. Equal opportunities for employment are essential in connecting education and training and attaining financial security. Advocacy is important for the disabled person in striving towards self-sufficiency and self-determination. Appropriate and accessible health care provision provides the security of health and well-being of people with a disability (Oliver et al., 2012).

The above essentials for independent living are being fought for by people with a disability, in particular people with visual impairments. The above list of essential provisions for people who have a disability are something that the general population takes for granted. This presents a problem in that it creates a disparity in access to services and opportunities for the disabled community.

Federally Funded State Policies Affecting Problem

In examining federal legislation that has been enacted for the blind and visually impaired, an historical perspective is required to show the contexts of where legislation has originated, the status presently, and the direction it needs to travel in the future. By showing the history of legislation for the blind and visually impaired, an association can be made to the satisfaction of life of individuals who are blind within this community.

Although legislative progress has been made for the visually impaired community in the United States, the reality of the well-being of individuals with a visual impairment depicts another narrative. As previously stated, individuals with a visual impairment experience disparities and inequities in employment opportunities, educational attainment, economic hardship, and poor health outcomes. The present legislation does not go far enough to ensure consistent adherence to the law. The laws do not have adequate provisions to oversee adherence to providing equal opportunity and accessibility to individuals with disabilities. (See Appendix A. Please note: Some of the terminology depicting individuals with disabilities over time has been modified and is no longer in use).

Role of Social Work in Addressing the Problem

The NASW Code of Ethics (2017) calls for the profession of social work to assist and facilitate clients to make their lives better. Regarding people with visual impairments, social workers have tools to make their lives better. The social work ethical principles of dignity and worth of a person, self-determination, social justice and empowerment are grounded in the duty of social workers to uphold.

Fit of Problem with Social Work Values

The problem of disparity in the visually impaired community relates well with the core values of social work specified in the NASW Code of Ethics (2017). The core value of service is stated as follows: "Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems" (NASW 2017, Ethical Principles, paragraph 2, sentence 1). Social workers are duty bound to advocate, facilitate or assist in alleviating the societal issues faced by the individual or group in need. Disabilities, in particular visual impairments, need more attention not only in providing services such as benefits, but also addressing the societal problems that detract from the accessibility of resources every person has a fundamental human right to.

Social justice is another social work value that is relevant. The blind and visually impaired community have marked disparities in the accessibility and opportunity to resources afforded to the general populace. It is the duty of social workers to be aware of and address these issues. Whether through advocacy or direct facilitation, there are societal barriers present that social workers are obliged to dismantle. The barriers can originate from within the person or from society in the form of physical, deprecating or biased practices. These obstacles are prevalent in the communities, agencies, and government in which we live in.

The core value of dignity and worth of a person addresses the self-sufficiency and self-determination of an individual. This core value extends the work of the social worker and empowers the person such that self-advocacy and self-determination become integral parts of that person. The result being the person with a disability exhibiting strengths and abilities within themselves and in the perspective of others.

The core value of importance of human relationships addresses the obligation of social workers to work with and advocate for the elimination of societal barriers for people with disabilities.

Relationship Between Research Problem and the Research Question

The relationship between the research problem and the research question stems from the subjective experience of satisfaction of life and connects to the actual life experience of exclusion, disparity in access to resources, lack of opportunity, and discrimination. The satisfaction of life (research question) can be considered an abstract conceptualization. The objective conceptualization of life experiences is the research problem. This enables a quantitative analysis of the research topic to be performed.

Chapter Three: Literature Review

The available literature on visual impairment and the related issue of quality of life is sparse. This section extrapolates the issues of the visually impaired community and shows a pattern of disparity in allocation of resources and opportunities and systematic discrimination. The 'history of blindness and rehabilitation measures' section provides the measures that have been taken over time and the influence of factors directly and indirectly related to the plight of the visually impaired. The 'brief summary of the degree and types of visual impairment' section describes the major eye disorders and what is meant by visual impairment and low vision from a functional perspective.

The 'definition of disability under federal programs for the consumer with a visual impairment' section describes federal benefits and entitlements and the eligibility requirements for individuals with a visual impairment. The 'demographics of people with a visual impairment' section shows the disparity evident in the visually impaired community and the trend for increased cases in the future. Next, the 'health disparities and healthcare discrimination of individuals with a visual impairment' section shows the barriers present for people with a visual impairment when needing healthcare services and the resulting discrimination directed towards them. The 'disparities in accessibility of services' section explains how the systematic biases are manifested in lack of opportunity, resources and services. The 'accessibility to benefits' section shows that, despite there being laws in the United States giving protection to the rights of individuals with a visual impairment, negative attitudinal barriers are still present.

The 'employment outcomes and employment barriers' section illustrates the negative attitudinal perceptions employers have of people with a visual impairment and the resulting lack of essential resources necessary to do their jobs. In the 'educational attainment for individuals with a visual impairment' section barriers are shown that prevent accommodations from being made available and for students with a visual impairment to have equity in attainment of education. The final section 'quality of life of adults with a visual impairment' shows a glimpse of the lives of people with a visual impairment and their difficulties in negotiating the intricacies of society.

History of Low Vision, Blindness and Rehabilitation Measures

Sassani (1995) presents an exceptional historical depiction of rehabilitating students with a visual impairment. In Paris 1784, an educational institution for the blind and visually impaired was created which was soon emulated in Liverpool, England in 1791 (Sassani, 1995). Although, this was a step in the right direction, the curriculum taught in the schools did not prepare students with a visual impairment for living self-sufficiently in mainstream society (Sassani, 1995). In 1832 the New England Asylum for the Blind opened in Boston, Massachusetts. It was renamed "the Perkins Institute in Watertown Massachusetts". Iin the same year, the New York Institute for the Blind was established in New York City, as was Overbrook School for the Blind in Philadelphia (Sassani, 1995).

The conceptualization of rehabilitation changed in focus under the leadership of Dr. Samuel Gridley at the Perkins Institute (Sassani, 1995). He strived to prepare his pupils to be directly involved in their communities. In 1837 Dr. Gridley created the first workshop for the blind and supported early classes in mobility training. Francis Campbell coordinated the effort (Sassani, 1995).

The road towards the present professional disciplines and how they became a part of current care and rehabilitation of the individuals with a visual impairment has slowly evolved and became more cohesive. The professions servicing the blind and visually impaired currently include, "rehabilitation teaching, orientation and mobility, social case work, vocational rehabilitation, vocational placement, special education, and occupational therapy" (Sassani, 1995, p. 145). The competition between the professions that serviced the blind and visually impaired inhibited progress (Sassani, 1995). The present use of the long cane and/or guide dog to assist in safe ambulation had not been common practice as it is today (Sassani, 1995). The advent of Seeing Eye Dog use in America brought orientation and mobility training to blind people. Richard Hoover was pivotal in developing standardized methods for using the cane in enhancing mobility following WW II military personnel returning home having lost their sight in the war (Sassani, 1995). Before this program was created, methods for mobility training "facial vision" were taught. Sassani (1995) noted it was "believed that blind individuals could sense the proximity of obstacles utilizing the non-contact effects of the object on the facial skin" (p. 146). It was thought that blind individuals could sense where they were by sensing vibrations on their facial skin. This belief was disproven when it was shown that acoustic indicators actually represented facial vision. Military hospitals remained resistant to adapting the use of the long cane (Sassani, 1995).

Rehabilitation teachers played an important role in the history of visual rehabilitation. Rehabilitation teachers began as 'home teachers' through the 1800s assisting blind individuals to read scripture (Sassani, 1995). A high percentage of these teachers were blind and used "raised embossed type" created by William Moon who was a blind priest. The concept of home teaching was expanded and supported with the establishment of the Home Teaching and Visiting Society of London in the 1850s.William Cooper began teaching in the London school and provided service to 71 clients in his initial year of his employment (Sassani, 1995).

John Rhodes and William Moon gathered their resources and created the Pennsylvania Home Teaching Society and Free Circulating Library for the Blind in

Philadelphia in 1892. The following year Connecticut was the first state to allocate funds towards home education. Over time home teachers began to shift their focus to teaching self-sufficiency and how to deal with everyday issues (Sassani, 1995).

World War I and World War II were unexpected influences towards further progress of rehabilitation for the blind and visually impaired. According to Sassani (1995), Father Thomas J. Carroll had vast influence on progress made towards providing visual services for the military and veterans administrations. After graduating from Holy Cross College in 1932, Father Carroll completed St. John's Seminary and subsequently was appointed assistant director of the Catholic Guild for the Blind. Later he was also appointed director of the Perkins School as well as chaplain. By the time WW II had begun Father Carroll amassed a great deal of expertise and practice working with people who had visual impairments. The demand for resources for soldiers that had become blind in WW II resulted in the Army and Navy creating centers where they could get rehabilitation services. During this time Father Carroll had been appointed chaplain to the facilities in the Northeast. Richard Hoover received the attention of Father Carroll. Hoover's creation of mobility training using the long cane would come to fruition with the help of Father Carroll. Sassani (1995) noted that the Veterans Administration and the public adapted the use of the long cane as an accepted technique for safe ambulation and if events had occurred differently, we would not have the options to services and equipment that individuals with visual impairments are afforded today.

Degree and Types of Visual Impairment

Visual impairment is defined in the US when visual acuity is $\leq$ 20/200 and/or a visual field of 20 degrees in the eye with better visual acuity when using the Snellen Scale. The term Low Vision is defined as having the visual acuity of 20/70 or less in the eye with better visual acuity (American Foundation for the Blind [AFB], n.d., "Low Vision and Legal Blindness" section).

There are numerous eye conditions. For this dissertation major eye disorders will be discussed. According to the CDC, the most common eye disorders are Refractory Errors which include Myopia (near-sightedness), Hyperopia (farsightedness), Astigmatism (distorted vision at all distances), as well as Presbyopia occurring after the age of 40 (loss of the ability to focus up close, lack of ability to read, the need to hold reading material farther away to read effectively). Approximately 11,000,000 people in the United States greater than age 12 have refractory error eye disorders. These disorders can be corrected with eyeglasses, contact lenses and, when appropriate surgery (CDC, n.d., "Common Eye Disorders" section).

Another eye disorder is Age-Related Macular Degeneration (AMD). This disorder can occur later in life and the result is a decrease in sharpness of vision and central vision. Age-Related Macular Degeneration disrupts the macula, the center part of the retina responsible for seeing fine details. There are two types of this disorder Wet AMD and Dry AMD. In Wet AMD there is an abnormal growth of capillaries posterior to the Macula causing edema and scars within the retina. The symptoms that are ordinarily presented as linear lines become undulated. The dry form of AMD decreases the thickness of the Macula as one ages. Approximately 70% to 90% of the instances of AMD are the dry form. The representation of AMD can be seen with the presence of abundant Drusen (tiny yellow or white deposits under the retina). Approximately 1,800,000 individuals age 40 and over have AMD and 7,300,000 with many drusen run the risk of acquiring AMD. The trend shows an increase of AMD cases over time (CDC, n.d., "Common Eye Disorders" section).

A debilitating and relatively common eye disorder worldwide is cataracts. A cataract is present when the eye lens begins to obscure the light that reaches the retina. Through the process of clouding of the lens blindness occurs. The treatment of cataract(s) is through the removal of the afflicted lens. This procedure and accessible extensively. Although issues such as health insurance, medical cost, opting not to have the procedure, and not being cognizant inhibit numerous individuals from having the treatment and restoring their sight, a projected 20.5 million or 17.2% of people in the United States ages 40 and over have had a cataract in either one or both eyes (CDC, n.d., “Common Eye Disorders” section). A mere 6.1 million or 5.1% have had the procedure performed to restore their sight. Approximately 30.1 million people had cataracts in 2020 (CDC, n.d., “Common Eye Disorders” section).

Another disorder that leads to blindness in US adults is Diabetic Retinopathy, a symptom of diabetes (CDC, n.d., “Common Eye Disorders” section). The presenting manifestations of the disorder are an advancing destruction to the blood vessels to the retina. The retina has light-sensitive tissue on the posterior of the eye necessary for optimal visual acuity. There are 4 stages of Diabetic Retinopathy, mild nonproliferative retinopathy (microaneurysms), moderate nonproliferative retinopathy (blockage in some retinal vessels), severe nonproliferative retinopathy (more vessels are blocked leading to deprived retina from blood supply leading to growing new blood vessels), as well as proliferative retinopathy – the most advanced stage) (CDC, n.d., “Common Eye Disorders” section). Preventive measures can be taken to decrease the risk of acquiring diabetic retinopathy through management of diabetes. An optimal control of blood glucose, any hypertension, as well as keeping within the threshold of healthy cholesterol levels is needed to keep risks manageable. Early intervention of diabetic retinopathy decreases the advent of vision loss. However, 50% of clients do not get eye examinations and therefore get diagnosed late and treatment is ineffective. In the United States, working adults between the ages of 20 and 74 are the predominant cohort acquiring blindness. An estimate of 4,100,000 United States residents have symptoms of diabetic retinopathy and 899,000 are at risk of vision loss due to diabetic retinopathy (CDC, n.d., "Common Eye Disorders" section)

Glaucoma is another disorder that has the risk of vision loss and blindness. Glaucoma can cause destruction of the optic nerve which occurs when there is an increase of fluid pressure in the eye. Glaucoma can also be presented with optimal fluid pressure inside the eye. Early intervention is essential in the protection of devastating vision loss. There are two types of glaucoma, Open angle and Closed Angle Glaucoma. The open angle type is a protracted disorder and its progression is insidious. The person inflicted with open angle glaucoma does not notice it until the disorder is well advanced. The closed angle type manifests itself in quick succession, is painful and vision loss is rapid. Even though the progression is rapid, patients with closed angle glaucoma tend to look for medical assistance and treatment (CDC, n.d., "Common Eye Disorders" section). Glaucoma affects 2,900,000 individuals 40 years and older in the United States; (1,400,000 women and 1,500,000 men) or 2.1% of the US population (Gupta et al, 2016).

A common affliction of visual impairment in children is Amblyopia. Another term used for this affliction is lazy eye. Amblyopia occurs when one eye loses vision due to the brain/eye connection not performing optimally. In appearances the eye is anatomically normal except that the individual favors the better seeing eye. Amblyopia needs to be treated early upon diagnosis otherwise the condition continues towards adulthood and can become a life-long disorder. Approximately 2% and 3% of the population are afflicted with Amblyopia (CDC, n.d., "Common Eye Disorders" section).

The eye affliction Strabismus occurs when there is an imbalance in the orientation of both eyes. Strabismus representation is either esotropia when eyes cross or exotropia when eyes turn out. Strabismus is due to the lack of coordination of the eyes and the result is difficulty in focusing on an object at a distance and thus depth perception is impaired. Approximately 50% of Strabismus occurrences are presented around the time of birth.

A rarer form of visual impairment is Retinitis Pigmentosa. The disorder occurs with 1 in 4,000 individuals from the overall populace. The disorder's epidemiology stems from the advancing destruction of photoreceptor cells. The forms of this disorder are hereditary and are manifested as follows: autosomal dominant (30% of the prevalence of disorder), autosomal recessive (20% of the prevalence of disorder), X-linked recessive (15% of the prevalence of disorder), sporadic/simplex traits (30% of the prevalence of disorder) and 5% of the cases are early-onset. This early-onset group is named Leber congenital amaurosis. The disorder can also be Usher Syndrome or Bardet-Biedl Syndrome when it affects one eye. Approximately 20%-30% of Retinitis Pigmentosa clients have these forms. Retinitis Pigmentosa manifests as loss of the peripheral field of vision. Some of the treatments that are used for Retinitis Pigmentosa are as follows: Gene Therapy, Retinal Implants, the administration of Neurotrophic Factors, Retinal Transplantation, the use of Stem Cells, the use of dark glasses to protect the eyes, Vitamin Therapy and Drug Therapy (Musarella & MacDonald, 2010).

Although the information on major eye disorders is invaluable to those afflicted and their families, the medical model is only a description of the presenting problem. The medical model in essence deals with what is presented. To only address the medical disorder is to neglect the biopsychosocial aspect of the individual or group of individuals.

Societal factors also affect the life and quality of life of a person with a disability and also need to be addressed.

Definition of Disability Under Federal Programs for Visually Impaired People

According to the Social Security Administration (SSA), disability is defined as not being able to participate in substantial gainful activity (SGA) due to medically determined physical or mental impairment(s) that occur for a year or more (SSA, 2018). SGA is used when considering work activity and earnings. SGA is defined by the social security administration as: “work performed for pay or profit; work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized (SSA, 2018, p.5).

SGA is used to ascertain whether eligibility to benefits is continued to a person with a disability. In the case of part-time paid work, it is also considered when assessing SGA. The social security administration does not use SGA to ascertain initial eligibility for Supplemental Security Income (SSI) for blind individuals (SSA, 2018).

For visually impaired individuals with partial sight, SGA can be used to evaluate eligibility for Social Security Disability Insurance (SSDI). For a person with a visual impairment who has an average monthly salary of over $1,180, SGA is satisfied. For a person that is blind and has an average salary of over $1,970, SGA is also satisfied. Both individuals with a visual impairment and blind are eligible for SSDI if their salaries are under the specified threshold.

The acquiring of employment requires the recipient of benefits to convey employment information. Information such as when you began work, salary amount, hours, place of employment and role of employment needs to be conveyed to the Social Security Administration as soon as possible. The forms of documentation needed will be pay stubs and deductions from one's pay. Periodic review of the recipients’ case to ascertain medical status is performed and whether SGA is satisfied. When SGA is satisfied a reevaluation of the recipient's eligibility for receiving benefits will be undertaken. When the criterion for disability is no longer satisfied proceedings for the cessation of benefits will begin. If either SGA level or medical improvement has become sufficiently amended SSDI benefits will continue for that month and two succeeding months. SSDI allotment can continue if the consumer's salary decreases below the SGA eligibility threshold. SSDI benefits also can continue given that there is evidence of medical improvement and the recipient is active in a vocational rehabilitation program or other service program. The same option to continue benefits is also available for SSI recipients.

The road towards attaining and maintaining employment for persons with a disability has federal program support in place. It is worth noting that there are an estimated 130,428 veterans in the United States who are legally blind and an estimated 1,000,000 former military personnel with low vision. There is trend towards more veterans in the ensuing years to acquire vision loss from macular degeneration, diabetic retinopathy and glaucoma. The Veterans Administration (VA) provides programs that service blind and visually impaired veterans. One of the programs is Vision Impairment Services In Outpatient Rehabilitation (VISOR). The VISOR program is short in duration and provides blind and vision rehabilitation. Some of the services available are overnight accommodations for veterans and active-duty personnel that are visually impaired. The criterion for attending VISOR is the ability to complete activities of daily living (ADLs) on their own and take prescribed medications unaided. Also, the VISOR program provides low vision, mobility services, training in communication, ADLs and computer training (Military.com, n.d., Services for the Blind section).

To augment low-vision services provided by the Veterans Administration Intermediate and Advanced Low Vision Clinics are available. Integrated services such as clinical examinations, comprehensive vision-enhancing devices, and specialized training are provided. Specialists such as Ophthalmologists and Blind Rehabilitation Specialists form interdisciplinary teams to make sure former and present military personnel with visual impairments are provided assistive technology and techniques to improve vision and to empower their lives (Military.com, n.d., Services for the Blind section).

For veterans and active-duty members who require inpatient residential services there are "Blind Rehabilitation Centers" which provide complete adaptation and training services. The services provide various skills training to assist in self-sufficiency. The skills training available are orientation and mobility training, communication skills, ADLs, manual skills, visual skills, computer access and social/recreational activities. There is also assistance in emotional and behavior adjustment to blindness through individual and group therapeutic modalities (Military.com, n.d., Services for the Blind section).

Another service that veterans have access to is "Blind Rehabilitation Outpatient Specialists (BROS)". This benefit involves professionals trained in multiple skills oriented in blind rehabilitation. These skills include assessments and visual skills, ADLs, orientation and mobility training. The BROS program provides the visually impaired client with home based, Veterans Administration centers and clinics, academic establishments, at the job location, and continuing care facilities assistance. The BROS program includes training before and after "Blind Rehabilitation Center admission, provides directions for those traveling to a "Blind Rehabilitation Center" and gives training to Veteran family members (Military.com, n.d., Services for the Blind section).

The next progression of service programs for visually impaired veterans is the “Visual Impairment Centers to Optimize Remaining Sight (VICTORS) program”. The VICTORS program consists of an interdisciplinary outpatient panel providing access to optometrists, ophthalmologists, social workers, psychologists and low vision therapeutic modalities. VICTORS focuses on rehabilitation implementing and incorporating medical diagnoses, functional vision evaluation and prescribing training to use low vision assistive devices (Military.com, n.d., Services for the Blind section).

The VA includes “Technology and Guide Dogs” programs that provide clients with technology that aids in empowering and attaining self-sufficiency. Some of the technology provided is a Prosthetics Service free of charge. The VA also provides referrals to guide dogs trained to service veterans with various disabilities and health issues (Military.com, n.d., Services for the Blind section).

One of the crucial services provided by the VA is “Family Centered Care”. Families after all are the closest and most knowledgeable of the Veteran. They are essential in the adjustment and rehabilitation journey (Military.com, n.d., “Services for the Blind” section). There are also “Research and Clinical Evaluation Programs”. The VA maintains the state-of-the-art sensory and prosthetic research. The VA has access to the forefront of devices that aid individuals with a visual impairment (Military.com, n.d., Services for the Blind section).

For those veterans that were honorably discharged aid is available. In addition, disability compensation, veterans pension programs, free or low-cost medical care at VA medical facilities. In addition, housing and home loans are guaranteed, job training, small businesses and business loans, counseling and burials and memorials is accessible to honorably discharged veterans (Military.com, n.d., Services for the Blind section).

Another benefit for visually impaired and blind individuals is Social Security. According to the Social Security Administration, visual impairment is not considered a disability. This is due to the present criterion of eligibility for Social Security benefits. Ordinarily, it takes 18-24 months of work to acquire Social Security benefits. The ability to work at past job positions for 4 months is the deciding factor in securing social security benefits for the visually impaired person. Although this rule is advantageous in getting social security benefits, the option of attaining work for the visually impaired community is limited. Less than 0.075% of the blind world population are gainfully employed. There are barriers to attaining social security benefits. For example, information on various topics at the Social Security Administration is available in large print and braille, except for the application itself (SSA, n.d., “Special Notice Option for the Blind” section). The process in acquiring benefits for individuals with a visual impairment is inconsistent and creates disparities.

Acquiring benefits for visually impaired individuals is difficult. The barriers that are present prevent successful acquisition of needed services. Services are not allocated equally and the difference between having capital and not having capital results in two different outcomes. For the individual with a disability and access to capital there is access to high standard benefits and services. Alternatively, a person with a disability that is at or below the poverty threshold gets the minimum of benefits and services. When considering VA benefits, veterans that had an honorable discharge fare better. They have access to a high standard of care.

Demographics of People with a Visual Impairment

According to the CDC, in 2015,1,020,000 individuals lived with blindness in the United States. Approximately 3,220,000 individuals had a visual impairment and 8,200,000 had a visual impairment that was caused by an untreated refractive error (CDC, 2020, “The Burden of Loss” section). The CDC further estimated that 61,000,000 adults in the US have a high risk of acquiring significant visual loss. Only 50% of individuals at high risk for vision loss saw an eye specialist in the previous year. When considering the yearly effects of visual impairment on the economy with adults 40 years of age and over, there was 145 billion dollars of lost productivity, decrease in satisfaction with life, and the anguish that comes with vision loss. When early preventive measures are taken for eye disorders such as Diabetic Retinopathy the results have shown both medically and economically beneficial effects on the community and individuals with visual impairment. Psychoeducation is needed to avert the increase in visual impairment in the years to follow since 11% know of the absence of symptoms for representation of glaucoma and diabetic retinopathy. (CDC, 2022, “Facts about Vision Loss” section).

Health Disparities and Healthcare Discrimination

Iezzoni asserts that the United States has not lived up to the guidelines of the ADA since it was first signed into law in 1990 (2011). People with disabilities continue to experience disparities in their health and health care. According to Iezzoni (2011), the contributing factors to these health disparities stem from substandard living arrangements, “persistent stigmatizing social attitudes” and lack of accessible medical “equipment and facilities” (p. 1948). These societal and attitudinal discriminatory practices create relentless and systematic obstacles for individuals with a disability. Furthermore, the inadequate instruction that health care professionals receive in addressing the needs of people with disabilities creates additional health and health care disparities for the disabled community (Iezzoni, 2011).

