

ABSTRACT

WALKER, CHARLES LEON. Counselor Attitudes Toward Persons who are Blind or Visually Impaired A National Counselor Study. (Under the direction of Dr. Edwin R. Gerler, Jr. and Dr. Jose A. Picart.)

This national counselor study was an investigation of counselor attitudes toward persons who are blind or visually impaired. The preparedness of counselors in training, to work with persons who are blind or visually impaired, was assessed. There were 300 counselors in training, enrolled in CACREP approved counselor education programs, across the nation that participated in this online investigation. The Attitudes Toward Disabled Persons Scale (ATDP-B) and the Contact with Disabled Persons Scale (CDP) were the instruments used in this study.

The professional literature associated with blindness and disability was reviewed. Among all of the disabilities, blindness is considered to be the most severe and feared condition (Ferguson, 2001; Tringo, 1970). Historically, sighted people have associated the condition of blindness with some moral culpability, fault, or defect within persons who are blind. The cultural epistemology of the sighted understanding about blindness and blind people has been negative across the eons, from ancient times unto the present (Ferguson, 2001; Saramago, 1997). According to Sue, Arredondo, and McDavis (1992), counselors may form initial impressions of their clients early in the clinical process and these impressions are resistant to change.

Overall, these findings showed that counselors in training in this study, held negative attitudes towards and had little to no contact with members of the blind or visually impaired population, ATDP-B mean 63.13 and CDP mean 36.39. There was no correlation between attitude scores and contact scores for counselors in training as associated with those who live with vision loss, $p=.164$. The lack of education about blindness, visual impairment and persons who live with vision loss, may also be one of the most important findings and opportunities in this study. Counselors, who hold negative attitudes towards potential client populations, may impair their own prescience. Blinded by negative attitudes towards these individuals, they may not see the hope and the glory of blind and visually impaired people.

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Counselor Attitudes Toward Persons Who are Blind or Visually Impaired
A National Counselor Study

by
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DEDICATION

It is indeed my distinguished honor and privilege to have this opportunity to thank you for your love, support, and faith through the years. I appreciate your encouragement and your belief in me as I have matriculated through my university efforts. I dedicate this dissertation to God, who made this and all things possible. In addition, I dedicate this work to my family, my friends and to blind people across the world. To my Cheryl, thank you for all of your effort and support, sacrifice and service. This work would not be possible without your love and your dedication.

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Dr. Charles L. Walker

BIOGRAPHY

Charles L. Walker is a Nationally Certified Counselor (NCC), and is board eligible in the state of North Carolina with the NC Board of Licensed Professional Counselors (NCBLPC) and is working to become a Licensed Professional Counselor (LPC). In addition, Walker is a Distance Credentialed Counselor (DCC) with the Center for Credentialing & Education (CCE) and is a member of the American Counseling Association (ACA). As a consultant on blindness issues, Walker serves as an advisory board member with ADA Insights at the Cecil G. Shepps Center for Health Services Research, at the University of North Carolina at Chapel Hill. Since 1991, he has been a consultant and guest lecturer at various universities, colleges and organizations and with the Department of Parks, Recreation and Tourism Management at North Carolina State University. Walker is a former Social Worker with Wake County Mental Health. His research interests include the identity development of blind and visually impaired adults, the social construction of disability and institutionalized attitudinal barriers that restrict and impair the lives of blind and disabled people across the world. As an expert on blindness, Walker developed an identity development model for blind and visually impaired persons (WBID) and an attitudinal barriers questionnaire (WABQ). As a scholar, Walker's master's thesis investigated the relationship between self-esteem and depression among blind and visually impaired adults, while his doctoral dissertation investigated counselor attitudes towards persons

who are blind or visually impaired. Additionally, he conducts computer training for blind and visually impaired people throughout North Carolina.

Charles L. Walker holds a Master of Education (M.Ed.) degree and a Doctor of Philosophy degree (Ph.D.) from North Carolina State University. Walker completed his practicum counseling in the Counselor Education Counseling Lab at NCSU, and his internships at the Governor Morehead School for the Blind, the Counseling Center in Disability Services at NCSU, and with Dr. Arnold Bell with the Cooperative Education Department at NCSU. Additionally, Walker supervised four masters students in Counselor Education under the direction of Dr. Stanley Baker at NCSU. In addition, Walker completed his student teaching with Dr. Tracy Robinson at NCSU. Moreover, he completed training as a career counselor instructor and served as an instructor with the Career Counseling Center at NCSU, where he taught a career course for the Career Center. Lastly, Walker conducted a continuing education workshop with the Counseling Center at NCSU on the identity development of persons who are blind or visually impaired.

While at NC State University, Walker served with distinction as the President of the Student Organization for Disability Awareness (SODA), as a Senator and Sergeant at Arms with the Student Senate, as a President Representative with the Chancellor's Roundtable, and as a Senator with the Graduate Student Senate. As a senator with the North Carolina State University Student Body Senate, Walker was successful in authoring a bill and passing

legislation to provide greater access to sporting events, venues and facilities for students with disabilities.

Additionally, Walker was successful at proposing a \$250,000 assistive technology allocation, to the Administration of NCSU, that was accepted and funded by Chancellor Larry K. Monteith and Chancellor Mary Ann Fox for adaptive equipment for blind and disabled people. This Adaptive equipment was purchased, placed and installed throughout the university. Walker also served as a consultant to the Division of Facility Services with the university. Additionally, Walker was instrumental in acquiring the technology for a talking elevator and a talking computer installed in the Learning Resource Library (LRL), in Poe Hall at NCSU. The talking elevator is one of the only talking elevators at a major university on the east coast.