The World Health Organization defines “disability” using medical and social models acknowledging “physical, social, and attitudinal environments – in causing or eliminating disability among people with functional impairments” (Iezzoni, 2011, p.

1948-1949). The World Health Organization has shifted the focus from the disease model of disability of “prevention and cure to maximizing function and well-being” (Iezzoni, 2011, p. 1949). By redirecting the focus to the quality of life and functionality of individuals with a disability, a more humanistic and solution-based definition of disability is achieved.

Drum et al. (2005) assert that health changes over time. The medical model defines “disability” as a pathology that needs to be addressed (Drum et al.,2005). According to Drum and his co-authors (2005) changes can occur in the definition of disability in “formal and informal social and political processes” (p. 30). As more is known about disability, a more complete definition can be attained. In expanding on the medical model and incorporating the social and functional aspects of disabilities, obstacles such as lack of access to needed services can be revealed and addressed (Drum et al., 2005). Another example is the process of communicating one's needs. For example, the chain of “communication” is broken when a visually impaired individual cannot read their prescriptions (Drum et al., 2005). If there are adverse effects to medications, a person with a visual disability cannot explain to their physician which prescription they took and in what dosage. Although there are devices that can read medication bottles, these devices are not widely accessible. Disability is multifaceted and any part that is taken in isolation runs the risk of limiting the future potential of individuals with a disability and hinders actions they can take to empower themselves.

Drum and colleagues (2005) continue to assert that not only are the definitions of disabilities insufficient, but there are also health disparities “between people with and without disabilities” (p. 37). These health disparities are “systemic in terms of health care providers behaviors, clinical site and medical equipment inaccessibility, transportation difficulties, inaccessible fitness facilities, and availability and accessibility of health information" (Drum et al., 2005, p. 37). The solution to remedying the disparities in health and healthcare for the visually impaired is to address the negative attitudes expressed explicitly or implicitly towards individuals with a visual impairment and blind. The stigma engrained in society that people with disabilities have less capacity and in turn need substandard benefits and services, needs to be exposed and a dialogue to ensue. Only when a dialogue is initiated can the veil of exclusion be lifted from the lives of the visually impaired community.

Disparities in Accessibility to Services

Discrimination and disparities are interrelated conceptualizations. Therefore, disparities in services and accessibility to services are also interrelated. Walker (2008) asserts that there are biases directed towards individuals with disabilities. Specifically, the visually impaired and blind community is discriminated against in the areas of employment income and educational attainment. Walker (2008) states that despite the enactment of the Americans with Disabilities Act, ADA (1990), an estimated 80 to 85 percent of blind persons remain unemployed. Additionally, only 45 percent of persons "with severe visual impairment graduate with a high school diploma, as opposed to 80 percent of non-disabled individuals" (Walker, 2008, p. 7). Furthermore, 5.7 million persons in the United States with a visual impairment have a family income under $20,000 per year (Walker, 2008). Walker attributes these discrepancies to systemic constructions created by society. The biased construction created by the populace extends to the professionals that provide services to individuals with disabilities (2008). Walker further asserts that the theories taught to generations of students are not empowering to people with a disability and considers a disability as something to be remedied (2008). A better position can be taken by providing opportunities and support for people with disabilities and taking a strengths-perspective approach when assisting people with visual impairments.

Accessibility to Medical Benefits

According to Silvers and Francis (2013), there are disparities between people with a disability and people without a disability. For example, access to private health insurance for individuals without a disability is significantly better than individuals with a disability. The crux of the issue is that employers are not willing to offer private health insurance to people with disabilities (Silvers & Francis, 2013). To add to the disparity disabled individuals are disproportionately unemployed and do not have the opportunity to acquire employment. The authors note that there is no clear legal obligation on the part of employer to provide health insurance for people with a disability (2013). I would note that the employer could state that the reason why health insurance was not offered was due to not having enough funds available. The employer also has the prerogative not to hire in the first place, not stating disability was the reason for rejecting the applicant. In addition, there is a negative attitudinal component cast upon individuals with a disability. Silvers and Francis assert that an assumption exists that providing health benefits to individuals with a disability detracts from "their quality of life" (2013). In reality, this misconception stems from the assumption that providing health services to individuals with a disability negates their independence and sustainability in society while creating a burden for the populace. This is a false conceptualization. The reality is that people with a disability are refused health care services ordinarily afforded to people without a disability.

Silvers and Francis (2013) note that the disparity goes further than accessibility to health care. Despite the ADA being the law in the United States, its administration has been inconsistent. Silvers and Francis (2013) assert that although the ADA was ratified over two decades ago, a substantial proportion of doctor's offices are not following the ADA's resolution of providing patients with accessibility to the premises.

The issue of accessibility to medical benefits is not isolated to the United States. A disturbing example in a publication from the United Kingdom in 2007 stated that there was ill-treatment of persons with learning disabilities in the National Health Service. A subsequent publication in 2013 found no improvement in the treatment of disabled individuals (Silvers & Francis, 2013). In response to this injustice, in 2007, the United Nations Convention on the Rights of People with Disabilities (CRPD) designated that "a high standard of health is a human right" (Silvers & Francis, 2013, p. 782). As of 2013, the CRPD had been accepted by 130 out of 155 sovereign countries. The United States had not accepted the CRPD at tht time (Silvers & Francis, 2013). The reason that the CRPD's proclamation of equity for people with a disability was created is that there is a lack of directive in place that can enforce it (Silvers and Francis, 2013).

To exacerbate the issue of quality of life as a human right, the premise of "human exceptionalism" segregates humans into haves and have nots. Human exceptionalism is the opposite of Strengths Theory. It contrasts Strengths Theory in that only certain humans that fall within certain prescribed dictates are deemed as having the right to receive a high standard of care (Silvers and Francis, 2013). The issue of the right to a quality of life has been debated for a significant part of the American narrative. Having the right to a quality of life stops short of actualizing the concept of equity for all. There has to be compelling legal recourse that is at its core moral and humanistic. In addition, there has to be a mechanism to oversee and when necessary, enforce the law. The philosophical discourse expressed by these authors is the beginning of the solution towards equality for all and needs to be extended to include legal precedent in a language that requires the actualization and oversight of equity in society.

Employment Outcomes and Employment Barriers

Wolffe and Spungin (2002) examined the employment and employment barriers for visually impaired adults from a global perspective. The study analyzed the economic status of developed and developing countries, education level and how categories of vocations were distributed. Globally higher levels of education for both blind and low vision participants resulted in acquiring higher level and higher paid job categories i.e., executive, administrative and managerial, professional specialty, technical and related support, marketing and sales, administrative support, including clerical, and service (Wolffe & Spungin, 2002).

When barriers to employment for individuals with a visual impairment were examined, developing countries showed a higher percentage (98%) for poverty as an employment barrier than developed countries (91%). Discrimination was also a significant barrier to employment with 67% of the participants in developed countries and 44% in developing countries attributing prejudice in the form of obstacles in acquiring employment (Wolffe & Spungin, 2002).

Another factor that is associated in the prevention of the attainment of employment is deficiency of education and lack of resources. In developed countries (43%), and (49%) in developing countries attributed deficiency of education and resources as a factor excluding individuals with a visual impairment from employment (Wolffe & Spungin, 2002). The absence of employers' recognition that people with a visual impairment have capabilities was also a factor that contributed to the exclusion of employment for individuals with a visual impairment. In developed countries 48% of participants attributed employers' lack of awareness of aptitudes of individuals' with a visual impairment as a factor for the exclusion of attaining employment, 43% of the participants responded to attribution of lack of ability in developing countries. The absence and or lack of availability of assistive technology required to perform the job role shows another barrier to employment. “33%” was shown in developed countries and 36% was exhibited in developing countries (Wolffe & Spungin, 2002).

The authors examined the issue of employment for individuals with a visual impairment in a systemic and balanced manner. A survey with broader focus examining the experience of people with a visual impairment looking for a job and or maintaining it is warranted. This would reveal what actually occurs when visually impaired people are actively looking for a job position. Only then can positive change occur when these facts are brought forward. (A table from this journal article exhibiting barriers and assets to employment for the visually impaired can be found in Appendix C)

Educational Attainment of Individuals with a Visual Impairment

In the proceedings from 7th European Conference of International Council for Education of People with Visual Impairment, Koutsoklenis and colleagues noted that “students with visual impairments face several structural and attitudinal barriers when entering higher education” (Koutsoklenis et al., 2009). One obstacle to accessibility for students with visual impairments is “mobility” in and about the academic institution. Accessibility to various sections of university areas can be improved by installing “elevators, automatic doors, special signing and assistive technology” (Koutsoklenis et al.,2009). Moreover, the availability of accessible class material in a format that can be read out loud by screen reader software is needed. In addition, university libraries have a scarcity of necessary books in accessible format such as braille and electronic books for their coursework. Koutsoklenis and co-authors (2009) state that 47% of registered students had not received books that were in accessible format. The authors continue to state that paternalism directed towards students with a visual impairment “run the risk of misconstruing the need for care instead of the right to education.” (Koutsoklenis et al, 2009, “Proceedings from the 7th European conference” section). There needs to be training and education of teaching personnel and library staff and general staff trained to work with students with a visual impairment.

Quality of Life of Adults with Visual Impairment

The loss of vision affects “quality of life” in several ways. There is a negative result to decreased quality of life in that individuals with a visual impairment show a loss in “independence, and mobility that has been linked to falls, injury, and worsened status in the domains spanning mental health, cognition, social function, employment and educational attainment” (Teutsch et al., 2016, p. 135). Economically, the effect of vision loss is influenced by “medical expenses, direct expenses, loss of productivity, and other indirect costs for visual disorders across all age groups were approximately $139 billion in 2013 dollars” (Teutsch et al., 2016, p. 135). The cost does not only affect national health care expenditure, but it also affects the visually impaired community and their families (Teutsch et al., 2016).

When considering quality of life in the context of visual impairment Teutsch and co-authors (2016) define the factors of QOL as “vision functioning, symptoms, emotional well-being, social relationships, concerns, and convenience” (p. 136). One of the aspects of vision loss as it pertains to quality of life is dependence. Teutsch and co-authors (2016) note that the level of autonomy in ADLs, “leisure, social activities and activities of interest influences dependence” (p. 138). Having greater self-sufficiency and independence in these aspects of life increases QOL (Teutsch et al., 2016).

Another factor that affects quality of life is mobility and falls. The difficulty of negotiating areas that are congested and have obstacles can cause falls in individuals with a visual impairment. Teutsch and co-authors (2016) note that a study from the United Kingdom showed 46% of ailing ageing persons self-reported having a hip fracture and a visual impairment. In addition, 49% had cataract(s) that were not remedied, 21% had macular degeneration, and 17% had uncorrected refractive error. Other effects that were noted were social deprivation and issues with mobility (p. 139). Falls were attributed to 46.7% of individuals 65 years of age and older with visual impairment (Teutsch et al., 2016). There is a critical need for mobility training and visual rehabilitation.

Visual impairment is also attributed to the increased frequency of fractures. Individuals with vision worse than 20/100 have a 200% chance of hip fracture as compared to visual acuity of 20/25 and better (Teutsch et al., 2016). Other factors increase the likelihood of fractures of individuals with visual impairment such as being diagnosed with osteoarthritis. A projected 40% increase in fractures has been shown when including difficulty in depth perception. Also, visual field loss contributes to an increased likelihood of fractures that are not related to the hip or spine. In contrast, successful treatment of cataracts had a 67% decrease in the chance of hip breakage. In a more representative sample study of 1,100,000 males and females with diagnosed cataract in the United States successful treatment decreased the risk of hip breakage by 16% and a 5% decrease for all fractures. Visually impaired individuals who had necessary cataract surgery also have the benefit of a 27% increase of likelihood of long-term mortality (Teutsch et al., 2016).

Visual impairment also impacts mental health. Teutsch and co-authors (2016) note that individuals with a visual impairment are at risk of acquiring anxiety, depression, and other psychological conditions. The causal relationship between visual impairment and mental health is unclear. Yet considering when anyone who has social deprivation, decreased self-reported health status, and a lack of resources and opportunities, it becomes clear how mental health can be an issue for individuals with a visual impairment. A structured and holistic approach to rehabilitation is warranted to address psychological issues for persons with a visual impairment.

Although the link between loss of cognitive function and persons with a visual impairment is not clear, 4% of people 65 years of age and older living in a community have visual and cognitive impairments (Teutsch et al., 2016). When examining individuals that have acquired age-related macular degeneration, augmented rates of cognitive impairment and greater rates of cases of dementia have been shown. Teutsch and co-authors (2016) note that it is difficult to isolate the factors contributing to the co-occurrence of visual impairment and cognitive loss. They suggest the loss of cognitive stimulation that occurs in activities such as reading could decrease cognitive ability. The lack of vision contribution can cause changes in neural pathways related to cognitive processes. The “common cause” theory is another suggested reason for cognitive decline in visually impaired people. The common cause theory suggests that “genetic, environmental, or medical risk factors cause disease in the brain and eye simultaneously” (Teutsch et al., 2016 p. 145).

Dual sensory impairment (DSI) - where individuals have both visual and audial impairment increases significantly as one ages (Teutsch et al., 2016). An estimated 9% to 21% of adults ages 70 and over have some measure of DSI. In another study cited by the authors 26.8% of individuals 80 years and over had DSI. Teutsch and colleagues noted that there needs to be studies done to verify whether visual loss can be attributed as a chance for acquiring hearing loss and what factors support this association (2016).

Teutsch and co-authors (2016) state that there is an association between vision impairment and an increased likelihood for injury-related mortality considering all causes in comparison to people without visual impairment. This causal association can be the result of worsening visual acuity and can lead to difficulty in ADLs and managing medical conditions. Although there is not a clear relationship between worsening visual acuity and medical diseases contributing to mortality, there is evidence that an association exists. Diseases and factors such as diabetes, obesity, hypertension, and autoimmune disorders, lifestyle factors (e.g., smoking, alcohol use), and socio-demographic factors contribute to this association (Teutsch et al., 2016).

According to Teutsch and co-authors (2016) chronic conditions are defined as "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living" (p. 146). The factors associated with chronic conditions increase the chances "of early mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicate tests, and conflicting medical advice" (p. 146). An estimate of 66% of health care expenditure in the United States corresponds to multiple chronic conditions. In 2010, 14% of Medicare recipients had six or more chronic conditions. Medicare expenditure for individuals who had multiple chronic conditions accounted for 46% of total Medicare spending for 2010. In contrast, 32% of Medicare recipients with one or fewer chronic conditions corresponded to 7% of health care expenditure (Teutsch et al., 2016). Although there has been evidence that visual impairment co-occurs with multiple chronic comorbid conditions, there is no clear causal association. More research needs to be done to reveal the possible interactions.

Various disorders impede physical and social tasks that visually impaired individuals must navigate daily. Having both a visual impairment and another ailment can increase the risk of social isolation and further disability (Teutsch et al., 2016). Therefore, in this preliminary examination being able to function physically and socially while having a visual impairment is essential to optimal QOL.

Another difficulty of visual impairment is the management of medical ailments. Some examples of areas of difficulty in managing chronic diseases are checking feet in diabetes, preparing a nutritious meal, and traveling to and from clinical visits. Another difficulty is compliance in taking medications as prescribed. One cause that can hinder compliance is not being able to read prescription bottles and order refills. In diseases like diabetes and glaucoma, difficulty in handling insulin injections and eye drops causes individuals to run the risk of getting into a cycle of deteriorating health (Teutsch et al., 2016). Other factors can exacerbate visual rehabilitation of co-occurring visual and medical conditions. Inconsistent health status due to comorbid medical issues is another major concern. Co-occurring conditions such as audial and cognitive impairment can create obstacles to communication between patients and doctors. Patients and caregivers can feel the strain of dealing with visual and medical issues. This Wan lead to negative consequences for the individuals with visual impairment (Teutsch et al., 2016). For example, engagement with rehabilitation services can be delayed due to medical issues experienced by caregivers. However, a major benefit showed that patients with co-occurring conditions can improve their situation by increased participation of caregivers (Teutsch et al., 2016).

The preceding literature review demonstrates that there is a need for research on the satisfaction of life of people with a visual impairment. The disparities shown stem from a deeper attitudinal bias in society that must be addressed in order for discrimination and exclusion of the visually impaired community to cease. The result will be beneficial to the entirety of society in increased general productivity, decreased unemployment, improved health status across the board, better quality of life, and equity for all. It seems logical to me that a social platform in addressing disability would be prudent since the inequity for people with a visual impairment stem in society. The interrelation between how individuals with visual impairment are treated in society and how society influences these individuals needs to be addressed. Therefore, this study will integrate the ‘Social Model of Disability’ and ‘Ecological Systems Theory’ as the theoretical frameworks.

Chapter Four: Theoretical Framework

I chose the Social Model of Disability as a guiding theoretical framework for this study. The rationale for this is in part due to the model's success in addressing the oppression that people with a disability negotiate on a daily basis in society. The Social Model of Disability originated from the exclusion of disabled individuals and the dissatisfaction of the medical model by people with disabilities. According to Lewitt (2017), the Social Model of Disability was formulated to address societal disabling barriers and bring about positive change in political and other arenas that benefit individuals with a disability. The Social Model of Disability also addresses the notion of ableism, which implies an elitist position assuming entitlement to resources and opportunities. The concept of ableism illuminates the biases that reject disabled individuals from full participation in society. The resulting systematic discrimination that is directed towards people with a disability presents the societal impasse we have today. In taking the social position to disability the balance of power can be restored and equity has a chance to thrive (Winance, 2016).

According to Winance, the limitation of the Social Model of Disability is in its treatment of biology and society (2016). There is a splitting of individual biology and society in the social model. Therefore, I adopted Urie Bronfenbrenner's Ecological Systems Theory as a second theoretical framework for the purpose of bridging the micro and the macro systems. When combining the Social Model of Disability and the Ecological Systems Theory individual biology and society interact with each other. Together these theories address pertinent factors that contribute to oppression. First, the Social Model of Disability will be discussed in reference to its development and impact on the lives of people with disabilities. Second, the Ecological Systems Theory will be examined for the purpose of connecting the gap between the individual with a disability and the individual and society.

Social Model of Disability

Finkelstein (2001) discusses the mechanics of the social model to clarify any assumptions considered ambiguous. Finkelstein states,“(i) the social interpretation of disability does **not** provide an *‘explanation’* of disability, and (ii) disabled people are **not** the *subject matter* of the social interpretation of disability” (p. 1). Finkelstein and Paul Hunt, the co-creators of UPIAS (Union of the Physically Impaired Against Segregation), deliberated on the definition of disability and arrived at an interpretation of the definition of disability. They concluded that the structure of society disables people with disabilities. The concept of disability is inflicted on and is forced onto impairments in the manner that “unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society” (Finkelstein, 2001, p. 1). Disability was placed in a broader scope in the context of society than it had previously been conceptualized in the medical model. The person with a disability in the context of the social model is the central focus in the sense that oppression is revealed as the factor that causes disablement.

In the further development of the social model of disability, Finkelstein and Hunt examined what prevents a disabled person from functioning in society. They pondered, “does a disabled person’s impairment correspond with not being able to function in society or does the construction of society prevent persons with impairments from social functioning?” (Finkelstein, 2001, p. 2). In the former conceptualization, impairment is considered a tragedy and the person with a disability is left with little recourse and disempowered. When considering that society and the construction of disability and impairment can be disempowering, the reason for the lack of resources and opportunities becomes evident (Finkelstein, 2001). When the focus is on society and the manner in which persons with a disability are treated, social change can occur. When only the individual is considered in the context of disability the issues of negative attitudinal and systematic discrimination are negated and not reflected upon.

Finkelstein notes that the competitive market foundation our civilization is based on gives individuals with a disability a label of disablement (2001). Through the lens of disablement, a strengths perspective cannot be attained. Therefore, disempowerment and oppression gain a foothold for the lives of people with a disability. Finkelstein continues to emphasize "*that what happens to disabled people* exactly *mirrors where humanity is going wrong*" (2001, p. 4).

Ecological Systems Theory

Gitterman and Germain (2008) note that the ecological systems theory emphasizes the interdependence of organism and environment. This theory gave the profession of social work the concept the person-and-environment. Gitterman and Germain (2008) note that Bronfenbrenner recognizes four interrelated constituents of the ecological model:

> "The first component is the developmental process that is shaped by and shapes the dynamic relationship between the individual and her or his context; the second component is the person's repertoire of biological, cognitive, emotional, and behavioral dispositions and characteristics and its impact on the developmental process; the third component is the context of human development, that is the nested systems levels; and the fourth component is the multidimensions of temporality that influence changes across the life course" (Gitterman & Germain, 2008, p. 51).
>
> In addition, the ecological theory consists of several major concepts:
>
> "(1) ecological thinking and reciprocity of person-environment exchanges; (2) person: environment fit, adaptedness, and adaptation; (3) habitat and niche; (4) abuse or misuse of power, oppression, and social and technological pollution; (5) the life course; (6) life stressors, stress and coping, and (7) resilience and protective factors"
> (Gitterman & Germain, 2008, p. 51).

Gitterman and Germain (2008) note that in the ecological perspective, ecological thinking emphasizes the reciprocity of person-environment interactions that forms and effects over time. In ecological systems theory, a person can influence the environment and the environment can affect the person. Therefore, "psychological phenomena are best understood as holistic events composed of inseparable and mutually defining psychological processes, physical environments and social environments, and temporal qualities" (p. 54).

In the person in environment fit concept, the person endeavors to attain an optimal degree of fit in the environment they inhabit. If the fit is optimal, the person senses adequacy in both personal and environmental resources and feels a state of adaptedness (Gitterman & Germaine, 2008). When there is a lack of fit between what the person perceives and the environmental resources, needs and capacities, stress is experienced. A person under stress has the option to adapt to their environment. In the ecological perspective three actions can be undertaken:

> "(1) change oneself (e.g., learn new skills) in order to meet the environment's perceived expectations or demands, and take advantage of its opportunities; (2) change the environment (e.g., emigrate) so that the social and physical environments are more responsive to one's needs and goals, or (3) change the person:environment transactions (e.g., teacher and student) in order to achieve an improved fit"
> (Gitterman & Germain, 2008, p. 55)

The process of adaptation and striving for an optimal fit is an ongoing life occurrence and continues through the life course.

Gitterman and Germain (2008) note that habitat and niche are also concepts that are part of the ecological model. The habitat concept consists of the physical and social settings within the cultural context. Gitterman and Germain (2008) note that habitats can either promote social integration and well-being or create social isolation and a sense of disempowerment. A niche can be referred to as a position occupied by groups and individuals in society. A niche can be growth and health affirming as in a country where people with disabilities are valued both individually and culturally and afforded the right to equal opportunity. In niches where the rights and needs are not sustained, there is a high chance for misuse of power to occur in political, social, and economic structures.

According to Gitterman and Germain (2008), the misuse of power creates devastating consequences. The misuse of power can occur in corporations and financial institutions and result in the depletion of pensions, unethical alteration of stock values, and insider trading giving unfair advantage to certain traders. In the political arena, lobbyists err on their self-interests instead of the public in which they were sworn to serve. The abuse of power creates and sustains "poverty; institutional racism and sexism, repressive gender roles in family, work, and community life; homophobia; and physical and social barriers to community participation by those with disabilities" (p. 56). The conditions created by social, physical and cultural factors are disempowering and jeopardize the health, social well-being and the continuance of life (p. 56).

The life course concept posits nonlinear, nondeterministic routes of biopsychosocial development within varied environments and cultures. The segments of the life course are as follows:

1. The distinctiveness of human diversity (race, ethnicity, gender, culture, socioeconomic status, religion, sexual orientation, and physical and mental states). The life course conception permits us to individualize personal and collective life experience, instead of forcing all people into predetermined universal developmental stages.
2. The self-regulating, self-directing nature of humans and their innate push toward growth and health.
3. Environmental diversity (economic, political, social, historical) that takes into account the effects of poverty or prejudicial discrimination on human development and functioning.
4. Newly emerging family forms and structures and their unique tasks and developmental issues in addition to those faced by traditional family structures and forms.

5. Rapid shifts in societal and community values and norms in today's world.
6. The critical significance of global as well as local environmental.
   (Gitterman & Germain, 2008, p. 57)

The life course conceptualization is structured around situations of life stressors, stress, and coping of which create life events that include, traumatic life events, poverty, and prejudicial practices and discrimination. The rectification of these processes results in increased maturity. On the other hand, lack of resolution results in physical, emotional, or social dysfunction, and can cause disorder of family, group or community. In addition, the life course can be further extrapolated into historical time, individual time, and social time. Historical time considers the historical context of social change in the time period of one's birth. (e.g., Chrono system) Individual time considers the person's life experiences and the meaning that are related to those life events. (e.g., Micro system) Social time involves unanticipated life events such as traumatic issues related to a family, group, or community and the collective empowerment or disempowerment that results (e.g., Macro system) (Gitterman & Germain, 2008).