As a member of the Mayor's Committee with the City of Raleigh, Walker proposed to the Mayor and the City Council an ADA compliant two-tiered ART system for the Raleigh Transportation program for blind and disabled people. The two-tiered ART system allows persons who are blind or disabled to access taxicabs at an affordable price. Tier one is an on demand service, while tier two requires a 24-hour schedule.

In addition, Walker provided testimony before the North Carolina State Legislature, and a state study commission investigating discrimination in state government, and the special legislative committee investigating discrimination on matters associated with discrimination and personnel policy for persons who are

blind, visually impaired or disabled. Further, he appeared on WTVD Channel 11's *Reflections* hosted by Gail Paschall, with the Investigative Reporter from the *Carolinian*, Cash Michaels and Civil Rights Attorney Alan McSurely, to continue and advance the discussion and public awareness of discrimination in state government. Moreover, he also provided representation, recommendations and advocacy for persons who are blind or visually impaired to a working committee with the Secretary of the state of North Carolina Health and Human Services Division. Walker had the distinguished opportunity to have lunch with Virginia Governor L. Douglas Wilder, the first African American elected to and serve as governor of a state in the United States of America. He used this occasion to advocate and advance the issue of employment as he represented persons who are blind or visually impaired and disabled in general. Continuing in his advocacy, Walker appeared on Saint Augustine's College TV 68 program, *Signatures*, hosted by Alvin John Waples, to discuss his own academic success and achievements and represent and advance the cause of persons who are blind, in education. Walker is a family man, intellectual, scholar, advocate, and counselor. He enjoys reading, music, computers, travel, golf and other sports.

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CHAPTER 1

Counselor Attitudes toward Persons Who are Blind or Visually Impaired

A National Counselor Study

Attitudinal barriers are a direct wrong of a personal character that may result in injury to the spirit. The injury may be psychological and subjective. It may impair the mental peace and comfort of the person and may cause suffering much more acute than that caused by physical or sensory disability. This could prompt or trigger a need for a counseling intervention. Are counselors prepared to respect, heal, understand, support and challenge and effectively work with this population? Do counselors know persons who live with visual privation? Do counselors have positive expectations of the potential of their clients who could be blind or visually impaired? It is important for counselors to examine the basis of their own biases and attitudes toward persons who are blind or visually impaired, in order to see their clients as whole persons. Counselor expectation can play a vital role in therapy. The ability to establish rapport, trust and empathy are essential elements for a congruent working relationship. Expectancy theory can be applied to counselors and their effectiveness. Vroom's 1964 expectancy theory maintains that people have behaviors as a result of conscious choices from a range of alternatives that maximize pleasure and minimize pain. Expectancy theory states that individuals can be motivated to achieve different sets of goals if they believe that there is a positive association between efforts and outcomes (Vroom, 1964). Moreover, individuals are motivated and

convinced when desirable rewards are a result of favorable performance, and the reward will satisfy an essential need. Additionally, the motivation to satisfy the need is powerful enough to make the effort worthwhile and valuable. Further, expectancy theory assumes valence. Valence refers to an individual's affective disposition towards specific outcomes (Vroom, 1964). Next, expectancy theory assumes negatively desired outcomes, positively desired outcomes, and results with a valence of zero, which means that individuals are indifferent to the outcome. Outcome valence is not the only determination of motivation. Expectancy, or the realistic probability that effort extended will result in preferred outcomes, is an essential component for success. Although an outcome may be extremely desirable (positive valence), motivation will be low if the probability of obtaining it is not realistic. Vroom's expectancy theory maintains that individuals will be motivated to extend effort on a task to the extent that there is a valuable outcome that can be achieved. Finally, expectancy theory recognizes that despite individual efforts, environmental factors may impact the attainment of desired outcomes. According to Vroom, 1964, $\text{motivation} = \text{valence} \times \text{expectancy}$ (Vroom, 1964). Counselors who hold positive attitudes toward persons, who are blind or visually impaired, may have positive expectations of successful interventions with this population. In contrast, counselors who hold negative attitudes towards this population may increase negative outcomes.

Without an awareness of the social construction of disability, counselors may not be aware of attitudinal barriers and biases interwoven throughout society

and biases that they may have learned. In fact, negative attitudes and biases towards persons who are blind, visually impaired or disabled may be embedded within psychological theory that counselors are taught (Davis, 1997; Ferguson, 2001; Jones, 1996; Sue & Sue, 1990; Vaughan 1998). Counselors in training and professional counselors live, grow, develop and train in a society and in societal institutions that have historically devalued and discriminated against persons who are blind or disabled. Counselors therefore have an ethical responsibility to question their own internal biases, in order to be intentional counselors and value and advocate effectively with and for this population.

When individuals who are in power and leadership roles affirm policies, practices, procedures and decisions that limit, restrict, alienate, or discriminate against blind or visually impaired people, they create institutionalized attitudinal barriers (Ferguson, 2001; Vaughan, 1998; Walker, 2001). These institutionalized attitudinal barriers may lead to the under achievement of blind and visually impaired persons in the areas of education and employment (Enright, Conyers, & Szymanski, 1996). These barriers may also contribute to counseling issues such as low self-esteem and depression for this population (Jones, 1996; Kemp, 1981; Vaughan, 1998; Walker, 2001). Academic and work environments typically are not designed with blind or visually impaired persons in mind. Therefore, these environments tend to be hostile and oppressive for members of this population. Issues of low self-esteem and depression experienced by blind or visually impaired persons may in fact be oppression. Because these environments are

socially constructed, the choices that the sighted powers make to exclude and discriminate against blind or visually impaired people, are also socially constructed (Ferguson, 2001; Jones, 1996; Newman, 1976; Vaughan, 1998). The identity development of persons who are blind or visually impaired may be impacted negatively. Counselors in training and counseling professionals must be efficacious in their agency for this population.