The life stressor, stress, coping, and challenge conceptualization deals with the physiological adaptation to stressful situations. The ecological model considers the constitutional aspects of a person, the mechanics of the environment, and the exchanges among them. The stress that is created by difficult situations can initiate negative or positive associations amongst the individual and the environment (Gitterman & Germain, 2008).

When the assessment of a life issue is perceived as a challenge, an energetic, focused, capable, and self-motivated perspective is created. The perception that a situation is a challenge stems from the interactions of personality, physical condition, environment, past experiences, personal and cultural-based meaning of a serious life issue, availability of resources for coping, and the absence of too many concurrent stressors. A person who perceives that a situation is a challenge is action-oriented and assesses what action can be implemented. Alternatively, a person that perceives a situation as a stressor will underestimate what actions they can take and what resources they have (Gitterman & Germain, 2008). I contend that the perception of available resources can be attributed to the person and the society in an integrated manner.

The concepts of resilience and protective factors are attributed to the person and environment when considering the ecological model. When a person is resilient, they regain homeostasis after experiencing a difficult situation. A person who is resilient is not impermeable from being hurt. They directly confront the difficult issue. They are flexible, persistent, and resolute in regaining their sense of balance. Protective factors are innate biological, psychological, and/or environmental processes that can have a preventative or a diminishing effect to a stressor. The protective factors to stressors are: "(1) temperament, (2) family patterns, (3) external supports, and (4) environmental resources" (Gitterman & Germain, 2008 p. 64).

Gitterman and Germain (2008) note that temperament consists of activity level, coping skills, and self-esteem. Activity level calls for adaptive coping which necessitates the successful managing of feelings in order to solve issues that are presented. Self-worth originates from positive intimate relationships and successful task accomplishment. A self-condemning self-perception will elicit a negative outcome. Another protective factor is altruism. "By helping and giving to others, we heal ourselves. One finds meaning in life, meaning in one's suffering through the process of giving and sharing rather than through the pursuit of self-gratification" (Gitterman & Germain, 2008, p. 66).

Family patterns, whether formal or informal, that are supportive and inherently sustaining are protective factors and increase self-worth. External support outside the family can also be a protective factor. External support from a teacher, clergy, or peer can have a marked positive benefit in dealing with difficult situations. Protecting a person that is in distress can be attained through four types of support: instrumental (goods or services), emotional (ie. empathy and encouragement), informational (advice and feedback), and appraisal (information relevant to self-evaluation). These supports promote overall well-being and assist in influencing the way a person perceives the world (Gitterman & Germaine, 2008).

Lastly, the broader social and physical environment and the opportunities that are available influence all of the factors discussed. Social structures and institutions can allocate resources and provisions and assist individuals in dealing with life's changes, environments, and interpersonal difficulties (Gitterman & Germain, 2008). Another crucial indicator in the direction that life could take is planning in making turning point decisions. By anticipating challenges and implementing actionable plans to deal with the environment, the direction and choices result in more beneficial outcomes.

The Social Model of Disability and the Ecological Systems Theory are two sides of the same concept. The social model addresses the intricacies of society and reveals the oppression and discrimination that people with a disability face daily. The social model also has made inroads towards a reality where equality is for everyone. It adds the social dimension to the discussion. The Ecological Systems Theory also has its merits. The ecological model connects all of the components of the person and society into one cohesive whole. Additionally, the ecological model permits all of its systems to interact with each other and it also acknowledges the oppression and discrimination present in society. The ecological model guides the person and environment toward equilibrium and satisfaction in life. The two theories in conjunction formulate the question(s), what factors, whether in isolation or interacting with other factors, affect satisfaction of life.

Chapter Five: The Research Questions and Related Hypotheses

The overarching research question of this study is, "what factors influence the satisfaction of life of individuals with a visual impairment and blind?" In examining this question I will first extrapolate demographics of the visually impaired community. Then an examination of the level of social support will be examined. Third, the satisfaction of life of visually impaired individuals will be examined. Finally, the adjustment to disability will be examined. The research questions were derived from the literature and from my professional experience working with individuals who have a visual impairment.

Demographics

SQ1: What is the relationship between age, visual impairment and the level of satisfaction with life?

H1a: The older the person with a visual impairment, the higher the satisfaction with life is perceived.

H1b: The younger the person with a visual impairment, the lower the satisfaction with life is perceived.

SQ2: What is the relationship between gender, visual impairment and the level of satisfaction with life?

H2a: Males with a visual impairment experience a lower level of satisfaction with life.

H2b: Females with a visual impairment experience a higher level of satisfaction with life.

SQ3: What is the relationship between education, visual impairment and the level of satisfaction with life?

H3a: The higher the level of education, the greater the satisfaction with life.

SQ4: What is the relationship between the type of school attended, visual impairment and the level of satisfaction with life?

H4a: The type of school attended has a positive effect on the satisfaction with life.

SQ5: What is the relationship between employment status, visual impairment and the satisfaction with life?

H5a: The employment status of a person with visual impairment has a positive effect on the level of satisfaction with life.

SQ6: What is the relationship between marital status, visual impairment on the level of satisfaction with life?

H6a: The level of satisfaction with life is higher for people with a visual impairment that have a partner or are married.

SQ7: What is the relationship between the living situation, visual impairment and the level of satisfaction with life?

H7a: The level of satisfaction with life is lower for individuals with a visual impairment who live alone.

SQ8: What is the relationship between having children in the household, visual impairment and the level of satisfaction with life?

H8a: The level of satisfaction with life is higher for individuals with a visual impairment who have children in the household.

SQ9: What is the relationship between the household economic status, visual impairment and the level of satisfaction with life?

H9a: The higher the household economic status, the higher the level of satisfaction with life.

SQ10: What is the relationship between having access to health insurance, visual impairment and the level of satisfaction with life?

H10a: The accessibility to health insurance results in a higher level of satisfaction with life.

H10b: The lack of accessibility to health insurance results in a lower level of satisfaction with life.

SQ11: What is the relationship between health benefit type, visual impairment and the level of satisfaction with life?

H11a: The type of health benefits is associated with a higher level of satisfaction with life.

SQ12: What is the relationship between acquired and congenital visual impairment and satisfaction with life?

H12a: The individual with an acquired visual impairment has a lower level of satisfaction with life.

SQ13: What is the relationship between age of onset of visual impairment, visual impairment and satisfaction with life?

H13a: The level of satisfaction with life is higher for individuals with earlier age of onset of visual impairment.

SQ14: What is the relationship between the presence of co-occurring disabilities, visual impairment and satisfaction with life?

H14a: The level of satisfaction with life is lower for individuals with co-occurring disabilities and visual impairment.

SQ15: What is the relationship between having a co-occurring disability, visual impairment and satisfaction with life?

H15a: The presence of co-occurring disabilities lowers the satisfaction with life.

SQ16: What is the relationship between the accessibility to services, visual impairment and the level of satisfaction with life?

H16a: The accessibility to services is associated to a higher level of satisfaction with life.

SQ17: What was the relationship between an individual’s housing situation, visual impairment and satisfaction with life?

H17a: The type of housing situation influenced the satisfaction with life of the individual with a visual impairment.

MOS Social Support Survey

SQ18: What was the relationship between the level of social support, visual impairment and the level of satisfaction with life?

H18a: The higher the level of social support, the higher the level of satisfaction with life.

Satisfaction with Life Scale

SQ19: What is the relationship between level of satisfaction with life and visual impairment?

H19a: Higher level of satisfaction with life is associated with greater quality of life for visually impaired individuals.

Nottingham Adjustment Scale

SQ20: What was the relationship between the level of adjustment to disability, visual impairment and the level of satisfaction with life?

H20a: The level of satisfaction with life was higher when the level of self-esteem was scored higher.

H20b: The level of satisfaction with life was higher when attitudes to disability/illness were scored higher.

H20c: The level of satisfaction with life was higher when anxiety/depression was scored lower.

H20d: The level of satisfaction with life was higher when locus of control was scored higher.

H20e: The level of satisfaction with life was higher when the acceptance of disability/illness is scored higher.

H20f: The level of satisfaction with life was higher when self-efficacy was scored higher.

H20g: The level of satisfaction with life was higher when attributions were scored higher.

This chapter of my dissertation has delineated the research questions and hypotheses that were included in the survey. The methodology chapter described in detail the method in which this study was implemented.

Chapter Six: Research Methodology

This exploratory study examined the satisfaction of life of individuals with visual impairment and blind. In my research I found that there was a scarcity of research studies on individuals with visual impairment and their satisfaction of life. My objective is to contribute to the knowledge base of the visually impaired and blind community. It was my hope that my findings could reach individuals to modify their lives for a better quality of life. In addition, this study presented evidence of the needs and actual situations that the visually impaired community face in society. The objective of this chapter was to explain how the research questions and stated hypotheses are incorporated and expanded to create this study (see Variables & Hypotheses Table at the end of this chapter).

The 'research design' and rationale for the study was explained, including the research perspective, type and subtype of research. In the 'context of the study' section, the methods of data collection have been presented. The necessary permissions to gather data from the ACB national membership and confirmation to access and use of the instruments have been provided. The unit of analysis implemented in the study was described. The selection criteria and the minimum number of participants necessary for a representative sample were explained and stated. The feasibility and methodological reasoning for the use of the sample was explained. In the 'Measures' section, the definition, key terms and variables were delineated. The instruments used in the study were operationalized and identified, and their applicability explained. The issues of reliability and validity were discussed for each instrument. The reasoning behind adaptation of the Nottingham Adjustment Scale to suit a quantitative study was explained. The specific changes made to the Nottingham Adjustment Scale and the reasoning for those changes were also addressed. The dependent and independent variables were itemized and described. In the 'Definitions of other relevant concepts' section all definitions relevant to this study were explained. In the ‘procedures’ section, the methods in which the data were collected and analyzed were described. A table describing each variable proposed in the study was included. Lastly, documentation such as the invitation email to the study, informed consent form included in the survey on SurveyMonkey and satisfaction of life survey was included (invitation email: Appendix D, informed consent form: Appendix E and satisfaction of life survey: Appendix F).

The Research Design

Quantitative design was chosen for this study because it is a research approach for testing objective theories by examining the relationship among variables (Creswell, 2014).

The Research Perspective

This research study examined the factors that influence satisfaction of life or quality of life of visually impaired and blind adults 18 years and older. A multiple question survey was used to collect data. The survey incorporated general demographics including access to health insurance, acquired or congenital visual impairment, age of onset of visual impairment, any presenting comorbid conditions, accessibility to services, and type of housing. The survey also included instruments such as the ‘Medical Outcome Study Social Support Survey’, ‘Satisfaction of Life Scale’ and the ‘Nottingham Adjustment Scale’ along with subscales.

The Context for The Study

The data collection period was the summer of 2020. Survey Monkey was the platform used to disseminate, collect data and analyze the findings. The survey was accessed from the American Council of the Blind (ACB) listserv via email burst and was sent to all ACB members nationwide. Permission for access to the ACB membership and usage of this study’s survey had been assured by the National Executive President of

ACB (see in Appendix F). In addition, permission to use and implement The Nottingham Adjustment Scale had been attained from Dr. Carol Sampson in the UK (see Appendix G). The Medical Outcomes Study Social Support Survey and Satisfaction of Life Scale were open sourced and needed no permissions.

Data & Subjects

The source of the data was from the American Council of the Blind (ACB) national membership. The data were gathered via a survey questionnaire using a Likert scale. The unit of analysis was numerical. The participants in the research study were adults 18 years and older who had a visual impairment or were blind. The selection process criteria included ACB members who have a visual impairment, blind and are 18 years and older. A minimum of 124 participants was necessary to satisfy statistical viability, but I anticipated that 200 people or more would participate, making the sample more representative. Multiple regression was used as the primary statistical method for data analysis. I considered the 122 minimum participants, and the number of independent variables (18 predictor variables in this study) in the survey was a minimum number of participants to achieve a representative sample of the population. The N of 124 participants satisfied the statistical requirements when using Multiple Regression as a statistical method for data analysis (Green, 1991). There were no excluded categories of people or vulnerable populations in the sample. The sample consists of visually impaired adults who have given consent to participate in the study.

Measures

Through the process of researching the topic of visual impairment, and having reflected upon my professional experience, common themes have arisen. The quality of life of visual impaired was disproportionately less when compared to non-disabled individuals. This realization initiated a journey to understand what factors influence satisfaction with life or quality of life. Therefore, the dependent variable was denoted as ‘satisfaction with life’. To extend and enrich the analysis of ‘satisfaction with life’ of individuals with visual impairment, I went through the literature and found factors that had the potential of significant influence for this inquiry. Reoccurring factors were found and correspond with my professional experience working with clients that had a visually impairment.

The relationship of age to visual impairment was one of the first factors to be included in the survey. A decision was made to include individuals aged 18 years and older with a visual impairment so that the individual could give consent. Gender was also an important factor. There was evidence in the literature that suggested there was a difference in how each gender navigated the challenges of society. The level of educational attainment was included because in the general population, and specifically with individuals with disabilities, educational attainment made the difference in quality of life. Furthermore, examining the type of school one attended might reveal the experience an individual had in school and indicate future motivation to pursue higher education. The matter of employment was included because individuals with visual impairment had a disproportionate rate of unemployment. When examining this disparity, level of ability or competence of the prospective employee with a disability cannot explain the high rate of unemployment. The marital status of a person with visual impairment was also an influential factor when considering quality of life or satisfaction with life due to the inherent instinct of humans to thrive in social groups. The living situation factor indicated how the individual was living socially. The children in the household factor was included because of the premise that children have a uniting influence on the family unit. The household economic status factor examined the relationship between financial stability and the satisfaction with life of people with disabilities. As self-sufficiency is associated with previous education and employment, this factor was included. Access to health insurance was associated with physical well-being and was included to examine the physical aspect of quality of life of people with a visual impairment. The benefit type that a person with a visual impairment had indicated their socio-economic status and therefore was an important factor to examine. The distinction between acquired and congenital visual impairment encompassed the social, cultural, psychological, economic and political aspects of the lives of people with visual impairment. The distinction can be internal and personal or external and societal. The age of onset can further examine acquired and congenital visual impairment. Other aspects of living with a visual impairment were the presence of co-occurring disabilities; living with visual impairment, co-occurring disabilities, and how these factors affect satisfaction with life. The distinction between the two sets of factors is that the first examines how co-occurring disabilities affected individuals with visual impairment, and the second interacted with having a visual impairment and co-occurring disabilities, and how it affected satisfaction with life. The next factor was access or lack of accessibility to services. This factor indirectly examined the perceptions of social service workers to people with visual impairment. This was important because accessibility to services is associated with the perceptions of the provider of services and any biases that they might have had. The next factor is the housing situation. An individual’s stability in their housing situation was associated with many other areas of a person’s life, such as general health and well-being.

The MOS Social Support Survey instrument created by Sherbourne and Stewart (1991) measured the relationship between level of social support and satisfaction with life and was included in the survey and subsequent analysis. The reasoning behind including the MOS Social Support Survey stems from the hypothesis that greater levels of social support equated to better well-being or satisfaction with life. The instrument measured four categories of social support - emotional/informational, tangible, affection and positive interaction; had 20 questions, and used a five-point Likert Scale that ascertained the level each individual's social network. The utilization of the MOS Social Support Survey in this study filled in the gap in the literature on the topic of visual impairment and social support. Although the instrument was not initially designed to be taken by individuals with a visual impairment, the progression of assistive technology made it possible.

The issues of validity and reliability for the instrument were examined by the authors Sherbourne and Stewart (1991) to examine individuals with treatable chronic conditions and the influence of social support from a functional perspective. In the analysis of the validity and reliability of the instrument to this study statistical tests such as Cronbach's Alpha, Pearson Product-Moment Correlations was performed to measure the appropriateness of the MOS Social Support Survey (Sherbourne & Stewart, 1991). The authors state that the measures of the instrument "are reliable and are fairly stable over time" (p. 705).

The Satisfaction of Life Scale created by Diener and colleagues in 1985 to measure global life satisfaction was denoted as the dependent variable or outcome variable in this study. The Satisfaction of Life Scale (SWLS) consisted of five questions and uses a seven-point Likert Scale scored from one to seven. The rationale for the inclusion of the Satisfaction of Life Scale originated from my professional experience and research and analysis of the visually impaired community. As I dwelled into research of the visual impairment community, I realized that the satisfaction of life or quality of life of individuals with visual impairment had not been addressed or researched. The literature on the topic of visual impairment was scattered and sparse and needed to be done, not only because of the gap in the knowledge base, but to address the social injustice that exists in the present. The creators of the SWLS scale strongly supported an examination of the effect and satisfaction with life (Diener, et al., 1985).

The Nottingham Adjustment Scale was developed by Dr. Carol Sampson for her doctoral research in Clinical Psychology at Leicester University in the United Kingdom in May 2000. Sampson (2000) examined the adjustment to disability and chronic illness of patients with Acquired Brain Injury (ABI). ABI is sometimes referred to as Traumatic Brain Injury or TBI. An assessment of the Nottingham Adjustment Scale revealed that for measuring the level of adjustment to disability this scale suited this study. Sampson stated that generally “the results of the present study indicate that the reliability of the NAS as a measure of adjustment is not affected by cognitive functioning” (2000, p. 70). Therefore, I found the Nottingham Adjustment Scale appropriate for the purpose of this study. It was anticipated that this study’s sample would have individuals with co-occurring disabilities including TBI, which may have presented cognitive deficits. This did not affect the measurement of adjustment to disability in the study.

The Nottingham Adjustment Scale was adopted from Dr. Sampson’s dissertation and modified to better suit this study. The following parts of the Nottingham Adjustment Scale were adopted for use in my research:

- NAS A – Self-esteem scale
- NAS B – Attitudes to disability/illness scale
- NAS C – Anxiety/depression scale (Modified Short form)

(NAS version 2)

- NAS D – Locus of control scale
- NAS E – Acceptance of disability/illness scale
- NAS F – Self efficacy scale
- NAS G – Attributions scale

(Sampson, 2000, Appendix A, I, II)

There were four minor changes made to the subscales of the Nottingham Adjustment Scale. First, for all of the subscales I changed the options in answering the questions in each subscale to exhibit letters consistently (i.e., A = strongly agree; B =

agree; C = don’t know; D = disagree; E = strongly disagree). Secondly, for the Modified short form of the NAS C, Anxiety/Depression scale, two words were changed to represent commonly used American English. In question 1, the words “out of sorts” were changed to ‘unwell’. In question 5, the words “strung up” were changed to ‘worried’. In NAS E, acceptance of disability/Illness scale, one word in question 2 was changed, “see” was changed to ‘notice’. In NAS G, Attributions Scale, in questions 1-3, the words “had have” was changed to ‘’has’ (Adopted from Dr. Carol Sampson’s dissertation, May 2000). These changes were made to keep the survey questionnaire consistent in format and for ease in taking the survey.

Definitions and Other Relevant Concepts

Operational definitions of constructs in the study are as follows:

Pattern of disparity – these were patterns of discrimination that became evident when examining the actual differences of disabled and nondisabled individuals in issues such as (i.e., rates of unemployment, educational attainment)

Systematic Discrimination – this was a repeated pattern of discrimination that originated on the Macro or societal level. (i.e., discrimination from healthcare providers employed in hospitals, teachers that are non-compliant in providing accommodations to disabled students)

Systematic biases – these were negative attitudes on disability and disabled individuals that were projected on the Macro level or societal level resulting in services not being made available to those that need them.

Quality of life – this is a multifaceted construct that transcended and was integrated to the person with a disability and society. The entirety of human existence pivots on whether an adequate level of quality of life was present.

Ableism – this was a construct related to the elitist position that individuals who are ‘able’ are entitled to receive resources. This is a limited and prejudicial perception.

Disempowerment – this occurred when agents or entities in the society took away a person’s sense of independence, power and ability to self-advocate.

Oppression – this occurred from the act of disempowering an individual. It also devalues the person in their sense of self, abilities and belief in themselves.

Societal barriers – these barriers can manifest as physical, psychological, economic, social and political obstacles that prevented upward mobility and satisfaction with life.

Procedure

Data were collected through a web survey using SurveyMonkey. Once the survey was inputted into SurveyMonkey a hyperlink was created which was sent to the ACB Convention Coordinator_along with the ‘Informed Consent Form’ in the body of an email and the web survey. The survey was forwarded to all ACB members nationwide through the ACB listserv. The participants completed the survey using JAWS or ZoomText software. JAWS software is a screen reader interface and outputs what was on the screen to audio through keyboard commands. ZoomText software was a screen reader/magnifier, was generally used by individuals with low vision and used a computer mouse. Weekly reminders were sent to the national ACB membership. The web survey on SurveyMonkey ran for a period of three months.

Data were analyzed using Multiple Regression as a statistical technique to analyze the multivariate relationships that were present. I proposed the hypothesis that as factors such as social support and/or adjustment to disability increase the level of satisfaction with life also increased (positive relationship). There was also a second hypothesis that stated that as factors such as social support and/or adjustment to disability decreased satisfaction with life also decreased.

Protection of Human Subjects

Measures were taken to protect participants in this study. All consent forms and letters related to protection of human subjects are included in the appendices. The letter from Eric Bridges, giving permission to use of the survey with the national ACB membership for the purpose of data collection, can be accessed in Appendix G. The informed consent form that was used in the email sent to the ACB national membership and can be accessed in Appendix D. Email correspondence from Dr. Carol Sampson providing permission to for me use the Nottingham Adjustment Scale can be accessed in Appendix H. A copy of my CITI certificate is in Appendix L. The study's information sheet and informed consent for participants are included in Appendix D and Appendix E.

Variables

Variable Components Table

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
1. Satisfaction with life among persons with visual impairment who are older have higher levels of satisfaction with life.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Age of person with visual impairment	The age of participants 18 years and older	Ratio	Independent Variable	
1a. Satisfaction with life among persons with visual impairment who are younger have lower levels of satisfaction with life.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Age of persons with visual impairment	The age of participants 18 years and older	Ratio	Independent Variable	
2. Males with visual impairment have lower levels of satisfaction with life.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Gender of person with visual impairment	Males 18 years and older	Nominal	Independent Variable	
2a. Females with visual impairment	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
have higher levels of satisfaction with life.	Gender of person with visual impairment	Females 18 years and older	Nominal	Independent Variable	Regression for Multivariate Analysis
3. Persons with visual impairment who have higher educational attainment have higher levels of satisfaction with life.	Satisfaction with life Educational attainment	Satisfaction with life Scale Educational attainment from < High School to Doctorate Degree	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
4. The type of school attended by a person with visual impairment has a positive effect on satisfaction with life.	Satisfaction with life Type of school attended	Satisfaction with Life Scale Categories of schools attended, Public, Vocational, IEP and Private School	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
5. The employment status of a person with visual impairment has a positive effect on satisfaction with life.	Satisfaction with life Employment status	Satisfaction with Life Scale Unemployed, employed PT, FT, Volunteer and Retired	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
6. The satisfaction with life is higher who have a partner or are married and have visual impairment.	Satisfaction with life Marital status	Satisfaction with Life Scale Single, Married, Divorced, Widowed and Living with a Partner	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
7. The level of satisfaction with life is lower for persons who live alone and have visual impairment.	Satisfaction with life Living situation	Satisfaction with Life Living alone, living with family and living with parents	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
8. Persons with visual impairment who have children in the household have	Satisfaction with life Children in household	Satisfaction with Life Scale Is there are children in the household	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
higher levels of satisfaction with life.					Multivariate Analysis
9. The higher the household economic status the higher the level of satisfaction with life for persons with visual impairment.	Satisfaction with life Household economic status	Satisfaction with Life Scale Annual Income $10,000 to $100,000 +	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
10. Accessibility to health insurance for persons with visual impairment results in higher levels of satisfaction with life.	Satisfaction with life Access to health insurance	Satisfaction with Life Scale Whether participant has health insurance	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
10a. Not having access to health insurance for persons with visual impairment results in lower levels of satisfaction with life.	Satisfaction with life Access to health insurance	Satisfaction with Life Scale Whether participant has health insurance	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
11. Types of health benefits received is associated with higher levels of satisfaction with life for persons with visual impairment.	Satisfaction with life Types of health benefits	Satisfaction with life Scale SSI, SSDI, VA Benefits, Social Security, Military Benefits and Other	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
12. Persons who have acquired their visual impairment have lower levels of satisfaction with life.	Satisfaction with life Acquired/ Congenital	Satisfaction with Life Scale Acquired visual impairment = Having a visual impairment later in life; Congenital = Born with visual impairment	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
13. Persons with early onset of visual impairment have higher levels	Satisfaction with life Age of onset	Satisfaction with Life Scale	Ordinal Nominal	Dependent Variable	Multiple Regression

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
of satisfaction with life.		Age the participant had a visual impairment		Independent Variable	for Multivariate Analysis
14.Satisfaction with life was lower for persons with co-occurring disabilities and visual impairment.	Satisfaction with life Co-occurring disabilities	Satisfaction with Life Scale co-occurring disability with visual impairment	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
16.Accessibility to services was associated with higher levels of satisfaction with life for persons with visual impairment.	Satisfaction with life Access to services	Satisfaction with Life Scale Having access to services (i.e., Personal Assistance)	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
17. Types of housing influences the level of satisfaction with life for persons with visual impairment.	Satisfaction with life Housing situation	Satisfaction with Life Scale Own Home, Rent Apt., Facing Eviction, In Residential Housing	Ordinal Nominal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
18. Greater level of social support the greater the satisfaction with life.	Satisfaction with life Social support	Satisfaction with Life Scale MOS Social Support Survey	Ordinal Ordinal	Dependent Variable Independent Variable	Multiple Regression for Multivariate Analysis
19. Greater the level of satisfaction with life equated to better QOL for a person with visual impairment.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
20. Satisfaction with life was greater when the level of self-esteem is scored higher.	Satisfaction with life Self-esteem	Satisfaction with Life Scale The NAS Scale	Ordinal Ordinal	Dependent Variable Independent Variable	Multiple Regression for Multivariate

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
					Analysis
20a.Satisfaction with life was greater with higher scores for attitudes disability/illness.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Attitudes to Disability/Illness	The NAS Scale	Ordinal	Independent Variable	
20b. The level of satisfaction with life was greater when anxiety/depression is scored lower.	Satisfaction with Life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Anxiety/Depression	The NAS Scale	Ordinal	Independent Variable	
20c. The level of satisfaction with life was greater when the locus of control is scored higher.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Locus of Control	The NAS Scale	Ordinal	Independent Variable	
20d. The level of satisfaction with life was greater when acceptance of disability/illness is scored higher.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Acceptance of disability/illness	The NAS Scale	Ordinal	Independent Variable	
20e. The level of satisfaction with life was greater when self-efficacy is scored higher.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent Variable	Multiple Regression for Multivariate Analysis
	Self-efficacy	The NAS Scale	Ordinal	Independent Variable	
20f. The level of satisfaction with life was greater when attributions are scored higher.	Satisfaction with life	Satisfaction with Life Scale	Ordinal	Dependent variable	Multiple Regression for Multivariate Analysis
	Attributions	The NAS Scale	Ordinal	Independent variable	

Abbreviations: FT, full time; IEP, individualized educational plan; NAS, Nottingham Adjustment Scale; PT, part time; SSDI, Social Security Disability Income; SSI, Supplemental Security Income; VA, Department of Veteran's Affairs.

Chapter Seven: Results

The data collection period for this study began on June 6, 2020 and ended on September 9, 2020. The initial request for participation was followed by two subsequent requests (June 6, 2020; July 11, 2020; and August 10, 2020). The final sample size at the conclusion of the data collection period was 203 participants (N =203). Of the initial 17 demographic factors that were proposed for the study, 15 demographic factors were included in the analysis. The survey item asking whether the participant's visual impairment was acquired or congenital was not consistent with the question pertaining to age of onset of visual impairment. Therefore, only the question of age of onset of visual impairment was retained. Additionally, the question asking the participants to specify any other disabilities could not be quantified due to the descriptive nature of the responses and was not retained. The solvency of the survey was maintained. The questions removed were better supported by similar questions in the survey.

The analysis of the factors and instruments from the study were performed through Stata 16. The statistical tests used to analyze the survey and instruments used were One-Way ANOVA and Independent Samples T-tests, multivariate and bivariate questions respectively.

Descriptive Statistics

The demographic questions in this study have revealed the presence of factors that are influential and or associative for satisfaction of life of individuals with visual impairment. In addition, the demographic factors conversely reveal disparities that are prevalent in the visually impaired community.

Demographics

The mean age of the participants was 57 (M = 57.846, SD = 13.606), with a range from 24 to 86 years of age. 142 participants were female (74.35%) and 49 were male

(25.65%). The mean highest level of educational attainment was a bachelor's degree (M = 4.805, SD = 1.432). 33.68% of the sample held a master's degree (N = 64). The highest level of educational attainment was a doctorate degree (N = 9, 4.74%). Most participants attended public schools (74.19%) (N = 138, M = 1.423, SD = 1.099).

The mean employment status for the participants was part-time (N = 29, 15.26%). Most of the participants were retired (N = 71, 37.37%). Regarding marital status, the mean was “married” (N = 68, M = 2.074, 36.17%). Although the highest number of respondents were single (N = 73, 38.83%). The mean for “living situation” was living with family (45.60%) (M = 1.565, SD = .597). The highest number of participants responded as living alone (48.90%). Most participants did not have children in the household (92.63%, SD = .261), while (7.37%) had children in the household. The mean responses to “housing situation” was rented an apartment (N = 60, M = 1.588, SD = .977, 31.25%). The highest number of participants owned a home (N = 116, 60.42%). Ten participants residing in a residence (5.21%).

184 participants had health insurance (N = 184, M = 1.968, SD = .175) which represented 96.84% of the sample. Six participants (3.16%) did not have access to health insurance. The mean annual income was $40,000-$49,999 (7.39%, M = 4.176, SD = 3.027). The highest number of responses for annual income was $10,000-$19,999 (N = 44, 25.0%). 52 participants received Social Security income (M= 3.656, SD = 1.704, 30.23%). The highest number of participants received SSDI (N = 64, 37.21%).

The mean age of onset for participants that have acquired visual impairment was 13 (N = 67, M = 13.619, SD = 14.276, 35.638%). The number of participants that have had congenital visual impairment was 121(64.36%). The highest number of participants did not have comorbid disabilities (N = 118, M = 1.368, SD = .480, 64.13%). While (N = 66, 35.87%) had comorbid disabilities. Most of the participants had access to services (N = 171, M = 1.9, SD = .480, 90.00%). While 19 participants (10.%) did not have access to services.

For a summary of the demographic factors used in the study please see table 7.1. For a summary of the descriptive statistics for the scales used in this study please see table 7.2. – table 7.10

Inferential Statistics

All the research questions and hypotheses were created *a priori*. An alpha level of ($p \leq 0.05$) was used to reject the null hypothesis in the statistical analyses. An eta-square calculation was performed to ascertain the effect size for each hypothesis and instrument. The satisfaction with life score ranged from a score of 35 signifying (extremely satisfied with life) to a score of 5 signifying (extremely dissatisfied with life).

The research questions used in the satisfaction of life survey that had statistically significant results are described in detail. Research questions that failed to reject the null hypothesis are summarized below.

Analysis of Demographic Factors With the Life Satisfaction Score

Statistically Significant Results

*H1a: the older the person with a visual impairment, the higher life satisfacti*on

The results were statistically significant ($F(4, 158) = 6.67$, $p < 0.0001$). The participants' age showed a significant increase in the satisfaction with life score. This increase began between the ages of 46-56 years of age, included ages 57-67 and continued to 68-maximum. The age of the participants was recoded into 5 categories to better discriminate and analyze the data (1 = 24-34 years of age; 2 = 35-45 years of age; 3 = 46-56 years of age; 4 = 57-67 years of age; 5 = 68-maximum age). The effect size was 15.909% of the variance observed. This signified a large effect size and confirmed that the older an individual with a visual impairment had a higher their satisfaction of life.

H1b: the younger the person with a visual impairment, the lower the satisfaction with life

The results were (F(4, 158) = 6.67, p < 0.0001). The mean for the satisfaction with life score of participants with ages 45 and younger were lower (i.e., ages 35-45 = ~ 20 and 46-56 = ~ 24), 'neutral' and 'slightly satisfied' respectively. The standard deviation (SD) with each proceeding age group was lower showing that the age group had less dispersion from the mean. (i.e., ages 35-45, SD = 10.505885; ages 46-56, SD = 7.1916299; ages 57-67, SD = 5.3016782). The results revealed that for participants with ages 46 and older the satisfaction with life ranged between 'Slightly satisfied with life' and 'Satisfied with life' whereas, participants with ages 45 and younger ages responded as neutral to their level of satisfaction with life. The resulting effect size was 15.909% of the variance observed. This signified a large effect size. Therefore, confirming that a younger individual with a visual impairment had a lower satisfaction of life.

H3a: The higher the level of education the greater the satisfaction with life.

The results were statistically significant (F(3, 167) = 3.56, p < 0.0156). The level of education was recoded combining participants who had an educational level of less than High School and High School. The resulting categories ended up in 6 levels of education. The effect size was calculated and showed 6.011% of the variance observed. This signified a medium effect size. This confirmed that attaining a higher level of education equated to a higher satisfaction with life.

H5a: The employment status of a person with visual impairment has a positive effect on the level of satisfaction with life.

The results were statistically significant (F(4, 166) = 6.56, p < 0.0001). The effect size was calculated and showed 13.656% of the variance observed. This signified a large effect size. Thus, confirming that having employment whether part-time or full-time equates to a higher satisfaction of life.

H6a: The level of satisfaction with life is higher for people with a visual impairment and have a partner or are married.

The results were statistically significant (F(4, 166) = 2.66, $p < 0.0348$). The effect size was 6.015% of the variance observed. This signified a medium effect size. This confirmed that living with a partner or being married equated to a higher satisfaction of life.

H9a: The higher the household economic status, the higher the satisfaction with life.

The results were statistically significant (F(9, 153) = 3.42, $p < 0.0007$). The effect size was 16.768% of the variance observed. This signified a large effect size. This confirmed that a higher economic status results in a higher satisfaction with life. Of note, the highest satisfaction with life scores were in annual incomes of \$40,000-\$49,999 and \$60,000-\$69,999. The satisfaction with life score means were 28.16667 and 28.142857, respectively. Both socio-economic statuses had high satisfaction of life scores (Diener, 2006).

H10a: *The accessibility to health insurance results in higher levels of satisfaction with life.*

The results were statistically significant (t(170) = - 2.6264, $p < 0.0094$). The effect size was 2.574% of the variance observed. This signified a small effect size. This confirms that having access to health insurance for a person with visual impairment was associated with a higher satisfaction of life.

H10b: The lack of accessibility to health insurance results in a lower level of life satisfaction

The results were statistically significant (t(170) = - 2.6264, $p < 0.0094$). Given that there was a significant result and that the mean satisfaction with life score was lower for participants answering that they did not have access to health insurance, which confirmed the hypothesis.

H11a: The type of health benefits is associated with a higher level of life satisfaction with

The results were statistically significant (F(4, 151) = 4.03, p < 0.0039). The effect size was 9.635% of the variance observed. This signified a greater than medium effect size. Considering that there was a significant result coupled with a greater than medium effect size showed that having a particular health benefit results in a higher satisfaction of life. The highest satisfaction with life mean was having 'Social Security' and 'Other Benefits'. The satisfaction with life scores was 27.765957 and 27.111111, respectively. Both satisfaction with life scores were high. In addition, the lowest satisfaction with life scores was 'VA Benefits', SSDI and SSI, in ascending order. (i.e., VA = 20; SSDI = 22.854545; SSI = 23.375) The preceding scores were average satisfaction with life. (Diener, 2006).

H13a: Life satisfaction is higher for earlier age of onset of visual impairment.

The results were statistically significant (F(30, 137) = 2.35, p < 0.00005). The effect size was 33.974% of the variance observed. This signified a large effect size. Considering that there was a significant result and a large effect size confirmed that age of onset of visual impairment confirms the hypothesis. The satisfaction of life significantly increased when looking at the results between congenital visual impairment and acquired visual impairment. One of the highest means for satisfaction with life scores were participants with congenital visual impairment (N = 103, M = 27.300971 a high satisfaction of life score) (Diener, 2006).

H17a: The type of housing influences life satisfaction of the individual with visual impairment.

The results were significant result ($F(4, 165) = 7.74, p < 0.0000$). The effect size was 15.797% of the variance observed. This signified a large effect size. Considering that there was a significant result and a large effect size, the hypothesis was confirmed. The highest satisfaction with life score means in ascending order were Own a home = 27.49 and In Residence = 30.142857. These scores represented a high and very high satisfaction with life score, respectively (Diener, 2006).

Results that Failed to Reject the Null hypothesis

It was hypothesized that gender would be associated with life satisfaction. It was further hypothesized that men would experience a lower level of life satisfaction and women would experience a higher level of life satisfaction (H2a and H2b respectively). The factors had a negligible effect size (.00722%), and the null hypothesis was supported in both cases (men = $p > 0.4407$; women = $p > 0.4407$).

It was thought that the type of school attended would have a positive effect on life satisfaction (H4a). The results failed to reject the null hypothesis ($F(3, 165) = 0.74, p > 0.5304$) with an effect size of 1.325% of the variance observed. This confirmed that there was no significant difference between the types of schools attended and satisfaction with life.

It was further hypothesized that life satisfaction would be lower for individuals with visual impairment who lived alone (H7a). The results ($F(2,162) = 1.90, p > 0.1534$) failed to reject the null hypothesis. There was no significant difference between living alone and living with family or living with parents. Conversely, it was hypothesized that life satisfaction would be higher for individuals with visual impairment who had children in the household (H8a). However the results ($t(170) = - 0.8753, p > 0.3826$) confirmed the null hypothesis and revealed there was no significant difference in satisfaction of life with having children in the household or having no children in the household. Of note, the satisfaction of life scores of either having children in the household or no children in the household are high despite a lack of significance. (i.e., no children in the household = 25.55625; children in the household = 27. 41667). These scores indicate high life satisfaction (Diener, 2006).

It was also hypothesized that life satisfaction would be lower for individuals with co-occurring disabilities and visual impairment (H14a). The results failed to reject the null hypothesis ($t(160) = 0.3325$, $p > 0.7399$). Finally, it was thought that accessibility to services would be associated with a higher level of satisfaction with life. The results revealed a lack of significance ($t(165) = - 1.0925$, $p > 0.2762$) and failed to reject the null hypothesis.

Analyzing the MOS Social Support Survey

H18a: The higher level of social support, the higher the level of satisfaction with life.

The results were statistically significant ($F(26, 152) = 1.91$, $p < 0.0087$). The effect size was 24.593% of the variance observed. This signified a large effect size. Considering that there was a significant result and the effect size was large, the hypothesis was confirmed.

Analysis of the Nottingham Adjustment Scale

The research questions used in the Nottingham Adjustment Scale that had statistically significant results are described in detail. Research questions that failed to reject the null hypothesis are summarized below.

Statistically Significant Results

Attitudes to Disability/Illness Scale

H20b: *Life satisfaction is higher when attitudes to disability/illness are scored higher.*

The independent variable was attitudes of disability/illness and the dependent variable was the satisfaction with life score. The results were statistically significant ($F(26, 148) = 2.01$, $p < 0.0050$). The effect size was 26.12% of the variance observed.

Considering that there was a significant result and a large effect size, the test hypothesis was confirmed.

Anxiety/Depression Scale

H20c: *Life satisfaction is higher when anxiety/depression is scored lower.*

The independent variable was anxiety/depression and the dependent variable was the satisfaction with life score. The results were statistically significant (F(26,147) = 2.57, p < 0.0002). The effect size was 31.264% of the variance observed. Considering that there was a significant result and a large effect size, the test hypothesis was confirmed.

Acceptance of Disability/Illness Scale

H20e**:** *Life satisfaction is higher when the acceptance of disability/illness is scored higher.*

The independent variable was acceptance of disability/illness and the dependent variable was the satisfaction of life score. The results were statistically significant (F(26, 145) = 4.75, p < 0.0000). The effect size was 45.994% of the variance observed. Considering that there was a significant result and a large effect size, the test hypothesis was confirmed.

Results That Failed to Reject the Null Hypothesis

It was hypothesized that life satisfaction would be higher when self esteem is higher (H20a). The self esteem scale was used. The effect size was 17.184% of the variance observed. The results were not statistically significant (F(26, 149), p > 0.2558) and failed to reject the null hypothesis. It was also hypothesized that life satisfaction would be higher when locus of control is higher (H20d). The Locus of control scale was used to test this. The effect size was 16.492% of the variance observed. The results were not statistically significant F(26, 145) = 1.10, p > 0.3471) and failed to reject the null hypothesis. It was further hypothesized that life satisfaction would be higher when self-efficacy is higher (H20f). The self-efficacy scale was used. The effect size was 20.8706%

of the variance observed. The results were not statistically significant ($F(26, 143) = 2.34$, $p > 0.0883$) and failed to reject the null hypothesis. Finally, it was hypothesized that life satisfaction would be higher when attributions are scored higher (H20g). The Attributes scale was used for this test. The effect size was 36.1553% of the variance observed. The results were not statistically significant ($F(50, 109) = 1.23$, $p > 0.1814$) and failed to reject the null hypothesis.

Analysis of Demographic Factors with Statistically Significant Results

Several demographic factors were found to be associated with various variables of interest in this study. Age of participants (**q0001)** is associated with acceptance of disability ($F(50, 110) = 1.57$, $p < 0.0269$). The effect size was 41.5790% of the variance observed and the results were statistically significant. Gender of the participants (q0002) was associated with both anxiety/depression ($t(170) = -2.2462$, $p < 0.0260$), effect size was 2.8823% of the variance observed; and self-efficacy ($t(166) = 1.8631$, $p < 0.0321$), effect size was 2.0482% of the variance observed.

Level of educational attainment (q003) was associated with both attitudes of disability/illness ($F(6, 161) = 2.71$, $p < 0.0155$), effect size was 8.9669% of the variance observed; and attributes ($F(6, 161) = 2.97$, $p < 0.0088$), effect size was 9.9801% of the variance observed.

Employment status (q005) was associated with a number of variables. Results were statistically significant when tested for attitudes of disability/illness ($F(4, 167) = 3.30$, $p < 0.0124$). The effect size was 7.3266% of the variance observed. Anxiety and Dpression were also associated with employment status ($F(4, 166) = 6.22$, $p < 0.0001$) and the effect size was 13.0261% of the variance observed. Acceptance of disability /illness was also associated with employment status ($F(4, 164) = 6.79$, $p < 0.0000$) with the effect size being 14,2098% of the variance observed. Finally self efficacy was associated with employment status ($F(4, 162) = 4.95$, $p < 0.0009$). The effect size was 10.8913% of the variance observed.

Marital status (q006) was associated with emotional/informational support ($F(4, 175) = 5.27$, $p < 0.0005$). The effect size was 10.7538% of the variance observed. It was also associated with positive interactions support ($F(4, 175) = 9.34$, $p < 0.0000$), effective size being 17.5964% of the variance observed; as well as self esteem ($F(4, 168) = 2.88$, $p < 0.0244$). The effect size was 6.4117% of the variance observed. Marital status was also associated with acceptance of disability/illness ($F(4, 164) = 2.83$, $p < 0.0265$). The effect size was 6.4532% of the variance observed. Finally marital status was associated with self efficacy ($F(4, 162) = 2.77$, $p < 0.0291$). The effect size was 6.4167% of the variance observed.

Living situation (q0007) was associated with several other variables including emotional/informational support ($F(2, 171) = 7.18$, $p < 0.0010$). The effect size was 7.7487% of the variance observed. Affectionate support was also associated with living situation ($F(2, 171) = 4.41$, $p < 0.0136$), as was positive interaction support ($F(2, 171) = 10.62$, $p < 0.0000$). The effect size of the variance observed were 4.9004% and 11.0486% respectively. Self-esteem was also associated with living situation ($F(2, 164) = 7.51$, $p < 0.0008$). The effect size 8.3863% of the variance observed. Finally, living situation was associated with attitudes of disability/illness ($F(2, 163) = 3.94$, $p < 0.0214$). The effect size was 4.6071% of the variance observed.

Children in the household (q0008) was associated with positive interactions support ($t(172) = -2.1636$, $p < 0.0318$). The effect size was 2.5485% of the variance observed. Annual income (q0009) was associated with acceptance of disability/illness ($F(9, 149) = 2.92$, $p < 0.0032$). The effect size was 15.0073% of the variance observed.

Access to health insurance (q0010) was associated with emotional/informational support ($t(179) = -2.0224$, $p < 0.0446$). The effect size was 2.2339% of the variance observed. It was also associated with attributes ($t(167) = 2.5614$, $p < 0.0113$). The effect size was 3.78% of the variance observed.

Type of benefit (q0011) was associated with a number of variables including self-esteem ($F(4,153) = 7.43$, $p < 0.0000$). The effect size was 16.2717% of the variance observed. Attitudes of disability/illness ($F(4, 152) = 3.52$, $p < 0.0089$) and acceptance of disability/illness ($F(4, 150) = 5.52$, $p < 0.0004$) were both associated with type of benefit. The effect size of the variance observed were 8.4677% and 12.8374% respectively. Attributes were also associated with type of benefit. The results were statistically significant ($F(4, 149) = 2.58$, $p < 0.0395$). The effect size was 6.4826% of the variance observed.

The age of onset of visual impairment (q0013) was associated with emotional/informational support ($F(30, 146) = 1.60$, $p < 0.0368$). The effect size was 24.6958% of the variance observed. It was also associated with total social support $F(30, 147) = 2.11$, $p < 0.0019$). The effect size was 30.0812% of the variance observed. Considering that there was a significant result and large effect size, the hypothesis was confirmed.

Co-occurring disabilities and visual impairment (q0014) were associated with self efficacy ($t(159) = 2.1901$, $p < 0.0300$). The effect size was 2.9283% of the variance observed. They were also associated with attributes ($t(159) = 1.9081$, $p < 0.0291$). The effect size was 2.2385% of the variance observed.

A participant's housing situation (q0017) was associated with the most variables in this study. Emotional/informational support ($F(4, 177) = 6.73$, $p < 0.0000$), tangible support $F(4, 177) = 2.64$, $p < 0.0353$), and affectionate support ($F(4, 177) = 5.60$, $p <$

0.0003) were all associated with housing situation with the effect sizes being 13.20%, 5.64%, and 11.24% respectfully. Positive interaction supports (F(4, 177) = 3.85, p < 0.0050) with an effect size of 8.0023% of the variance observed was also associated with housing situation. Total social support (F(4, 177) = 4.88, p < 0.0009) was also associated with housing situation. The effect size was 9.94% of the variance observed.

Housing situation (q0017) was also associated with anxiety/depression (F(4, 165) = 2.63, p < 0.0364). The effect size was 5.99% of the variance observed. Acceptance of disability/illness was also associated with housing situation (F(4, 163) = 3.00, p < 0.0202). The effect size 6.8531% of the variance observed. Self efficacy (F(4, 161) = 3.55, p < 0.0084) was associated with housing situation. The effect size was 8.0988% of the variance observed. Finally housing situation was associated with attributes (F(4, 162) = 3.18, p < 0.0151). The effect size was 7.2813% of the variance observed.

Analysis of Factors with Lack of Significance

When tested with other factors, a number of variables in this study failed to reject the null hypothesis and no association between the two factors could be made. For example, the age of the participants (q0001) was not associated with emotional/information support (F(50, 121) = 0.98, p > 0.5185), tangible support (F(50, 122) = 0.67, p > 0.9476), affectionate support F(50, 121) = 1.22, p > 0.1854), positive interactions support (F(50, 121) = 0.99, p > 0.5060), or total support (F(50, 122) = 0.74, p > 0.8897). There was no association between age of the participants and self-esteem (F(50, 114) = 1.25, p < 0.1635), anxiety/depression (F(50, 112) = 1.19, p > 0.2224), or locus of control (F(50, 111) = 0.78, p > 0.8311). Age of participants was not associated with self-efficacy (F(50, 108) = 1.02, p > 0.4489) or attributes (F(50, 109) = 1.23, p > 0.1814).

Gender of participants (q0002) was not associated with emotional/informational support (t(179) = 1.3773, p > 0.1701), tangible support (t(180) = 1.3978, p > 0.1639) or affectionate support (t(179) = 0.4636, p > 0.7345). Total social support (t(180) = 1.1600, p > 0.2476) was not associated with the gender of participants either. Self-esteem was not associated with gender t(172) = -0.0315, p > 0.9749). None of the following factors were associated with gender of the participants: attitudes of disability/illness (t(171) = -0.7664, p > 0.4445), locus of control t(169) = 1.6808, p > 0.0946), acceptance of disability/illness (t(168) = 0.7756, p > 0.4391), or attributes (t(167) = 0.9966, p > 0.3204).