1.1 Definition of Blindness

Blindness implies total loss of vision but is often used to refer to partial loss of vision in one or both eyes. The legal definition of blindness varies in different countries. The World Health Organization refers to blindness as “the world's burden of blindness” (WHO.int). The World Health Organization differentiates blindness from both “low vision” and “normal vision.” Three levels of blindness are indicated in the category “severe low vision,” ranging from “profound” (less than 5 percent vision, or 20/400 on a Snellen chart) to “near-total” blindness (less than 2 percent, or 3/200 Snellen) to “total blindness” (no light perception, including the absence of eyes) (Kemp 1981, Vaughan 1998).

In the United States, legal blindness is defined in a section of the Social Security Act. Legal blindness refers to visual acuity of 20/200 or less (Snellen chart) in the better eye with best correction, or a visual field of 20 degrees or less. This means that a person at the higher-acuity limit of the definition can see at 20 feet away from the testing chart what a person with normal vision can see from 200 feet away. Without respect to acuity, a person with a severely limited

field of vision may be described as having "tunnel vision," or may have blind spots in scattered parts of his or her visual field (Ferguson, 2001; Kemp 1981, Vaughan 1998).

1.2 Major Causes of Blindness

Without uniform data collection no accurate estimate of the number of people worldwide who are blind can be documented, regardless to which definition is used. General estimates in the early 1990's predicted about 30 million people worldwide who are blind, using as the criterion a visual acuity of 10/200 or less in the better eye, whereas the estimates ranged up to 50 million if the criterion was increased to 20/200 or less in the better eye, a criterion used in several other industrialized nations besides the United States (Vaughan, 1998, WHO.int). Currently, the world population of blind or visually impaired persons is estimated to be 161 million (WHO.int).

The major causes of blindness vary according to physical and economic characteristics of geographic locations. Therefore, in tropical areas, a high rate of blind persons is due to the massive prevalence of many eye diseases such as trachoma, onchocerciasis (river blindness), and the nutritional-deficiency diseases keratomalacia and xerophthalmia found in developing countries. Moreover, few eye doctors are present in developing regions to treat cataract or accidental eye injuries or to prevent blindness from glaucoma. Additionally, it is important to note that an individual's socioeconomic status is highly correlated with access to prevention and treatment, as reflected in higher rates of blindness

in lower economic strata in different parts of the world. Similarly, blindness is a risk factor for job insecurity and poverty. The main causes of blindness in the United States (and other developed countries) are age-related cataracts, glaucoma, diabetes, and macular degeneration (Vaughan, 1998; WHO.int).

1.3 Social Impact of Blindness

Any degree of severity of blindness may impact negatively on an individual's performance of daily activities, unless, techniques that serve as alternatives to loss of sight are learned. The degree of the negative impact of blindness varies according to societal norms and attitudes and environmental access, as well as skills blind individuals have learned through rehabilitation and thus cannot be predicted from visual measurements alone. Rather, the negative impact of blindness would best be viewed in terms of the negative impact of the society on people who happen to be blind. Educational, employment, and economic factors are better indicators of societal accessibility for persons who are blind or visually impaired (Newman, 1976, Vaughn, 1998, Walker, 1999, 2001).

Blindness is viewed as a burden to both the individual and the entire world. The World Health Organization refers to the 161 million blind or visually impaired human beings living across the planet as the world's burden of blindness (WHO.int). Although progress has been made for blind and visually impaired people as well as disabled people in general, the social impact of blindness or disability remains predominantly negative for this population. For

example, eighteen years after the passage of the Americans with Disabilities Act, ADA, (1990), 80 to 85 percent of blind persons remain unemployed (NFB.org). There are approximately 21.2 million persons who are blind or visually impaired living in the United States (AFB.org). Among the 21.2 million blind and visually impaired Americans, there are approximately 80 percent White, 18 percent Black, 8 percent Hispanic and 2 percent from other races (AFB.org).

Further, only an estimated 45 percent of people with severe visual impairment or blindness have a high school diploma, compared to 80 percent among fully sighted persons. Blind or visually impaired high school graduates are just as likely to take some college courses as their sighted peers, however, they are less likely to complete and graduate from college. According to the American Foundation for the Blind, approximately 62 percent of blind or visually impaired students that are White, 41 percent of Black students, and 44 percent of Hispanic students who are blind or visually impaired complete high school and graduate from college.

Among the 21.2 million visually impaired Americans who are 25 years of age and over, 4.5 million have less than a high school diploma, 6.0 million have a high school diploma or a GED, 5.4 million have some college education, and 3.6 million have a bachelor's degree or higher (afb.org). An estimated 5.7 million individuals, with vision loss living in the United States, have a family income under \$20,000 per year. Approximately 14.6 million individuals with vision loss living in the United States, have a family income of \$20,000 per year or more

(afb.org). Data indicate that 11.3 million visually impaired Americans are married, 2.3 million are widowed, 3.4 million are divorced or separated, 3.1 million have never married, and 1.1 million live with a companion. Race data for visually impaired Americans indicate that there are 17.5 million whites, 2.5 million blacks or African Americans, 2.3 million Hispanics or Latinos, 580,000 Asians, and 274,000 American Indians or Alaska Natives. Finally, according to reports from the American Foundation for the Blind, there are an estimated 57,696 legally blind children living in the United States (afb.org).