The educational attainment of the participants (q0003) was not associated with a number of other factors in this study including emotional/informational support F(6, 173) = 0.85, p > .5341), tangible support (F(6, 174) = 0.66, p > 0.6825), affectionate support ((F(6, 173) = 0.77, p > 0.5978), positive interaction support (F(6, 173) = 1.26, p > 0.2797), or total social support F(6, 174) = 0.21, p > 0.9738). Neither self-esteem (F(6, 166) = 0.33, p > 0.9188), nor anxiety/depression (F(6, 164) = 0.31, p > 0.9333) were associated with educational attainment. Educational attainment was not associated with locus of control (F(6, 163) = 0.40, p > 0.8793) or acceptance of disability/illness (F(6, 162) = 1.05, p > 0.3940). Self-efficacy was not associated with educational attainment either (F(6, 161) = 1.24, p > 0.2910).

The type of school attended (q0004) was not associated with emotional/informational support (F(3, 174) = 1.76, p > 0.1571), tangible support (F(3, 175) = 1.82, p > 0.1450), affectionate support (F(3, 174) = 1.34, p > 0.2632), positive interactions support (F(3, 174) = 1.85, p > 0.1395), or total support (F(3, 175) = 1.35, p > 0.2603). Self-esteem was not associated with type of school attended (F(3, 167) = 0.55, p > 0.6463). Neither Attitudes of disability/illness (F(3, 166) = 0.27, p > 0.8448) nor anxiety/depression (F(3, 165) = 2.51, p > 0.0608) were associated with type of school attended. Locus of control (F(3,164) = 0.81, p > 0.4884) was not associated with type of school attended. Type of school attended was not associated with acceptance of disability/illness (F(3, 163) = 0.80, p > 0.4941), self-efficacy (F(3, 161) = 1.65, p > 0.1794), or attributes (F(3, 162) = 0.78, p > 0.5045).

The employment status of the participants (q0005) was not associated with emotional/informational support F(4, 175) = 1.08, p > 0.3678), tangible support (F(4, 176) = 1.88, p > 0.1157), affectionate support (F(4, 175) = 0.63, p > 0.6444), positive interaction support (F(4, 175) = 0.49, p > 0.7436), or total support (F(4, 176) = 1.19, p > 0.3161). Self-esteem was not associated with employment status (F(4, 168) = 1.71, p > 0.1503), and neither were locus of control (F(4, 165) = 1.63, p > 0.1685) or attributes (F(4, 163) = 1.26, p > 0.2865).

Marital status of the participants (q0006) was not associated with tangible support (F(4, 176) = 0.31, p > 0.8730, affectionate support (F(4, 175) = 1.87, p > 0.1185), or total support (F(4, 176) = 0.95, p > 0.4385). Attitudes of disability/illness was associated with marital status (F(4, 167) = 1.49, p > 0.2069), and neither was anxiety/depression (F(4, 166) = 0.79, p > 0.5300). Marital status was also not associated with locus of control (F(4, 165) = 0.75, p > 0.5606) or attributes (F(4, 163) = 1.91, p > 0.1106).

A participant's living situation (q0007) was not associated with tangible support (F(2, 172) = 0.13, p > 0.8763) or total support (F(2, 172) = 0.59, p > 0.5567). Anxiety/depression was not associated with living situation (F(2, 162) = 0.63, p > 0.5324), neither were locus of control (F(2, 161) = 0.43, p > 0.6492), or acceptance of disability/illness (F(2, 160) = 0.48, p > 0.6169). Living situation was not associated with self-efficacy (F(2, 158) = 0.51, p > 0.5986), or attributes (F(2, 159) = 1.75, p > 0.1766).

Having children in the household (q0008) was not associated with emotional/informational support (t(179) = -1.4401, p > 0.1516), tangible support (t(180)

= -1.5129, $p > 0.1321$), affectionate support ($t(179) = -1.4687$, $p > 0.1437$), or total social support ($t(180) = -1.3798$, $p > 0.1693$). Children in the household was also not associated with self-esteem ($t(172) = 0.3192$, $p > 0.7500$), attitudes of disability/illness ($t(171) = 0.3674$, $p > 0.7138$), anxiety/depression ($t(170) = -1.1240$, $p > 0.2626$), or locus of control ($t(169) = -0.7838$, $p > 0.4343$). Acceptance of disability/illness ($t(168) = -0.0491$, $p > 0.9609$), self-efficacy ($t(168) = -0.6004$, $p > 0.5490$), or attributes ($t(167) = -1.2290$, $p > 0.2208$) were not associated with children in the household either.

It was hypothesized that annual income (q0009) would be associated emotional/informational support, however the rest failed to reject the null hypothesis ($F(9, 159) = 1.82$, $p > 0.0686$). Annual income was also not associated with tangible support ($F(9, 160) = 0.40$, $p > 0.9317$), affectionate support ($F(9, 159) = 1.17$, $p > 0.3207$), positive interactions support ($F(9, 159) = 1.36$, $p > 0.2098$), or total social support ($F(9, 160) = 1.02$, $p > 0.4289$). Self- esteem was not associated with annual income ($F(9, 153) = 0.95$, $p > 0.4857$), neither was attitudes of disability/illness ($F(9, 152) = 1.57$, $p > 0.1290$), nor anxiety/depression ($F(9, 151) = 1.49$, $p > 0.1566$). Locus of control was not associated with annual income ($F(9, 150) = 1.57$, $p > 0.1278$). Annual income was not associate with either self-efficacy ($F(9, 147) = 1.55$, $p > 0.1365$) or attributes ($F(9, 148) = 1.83$, $p > 0.0675$).

There was no statistically significant association between access to health insurance (q0010) and tangible support ($t(180) = -1.5871$, $p > 0.1143$), affectionate support ($t(179) = -0.7683$, $p > 0.4433$), positive interaction support ($t(179) = -0.9277$, $p > 0.3548$), or total social support ($t(180) = -1.6447$, $p > 0.1018$). Self-esteem ($t(172) = 0.0214$, $p > 0.9830$) was not associated with access to health insurance ($t(172) = 0.0214$, $p > 0.9830$), nor was attitudes of disability/illness ($t(171) = 0.2105$, $p > 0.8336$), or having anxiety/depression ($t(170) = 1.3983$, $p > 0.1638$). Access to health insurance was also not associated with locus of control ($t(169) = -1.3409$, $p > 0.1817$), acceptance of disability/illness ($t(168) = -1.6249$, $p > 0.1061$), or self-efficacy ($t(166) = -1.3308$, $p > 0.1851$).

The types of benefits (q0011) participants received was not associated with emotional/informational support ($F(4, 158) = 2.41$, $p > 0.0518$), tangible support ($F(4, 159) = 2.06$, $p > 0.0887$), affectionate support ($F(4, 158) = 2.02$, $p > 0.0948$), positive interactions support ($F(4, 158) = 1.22$, $p > 0.3048$), or total social support ($F(4, 159) = 2.36$, $p > 0.0559$). Anxiety/depression was not associated with types of benefits ($F(4, 151) = 0.83$, $p > 0.5088$). Locus of control ($F(4, 150) = 0.48$, $p > 0.7483$) or self-efficacy were not associated with type of benefits ($F(4, 148) = 1.82$, $p > 0.1285$).

Age of onset of visual impairment (q 0013) was not associated with tangible support ($F(30, 147) = 0.55$, $p > 0.9731$), affectionate support ($F(30, 146) = 1.08$, $p > 0.3704$), or positive interactions support ($F(30, 146) = 1.31$, $p > 0.1516$). Self –esteem ($F(30, 139) = 0.82$, $p > 0.7284$), attitudes of disability/illness ($F(29, 139) = 0.55$, $p > 0.9685$), anxiety/depression ($F(29, 138) = 1.00$, $p > 0.4766$), locus of control ($F(29, 137) = 0.61$, $p > 9410$), or acceptance of disability/illness ($F(29, 136) = 1.51$, $p > 0.0625$) were not associated with age of onset of visual impairment. Age of onset of visual impairment was not associated with self-efficacy ($F(29, 134) = 1.29$, $p > 0.1689$) or attributes ($F(29, 135) = 0.98$, $p > 0.5082$).

It was hypothesized that co-occurring disabilities and visual impairment (q0014) would be associated with emotional/informational support, but the results failed to reject the null hypothesis ($t(171) = 0.3571$, $p > 0.7215$). It was further not associated with tangible support ($t(171) = 0.6118$, $p > 0.5415$), affectionate support ($t(171) = 0.6647$, $p > 0.5072$), positive interactions support ($t(171) = 0.0312$, $p > 0.9752$), or total social support ($t(171) = 0.5758$, $p > 0.5655$). Co-occurring disabilities and visual impairment was not associated with self-esteem (t(163) = 0.2645, p > 0.7917), attitudes of disability/illness (t(162) = 0.5145, p > 0.6076), anxiety/depression (t(162) = -0.3232, p > 0.7470), or locus of control (t(161) = -0.1238, p > 0.9016). Acceptance of disability/illness was not associated with co-occurring disabilities and visual impairment either (t160) = 1.4089, p > 0.1608).

Access to services (q0016) was not associated with emotional/informational support (t(177) = -0.2454, p > 0.8064), tangible support (t(177) = -1.3854, p > 0.1677), or affectionate support (t(175) = 0.5908, p > 0.5554). Positive interaction support was not associated with accessibility to services (t(177) = 0.1294, p > 0.8972), and neither was total social support (t(177) = -0.9239, p > 0.3568). Self-esteem (t(167) = -0.0067, p > 0.9947), attitudes of disability/illness (t(166) = -0.3720, p > 0.7104), and anxiety/depression (t(165) = -1.5539, p > 0.1221) were not associated with access to services. Access to services was not associated with locus of control (t(163) = 1.4074, p > 0.1612), acceptance of disability/illness (t(163) = -1.0815, p > 0.2811), self-efficacy (t(162) = -1.2085, p > 0.2286), or attributes (t(162) = -0.1539, p > 0.8779).

It was thought that a participant's housing situation (q0017) would be associated with self-esteem, however the results failed to reject the null hypothesis (F(4, 167) = 2.12, p > 0.0803). Neither attitudes of disability/illness (F(4, 166) = 2.17, p > 0.0750), nor locus of control (F(4, 163) = 2.11, p > 0.0817) were associated with housing situation either.

Chapter Eight: Discussion

This chapter interprets the results of this study and discusses the implications of the findings for social work education, social work practice, and social work policy as they pertain to individuals living with visual impairment and their satisfaction with life. The consistency of empirical work and theoretical framework fit are discussed as they pertain to the findings. The implications of the findings and their contributions to the social work knowledge base are delineated. Suggestions for future research are proposed. Lastly, the limitations of the study and any suggestions for improvements are discussed.

Consistency of the Results with the Empirical Body of Knowledge

The findings from this study were consistent with the empirical body of knowledge on individuals with visual impairment and life satisfaction. This study's findings and existing empirical work both incorporated and emphasized the actual concerns and priorities of individuals with a visual impairment. A synthesis of the study's findings will be explained.

Federal programs designated for people with visual impairments allocate benefits to improve their lives. These programs provide minimally adequate provisions of benefits. There are limitations to participating in federal programs for individuals with disabilities. Although some needs are met, the empowerment of individuals is lacking. Individuals with disabilities need to be self-sufficient. This is contrary to the design of federal programs. These programs are designed to retain recipients for the long term. Over time recipients of federal programs become dependent and disempowered. In my findings, earned benefits had the contrary result (i.e., social security and other benefits). Earned benefits in my study equated to greater satisfaction with life. Therefore, recipients were empowered and self-sufficient in their lives. It would stand to reason that when creating benefits, it is prudent to incorporate provisions into federal programs that promote empowerment and self-sufficiency to increase quality of life for individuals with disabilities.

The literature has shown that health disparities and healthcare discrimination are interrelated in the schema of society. The result of healthcare discrimination is evident in the health disparities present in society. In this study, healthcare discrimination has repercussions stemming from the individual to the societal perspectives. Individuals with a disability experience healthcare discrimination whether it was covertly or overtly exhibited. The consequences resulting from biases shown to individuals with a disability can be internalized and eventually believed as the truth about themselves. This dynamic extends to society in that opportunities and resources are not allocated to persons with disabilities. The cause stems from assumptions about the abilities and skills of individuals with disabilities. Healthcare discrimination originates from and can be addressed by revisiting the curriculum taught in medical and social work schools. The intricacies of disability need to be researched and information taught to the next generation of helping professionals. Only then can the misinformation be eliminated, and humanistic and compassionate practice modalities be implemented to address the health disparities present. Healthcare disparities and healthcare discrimination are interrelated and different sides of the same coin.

Accessibility to medical benefits is related to attitudinal biases toward persons with disabilities. According to Silvers and Francis (2013), employers were reluctant to offer health insurance to individuals with disabilities. Unfortunately, there is no consistent oversight to administer fair and equitable medical benefits. The ADA is not consistent in overseeing direct or indirect discrimination against individuals with disabilities. There can be a legislative remedy. A law can be ratified that protects and enforces the right to health insurance for all. Countries such as Australia have universal healthcare. In Australia's healthcare system, the government provides public health insurance called Medicare, and runs public hospitals. Every citizen "receives coverage and people must pay deductibles before government payments kick in. There is also an option to purchase private hospital coverage or pay a tax surcharge" (Amadeo, 2022, Examples of Developed Countries with UHC, Australia section, para. 1). Countries that have Universal Health Care generally have citizens that present better outcomes in life. "Universal Health coverage requires strong, people-centered primary health care. Good health systems are rooted in the communities they serve. They not only focus on preventing and treating disease and illness, but also helping to improve well-being and quality of life" (WHO, 2023, Universal Health Coverage, Overview section, para. 4)

When considering employment outcomes, employment barriers discrimination is prevalent in both developed and developing countries; attributing prejudice in the form of obstacles to acquiring employment (Wolffe & Spungin, 2002). Additional bias exhibited by employers was the lack of recognition of abilities for individuals with visual impairments. Also, the lack of availability of assistive technology required to perform their job role was another barrier to employment (Wolffe & Spungin, 2002). The ADA stipulates protections from all these barriers. Although the ADA's language clearly states the protections to be provided for individuals with disabilities, no clear actions are stated for infringements of the ADA. Therefore, infringements go unanswered and unresolved.

In this study, individuals with visual impairments faced unique obstacles in educational attainment when compared to individuals without disabilities. To successfully achieve educational goals, resources need to be available for the student with a disability. The first resource was the consistent administration of ADA. Staff designated to advocate and assist students with disabilities in achieving their educational goals are essential. Negative attitudinal biases on the part of educators directed toward students with disabilities need to be addressed. The biases not only disrupt lives and hurt emotions, but they also impede educational attainment. As a result, national revenue in taxes of over 100 billion dollars is lost annually. This does not factor in the untold loss of human capital.

Goodness of Fit with the Theoretical Frameworks

By considering the micro and macro perspectives in understanding individuals with visual impairments and their association with satisfaction with life, issues faced in their daily lives gain clarity. The issues relating to levels of satisfaction with life in this study's findings correspond to the issues faced by the blind and visually impaired community. The micro and macro perspectives are interrelated as the social model of disability and ecological systems theory are symbiotic in their association. As previously stated, the 'web of society' has causal relationships to society, the survey presented, and the findings of this study. When considering the micro aspects of the visually impaired community certain factors stand out, are statistically significant, and are delineated in the result chapter. To reveal the deeper meaning of satisfaction with life of the visually impaired community, both micro and macro perspectives must be accounted for in the analysis. The person and the community (i.e., individuals, and the group of persons with a visual impairment, respectively) are interrelated and shaped by each other. The social model of disability addressed the societal disparities in resource accessibility and access to opportunities, and the discrimination and oppression present for individuals with visual impairments. Overall, the social model of disability explains and addresses these disparities in society quite well. The ecological systems theory explains the interactions beginning with the person and extending toward the intricacies of society. It is only when the social model of disability and the ecological systems theory are both considered, a clearer picture of issues that are faced by the blind and visually impaired community becomes evident.

The structure of society explains how negative attitudinal biases, discrimination, and disparities in opportunities and resources are lacking in availability to individuals with visual impairments. The negative attitudinal biases and discrimination directed toward individuals with visual impairments can be traced back to both the individual with a disability and societal influences. These forces are interrelated. A person with a disability potentially begins to internalize negative attitudinal biases and eventually starts accepting them. Also, society can make assumptions about the potential of persons with a disability. The forces in society (i.e., employers, physicians, politicians, and helping professionals) assume that individuals with a disability cannot sustain work, self-advocate, have autonomy, and have the human right to benefits and services. It has been my experience that this is a false conceptualization of individuals with a disability. Persons with a disability want to have and maintain employment, can self-advocate, deserve to have autonomy, and have the human right to benefits and services. The proverbial scales of justice are balanced and provide opportunities and resources to have a quality of life. A simple remedy is to listen to what people with a disability say, feel, and need. This study has been developed and implemented to provide a voice for this exact purpose.

Implications and Contributions

The process of this study and its implementation involved planning, understanding of disability, specifically individuals with visual impairment, and a belief in rectifying the inequities present in society. This directly informed the writing of this dissertation. The disparities and subsequent discrimination of individuals with visual impairments are prevalent in society. This study addressed and revealed the inequities that were present for persons with a disability. Specifically, negative attitudinal biases, lack of resources and opportunities, and barriers to attaining education, employment, and acquiring housing are encountered daily by individuals with a disability. In the development of this study, a few important conceptualizations were a priority. First, treating individuals with visual impairments with dignity and care throughout the writing process. Second, to provide an avenue for empowerment from the data collected. Third, impart valuable information that can be used in future research for social work education, and practice modalities. Fourth, to initiate the process of creating equitable and fair policies. Overall, these priorities were met.

Social Work Education

The implications of the findings as they pertain to social work education stem from the fact that there was a significant disparity in educational attainment with individuals with a visual impairment. In addition, there were systemic barriers and discriminatory practices preventing educational attainment. The barriers were structured, attitudinal, lack of resources, and paternalism. The structured barriers present were physical in nature and prevented the students from accessing and navigating the spaces of the university and libraries. Students with a visual impairment have significant difficulty getting to scheduled classes, the registrar, the financial aid office, etc. These obstacles impede the student with a disability from actualizing their potential, which is and should be the purpose of higher education.

The attitudinal barriers were based on the lack of knowledge of disabilities, lack of experience working with students with disabilities, or blatant bias directed towards students with a disability. Professors are resistant to adhering to the ADA. In my experience working at Hunter College as a Peer Counselor, I have seen some of the difficulties students with disabilities face getting accommodations for documented disabilities for which the students are registered with the student with disabilities office. Thankfully the prejudicial occurrences were in the minority. There is an expression I will paraphrase, it takes a village to assist someone to succeed, it only takes one negative person to disrupt one's dreams.

The solution is straightforward. Have mandatory workshops in the workplace focused on presenting evidence-based empirical work pertaining to students with disabilities. These workshops would focus on bringing sensitivity to the reality that students with disabilities face while eliminating misconceptions and falsehoods. Another solution that would stimulate change for the disparities and discrimination that is occurring is for the development and implementation of a university curriculum. The curriculum would be evidence-based practice modalities that bring a compassionate and holistic method to working with students with a disability. After all, when social work students graduate and enter the workforce they will be working with individuals with a disability. Bringing greater empathy and compassion into the learning environment would change and shape students' minds and hearts into competent practitioners. There will be a new generation of social workers on track to creating a more just world.

Lastly, paternalism can be well-intentioned, but in the long term it is the antithesis of empowerment and inhibits self-determination. Assistance and assuming a deficit perspective are two different things. Offering assistance to a person with a disability is warranted and beneficial if it is in a collaborative manner. Taking a deficit stance leaves no room for attaining empowerment, self-sufficiency, and opportunities and is detrimental to the person with a disability.

Of note, Dr. Hye-Kyung Kang expressed in the article "Re-Envisioning Social Work Education: Building and Living a Social Justice-focused Clinical Social Work Curriculum" has similar assertions this researcher has expressed in this study (Kang,

2022) The issue of social justice is at the forefront of developing equity and opportunity for individuals with a disability.

Schley and colleagues also devised a semester-long professional learning community focusing on effectual teaching strategies to better educate students with disabilities in higher education (Schley et al, 2021). Their "faculty development model" was built upon establishing relations between students in faculty-mentors role and faculty learning community participants" (Schley et al, 2021, p. 44).

Social Work Practice

The implications of the findings as they pertain to social work practice are related and starts with the accredited curriculum in medical and social work universities. As Kang (2022) articulated, social justice is at the crux of the discussion and implementation in providing a better education for students working to attain degrees in the social work profession. The students would be informed of the implications and implementation of social justice in their practice when working with clients in their workplace. The Strengths Perspective discussed in this study is also essential in attaining the same aim.

Saleebey (2000) discussed the strengths-based social work approach to practice and it appealed to me. It also corroborated this study throughout its delineation. Through the strengths-based focus of social work practice, aspects of the client's internal and external assets and resources were realized and acknowledged. Saleebey says:

> Empowerment as a process is the collaboration between, say a social worker and a family or individual, working together on a mutually-crafted project that in some sense will move people closer to their visions and aspirations. The strengths perspective then, is about "uncovering, naming embellishing, and celebrating abilities, talents, and aspiration in the service of desired change (Saleebey, 2000, p. 128).

The theoretical frameworks that were designed to treat patients, clients, victims, and the disadvantaged have been around for a while. The limited stigmatizing perspective that clients were victims and disadvantaged sets the connotation that people with disabilities have no recourse towards bettering their lives. It also alludes that clients have no internal or external abilities and resources. When looking solely at deficit that is what is seen and there is no room for resolution of issues or catharsis. On the other hand, when looking at clients through the strengths perspective lens a different narrative appears. Hope and the resources in which to actualize dreams and aspirations are realized and opportunity can be created (Saleebey, 2000). Saleebey cites a quote from the author Paulo Freire a Brazilian educator and philosopher, "There is no change without a dream, as there is no dream without hope." (Saleebey, 2000, p. 133)

Social Policy Development

Barry and colleagues (2009), compare the ADA in its original form and the amended form (ADA as amended [ADAAA]). The authors discuss the following: "Scope of the Definition: In General", "Mitigating Measures", "Sustainability Limits", the "Major Life Activity Requirement", "Episodic Conditions and Multiple Major Life Activities", "Regarded as Having a Disability", "Findings and Narrow Construction", "Regulatory Authority" and "Academic Requirements in Higher Education". I will briefly discuss all these aspects within the ADA and the ADAAA.

The ADA states that the breadth of the definition of disability, in part, as "a physical or mental impairment that sustainability limits a major life activity of an individual" (Barry et al., 2009, p1). Cases that were heard before the Supreme Court limited and interpreted the definition of disability in the "lower courts to exclude a range of individuals from coverage, including individuals with diabetes, epilepsy, cancer, muscular dystrophy, and artificial limbs" (Barry et al., 2009, p1). This placed an already heavy burden on individuals with a disability. In the amended version a disability was defined in part as "a physical or mental impairment that substantially limits a major activity of an individual" (Barry et al., 2009, p1). When the amended ADA was ratified, the definition of disability declared a more expansive coverage for individuals with disabilities than described in the ADA (Barry et al., 2009).

The ADA's interpretation of "Mitigating Measures" went back to the case of *Sutton v. United Airlines.* Mitigating measures (such as medication or devices) were recognized when an individual "was substantially limited in a major life activity." For example, with regard to medications, the court would decide that the individual did not have a disability under the ADA – even if the impairment was the basis of discrimination. Under the ADAAA these issues "of mitigating measures" were addressed and the courts decided that "mitigating measures" would not be used to determine if a person has "an impairment that substantially limits a major life activity" (Barry et al., 2009, pp. 1-2).

In the interpretation of the ADA "substantially limits", the Supreme Court decided in *Toyota Motor Manufacturing of Kentucky v. Williams* that an impairment substantially limits a major life activity if it prevents or severely restricts and individual from performing the activity. The ADAAA necessitates that the term "substantially limits" be interpreted consistently with the findings and purposes of the Act. The EEOC stated "the Supreme Court have incorrectly interpreted the term "substantially limits" and had expanded a broader definition of limits than have been determined by Congress. This was a major step towards providing coverage for individuals with a disability" (Barry et al., 2009, p. 2).

The issue of "Major Life Activity" with regard to the ADA was deliberated during the Supreme Court case *Toyota Motor Mfg. of Kentucky v. Williams*. The court ruled that a major life activity must be of central importance to most people's daily lives. According to the ADAAA major life activities include seeing hearing, eating, sleeping, walking, learning, and concentrating. In addition, the ADAAA included major bodily functions such as immune system, normal cell growth, and the endocrine system. These aspects of disability were instrumental in addressing the issues that prevented individuals with a disability from having a chance to participate fully in society (Barry et al., 2009).

Another issue, “Episodic Conditions and Multiple Major Life Activities” in a few lower courts interpreted this issue in that multiple major life activities were necessary for a person to be declared as having a disability in the ADA. Ailments such as epilepsy or post-traumatic stress disorder were not protected under the ADA under this interpretation. In the ADAAA this issue was clarified and declared ‘that an impairment that substantially limits a major life activity need not also limit other major life activities in order to be considered a disability” (Barry et al., 2009, p 2). A further clarification was made for disabilities that were episodic or in remission. When an impairment substantially limits a major life activity, as in the case of conditions such as lupus, the designation of disability applies. The original version of the ADA would not have recognized this condition and provided no coverage. With the amendment of the ADA, any ambiguity was eliminated from legal precedent (Barry et al., 2009).

The issue of “Regarded as Having a Disability” was the central issue in the Supreme Court case, *Sutton v. United Airlines.* Here the court created a high bar to demonstrate when an individual is substantially limited in maintaining a job position. This ruling made it obligatory for an individual to provide evidence that their employer knew that many other employers would have discriminated against the individual as well. The lower courts required the person with a disability to prove the company’s intent when engaging in discriminatory practices to be covered under the ADA (Barry et al., 2009). Under the ADAAA a person with a disability can demonstrate coverage using the regarded as clause and demonstrate that they experienced a discriminatory practice prohibited by the ADA on an actual or perceived impairment, regardless of whether the impairment limits a major life activity. The ruling reestablished the 1987 Supreme Court case *School Board of Nassau County v. Arline*. In this ruling "transitory and minor impairments are excluded from this coverage, and employers and other entities under the ADA have no duty to provide a reasonable accommodation or modification to individuals who fall solely under 'regarded as' point of reference" (Barry et al., 2009, pp 2-3). In terms of creating equity this provision in the amended ADA brought the reality of equal opportunity one step closer to fruition.

The issue of "Findings and Narrow Construction" for the ADA was associated with two cases, *Sutton v. United Airlines* and *Toyota Motor Mfg. of Kentucky v. Williams*." As far as the Sutton case, the Supreme Court interpreted the ADA in a narrow reading for the definition of "disability." When considering the Williams case, the Court confirmed its conclusion that the terms "substantially limits" and "major life activity" must be interpreted strictly to create a demanding standard for qualifying as disabled. When considering these two Supreme Court findings the terms "substantially limits" and "substantially restricts" were not aligned "with congressional objective and placed a too high a standard" (Barry et al., 2009, p. 2). In the ADAAA there were other revisions such as redefining "substantially limit" as excessively severe. The focus was to assess whether covered entities have complied with their obligations. The Court found that "further deliberation of an individual's impairment is a disability is not warranted" (Barry et al., 2009, p. 3).

The term "Regulatory Authority" was central to the Supreme Court case *Sutton v. United Airlines.* The Court held that no agency has been delegated authority to interpret the term 'disability'" through regulations. There was a distinct difference when considering the ADAAA. In "Title V of the ADA (42 U.S.C. 12201) gives the EEOC, the Attorney General, and the Secretary of Transportation the power to issue regulations interpreting the definition of disability under the ADA" (Barry et al., 2009, p. 4). This ruling brought one step closer to having oversight over cases as prescribed in the ADAAA.

Lastly, regarding the issue of "Academic Requirements in Higher Education" in the ADA, Title III made it mandatory for institutes of education to "make reasonable modifications in their policies, unless the university can demonstrate that making such modifications would fundamentally alter the nature of the educational service being offered" (Barry et al., 2009, p.4). This allowed for alternative interpretation of the ADA, that other reasons could be expressed by educational institutions for not adhering to the ADA. In the ADAAA in addressing the issues of "higher education institutions, S. 3406 explicitly states that "nothing in this Act alters the [Title III fundamental alteration provision] (Barry et al., 2009, p.4) The ADAAA elucidates "that the changes in the definition of disability do not change the fundamental alteration (Barry et al., p.4) provision of the ADA." This assured that students with disabilities would get appropriate accommodations under the ADAAA.

The ADA and the ADAAA have set the stage for more equitable treatment of individuals with a disability under the law. The ADAAA clarified the definition of a disability and the language that was involved in its deliberation and implementation. More work must be done around oversight of the ADAAA. This issue of adherence to the language, spirit, and intent of the ADAAA is paramount in achieving equal treatment of persons with a disability and permitting the allocation of resources and opportunities.

Social Work Code of Ethics

Service

The NASW Code of Ethics (2017) guides social workers' practice with clients. Service is professional value. Social workers are obliged to uphold the tenets above ourselves. We also are duty bound to advocate, facilitate or assist in alleviating the societal issues faced by the individual or group in need. Concerning the service of individuals with visual impairments there has never been more of a need than at present.

Social Justice

Another important tenet of the NASW Code of Ethics (2017) is social justice. It is imperative that the field of social work address the disparities present with the blind and visually impaired community. The main issue is accessibility and lack of resources. The barriers can originate from within the person or in society in the form of physical, deprecating or biased practices. The only remedy has been to apply strategic pressure to the appropriate agencies of government (i.e., Legislature, Executive Branch) to get the desired result. As social workers, we have the right platform to address the disparity and discrimination plaguing individuals with visual impairment. Furthermore, education for the blind and visually impaired community, as well as social work students and the general populace, needs to be undertaken. Only then will the stigma and biased practices cease and be extinguished from society.

Dignity and Worth of a Person

An essential tenet of the NASW Code of Ethics (2017) is dignity and worth of a person. This tenet addresses the self-sufficiency and self-determination of an individual. The aim for the social worker is to empower the client towards self-advocacy and self-determination. Once empowered, many possibilities become a potential reality. Without the sense of empowerment, risk of lack of self-sufficiency and self-determination are presented. This happens in society where disparities and discrimination are present due to attitudinal and biased practices.

Importance of Human Relations

The social work value of importance of human relations needs more attention because it addresses the obligation of advocacy for our clients. By advocating for clients and assisting with the attainment of self-advocacy, societal issues will dissipate. The experience of advocating for oneself will have the result in two aspects. First, the client's self-esteem and self-confidence and their belief in themselves will increase. Second, others will begin to perceive them as competent and self-assured individuals and the attitudes of individuals with a disability will inevitably change for the better.

Society as a Whole

The stigma and subsequent discrimination of persons with disabilities is prevalent in society. Despite the protections of the ADAAA discrimination occurs. Employers express various reasons why a person with a disability was not hired or did not receive health benefits. In the educational arena, attitudinal biases and structural deficiencies were extended to students with disabilities. These biases were also present in the general populace. "Stigma often comes from a lack of understanding or fear" (Borenstein, 2020, Stigma, Prejudice, and Discrimination section, para. 1). Stigma is also present in individuals with a disability when it is internalized and manifests as shame (Borenstein, 2020).

Institutional stigma is more insidious and systemic, "involving policies of government and private organizations that intentionally or unintentionally limit opportunities for people with disabilities" (Borenstein, 2020, Harmful Effects of Stigma section, para. 1). I assert that biases directed towards persons with a disability were detrimental in many respects. For example, some of the results from this study such as reduced hope, lower self-esteem, social isolation, the lack of understanding by family, friends, coworkers, or others; fewer opportunities for work, school, or social activities or trouble finding housing; bullying, physical violence, or harassment were all indicative of stigma and discrimination. "The belief that you'll never succeed at certain challenges or that you can’t improve your situation” (Borenstein, 2020, Harmful Effects of Stigma section, para. 4).

In ameliorating stigma one of the strategies shows that knowing or having contact with someone with a disability is one of the best ways to reduce stigma. Persons expressing their experiences is another effective way to address stigma. A disability becomes less scary and more real and relatable (Borenstein, 2020). “Social marketing campaigns can also be effective. In research performed on how effectual an anti-stigma social marketing campaign in California was for the fight against stigma, the study’s resulted in better understand symptoms of distress and increasing awareness” (Borenstein, 2020, Addressing Stigma section, para. 6). These anti-stigma actions can be used for persons with a visual impairment. Employers and educators can become more cognizant of their institutional culture and make necessary changes. This would change the dynamic in all settings to be more equitable for individuals with a disability. It is my assertion that this change would also benefit the overall economy in that the loss in productivity would be eliminated.

Human Condition

There is a paradoxical dual nature of humankind referred to as “the human condition”. This term is used to refer to the state of being a human, with both the wondrous and the woeful feelings we experience. “We are the species that can describe in words and works of art our perceptions, thoughts, and feelings to ourselves and to others., We all have diverse and unique life stories, but each one of them depicts times of loss, communality and loneliness, joy and sadness” (Levinson, 2021, para.1).

The dual aspects of humankind beg inquiry of whether “the “human condition” is a serious affliction with which we cope or endure, or conversely, whether it is a privilege and blessing for which we should be grateful and enjoy? The answer is of course, both.

Human beings are a social species. Humankind flourishes on social cohesion and our relationships with others. This premise has been tested in recent events such as the COVID-19 pandemic. With social media platforms we have the world at our fingertips. Yet we have neglected our true nature of authentic real human interactions. It has decreased our quality of life. “We were so preoccupied that we haven’t the time or interest to listen and really hear each other” (Levinson, 2021, para.13).

Human beings can inhabit habitats of isolation, camaraderie, or enmity. Humanity is capable of “mutual cooperation, tolerance, and love, or we succumb to the negative parts of our natures, like intolerance, aggression, racism, and hatred. We can exist isolated lives or exist in social atmospheres of communality and harmony” (Levinson, 2021, para.14). The “human condition” can bring psychosocial, social, and spiritual sustenance and meaning to our lives. But it can also create major distress.

Fortunately, humankind has inherited a strong sense of resilience in tapping into our innate ability to overcome obstacles. Through “education and egalitarianism, and exposure to our better selves, we can capitalize on our strengths and overcome our intrinsic human quandaries” (Levinson, 2021, para. 17). I assert that humankind can right the issues of society by addressing their internal selves and external actions affecting society.

This study has strived to ascertain the influences of the well-being of persons with a visual impairment. The study has produced an invaluable analysis of the satisfaction with life of persons with a visual impairment. This research presented has produced new data and analyses. Given that persons with a visual impairment consist of nearly an estimated 10% of the population of the United States, the well-being of this diverse population needs our attention. The benefit that was related to this study spans the economic, political, psychological, and social dimensions of society. Thus, the findings improve our understanding of persons with visual disabilities in the realm of education, social work practice, and the social development of policy.

Areas of Future Research

This study's intent was to better understand the satisfaction with life of persons with a visual impairment. Given that a quantitative research study on satisfaction with life had not been attempted, there is room for more research into this topic. There were a series of questions I felt were unanswered within the confines of this study's design and purpose. In future research studies, these questions could be answered. The following are questions to prospective studies that can be implemented:

1. What are the differences between need-based benefits and benefits (i.e. SSI) that were earned through work for individuals with a visual impairment? How does it affect satisfaction with life or QOL?
2. What is the relationship with the increased prevalence of vision loss in the coming decades? What actions can be taken (locally and globally to improve or prevent this trend?
3. What is the importance of vision screening, treatment, and prevention and what actions can be taken?
4. What aspects of societal and institutional stigma is associated with attitudinal and structural barriers (i.e. study on non-compliance with the ADAAA)?
5. What are the experiences of individuals with a visual impairment as it pertains to satisfaction with life?
6. What are the perceived attitudes of medical and helping professionals servicing individuals with a disability?
7. What are the health care disparities and subsequent discriminatory practices as it pertains to helping and medical professionals?

8. What design and implementation of a CSWE curriculum could be added in the form of evidence-based educational modalities for students with a disability?
9. What social policy focusing on the improved oversight of the ADAAA can be created (i.e., social policy focusing on adherence to the United Nations Convention on the Rights of People with Disabilities)?
10. What are the associations with the barriers to employment (global or local) for individuals with a disability and company attitudinal bias?
11. What is the current status of education for persons with disabilities? How can this status be improved?
12. Is there an association with cognitive decline and visual impairment?

Additionally, a series of questions were raised from analyzing the findings of this dissertation that can inform future research. Some questions include:

1. What is the association between <u>need-based benefits</u> and <u>earned benefits</u>? How does it affect satisfaction with life or QOL?
2. What is the relationship with the increased prevalence of vision loss in the coming decades? What are the actions that can be taken to improve or prevent this trend?
3. Write an article on the importance of vision screening, treatment and prevention.
4. How does the societal and institutional stigma associated with attitudinal and structural barriers affect persons with disabilities (i.e., non-compliance with ADAAA as it relates to individuals with a vision loss, and employers)?
5. What are the experiences of individuals with a visual impairment as it pertains to satisfaction with life or quality of life?

6. What are the attitudes medical and helping professionals to servicing individuals with a disability?
7. What healthcare disparities and discrimination are present in the medical and helping professions? What can be done about it?
8. How can we as educators design and implement a CSWE curriculum adding evidence-based modalities for persons with a disability and incorporating it into social work practice?
9. What specific social policy can be designed and implemented to improve oversight of the ADAAA (i.e., with adherence to the United Nations Convention on the Rights of People with Disabilities)?
10. What are the associations between barriers to employment (global or local) and company attitudinal biases?
11. What is the status of education for persons with disabilities/ How can it be ameliorated?
12. Is there an association with cognitive decline, visual impairment, and satisfaction with life?

Exploring these questions can reveal more potential disparities and provide a better assessment of individuals with a visual impairment and their community.

Limitations of Study

The limitations of this study are related to the breadth of the data collected and analyzed. To the extent possible in a quantitative survey study, the questions were answered. To achieve a better understanding of the context of the participants' answers, a qualitative study using in-depth interviewing needs to be done.

Furthermore, a more expansive study using several agencies could garner a deeper understanding into the satisfaction with life of persons with a visual impairment. A quantitative study using multiple agencies resulting a larger sample size would have a greater statistical representation and have more validity. This study could also be modified to use qualitative in-depth interviews from each agency.

Improvements in Design and Measurement

I would suggest decreasing the number of questions in this study to avoid fatigue for the participants responding to the survey. The questions in the survey should be more focused on what matters to the participants.

Significance of the Study

The significance of this study was to establish self-reported priorities and perceptions of the blind and visually impaired community as it pertains to their satisfaction with life. Satisfaction with life is interrelated to quality of life. Having a knowledge base that accurately emphasizes what the blind and visually impaired community needs to have fulfilling lives will inform education, practice modalities, and policy development. Ultimately, the lives of individuals with visual impairments can be improved.

Level of Success in Implementing this Study's Objectives

Within the scope of this study, the objectives were achieved. The study produced new data on this topic. The analysis of the data revealed facts not frequently shown. The participants were afforded the opportunity to express their perceptions and their priorities in their lives. It is my assertion that better preparation of the survey would have improved the final draft and avoided recoding the factor labels prior to disseminating the survey.

Through the process of implementing this study and writing this dissertation, I believe that the research agenda was achieved. The data collected provided unexplored knowledge for the field of social work. The results corresponded in large part with the empirical work presented. The theoretical framework fit with the research agenda and how society interacts and treats persons with a visual impairment.

Persons who lost their sight or have low vision or have congenital or acquired vision loss are diverse individuals filled with potential and motivation to achieve their dreams and promise for the future. Society would be better off if the inclusion of people with disabilities became a reality. People with disabilities have the same human dreams, ambitions, and concerns, and need to be treated with respect and dignity. People with disabilities have strengths and an abundance of skills and gifts that need to be utilized and shared with society. The resources and opportunities afforded to persons without a disability need to be provided to them. Society can benefit from the skills and apparent motivation to succeed inherent that persons with disabilities possess. For instance, the monetary cost of lost productivity mentioned in this dissertation can be eliminated when persons with a disability were afforded the same opportunities as the rest of society. Educational attainment and employment were related to achieving a successful life outcome. This supports the assertion that appropriate resources need be made available to achieve the mandate of providing a quality educational experience. Furthermore, negative attitudinal biases inhibit societal progression and growth. When one can sit down with someone with a disability and truly have an open and honest conversation with them, the person will be changed and learn from that experience.

The consequences of not addressing the stigma and discrimination directed against people with disabilities have a great cost to society. We lose untold human potential by excluding persons with a disability. We all lose and pay the consequences of our actions. As mentioned in this dissertation, the economic consequences are staggering. By not utilizing the skills and abilities of people with a disability, we are all severely disadvantaged and self-actualization is inhibited. The social isolation of persons with a disability is also a cost. Chronic medical diseases, substance abuse, and other factors prevent or stop societal growth and progress. This is linked to the loss of productivity and higher healthcare costs. The human species goes against its nature as a social being when it excludes persons with a visual impairment. When we don't celebrate the abundance of human capital inherent in the diversity of the human species, we all are disadvantaged. We lose the opportunity to learn and understand each other.

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Table 7.1

Descriptive Demographic Statistics for Satisfaction of Life Survey

Factor	*n*	%	Mean	SD	Minimum	Maximum
Age	183		57.84699	13.60609	24	86
Gender	191		1.743455	0.4378736	1	2
Male	49	25.65				
Female	142	74.35				
Education	190		4.805263	1.432419	1	7
<High school	3	1.58				
High school/GED	14	7.37				
Some college	28	14.74				
Associates	9	4.74				
Bachelors	63	33.16				
Masters	64	33.68				
Doctorate	9	4.74				
Type of school attended	186		1.423656	1.099523	1	4
Public school	138	74.19				
Vocational/technical	2	1.08				
IEP	24	12.90				
Private	22	11.38				
Employment status	190		3.257895	1.58091	1	5
Unemployed	37	19.47				
Employed	36	8.95				
Part time	29	15.26				
Volunteer work	17	8.95				
Retired	71	37.37				
Marital status	188		2.074468	1.19033	1	5
Single	73	38.863				
Married	68	36.17				
Divorced	20	10.64				
Widowed	14	7.45	6.91			
Living with a partner	12					
Living situation	182		1.565934	0.597919	1	3
Living alone	89	48.90				
Living with family	83	45.60				
Living with parent(s)	10	5.69				
Children in household	190		1.073684	0.2619465	1	2
No	176	82.63				
Yes	14	7.37				
Annual income	176		4.176136	3.027059	1	10
$10,000–$19,999	44	25.00				
$20.000–$29.999	25	14.20				
$30,000–$39,999	25	14.20				
$40,000–$49,999	13	7.39				
$50,000–$59,999	17	9.66				
$60,000–$69,999	9	5.11				
$70,000–$79,999	14	7.95				
$80,000–$89,999	4	2.27				
$90,000–$99,000	5	2.84				
>$100,000	20	11.36				
Access to health insurance	190		1.968421	0.1753383	1	2
No	6	3.16				
Yes	184	96.84				
Type of benefits	172		3.656977	1.704417	1	6
SSI	8	4.65				
VA benefits	1	0.58				

Factor	*n*	%	Mean	SD	Minimum	Maximum
Social Security	52	30.23				
Other benefits	47	37.33				
Age of onset of visual impairment	188		4.853723	10.71026	0	50
Comorbid disabilities	184		1.368696	0.4809263	1	2
Access to services	190		1.900000	0.3007926	1	2
Yes	19	10.00				
No	171	90.00				
Housing situation	192		1.588542	0.9774815	1	5
Own a home	116	60.42				
Rent an apartment	60	31.25				
Rent a room	5	2.60				
Facing eviction	1	0.52				
In residence	10	5.21				

Abbreviations: IEP, individualized educational plan; SD, standard deviation; SSI, Supplemental Securities Income; VA, Veteran’s Administration.

Table 7.2

Descriptive Statistics for MOS Social Support Survey

Factor	*n*	Mean	SD	Minimum	Maximum
Emotional/informational support					
q0019	180	3.388889	1.291956	1	5
q0020	184	4.201087	0.7807793	1	5
q0024	183	3.84153	0.9900726	1	5
q0025	186	3.983871	0.8666544	1	5
q0029	182	3.494505	1.328594	1	5
q0032	187	3.705882	1.142586	1	5
q0033	184	3.788043	1.036845	1	5
q0035	184	3.744565	1.005435	1	5
Tangible support					
q0018	175	10.93714	12.18495	1	100
q0021	183	4.087432	0.9035981	1	5
q0028	183	3.595628	1.058914	1	5
q0031	187	3.812834	1.249622	1	5
Affectionate support					
q0022	184	3.869565	1.156756	1	5
q0026	185	4.00	0.9383149	1	5
q0036	183	3.868852	1.164617	1	5
Positive social interaction					
q0023	185	4.097297	1.170861	1	5
q0027	184	3.581522	1.269175	1	5
q0034	184	3.668478	0.9603539	1	5

Abbreviations: MOS, Medical Outcomes Study; SD, standard deviation.

Note: 1.0 = None of the time; 2.0 = A little of the time; 3.0 = Some of the time; 4.0 = Most of the time 5.0 = All of the time

Question q0030 was not included in the analysis, as noted in the web article (i.e., question #13 on the MOS Social Support Survey).

Description and Scoring Instructions: MOS Social Support Survey. Retrieved from https://cadc.ucsf.edu/sites/g/files/tkssra881/f/Description%20and%20Scoring%20Instructions%20MOS%20Social%20Support%20Survey.pdf

Table 7.3

Descriptive Statistics for the Satisfaction with Life Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0037	183		5.240437	1.616231	1	7
Strongly disagree	9	4.92				
Disagree slightly	9	4.92				
Disagree	10	5.46				
Neither agree or disagree	14	7.65				
Slightly agree	33	18.03				
Agree	75	40.98				
Strongly agree	33	18.03				
q0038	181		5.187845	1.649265	1	7
Strongly disagree	5	2.84				
Slightly disagree	15	8.29				
Slightly disagree	13	7.18				
Neither agree or disagree	17	9.39				
Slightly agree	24	13.26				
Agree	72	39.78				
Strongly agree	35	19.34				
q0039	182		5.335165	1.705621	1	7
Strongly disagree	9	4.95				
Disagree	11	6.04				
Slightly disagree	12	6.59				
Neither agree or disagree	7	3.85				
Slightly agree	26	14.29				
Agree	73	40.11				
Strongly agree	44	24.18				
q0040	181		5.552486	1.484646	1	7
Strongly disagree	3	1.66				
Disagree	7	3.87				
Slightly disagree	15	8.27				
Neither agree or disagree	7	3.87				
Slightly agree	31	17.13				
Agree	66	36.46				
Strongly agree	52	28.73				
q0041	183		4.15847	2.0033	1	7
Strongly disagree	21	11.48				
Disagree	31	16.94				
Slightly disagree	24	13.11				
Neither agree or disagree	15	18.20				
Slightly agree	30	16.39				
Agree	38	20.77				
Strongly agree	24	13.11				

Abbreviation: SD, standard deviation.

Note: 1.0 = Strongly disagree; 2.0 = Disagree; 3.0 = Slightly disagree; 4.0 = Neither agree or disagree; 1.0 = Slightly agree; 6.0 = Agree; 7.0 = Strongly agree.

Table 7.4
Descriptive Statistics for the Nottingham Adjustment Scale A, Self-Esteem Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0042	160		3.76875	1.04744	1	5
Strongly disagree	4	2.50				
Disagree	25	15.63				
Don't know	11	6.88				
Agree	84	52.50				
Strongly agree	36	22.50				
q0043	159		2.553459	1.343752	1	5
Strongly disagree	40	25.16				
Disagree	58	36.48				
Don't know	10	6.29				
Agree	35	22.01				
Strongly agree	16	16.06				
q0044	159		3.742138	1.103584	1	5
Strongly disagree	5	3.14				
Disagree	26	16.35				
Don't know	14	8.81				
Agree	74	46.54				
Strongly agree	40	25.16				
q0045	159		2.735849	1.407272	1	5
Strongly disagree	42	26.42				
Disagree	41	25.79				
Don't know	9	5.66				
Agree	51	32.08				
Strongly agree	16	10.06				
q0046		160	1.84375	1.037334	1	5
Strongly disagree	72 45.00					
Disagree	64	40.00				
Don't know	6	3.75				
Agree	13	8.13				
Strongly agree	5	3.13				
q0047		161	4.223602	0.9419073	1	5
Strongly disagree	4 2.48					
Disagree	8	4.97				
Don't know	9	5.49				
Agree	67	41.61				
Strongly agree	73	45.34				
q0048		161	2.509317	1.270423	1	5
Strongly disagree	37	22.98				
Disagree	65	40.37				
Don't know	11	6.83				
Agree	36	22.36				
Strongly agree	12	7.45				
q0049		179	1.726257	0.9586583	1	5
Strongly disagree	90	50.28				
Disagree	66	36.87				
Don't know	11	6.18				
Agree	8	4.47				
Strongly agree	5	2.79				
q0050		178	3.966292	1.083512	1	5
Strongly disagree	5	2.81				
Disagree	22	12.86				
Don't know	11	6.18				

Factor	*n*	%	Mean	SD	Minimum	Maximum
Agree	76	42.70				
Strongly agree	64	35.96				

Abbreviation: SD, standard deviation.