1.4 Social Construction of Disability

The social construction of disability refers to institutionalized attitudinal barriers constructed by society that restrict and disable the lives of persons with physical or sensory impairments. In addition, the social construction of disability refers to the dominant discourse reflected in the use of negative language towards those who are blind, visually impaired, or disabled. Moreover, blind, visually impaired, and disabled persons are situated in an inferior social status as reflected by this dominant discourse (Ferguson, 2001; Swain, French, & Cameron, 2003).

Linguistically the term “disabled” is negative when applied to persons with a physical or visual impairment because the “dis” means not. Therefore, by referring to the visually impaired as something that they are not as oppose to who they are, creates a perpetual state or oppressive environment of negativity. The social constructivist worldview states that to be considered “abled” is

considered to be the “norm.” And to be “disabled” is to be “abnormal,” “not normal” or not abled, therefore disabled, which is negative. In an effort to facilitate identity development, political empowerment, and community unity, the disabled community chose to self identify as disabled. Although not optimal, the disability rights community chose to reclaim the term “disabled” in an effort to combat oppression and the negative environment that exist in society as reflected by the negative dominant discourse towards persons with disabilities (Ferguson, 2001; Swain, French, & Cameron, 2003).

By identifying themselves as disabled, this population views the term disabled as the norm. Disability researchers and advocates can now refer to the physically or sensory impaired as the norm of what they are, “disabled,” juxtaposed to what they are not, “not abled.” They can then refer to the abled as what they are not “non disabled”, all in an effort to combat and dispute the negative societal connotation of what it means to be disabled. This extraordinary attempt to turn a negative (abled) into a positive (disabled) demonstrates a desperate yearning and search for validation, meaning, acknowledgment, inclusion and integration by disabled people. These tremendous efforts are provoked by the dominants of the able bodied and ablest and ablism (Ferguson, 2003; Swain, French, & Cameron, 2003).

This indication of tension between the dominant group and the oppressed minority group may result in conditions that call for counseling interventions for many individuals. The dispute between the dominant group and the minority

group over the terms disabled and non disabled is counter productive. For either group to refer to the other group as something that they are not is negative. For the disabled population to redefine a negative term “disabled” as a positive is suboptimal. This entire process can be reduced to so much madness because it is circular. It is liken unto a dog chasing his tail, or more aptly a snake swallowing his tail (Ferguson, 2001; Swain, et al).

Finding ways to ameliorate the effects of the condition of disability in terms of power imbalances, oppression and psychological distress must be the purpose of counselors for this population. In order to be effective and intentional counselors with blind and visually impaired persons, counselors must be culturally competent and aware of the context of these individuals lived experiences. The infrastructure does not currently exist within the constructed environment to sufficiently support the full independence and integration of blind and visually impaired persons, particularly in education and employment, i.e., high college dropout rate, high unemployment (Ferguson, 2001; Swain, et al).

The social construction of beliefs about blindness and the blind has created policy decisions and assumptions that result in educational and economic disparities among this group. Negative assumptions held towards the blind are based on assumptions of pity, sin, and myths (Ferguson, 2001). These negative attitudes and beliefs about the blind have been internalized by many individuals who are blind. These internalized beliefs have negatively effected the growth and development of this population. The negative impact may effect their

identity development. Institutionalized attitudinal barriers are woven throughout the society. Unfortunately, counseling theories are not omitted. The major theorists come from a sighted worldview that has imbedded within it negative assumptions about blind and visually impaired people and their worth or value to society. Most major theorists do not mention blind persons directly. When referring to physically disabled persons, the theorists refer to maladjustment and defect. However, the major theorists provide useful and valuable understandings about human development. A published observation of persons who are blind in 1919 reflect prevailing attitudes towards this population.

“They sustained their lives as miserable, despised beggars asking for the scraps that dropped from the tables of the government and the rich. Accompanied by a dog, they roamed the streets and tried to arouse compassion through their defect. Their refuge may have been an open shelter, their dog perhaps the only companion of their misery. Their food may have been dog food, their only possession a staff, a cover or mat, and a knapsack, and their only deliverance death in a lonely corner.” (Friedlander & Wissowa, 1919).

1.5 Purpose

The purpose of this investigation is to assess whether counselors in training, at the graduate level, feel prepared to work with blind or visually impaired persons effectively, based upon attitudes they may possess towards this population. This study uses the Attitude Towards Disabled Persons Scale Form B (ATDP-B) developed by Yunker, Block and Campbell (1960) to measure attitudes. In addition, attitudes possessed by novice counselors towards blind or

visually impaired people, are assessed in association with the amount of contact counselors in training, have or had with these individuals. Contact with Disabled Persons Scale (CDP) developed by Yuker and Hurley, (1987) is the measure used to assess the degree of contact counselors in training have or had with this group. Moreover, data collected from the demographic instrument is used to correlate with the ADTP-B and the CDP scales to measure the magnitude of contact counselors in training experience or experienced with this population. Other variables incorporated for examination include educational level, type of experience, gender, age, race, and disability of counselors in training. These constructs are evaluated to assess the attitudes held by counselors in training towards persons who are blind or visually impaired, and the types of experiences, along with the extent of contact novice counselors have or had with people who are blind or visually impaired. The researcher maintains that the magnitude or strength of the attitude correlations may increase in a positive or negative direction between type of experience and the level of relationship intimacy. In other words, as type of experience increases the level of relationship intimacy may increase, due to the variance that exists within human populations. The types of relationships that counselors in training may have with blind or visually impaired persons to be considered include: 1. casual/incidental, 2. work related associations, or 3. personal/intimate relationships.