Note: 1.0 = Strongly disagree; 2.0 = Disagree; 3.0 = Don’t know; 4.0 = Agree; 5.0 = Strongly agree.

Table 7.5

Descriptive Statistics for Nottingham Adjustment Scale B, Attitudes of Disability/Illness Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0051	179		4.011173	0.9539323	1	5
Strongly agree	5	2.79				
Agree	7	3.91				
Don't know	29	16.20				
Disagree	78	43.58				
Strongly disagree	60	33.52				
q0052	178		3.067416	1.097483	1	5
Strongly agree	12	6.74				
Agree	48	26.97				
Don't know	51	28.65				
Disagree	50	28.09				
Strongly disagree	17	9.55				
q0053	180		2.755556	1.02277	1	5
Strongly agree	20	11.11				
Agree	52	28.89				
Don't know	69	38.33				
Disagree	30	16.67				
Strongly disagree	9	5.00				
q0054	179		3.636872	0.8849448	1	5
Strongly agree	3	1.68				
Agree	11	6.15				
Don't know	63	35.20				
Disagree	73	40.78				
Strongly disagree	29	16.20				
q0055		179	3.558659	0.9718917	1	5
Strongly agree	7	3.91				
Agree	15	8.38				
Don't know	54	30.17				
Disagree	77	43.02				
Strongly disagree	26	14.53				
q0056	180		3.427778	0.9033183	1	5
Strongly agree	3	1.67				
Agree	23	12.78				
Don't know	67	37.22				
Disagree	68	37.78				
Strongly disagree	19	10.56				
q0057	180		3.688889	0.9646772	1	5
Strongly agree	4	2.22				
Agree	20	11.11				
Don't know	36	20.00				
Disagree	88	48.89				
Strongly disagree	32	17.78				

Abbreviation: SD, standard deviation.

Note: 1.0 = Strongly agree; 2.0 = Agree; 3.0 = Don't know; 4.0 = Disagree; 5.0 = Strongly disagree.

Table 7.6

Descriptive Statistics for Nottingham Adjustment Scale C, Anxiety/Depression Scale (Modified Short Form)

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0058	176		1.801136	0.8945542	1	4
Not at all	81	46.02				
A little	59	33.52				
Moderately	26	14.77				
Extremely	10	5.68				
q0059	177		1.451977	0.7681213	1	4
Not at all	121	68.36				
A little	38	21.47				
Moderately	12	6.78				
Extremely	6	3.39				
q0060	178		2.016854	0.8334444	1	4
Not at all	49	27.53				
A little	88	49.44				
Moderately	30	16.85				
Extremely	11	6.18				
q0061	178		1.848315	0.8858731	1	4
Not at all	73	41.01				
A little	71	39.89				
Moderately	22	12.36				
Extremely	12	6.74				
q0062	178		1.769663	0.7795268	1	4
Not at all	73	41.01				
A little	79	44.38				
Moderately	20	11.24				
Extremely	6	3.37				

Abbreviation: SD, standard deviation.
Note: 1.0 = Not at all; 2.0 = A little; 3.0 = Moderately; 4.0 = Extremely.

Table 7.7

Descriptive Statistics for Nottingham Adjustment Scale D, Locus of Control Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0063	172		4.325581	0.808462	1	5
Strongly disagree	2	1.16				
Disagree	5	2.91				
Don’t know	10	5.81				
Agree	73	42.44				
Strongly agree	82	47.67				
q0064	173		3.375723	0.787172	1	5
Strongly disagree	1	0.58				
Disagree	7	4.05				
Don’t know	6	3.47				
Agree	71	41.04				
Strongly agree	88	50.87				
q0065	171		1.643275	0.8444969	1	5
Strongly disagree	88	51.46				
Disagree	66	38.60				
Don’t know	11	6.43				
Agree	2	1.17				
Strongly agree	4	2.34				
q0066	176		1.630682	0.7819182	1	5
Strongly disagree	88	50.00				
Disagree	73	41.48				
Don’t know	9	5.11				
Agree	4	2.27				
Strongly agree	2	1.14				

Abbreviation: SD, standard deviation.

Note: 1.0 = Strongly disagree; 2.0 = Disagree; 3.0 = Don’t know; 4.0 = Agree; 5.0 = Strongly agree.

Table 7.8

Descriptive Statistics for Nottingham Adjustment Scale E, Acceptance of Disability/Illness Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0067	170		3.364706	0.9275157	1	5
Strongly agree	4	2.35				
Agree	7	4.12				
Don’t know	8	4.71				
Disagree	55	32.35				
Strongly disagree	96	56.47				
q0068	171		3.74269	1.223972	1	5
Strongly agree	10	5.85				
Agree	28	16.37				
Don’t know	11	6.43				
Disagree	69	40.35				
Strongly disagree	53	30.99				
q0069	170		4.423529	0.8888057	1	5
Strongly agree	3	1.76				
Agree	9	5.29				
Don’t know	1	0.59				
Disagree	37	33.53				
Strongly disagree	100	58.82				
q0070	170		4.452941	0.8841943	1	5
Strongly agree	4	2.35				
Agree	5	2.94				
Don’t know	6	3.53				

Factor	*n*	%	Mean	SD	Minimum	Maximum
Disagree	50	29.41				
Strongly disagree	105	61.76				
q0071	175		1.982857	1.121751	1	5
Strongly agree	71	40.57				
Agree	69	39.43				
Don’t know	9	5.14				
Disagree	19	10.86				
Strongly disagree	7	4.00				
q0072	176		4.278409	0.8987545	1	5
Strongly agree	4	2.27				
Agree	8	4.55				
Don’t know	5	2.84				
Disagree	77	43.75				
Strongly disagree	82	46.59				
q0073	174		4.281609	0.9947874	1	5
Strongly agree	6	3.45				
Agree	10	5.75				
Don’t know	2	1.15				
Disagree	67	38.51				
Strongly disagree	89	51.15				
q0074	176		4.522727	0.7555853	1	5
Strongly agree	3	1.70				
Agree	2	1.14				
Don’t know	4	2.27				
Disagree	58	32,95				
Strongly disagree	109	61.93				
q0075	177		4.435028	0.8966567	1	5
Strongly agree	3	1.69				
Agree	10	5.65				
Don’t know	1	0.56				
Disagree	56	31.64				
Strongly disagree	107	60.45				

Abbreviation: SD, standard deviation.
Note: 1.0 = Strongly agree; 2.0 = Agree; 3.0 = Don’t know = 4.0; 5.0 = Strongly disagree.

Table 7.9

Descriptive Statistics for Nottingham Adjustment Scale F, Self-Efficacy Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0076	172		3.953488	0.9782067	1	5
Strongly disagree	5	2.91				
Disagree	16	9.30				
Don’t know	8	4.65				
Agree	96	55.81				
Strongly agree	47	27.33				
q0077	173		3.901734	0.9804172	1	5
Strongly disagree	3	1.73				
Disagree	23	13.29				
Don’t know	5	2.89				
Agree	99	57.23				
Strongly agree	43	24.86				
q0078	174		1.91954	0.9522519	1	5
Strongly disagree	61	35.06				
Disagree	88	50.57				
Don’t know	6	3.45				
Agree	16	9.20				
Strongly agree	3	1.72				
q0079	174		3.91954	0.9522519	1	5
Strongly disagree	5	2.87				
Disagree	16	9.20				
Don’t know	8	4.60				
Agree	104	59.77				
Strongly agree	41	23.56				
q0080	175		3.937143	0.9951277	1	5
Strongly disagree	4	2.29				
Disagree	20	11.43				
Don’t know	8	4.57				
Agree	94	53.71				
Strongly agree	49	20.00				
q0081	175		2.217143	1.010714	1	5
Strongly disagree	41	23.43				
Disagree	84	48.00				
Don’t know	25	14.29				
Agree	21	12.00				
Strongly agree	4	2.29				
q0082	173		4.144509	0.8190582	1	5
Strongly disagree	2	1.16				
Disagree	8	4.62				
Don’t know	11	6.36				
Agree	94	54.34				
Strongly agree	58	33.53				
q0083	174		4.425287	0.6474884	1	5
Strongly disagree	1	0.57				
Disagree	2	1.15				
Don’t know	3	1.72				
Agree	84	48.28				
Strongly agree	84	48.28				

Abbreviation: SD, standard deviation.
Note: 1.0 = Strongly agree; 2.0 = Agree; 3.0 = Don’t know; 4.0 = Disagree; 5.0 = Strongly disagree.

Table 7.10

Descriptive Statistics for Nottingham Adjustment Scale G, Attributes Scale

Factor	*n*	%	Mean	SD	Minimum	Maximum
q0084	175		3.188571	0.9121691	1	5
Always	6	3.43				
Often	24	13.71				
Sometimes	93	53.14				
Rarely	35	20.00				
Never	17	9.71				
q0085	176		2.909091	0.7032393	1	5
Always	6	3.41				
Often	33	18.75				
Sometimes	109	61.93				
Rarely	27	15.34				
Never	1	0.57				
q0086 175		3.291429	.8581494	1	5	
Always	7	4.00				
Often	13	7.43				
Sometimes	89	50.86				
Rarely	54	30.86				
Never	12	6.86				
q0087	176		3.102273	0.8557673	1	5
Always	5	2.84				
Often	30	17.05				
Sometimes	94	53.41				
Rarely	36	20.45				
Never	11	6.25				
q0088	174		3.685655	0.8643263	1	5
Always	3	1.72				
Often	7	4.02				
Sometimes	61	35.06				
Rarely	73	41.95				
Never	30	17.34				
q0089	175		3.331429	0.8735485	1	5
Always	6	3.41				
Often	33	18.75				
Sometimes	109	61.93				
Rarely	27	15.34				
Never	1	0.57				

Abbreviation: SD, standard deviation.

Note: 1 = Always; 2 = Often; 4 = Sometimes; 4 = Rarely; 5 = Never.

Appendix A: Federally Funded United States Laws, Historical Perspective

Year	Name of Law	Law Designation	Brief Description of Law
1879 [a]	"Act to Promote the Education for the Blind" [a]	P.L. 45-186 [a]	Congress allocated federal money for "American Printing House for the Blind."[a]
1906 [a]	"Act to Promote the Education for the Blind" [a] (Modification made)	P.L. 59-288 [a]	A requirement to allocate more money for the "American Printing House for the Blind." [a]
1919 [a]	"Act to Promote the Education for the Blind" [a] (Amendment)	P.L. 66-24 [a]	Requirement to allocate more money for the "American Printing House for the Blind." [a] (Amended)
1920 [b]	"The Smith-Fess Act" [b]	P.L. 66-236 [b]	The law created "National Civilian Vocational Rehabilitation Program."[b] Law provided rehab services for returning WWII soldiers. Rehab focused on preparing soldiers for attaining financial security. (employment)
1931 [a]	"The Pratt-Smoot Act" [a]	P.L. 71-787 [a]	The law created a provision that provided "books for the blind."[b] In addition, "the Division for the Blind of the Library of Congress" was established. It is now "the National Library Service for the Blind and Physically Handicapped."[b]
1935 [c]	"The Social Security Act" [c]	P.L. 74-721 [c]	The law created a "grant program" that provided "rehabilitation training" for the purpose of assisting the blind in becoming financially self-sufficient (employed).[b]
1936 [d]	"The Randolph-Sheppard Act" [d]	20 U.S.C. § 107 et seq. [d]	The law created "employment opportunities for the blind in vending facilities located on federal property."[b] It became evident "to the public" that the visually impaired were able to participate in "competitive employment." [b]
1938[b]	"The Wagner O'Day Act" [b]		The law "required that the federal government purchase" products made "from sheltered shops for the blind." [b]
1938 [b]	"The Wagner O'Day Act" [b] (Amended)		The law was amended to include "the new federal minimum wage law" which decreased the wages for "blind sheltered shop workers" to below the "federal minimum wage." [b]
1941 [a]	"Act to Promote the Education of the Blind" [a] (Amended)	P.L. 77-270 [a]	The law allowed "Franking Privileges" for people who are blind" to circulate literary material, send braillewriters" as well as "other appliances when mailed for repair." "Franking Privileges" permits

			sending “letters and parcels” excluding the need for “a postage stamp.” [a]
1943 [b]	“Barden-LaFollette Act” [b]	P.L. 78-133 [b]	Soldiers who returned blind “from the Second World War” had gained access to “state/federal VR programs” and began to have opportunities for attaining “employment.” [b]
1949 [a]	“Barden LaFollette Act” [a] (Amended)	P.L. 81-290 [a]	The law permitted “the sending” and receiving “of braillewriters for individuals who are blind by the postal service for the same rate as provided, regardless of the purpose for which they were mailed.” [a]
1963 [e]	“The Mental Retardation Facilities and Community Mental Health Centers Construction Act” [e]	P.L. 88-164 [e]	The allocated funds for building facilities for children that are handicapped, including “visually handicapped” children. Funds were also distributed for research and preparation of educators specializing in “handicapped children.” (p. 13, 14) [e]
1931 [a]	“The Pratt-Smoot Act” [a]	P.L. 71-787 [a]	The law created a provision that provided “books for the blind.”[b] In addition, “the Division for the Blind of the Library of Congress” was established. It is now “the National Library Service for the Blind and Physically Handicapped.”[b]
1935 [c]	“The Social Security Act” [c]	P.L. 74-721 [c]	The law created a “grant program” that provided “rehabilitation training” for the purpose of assisting the blind in becoming financially self-sufficient (employed).[b]
1936 [d]	“The Randolph-Sheppard Act” [d]	20 U.S.C. § 107 et seq. [d]	The law created “employment opportunities for the blind in vending facilities located on federal property.”[b] It became evident “to the public” that the visually impaired were able to participate in “competitive employment.” [b]
1938 [b]	“The Wagner O’Day Act” [b]		The law “required that the federal government purchase” products made “from sheltered shops for the blind.” [b]
1938 [b]	“The Wagner O’Day Act” [b] (Amended)		The law was amended to include “the new federal minimum wage law” which decreased the wages for “blind sheltered shop workers” to below the “federal minimum wage.” [b]
1941 [a]	“Act to Promote the Education of the Blind” [a] (Amended)	P.L. 77-270 [a]	The law allowed “Franking Privileges” for people who are blind” to circulate literary material, send braillewriters” as well as “other appliances when mailed for repair.” “Franking Privileges” permits sending “letters and parcels” excluding the need for “a postage stamp.” [a]
1943 [b]	“Barden-LaFollette Act” [b]	P.L. 78-133 [b]	Soldiers who returned blind “from the Second World War” had gained access to “state/federal VR programs” and began to have opportunities for attaining “employment.” [b]

1949 [a]	"Barden LaFollette Act" [a] (Amended)	P.L. 81-290 [a]	The law permitted "the sending" and receiving "of braillewriters for individuals who are blind by the postal service for the same rate as provided, regardless of the purpose for which they were mailed." [a]
1963 [e]	"The Mental Retardation Facilities and Community Mental Health Centers Construction Act" [e]	P.L. 88-164 [e]	The allocated funds for building facilities for children that are handicapped, including "visually handicapped" children. Funds were also distributed for research and preparation of educators specializing in "handicapped children." (p. 13, 14) [e]
1931 [a]	"The Pratt-Smoot Act" [a]	P.L. 71-787 [a]	The law created a provision that provided "books for the blind."[b] In addition, "the Division for the Blind of the Library of Congress" was established. It is now "the National Library Service for the Blind and Physically Handicapped."[b]
1935 [c]	"The Social Security Act" [c]	P.L. 74-721 [c]	The law created a "grant program" that provided "rehabilitation training" for the purpose of assisting the blind in becoming financially self-sufficient (employed).[b]
1936 [d]	"The Randolph-Sheppard Act" [d]	20 U.S.C. § 107 et seq. [d]	The law created "employment opportunities for the blind in vending facilities located on federal property."[b] It became evident "to the public" that the visually impaired were able to participate in "competitive employment." [b]
1938[b]	"The Wagner O'Day Act" [b]		The law "required that the federal government purchase" products made "from sheltered shops for the blind." [b]
1938 [b]	"The Wagner O'Day Act" [b] (Amended)		The law was amended to include "the new federal minimum wage law" which decreased the wages for "blind sheltered shop workers" to below the "federal minimum wage." [b]
1941 [a]	"Act to Promote the Education of the Blind" [a] (Amended)	P.L. 77-270 [a]	The law allowed "Franking Privileges" for people who are blind" to circulate literary material, send braillewriters" as well as "other appliances when mailed for repair." "Franking Privileges" permits sending "letters and parcels" excluding the need for "a postage stamp." [a]
1943 [b]	"Barden-LaFollette Act" [b]	P.L. 78-133 [b]	Soldiers who returned blind "from the Second World War" had gained access to "state/federal VR programs" and began to have opportunities for attaining "employment." [b]
1949 [a]	"Barden LaFollette Act" [a] (Amended)	P.L. 81-290 [a]	The law permitted "the sending" and receiving "of braillewriters for individuals who are blind by the postal service for the same rate as provided, regardless of the purpose for which they were mailed." [a]
1963 [e]	"The Mental Retardation Facilities and Community	P.L. 88-164 [e]	The allocated funds for building facilities for children that are handicapped, including "visually handicapped" children. Funds were

	Mental Health Centers Construction Act” [e]		also distributed for research and preparation of educators specializing in “handicapped children.” (p. 13, 14) [e]
1931 [a]	“The Pratt-Smoot Act” [a]	P.L. 71-787 [a]	The law created a provision that provided “books for the blind.”[b] In addition, “the Division for the Blind of the Library of Congress” was established. It is now “the National Library Service for the Blind and Physically Handicapped.”[b]
1935 [c]	“The Social Security Act” [c]	P.L. 74-721 [c]	The law created a “grant program” that provided “rehabilitation training” for the purpose of assisting the blind in becoming financially self-sufficient (employed).[b]
1936 [d]	“The Randolph-Sheppard Act” [d]	20 U.S.C. § 107 et seq. [d]	The law created “employment opportunities for the blind in vending facilities located on federal property.”[b] It became evident “to the public” that the visually impaired were able to participate in “competitive employment.” [b]
1938 [b]	“The Wagner O’Day Act” [b]		The law “required that the federal government purchase” products made “from sheltered shops for the blind.” [b]
1938 [b]	“The Wagner O’Day Act” [b] (Amended)		The law was amended to include “the new federal minimum wage law” which decreased the wages for “blind sheltered shop workers” to below the “federal minimum wage.” [b]
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1990 [a]	"Americans with Disabilities Act" [a]	P.L. 101-336 [a]	"Title III" addresses and "prohibits" discrimination of people with disabilities in "places of public accommodation." This includes any publicly or "privately owned, leased or operated facilities." A series of "minimum standards for accessibility for alteration of new construction of commercial facilities and privately owned public accommodations" were established. The "public accommodations" were mandatory and required the removal of "barriers in existing buildings." "Title III instructs "businesses to make "reasonable modifications" in their daily business transactions with "people with disabilities." A requirement was set forth "that businesses take steps to communicate effectively

			with consumers” specifically people with disabilities. The regulating body is the U.S. Department of Justice.” (p. 2) [g]
1990 [a]	“Americans with Disabilities Act” [a]	P.L. 101-336 [a]	“Title IV” makes it mandatory for “telephone and internet companies to provide a nationwide system of interstate and intrastate telecommunications relay services” allowing people with “disabilities” “to communicate over the telephone.” “Title IV” includes “hearing and speech disabilities.” The ADA made it mandatory to have “closed captioning of federally funded public service announcements.” The governing body to “Title IV” is “the Federal Communication Commission.” (p. 2) [g]
1990 [a]	“Individuals with Disabilities Education Act [a]	P.L. 101-476 [a]	The law included “transition services to the required content of the individualized education program (IEP), which was viewed as a statutory clarification of an existing requirement; added traumatic brain injury and autism to the disability categories; changed the name of the” [e] “Education for All Handicapped Children Act” [a] “to the Individuals with Disabilities Education Act (IDEA); and established the parent training and information center (PTIC) system on a nationwide basis.” (p. 30) [f]
1996 [a]	“Telecommunications Act of 1996” [i] “Section 255” [a] (Amendment)	P.L. 104-104 [i]	This amendment to “the telecommunications law” required “telephones and telephone services to be more accessible.” [a] “Section 255 ensures that new telephones would be designed for use by people with disabilities including those that are blind or visually impaired.” [a]
1997 [f]	“Individuals with Disabilities Education Act Amendments of 1997” [f]	P.L. 105-17 [f]	The law adjusted “Part B” of “Public Law No. 94-142” (“Individuals with Disabilities Act”). [f] The law enhanced “the relationship to the general curriculum, overhauled the evaluation and reevaluation provisions, added new stipulations in the IEP regarding state- and districtwide tests, and designed controversial procedures related to behavior and discipline.” [f]
1998 [a]	“Amendment to the Rehabilitation Act of 1973”, “Section 508” [a]	29 U.S.C. § 794d [h]	The law addressed “access to electronic information technology. The law was created “to eliminate barriers in information technology, to make available new opportunities for people with disabilities and to encourage development of technologies that will achieve these goals.” [a]
2006 [j]	“Americans with Disabilities Act Restoration Act of 2006 [j]	H.R. 6258 [j]	The law’s purpose was for the restoration “of the Americans with Disabilities Act of 1990 to more fully remove the barriers that confront disabled Americans.”

			(p. 1) [j] The law stated that “Discrimination results when individuals with actual or perceived physical or mental impairments are met with attitudinal, societal, and physical barriers in society.” (p. 2) [j]
2008 [k]	“ADA Amendments Act of 2008 [k]	P.L. 110-325 [k]	The law made changes to the “ADA.” [k] The law “rejected” “regulations published by the Equal Employment Opportunity Commission that interpret Title I (the employment-related title) of the ADA.” [k] The law made “changes to the definition of the term “disability,” clarifying and broadening the definition.” [k] The law struck “a balance between employer and employee interests.” [k]

Sources:

[a] https://www.teachingvisuallyimpaired.com/legislation.html

[b] https://www.actionfund.org/history-blindness

[c] https://en.wikipedia.org/wiki/Social_Security_Act

[d] https://en.wikipedia.org/wiki/Timeline_of_disability_rights_in_the_United_States

[e] https://www.govinfo.gov/content/pkg/STATUTE-77/pdf/STATUTE-77-pg282.pdf

[f] https://www.advocacyinstitute.org/academy/Dec10IDEA35/Chapter_3_Legal_Aspects_of_Special_Education.pdf

[g] https://adata.org/sites/adata.org/files/files/ADA_Overviewfinal2017.pdf

[h] https://www.access-board.gov/the-board/laws/rehabilitation-act-of-1973#508

[i] https://www.gpo.gov/fdsys/pkg/PLAW-104publ104/pdf/PLAW-104publ104.pdf

[j] https://www.govinfo.gov/content/pkg/BILLS-109hr6258ih/pdf/BILLS-109hr6258ih.pdf

[k] https://en.wikipedia.org/wiki/ADA_Amendments_Act_of_2008

Appendix B: Current Estimate and Projections of Prevalent Populations with Vision Problems

	Current Estimates		Projections	
	2010	2014	2032	2050
Cataract	24,409,978	25,666,427	38,477,608	45,620,606
Diabetic retinopathy	7,685,237	8,084,767	10,938,504	13,190,538
Impaired	2,907,691	3,058,852	5,073,572	7,301,814
Glaucoma	2,719,379	2,858,572	4,275,758	5,526,347
AMD	2,069,403	2,176,985	3,387,560	4,425,989
Blind	1,288,275	1,355,428	2,161,164	3,088,249

Abbreviation: AMD, Age-related macular degeneration

Source: Wittenborn, John S. & Rein B. *The Future of Vision: Forecasting the Prevalence and Cost of Vision Problems.* NORC at the University of Chicago. Prepared for Prevent Blindness, Chicago, IL. June 11, 2014. Available: http://forecasting.preventblindness.org; and The Burden of Loss: Available: https://www.cdc.gov/visionhealth/risk/burden.htm. Accessed April 5, 2019.