CHAPTER 2

Literature Review

2.1 Social Context of Blindness and Disability

In order to understand the difficulty with the process of adjusting to blindness, the social context of blindness and disability must be considered. People who become adventitiously blind are blind people; therefore, they share the same social status as congenitally blind persons (Vaughan, 1998). Albeit by way of different paths, adventitiously blind and congenitally blind adults face the same issues in terms of their relationship to the dominant society as disabled persons (Kemp, 1981). Research indicates that to be blind is to be a member of an inferior, socially and economically deprived group (Harlan & Robert, 1998; Kemp, 1981). Further research indicates that among all of the disabilities, blindness is considered to be the most severe and feared (Ferguson, 2001; Newman, 1976; Siller & Chapman, 1967; Tringo, 1970).

Perceptions towards blindness from the dominant sighted society are negative. Individuals who are blind are politically, economically, and socially devalued and marginalized (Davis, 1997; Ferguson, 2001; Vaughan, 1998). Therefore, the psychological cost of adjusting to blindness can be tremendous for most people. There are an estimated 161 million visually impaired people living in the world today. Data indicate blindness is viewed as a burden to the family, the community, the society, and to the world, by sighted individuals (WHO.int).

Historically, sighted people have associated the condition of blindness with some culpability or fault within individuals who are blind. The epistemology of the sighted understanding of blindness and blind people was indicated by the disciples more than two thousand years ago, when they revealed this belief in their inquiry of Jesus. "And his disciples asked him, saying, Master who did sin, this man, or his parents, that he was born blind?" (Ferguson, 2001; John 9:2, KJV). Conversely, neither Jesus nor individuals who are blind share in this perception about people who are blind. Rather, individuals who are blind with achieved identities understand that the problem is not them because of their condition of blindness, but the degree to which they are welcomed and included in the society (Cook, 1998; Davis, 1997; Ferguson, 2001; Jones, 1996; Kemp, 1981; Matson, 1990; Vaughan, 1998). In responding to the disciples, Jesus answered, "Neither hath this man sinned, nor his parents: but that the works of God should be made manifest in him" (Ferguson, 2001; John 9:3, KJV).

Acquired vision loss (i.e., blindness) can have a profound impact on a person's life, beginning with a sense of identity crises and leading to social, educational, and economic deprivation (Thomas & Siller, 1999). Blind and disabled people are socially isolated and rejected as valuable contributing members of society (Albrecht, Walker & Led, 1982; Cook, 1998; Newman, 1976; Siller & Chapman, 1967; Vaughan, 1998). Research indicates that institutionalized attitudinal barriers restrict and limit the growth and self-actualization of individuals adjusting to blindness (Albrecht, Walker & Led, 1982;

Altman, 1981; Antonak & Livneh, 1988; Belgntve, 1984; Ferguson, 2001; Newman, 1976; Siller & Chapman, 1967). Some studies suggest that attitudes of sighted persons about and towards blind and visually impaired people have a significant impact on the successful adjustment to blindness (Bauman & Yoder, 1966; Blank, 1991). Research findings suggest that the reaction to the disabled person by others is the most important factor in the adjustment process (Kemp, 1981).

2.2 Psychosocial Adaptation to Blindness

Early models of adaptation to blindness emphasized the mourning and grief associated with vision loss, and implied that individuals moved through stages of shock, depression and eventual recovery (Antonak & Livneh, 1988; Lowenfield, 1957). Adjustment to blindness or any disability is difficult. The self-concept and identity may be damaged. Individuals may experience psychological and emotional pain due to incongruity between the real self and the ideal self (Rogers, 1951). Initially, individuals may lose their status as valued members of the dominant able-bodied, privileged group (Cook, 1998; Vaughan, 1998). The loss of privileged status may result in rejection, social isolation and economic deprivation (Harlan & Roberts, 1998; Tringo, 1970; Wacker, 1984).

Individuals may experience disability related denial or distortion (Rogers 1951). Some research suggests individuals may experience grief, loss, shame, learned helplessness, and depression associated with their acquired disability (Dodds, Bailey, Pearson, & Yates, 1991; Wang & Rogolsky, 1970). Similarly,

other research supports the notion that individuals may experience psychological numbness, denial, mistrust, obsessional thoughts of blame, and posttraumatic stress disorder (Dale, 1992). Additionally, a researcher who happens to be adventitiously blind, suggest that the major factors in the adjustment to blindness include grief, loss, conflict between independence and dependence roles, social stigma associated with blindness, prejudice, and communication without visual cues (Giarratana-Oehler, 1976).

Other research suggests that individuals experience extended periods of grief and loss over their acquired disabilities. It is suggested that the able bodied expect the disabled to grieve their disabilities (Livneh, 1988). Others view people who are blind as being in a perpetual state of crisis. On the other hand, a psychologically adjusted person who is blind is one who is self-actualized and fully functioning. The self-concept is congruent with the reality of actual experiences and self-trust is established (Rogers, 1951).

Additionally, a model of adjustment proposed by Allen (1990) describes the adaptation process in three phases: 1) preimpact, where the person is not fully aware of the seriousness or extent of their visual loss; 2) impact, where the person realizes the extent of their vision loss and reacts with a degree of depression, withdrawal, anger or insecurity, and 3) learning to live with the visual impairment. This final step indicates adjustment and is characterized by acceptance of the condition, learning new ways to function and carry on typical activities, and a sense of optimism or hope for the future.