Appendix C: Barriers and Assets to Employment

	Percent of all Respondents	Percent of Respondents in Developed Countries	Percent of Respondents in Developing Countries
Barriers			
Poverty	96	91	98
Discrimination	59	67	55
Lack of education and resources	48	43	49
Employers' lack of awareness of the abilities of visually impaired people	44	48	43
Lack of necessary technologies	35	33	36
Inadequate legislative support	31	24	34
Economic factors affecting the larger society	20	14	23
Immobility	13	19	11
High-tech industries	12	10	13
Lack of empowerment among blind people	12	19	9
Inability to read print	11	24	6
Lack of exposure to the work world	11	14	9
Workplace policies	9	5	11
Lack of social skills	7	10	6
Lack of role models	3	5	2
Assets			
Increased advocacy	36	33	38
Individual work qualities	35	38	34
Individual character qualities	29	38	26
Improved education for people who are disabled	29	38	27
Assistive technology	19	24	17
General skills	19	14	21
Increased rehabilitative services for disabled people	15	19	11
Tax incentives for employers	13	29	8
Social skills	8	10	8
Employers' flexibility	7	10	6
Other environmental factors	5	10	4
Good health	3	5	2

Source: Wolffe, K. E., & Spungin, S. J. (2002, April). A glance at worldwide employment of people with visual impairments. *Journal of Visual Impairment & Blindness, 96* (4), 251.

Appendix D: Satisfaction of Life Survey

Informed Consent Form

My name is Mirko Kunstek, a Ph.D. student in the Social Welfare Program at Wurzweiler School of Social Work, Yeshiva University in New York City. I am undertaking a research study on factors predicting the life satisfaction of visually impaired adults, 18 years and older. Data will be collected via a survey. Access to the survey will be sent via ACB listserv with a link to the survey which you can complete and submit at your convenience. The survey will take between 20 to 30 minutes of your time. The duration of the survey participation will be a period of 3 months from when the survey becomes available. Your participation in this study will provide a valuable contribution to the visually impaired community and to people with disabilities as a whole. The data will be collected aggregately and there no information identifying anyone participating in the study. The data will only be available to the researcher. Your participation in this study is voluntary. You may withdraw from the study at any time before or during the data collection, for any reason without penalty. A summary of the results for the study will be provided to all ACB members via email after the conclusion of the research.

Thank you in advance for your willingness to participate in this study.

Sincerely,

Mirko Kunstek

Appendix E: Satisfaction of Life Survey Informed Consent Form used in SurveyMonkey

INFORMED CONSENT FORM

INFORMED CONSENT FORM:

As a member of the American Council of the Blind you are invited to complete a survey regarding your level of satisfaction of life.

This survey is part of a dissertation, the purpose is to better understand the satisfaction of life of visually impaired and blind individuals. Please complete this survey only once.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THIS STUDY

Your participation in this study is completely voluntary. Your participation in this study will require a completion of the survey only one time. The survey will examine the satisfaction of life of individuals with a visual impairment 18 years and older. The survey will take between 15 to 20 minutes of your time. The survey and your responses will be anonymous; you will not be asked to provide any information that can identify you and your responses can not be linked back to you. At the end of the survey, you will submit your survey on Survey Monkey through the link provided at the end of this consent form.

RISKS:

There are no known risks to you for participating in the study, all of the information provided remain strictly anonymous. You may choose not to participate in this study prior to or anytime during your participation, you can skip any questions that you wish not to answer, and you may end the survey at any time by simply exiting the web link.

BENEFITS:

The responses from this study will be used to explore the satisfaction of life of visually impaired and blind individuals. This exploration can assist in expanding social work education and knowledge of visual impairments. The contribution to social work practice can benefit clients with visual impairments by informing the clinician on the actual issues that are present. The contribution to social policy can potentially address inequality and injustice in the visually impaired and blind community in the United States.

PROTECTIONS:

All information and data collected from you through your participation in this study will remain strictly anonymous. No identifying information will be collected from you. The researcher will keep all study materials (e.g., collected data) on the investigator's password-protected computer. No one other than the principal investigator and his dissertation chair will be able to access the data collected from this study. For analyzing and reporting the findings of this study, all demographic information will be summarized and collected together to further the protections of the human participants in this study.

CONTACT INFORMATION:

If you have any questions at any time about the study or its procedures, you may contact the student investigator for this study:

Susan E. Mason, Ph.D.
Professor of Social Work and Sociology
Wurzweiler School of Social Work
Yeshiva University
2495 Amsterdam Ave.
New York, NY 10033
646-592-6806
masonse@yu.edu

Mirko Kunstek, LMSW
Wurzweiler School of Social Work
Yeshiva University
646-873-0272
mirko.kunstek@mail.yu.edu

PARTICIPATION:

Your participation is completely voluntary. By selecting the survey link below, you are accepting the terms of this informed consent. If you choose to participate in this study, you are asked to complete the survey only one time.

If you wish to not participate in this study, please exit this email at this time.

Thank you!

Appendix F: Satisfaction of Life Survey

Part A

1. What was your age on your last birthday? __________

2. What is your gender?

- Male _____
- Female _____

3. What is your highest level of education?

- Less than High School Diploma _____
- High School Diploma/ GED _____
- Some College _____
- Associates Degree _____
- Bachelors Degree _____
- Masters Degree _____
- Doctoral Degree _____

4. What type of school did you attend?

- Public School _____
- Vocational & Technical School _____
- IEP School (Special Needs) _____
- Private School _____

5. What is your employment status?

- Unemployed _____
- Employed _____
- Part time work _____
- Volunteer work _____
- Retired _____

6. What is your marital status?

- Single _____
- Married _____
- Divorced _____
- Widowed _____

- Living with Partner _____

7. What is your living situation?

- Living Alone _____
- Living with Family _____
- Living with Parent(s) _____

8. Do you have children in your household?

- No _____
- Yes _____

9. What is your annual income?

- $10,000 – $19,999 _____
- $20,000 – $29,999 _____
- $30,000 – $39,999 _____
- $40,000 – $49,999 _____
- $50,000 – $59,999 _____
- $60,000 – $69,999 _____
- $70,000 – $79,999 _____
- $80,000 – $89,999 _____
- $90,000 – $99,999 _____
- $100,000 + _____

10. Do you have health insurance?

- No, I do not have Health Insurance _____
- Yes, I do have Health Insurance _____

11. What type of benefit do you have?

- SSI (Supplemental Security Income) _____
- SSDI (Supplemental Security Disability Income) _____
- VA Benefits (Veterans Administration Benefits) _____
- Social Security Benefits _____
- Military Benefits _____
- Other Benefits _____

12. Which would describe your visual impairment? If your visual impairment is congenital skip next question and answer question 14.

- Acquired _____
- Congenital _____

13. At what age did you first have a visual impairment?

____

14. Do you have any other disabilities? If no skip next question and answer question 16.

- No _____
- Yes _____

15. Please specify what other disabilities you have?

____

____

____

____

16. Do you have accessibility to services?

- No, I don’t have accessibility to services _____
- Yes, I have accessibility to services _____

17. Which describes your housing situation?

- Own a home _____
- Rent an apartment _____
- Rent a room _____
- Facing eviction _____
- In residence _____

Part B

About how many close friends and close relatives do you have (people you feel at ease with and can talk to you about what is on your mind)?

1. Write in number of close friends and close relatives: __________

People sometimes look to others for companionship, assurance, or other types of support. How often is each of the following kinds of support available to you if you need it.

Select one number for each question

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
2. Someone to help you if you were confined to bed	1	2	3	4	5
3. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
4. Someone to give you good advice about a crisis	1	2	3	4	5
5. Someone to take you to the doctor if you needed it	1	2	3	4	5
6. Someone who shows you love and affection	1	2	3	4	5
7. Someone to have a good time with	1	2	3	4	5
8. Someone to give you information to help you understand a situation	1	2	3	4	5
9. Someone to confide with or talk to about yourself or problems	1	2	3	4	5
10. Someone who hugs you	1	2	3	4	5
11. Someone to get together with for relaxation	1	2	3	4	5
12. Someone to prepare your meals if you are unable to do it yourself	1	2	3	4	5
13. Someone whose advice you really want	1	2	3	4	5
14. Someone to help you with your choices if you are sick	1	2	3	4	5
15. Someone to share your most private worries and fears with	1	2	3	4	5
16. Someone to turn for suggestions about how to deal with a personal problem	1	2	3	4	5
17. Someone to do something enjoyable with	1	2	3	4	5

18. Someone who understands your problems	**1**	**2**	**3**	**4**	**5**
19. Someone to love and make you feel wanted	**1**	**2**	**3**	**4**	**5**

Part C

Instructions: Below are few statements that you may agree or disagree with. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding the item.

- 7 – Strongly agree
- 6 – Agree
- 5 – Slightly agree
- 4 – Neither agree or disagree
- 3 – Slightly disagree
- 2 – Disagree
- 1 – Strongly disagree

_____ In most ways my life is close to ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

Part D

Instructions: Please decide how much you agree or disagree with the statements below by choosing one of the following options:
A = strongly agree; B = agree; C = don’t know; D = disagree; E = strongly disagree.

1. On the whole I am satisfied with myself. __________

2. At times I think I am not good at all. __________

3. I am able to do things as well as other people. __________

4. I certainly feel useless at times. __________

5. I feel that I do not have much to be proud of. __________

6. I feel that I am a person of worth; at least on an equal plane with others. __________

7. I wish that I could have more respect for myself. _________

8. All in all, I’m inclined to feel that I am a failure. __________

9. I have a positive attitude towards myself. __________

Part E

Instructions: Please decide how much you agree or disagree with the statements below by choosing one of the following options:
A = strongly agree; B = agree; C = don't know; D = disagree; E = strongly disagree.

1. Disabled people are used to failing at most things they do. __________

2. Most disabled people are constantly worried about what might happen to them. __________

3. Most disabled people keep a lot of things to themselves. __________

4. Most disabled people feel that they are worthless. __________

5. Disabled people are generally more easily upset than non disabled people. __________

6. Most disabled people are dissatisfied with themselves. __________

7. Most disabled people believe that their disability is the worst thing that could happen to them. __________

Part F

Instructions: Please decide how much each question applies to you by choosing one of the following options:
A = not at all; B = a little; C = moderately; D = extremely

(Recently = in the last two weeks).

1. Have you been feeling run down and unwell? __________

2. Have you recently felt that you are ill? __________

3. Have you recently felt constantly under strain? __________

4. Have you recently found everything getting on top of you? __________

5. Have you recently been feeling nervous or worried all the time? __________

Part G

Instructions: Please decide how much you agree or disagree with the statements below by choosing one of the following options:
A = strongly agree; B = agree; C = don't know; D = disagree; E = strongly disagree.

1. It's what I can do to help myself that's really going to make all of the difference. __________

2. It's up to me to make sure I make the best of my future in all circumstances. __________

3. My own contribution to my rehabilitation doesn't amount to much. __________

4. I have little or no control over my progress from now on. __________

Part H

Instructions: Please decide how much you agree or disagree with the statements below by choosing one of the following options:
A = strongly agree; B = agree; C = don't know; D = disagree; E = strongly disagree.

1. Because of my disability/illness, I feel miserable most of the time. __________

2. It makes me feel very sad to notice all of the things non disabled people can do which I cannot. __________

3. Because of my disability/illness, I have little to offer other people. __________

4. Because of my disability/illness, other people's lives have more meaning than my own. __________

5. I feel satisfied with my abilities, and my disability/illness doesn't bother me too much. __________

6. Almost every area of life is closed to me because of my disability/illness. __________

7. My disability/illness prevents me from doing just about everything I really want to do and from being the kind of person I really want to be. __________

8. In just about everything, my disability/illness is so annoying that I can't enjoy anything. __________

9. Often there are times when I think about my disability/illness and it upsets me so much that I am unable to think of or do anything else. __________

Part I

Instructions: Please decide how much you agree or disagree with the statement below by choosing one of the following options:
A = strongly agree; B = agree; C = don't know; D = disagree; E = strongly disagree.

1. I give up on things before completing them. __________

2. If something looks too complicated, I will not bother to try. __________

3. When I decide to do something, I go right to work on it. __________

4. When trying to learn something new, I soon give up if I am not initially successful. __________

5. I avoid trying to learn new things when they look too difficult to me. __________

6. Failure just makes me try harder. __________

7. I give up easily. __________

8. I do not seem capable of dealing with problems that come up with life. __________

Part J

1. Any success I have has been due to good fortune. __________

2. When things go wrong it's because of circumstances beyond my control. __________

3. Any success I've had has been due to outside influences. __________

4. Any success I've had has been due to the fact that circumstances have happened to be right. __________

5. If things go well it's just good luck. __________

6. If things go well it's because the system has helped me. __________

Appendix G: ACB Letter

ACB | American Council of the Blind
Together for a bright future

1703 N. Beauregard St.,
Suite 420

Alexandria, VA 22311

Tel: (202) 467-5081

Fax: (703) 465-5085

January 11, 2019

To Whom It May Concern:

Mirko Kunstek has contacted the American Council of the Blind regarding his Ph.D. dissertation in the Social Welfare Program at Wurzweiler School of Social Work at Yeshiva University. He has asked to conduct a study on "Factors Predicting the Life Satisfaction of Visually Impaired Adults" during the 2019 conference and convention in Rochester, N.Y. in July 2019.

ACB has extensive experience in collaborating and conducting studies of its members. Holding the study during ACB's national conference, as well as having an online version that people can do on their own, make this study doable, as they remove numerous accessibility barriers that people with vision disabilities often experience in clinical and other public settings.

I confirm that ACB will send invitations to participate in the study through its membership listservs. As the executive director, I authorize Mirko to conduct this study during our convention. He understands there will be a cost for a meeting room, that all information is confidential, and that each participant will sign an agreement that the information they provide will be used for this study only. Mirko agrees to work with our convention coordinator, Janet Dickelman, to set up dates and times for his survey during the convention, and to pay for the meeting room prior to the start of the conference.

If you have any questions, please contact me at (202) 467-5081, or via email, ebridges@acb.org.

Sincerely,

Eric Bridges
Executive Director

Appendix H: Permision to use the Nottingham Adjustment Scale

From Dr. Carol Sampson, via email

mkunstek@yahoo..../Inbox

Re: Mirko Kunstek: Question about your dissertation

Jan 4, 2018 at 6:09 AM

Dr Carol Sampson <carolsampson@insneuro.co.uk>

To: mirko kunstek <mkunstek@yahoo.com>

Hello Mirko,
Apologies for the late reply, this was due to the Christmas break. I have no problem with you using the subscales as required.
Good luck with your research

Kind regards,
Dr Carol Sampson
Consultant Clinical Neuropsychologist
Integrity Neuropsychology Services
07562 663445
www.insneuro.co.uk

On 16/12/2017 21:42, mirko kunstek wrote:

> Hello Dr. Sampson:
>
> My name is Mirko Kunstek and I am a PhD candidate at Wurzweiler School of Social Work, Yeshiva University, in New York City, in the United States. I am presently working to complete my dissertation proposal for submission to the IRB so that I can begin my dissertation. I am using a survey questionnaire incorporating three scales and one of them is the Nottingham Adjustment Scale you used in your May, 2000 dissertation at Leicester University. I would respectfully ask your permission to use part of the scale you used in your dissertation. I am researching the satisfaction of life of Blind and Visually Impaired adults, using quantitatively analysis.
>
> I can be reached either by email, landline or the postal service:
>
> Email -
>
> Mkunstek@yahoo.com

Landline # -

00 1 718 728 8644

If calling my landline please email in advance of the time you wish to call. (- 5 hours from the UK)

Mailing address -

Mirko Kunstek
2836 48 Street
Astoria, NY 11103-1240

I thank you for your consideration,

Mirko Kunstek

Appendix I: Satisfaction with Life Scale

Instructions for administering the scale are: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. The 7-point scale is: 1 = strongly disagree, 2 = disagree, 3 = slightly disagree, 4 = neither agree nor disagree, 5 = slightly agree, 6 = agree, 7 = strongly agree.

1. In most ways my life is close to ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Diener, E., Emmons, Robert A., Larsen, Randy J., Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment, 49*(1), 72.

Appendix J: The MOS Social Support Survey

Next are some questions about the support that is available to you.

1. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?

Write in the number of close friends and
close relatives: _______

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it.

(Circle One Number on Each Line)

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
2.	Someone to help if you were confined to bed.	1	2	3	4	5
3.	Someone you can count on to listen to you when you need to talk.	1	2	3	4	5
4.	Someone to give you good advice about a crisis.	1	2	3	4	5
	Someone to take you to the doctor is you need it.	1	2	3	4	5
5.	Someone who shows you love and affection.	1	2	3	4	5
6.	Someone to have a good talk with.	1	2	3	4	5
7.	Someone to give you information to help you understand a situation.	1	2	3	4	5
8.	Someone to confide in or talk to about yourself or your problems.	1	2	3	4	5
9.	Someone who hugs you.	1	2	3	4	5
10.	Someone to get together for relaxation.	1	2	3	4	5
11.	Someone to prepare your meals if you were unable to do it yourself.	1	2	3	4	5
12.	Someone whose advice you really want.	1	2	3	4	5
13.	Someone to do things with to help you get your mind off things.	1	2	3	4	5
14.	Someone to help with daily chores if you were sick.	1	2	3	4	5
15.	Someone to share your most private worries and fears with.	1	2	3	4	5
16.	Someone to turn to for suggestions about how to deal with a personal problem.	1	2	3	4	5
17.	Someone to do something enjoyable with.	1	2	3	4	5
18.	Someone who understands your problems.	1	2	3	4	5
19.	Someone to love and make you feel wanted.	1	2	3	4	5

Sherbourne, Cathy D., Stewart, Anita L. (1991). The MOS Social Support Survey. *Social Science & Medicine, 32*(6), 713-714.

Appendix K: Nottingham Adjustment Scale

FORM 1

NOTTINGHAM ADJUSTMENT SCALE – Revised

SECTION A. Instructions: Please decide how much you agree: disagree with the statements by choosing one of the following options: A = strongly agree; a = agree; * = don't know; d = disagree; D = strongly disagree. Put a tick in the appropriate column next to each statement.

A | a | * | d | D

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I am able to do things as well as most other people.
4. I certainly feel useless at times.
5. I feel that I do not have much to be proud of.
6. I feel that I am a person of worth; at least on an equal plane with others.
7. I wish that I could have more respect for myself.
8. All in all, I'm inclined to feel that I'm a failure.
9. I have a positive attitude towards myself.

FORM I

SECTION B. Instructions: Please decide how much you agree: disagree with the statements by choosing one of the following options: A = strongly agree; a = agree; * = don't know d = disagree; D = strongly disagree. Put a tick in the appropriate column next to each statement.

A | a | * | d | D

1. Disabled people are used to failing at most things they do.
2. Most disabled people are constantly worried about what might happen to them.
3. Most disabled people keep a lot of things to themselves.
4. Most disabled people feel that they are worthless.
5. Disabled people are generally more easily upset than non disabled people.
6. Most disabled people are dissatisfied with themselves.
7. Most disabled people believe that their disability is the worst thing that could happen to them.

FORM II

SECTION C. Instructions: Please decide how much each question applies to you by choosing one of the following options: A = not at all; B = a little; C = moderately; D = extremely. Put a tick in the corresponding column next to each question. (Recently = in the last two weeks).

A | B | C | D

2. Have you been feeling run down and out of sorts?
3. Have you recently felt that you are ill?
4. Have you recently felt constantly under strain?
5. Have you recently found everything getting on top of you?
6. Have you recently been feeling nervous and strung out all the time?

FORM I

SECTION D. Instructions; Please decide how much you agree: disagree with the statements below by choosing one of the following options: A = strongly agree; a = agree; * = don't know; d = disagree; D = strongly disagree. Put a tick in the appropriate column next to each statement.

A | a | * | d | D

1. It's what I can do to help myself that's really going to make all the difference.
2. It's up to me to make sure I make the best of my future in these circumstances.
3. My own contribution to my rehabilitation doesn't amount to much.
4. I have little or no control over my progress from now on.

FORM I

SECTION E. Instructions: Please decide how much you agree: disagree with the statements below by choosing one of the following options: A = strongly agree; a = agree; * = don't know; d = disagree; D = strongly disagree. Put a tick in the appropriate column next to each statement.

A | a | * | d | D

1. Because of my disability/illness, I feel miserable most of the time.
2. It makes me feel very sad to see all the things non disabled can do which I cannot.
3. Because of my disability/illness, I have little to offer other people.
4. Because of my disability/illness, other people's lives have more meaning than my own.
5. I feel satisfied with my abilities, and my disability/illness doesn't bother me too much.
6. Almost every area of my life is closed to me because of my disability/illness.
7. My disability/illness prevents me from doing just about everything I really want to do and from being the kind of person I really want to be.
8. In just about everything, my disability/illness is so annoying that I can't enjoy anything.
9. Often there are times when I think about my disability/illness, and it upsets me so much that I am able to think or do anything else.

FORM I

SECTION F. **Instructions: please decide how much you agree: disagree with the statements below by choosing one of the following options: A = strongly agree; a = agree; * don’t know; d = disagree; D = strongly disagree. Put a tick in the appropriate column next to the statement.**

A | a | * | d | D

1. I give up on things before completing them.
2. If something looks too complicated, I will not even bother to try.
3. When I decide to do something, I go right to work on it.
4. When trying to learn something new, I soon give up if I not initially successful.
5. I avoid trying to learn new things when they look too difficult to me.
6. Failure just makes me try harder.
7. I give up easily.
8. I don’t seem capable of dealing with most problems that come up in life.

FORM I

SECTION G. **Instructions: Please indicate how often each statement refers to you by choosing one of the following options: A = always; B = often; C = sometimes D = rarely; E=Never**

A | B | C | D | E

1. Any successes I have had have been to good fortune.
2. When things go wrong it’s because of circumstances beyond my control.
3. Any successes have been due to outside influences.
4. Any successes I’ve had have been due to the fact that circumstances have happened to be right.
5. If things go well it’s just good luck.
6. If things go well it’s because the system has helped me.

Appendix L: CITI Program Letter

CITI PROGRAM

Completion Date 15-May-2020
Expiration Date 15-May-2022
Record ID 36612058

This is to certify that:

Mirko Kunstek

Has completed the following CITI Program course:

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Human Research	(Curriculum Group)
Group 2. SOCIAL / HUMANISTIC / BEHAVIORAL RESEARCH	(Course Learner Group)
1 - Basic Course	(Stage)

Under requirements set by:

Western IRB

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wc4ea3389-248f-4c80-98eb-de3d68bb20cf-36612058

Appendix M: WIRB Letter

WIRB®
Global Leader | Proven Expert

June 1, 2020

Susan Mason, PhD, MSSW
Yeshiva University
Wurzweiler School of Social Work
2495 Amsterdam Avenue
New York, New York 10033

Dear Dr. Mason:

SUBJECT: IRB EXEMPTION—REGULATORY OPINION
Investigator: Susan Mason, PhD, MSSW
Protocol Title: Examining the Satisfaction of life of Adults with Visual Impairments: A Social and Ecological Perspective of Disability

This is in response to your request for an exempt status determination for the above-referenced protocol. Western Institutional Review Board's (WIRB's) IRB Affairs Department reviewed the study under the Common Rule and applicable guidance.

We believe the study is exempt under 45 CFR § 46.104(d)(2), because the research only includes interactions involving educational tests, survey procedures, interview procedures, or observations of public behavior; and the information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

This exemption determination can apply to multiple sites, but it does not apply to any institution that has an institutional policy of requiring an entity other than WIRB (such as an internal IRB) to make exemption determinations. WIRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions. You are responsible for ensuring that each site to which this exemption applies can and will accept WIRB's exemption decision.

Please note that any future changes to the project may affect its exempt status, and you may want to contact WIRB about the effect these changes may have on the exemption status before implementing them. WIRB does not impose an expiration date on its IRB exemption determinations.

If you have any questions, or if we can be of further assistance, please contact Bridget D. Brave, JD, at 360-252-2466, or e-mail regulatoryaffairs@wirb.com.

BDB:dj
D2-Exemption-Mason (06-01-2020)
cc: Edward Berliner, Yeshiva University
WIRB Accounting
WIRB Work Order #1-1310298-1

Western Institutional Review Board®
1019 39th Avenue SE Suite 120 | Puyallup, WA 98374-2115
Office: (360) 252-2500 | **Fax**: (360) 252-2498 | **www.wirb.com**