After reviewing the literature on psychosocial adaptation to blindness and visual impairment, Dodd and Ferguson (1994) indicate that a lack of empirical research in this area limits our understanding of this process. However, they draw several reserved conclusions about reactions to vision loss, including that depression is common following the onset of blindness, and that more extensive vision loss is associated with higher levels of depression. They suggest that such depression and anxiety appear to diminish over time for a significant percentage of individuals. Additionally, these authors suggest that higher levels of education and achievement appear to facilitate successful adaptation to vision loss. Other variables, such as self-efficacy and acceptance of vision loss, were associated with more positive adaptation and adjustment (Dodd & Ferguson, 1994). The process of adjusting to blindness correlates with the process of identity development.

According to Walker (2001), the identity development of adventitiously blind adults moves along a continuum from adjustment, to dependence, to independence, to interdependence. These stages of identity development are impacted negatively or positively depending upon the degree to which adventitiously blind adults internalize the dominant worldview towards blindness (Ferguson, 2001; Kemp, 1981; Wagner-Lampl & Oliver, 1994, Vaughan, 1998). Congruent with these stages of identity development are the deficit model, the functional limitations model, the minority model, and the social constructivist model of disability (Jones, 1996). These models of disability serve as theoretical

frameworks for the stages within the Walker Blind Identity Development Model (Walker 2001).

Studies show that support, attitude, and income are among some of the factors that impact adjustment. For example, (Cimarolli & Boerner, 2005) investigated multiple aspects of social support and their links to the well-being of working-age adults with visual impairments. The study included 86 participants who were first time applicants to a rehabilitation center serving the greater New York metropolitan area. Instrumental help from family members was the most frequent type of positive support that was received, and underestimation of the participants' capabilities was the most frequent type of negative support that was received. Less-optimal well-being appeared to be linked with experiencing a lack of support and with receiving only negative support.

The investigators used interview questions associated with basic demographic characteristics. Age, gender, race, and onset of functional vision problems were evaluated. The researchers asked two questions to assess positive or negative social support. 1. People often get help and support from their family members, friends, and neighbors. They get help with everyday tasks, such as getting rides or running errands, and emotional support, for example, having someone to talk to. "Thinking about your social support system, could you please describe aspects of the support you are currently receiving that you consider helpful to you and that you view as positive?" 2. Although the people who are close to us can be helpful, they can also make us angry or upset at

times, for example, by assisting us with things we could do ourselves or by providing too much help. “Could you please describe aspects of your social support system that are not helpful to you or that upset you?” (Cimarolli & Boerner, 2005). Life satisfaction was measured with the 5-item Satisfaction with Life Scale (SWLS) (Pavot & Diener, 1993). The SWLS is designed to assess a person's global judgment of life satisfaction.

Participants reported 83 instances of positive instrumental and emotional support from family and 53 instances of positive support from friends. About 33% of the participants ($n = 28$) reported that they did not have any types of negative social instances with members of their networks. The most frequently reported type of negative support was Social network underestimates my capabilities, also Social network does not understand my need for personal independence, Conflict with social network members, and Social network underestimates my limitations. Provider's lack of understanding of the impact of visual impairment on the recipient of support emerged as a central issue for these severely visually impaired adults.

Kleinschmidt, (1999) conducted a qualitative study investigating the successful adjustment to vision loss for 12 visually impaired older adults. All 12 participants were found to be in the normal range on the Geriatric Depression Scale and the Spielberger State Trait Anxiety Inventory. In terms of successful adjustment, the participants with visual deprivation reported an importance of having a positive outlook on life. The participants ranged in age from 68 to 93

years and were able to draw from past life challenges, i.e., divorce, death, and illness to help them meet the challenges of visual limitation. These participants appear to follow the loss-bereavement-acceptance model reported by Tuttle (1984). Important factors with these participants revealed that they all had good jobs before they lost their sight, decent housing, and fairly good incomes after they lost their sight, which appear to be major factors in their adjustment.

The findings indicate that prior life experiences critically influence current functioning and the ability to deal with a difficult life event, i.e., vision loss. This finding supports the use of such therapeutic interventions as reminiscence or life-review activities and group therapy. Assistive technology and adaptive equipment were extremely important to this population. Professionals are reminded that it is important that support services for this population include timely and appropriate information on and access to resources and services.

The adjustment to visual impairment themes identified in this study, including attitudes, a sense of humor, a positive problem solving perspective, and a resolve to remain active and productive, suggest the importance of access to persons who can model these attributes. The author suggests that individuals who have adjusted successfully to vision loss can be powerful teachers of those who follow, and providers should consider the use of peers in support programs (Kleinschmidt, 1999).

2.3 Attitudes Toward Persons With Disabilities

When considering vision loss or blindness, people visualize a debilitating, black hole filled with an extreme sense of isolation and loneliness. This view towards blindness and vision loss can have a direct impact on how people treat those who have lost their sight. Many individuals have an image of a person surrounded, trapped and incarcerated by utter and total darkness—stumbling, falling, rolling, clawing, bumping or groping around in the dark. They envision an individual who is completely inadequate and unable to take care of him or her self (Ferguson, 2001; Shontz, 1984). In fact, blindness is the most feared affliction, because visual acuity is viewed as one of the most important senses that people have, blindness is therefore dreaded and feared (Ferguson, 2001; Wagner-Lampl & Oliver, 1994). Due to an environmental press with built in bias, buried in the collective subconscious are the images of Mr. MaGoo and the blind beggar. The average person cannot understand life being meaningful without being able to drive or appreciate visual beauty (Ferguson, 2001; Tuttle, 1984).

Blindness has existed since ancient times. However, issues associated with improving the plight of blind persons gained momentum in the United States after World War II, with the advent of blinded veterans. Rehabilitation professionals began to consider and think about the issues of living without sight. Theory focused on the psychological death of the sighted person and his rebirth as a blind man (Cholden, 1958; Lowenfield, 1957). Additional analysis considered and examined the losses and psychosocial impact, independent

living skills, communication, appreciation of aesthetic beauty, economic and occupational status, as well as personality development associated with blindness (Cholden, 1958). Anger, resentment, shock, depression, and grief have been observed as reactions to vision loss by individuals who lose their sight (Cholden, 1958).

Other factors affect the status of visual impaired people in society other than personality issues. According to Wagner-Lampl and Oliver (1994), adjustment to blindness was felt to be effected by beliefs and superstitions held by the culture and the individual. Even though many perceived people who are visually impaired as helpless, resentful, bitter, and unhappy, others argued that blindness itself does not create emotional disturbance (Wagner-Lampl & Oliver, 1994). Instead, it is societal prejudices that cause emotional distress; many people who are blind concurred that the misconceptions others have about blindness, and not the loss of vision or the need for adaptive skills, is what causes anxiety (Davis, 1997, Tuttle, 1984, Vaughan, 1998).

Additional examination of the impact that stereotypes have on the self concept revealed that people without vision often experience feelings of shame and inadequacy (Scott, 1969). Professionals in the blindness field suggest that attitudes of significant others (i.e. family and friends) have the most important impact on the blind individual's self-concept; families with positive attitudes help the blind person maintain a positive outlook on life (Walker, 2001). Researchers indicate that the attitudinal reactions of medical personnel have a significant

impact on the adjustment process (Bauman & Yoder, 1966). Therefore, researchers advise rehabilitation agencies to incorporate the impact of attitudes into the service dynamic by validating the experiences of being blind in a sighted world. It is suggested that agencies should engage in counseling and educating members of the support network, and lobbying and advocating to change laws and attitudes (Wyatt, 1985).

Due to stereotypes, folklore, and fear surrounding blindness, it has been important to realize the effects of blindness on people, in order to develop successful coping strategies (Goffman, 1963; Tuttle, 1984). The professional literature reflects two general categories of psychosocial findings regarding attitudes toward people with disabilities: 1) literature associated with negative attitudes and 2) literature associated with ambiguous attitudes.

According to Antonak and Livneh (1988), the multidimensional view of attitude is used to understand this phenomenon. According to this view, an attitude is an idea with two features: 1. a cognitive feature charged with emotion and 2. an affective feature, which predisposes a connotative component that is a class of actions to a particular class of social situations. According to Triandis (1995), an attitude is made up of three distinct components: 1. The cognitive component (deals with beliefs associated with information about a stimulus), 2. The affective component (the person's feelings regarding the stimulus and 3. The connotative component (conceived as the individual's intent to behave in a certain manner with respect to the stimulus). The connotative component is

assumed to be influenced by both the cognitive and the affective components.

Triandis (1995) suggests that attitudes are learned through experience and interaction with other people, social objects and environmental events.

2.4 Generalized Negative Attitudes

According to the disability literature, negative attitudes exist in our society toward people with disabilities. Society has historically devalued individuals with disabilities. They are denied rights to education and employment, and creating a "sick role" that people with disabilities are expected to adopt (Hume, Szymanski, & Hohenshil, 1989; Katz, Glass, & Bailey, 1988). Individuals with disabilities often find that they are expected to grieve over the loss of body function, they consistently recognize their situation as undesirable, and they allow paternalistic others to care for them (Miller, 1992). Due to negative societal views, the underestimation of capabilities, and the lack of effective support, the inferior social status of persons with disabilities has been established (Atkinson & Hackett, 1988; Ferguson, 2001).

Katz, Glass and Bailey (1988) assessed college students' willingness to assist disabled and able bodied interviewees who were either pleasant or obnoxious. They found that the college students were significantly more likely to help an obnoxious, apathetic interviewee with a disability, than a more assertive, kind, outgoing interviewee with a disability. With the able bodied category, they found students three times more likely to help the pleasant able bodied interviewee than the disabled.

Relatively, Matthews (1983) investigated women with disabilities regarding their relationship with caregivers. The participants of the study provided multiple examples of rehabilitation professionals, physicians, and family members pressuring them to acquiesce to a dependent status rather than attempt independence. A study by Hopkins-Best (1987) reflects the impact of negative attitudes on opportunities for people with disabilities. Hopkins-Best investigated 450 high school guidance counselors' expectations of career goals for students with and without disabilities. Findings revealed that counselors had a significantly higher agreement rate for professional careers for able bodied students than for students with disabilities.

Although not uniformed, Esses and Beaufoy (1994) found that students over the last 30 years had stereotypical and negative attitudes toward persons with disabilities. People with visible physical disabilities have often been described as lazy, passive, submissive, absent minded, aloof and introverted (Fichten & Amsel, 1986). According to Marinelli and Dell Orto (1999), pervasive stereotypes related to people with disabilities exist. Some of them include the assumption of general maladaptiveness, the assumption of total frustration and the assumption of tragedy and a continuous state of crisis.

Studies of Yuker, Block, and Campbell (1960) and Yuker, Block and Young (1979), found that able-bodied persons tend to respond to people with disabilities with feelings of pity, revulsion, frustration, and anxiety. Comparatively, Gething, (1991) found that due to stereotypes, generalized contact with people

with disabilities has been frequently described as eliciting negative emotions such as discomfort, tension, and unease. Similarly, Siller & Chapman (1967) defined the anxiety and discomforts that able-bodied people experience when interacting with people with disabilities as interaction strain. Able-bodied person's discomfort, curiosity, or the desire to stare at the disabled may produce interaction strain, typically during initial meetings with persons with disabilities (Gordon, Lann & Winter 1997; Siller 1970). As a consequence, this discomfort leads individuals with no disability to tend to avoid interaction, end interactions sooner, and physically distance themselves when interacting with individuals with disabilities (Gordon, Lann & Winter 1997; Siller 1970).

According to Wright (1983), the concept of spread is a factor. The negative attitudes held about a person's disability is transferred to and superimposed upon other aspects of the disabled person's person. Typically, able-bodied people assign labels to people with disabilities based on their deficits, as oppose to their assets, then expect disabled people to conform to the expectations of the label (Wright, 1983).

2.5 Ambiguous Attitudes

Research shows that, in general, people have ambiguous attitudes toward persons with disabilities. Their attitudes tend to be both negative and positive (Katz, Glass, and Bailey, 1988). Reactions seem to depend on a number of variables including the nature of the disability, how the disability was acquired, the context of the interaction, and personal characteristics of the perceiver of the

disability. An investigation by Esses and Beaufoy (1994) on the cognitive and affective components of attitudes toward people who are chronically depressed, and people with amputations yielded mixed findings. Participants showed significantly positive emotions toward people with amputations, for example, respect, on the other hand, emotions toward people who were chronically depressed were generally neutral or negative, i.e. sympathy, anger). Participants described people with amputations as courageous and promoting a strong work ethic, while they described people who are chronically depressed as unsuccessful and blocking the work ethic. Conclusions indicate that multiple components need to be considered when assessing attitudes toward people with disabilities (Esses and Beaufoy, 1994).

Ambiguous attitudes and biases are present in evaluations (Miller, 1992). In an investigation of evaluative rating differences, able bodied supervisors reported feeling that they were compelled to offer more positive evaluative ratings for people with disabilities than for employees with no disability (Makas, 1988). Although these ratings may reflect positive attitudes of supervisors toward employees with disabilities, the author suggests that these ratings may also imply a negative paternalistic attitude or sense of pity (Makas, 1988).

Further, ambiguous attitudes were noted by Nathanson (1979). The author suggests that able bodied persons have tended to attribute both overly positive and overly negative qualities to people with disabilities, attributing characteristics such as courageous and remarkable as well as helpless and inadequate.

Patterson and Witten (1986) emphasized both positive and negative myths associated with people with disabilities. According to the authors' illustrations of these myths/misconceptions include: 1. disability is a constantly frustrating tragedy; 2. people with disabilities do not recognize their limitations; 3. people with disabilities have special personalities and abilities; and 4. people with visual impairments can hear things no one else can. The attribution of unrealistic qualities to persons with disabilities reflects a mixed state of values toward this population. For Example, humanitarianism vs. individualism, and competing responses whether to assist or avoid on the part of the able bodied (Katz, Glass & Bailey, 1988).

Researchers posit that it is the specificity of the context of the situation that determines if the attitude toward an individual with a disability is negative, neutral, or positive (Wright, 1988). Wright suggests three conditions for the functioning of fundamental negative bias: 1. saliency (the object attracts notice), 2. value (the observed object is considered to be negative), and 3. context (vague or specific). For example, if a person with a disability in a wheelchair approaches you, the theory of fundamental negative bias indicates that the vague context (the disabled person being a stranger) will result in the negative value (the disability) guiding the entire perception. Conversely, if the person in the wheelchair is a well-known professor, the context of the situation is no longer vague and most likely the negativity of the perception will minimize (Wright, 1988).

Cook (1992), attributes ambiguous attitudes toward people with disabilities to social desirability bias. However, other researchers indicate that publicly expressed attitudes toward the disabled are generally positive (Comer & Piliavin, 1975). According to Cook (1992), public attitudes toward people with disabilities tend to be positive. People generally do not express negative feelings when verbalizing public attitudes, reflecting the social desirability bias. This suggests that any score obtained on an attitude measure may not accurately reflect the thoughts and feelings of the respondent but rather the person's perception of what is socially desirable (Yuker, Block, & Young, 1970). One limitation to paper pencil test including measurements of attitudes toward individuals with disabilities, such as the Attitude Toward Disabled Persons Scale (ATDP), are unidimensional, and therefore susceptible to social desirability bias (Yuker, Block, & Young, 1970).

2.6 Variables That Influence Attitudes

Research focusing upon attitudes toward persons with disabilities has yielded several key factors believed to influence attitudes. According to Yuker (1994), the factors or variables may include information associated with and contact with people with disabilities. A study conducted by Weiner (1993) found that information about the origin and causes of a disability can positively influence attitudes. Wright (1998) suggests that messages that target personal inadequacies and problems in coping with a disability lead to negative attitudes. Similarly, researchers indicate that knowledge about disabilities without

contextual contact with people with disabilities may lead to negative attitudes (Yuker, 1994). The researcher suggests that without personal constructive contact, knowledge may maximize disabilities rather than abilities.

According to Yuker (1994), effective contextual contact with people with disabilities is characterized by it being personal, rewarding, cooperative, and intimate and of equal status. This contact usually provides positive information and tends to result in positive attitudes. According to Cook (1992), the most powerful strategies for changing attitudes toward people with disabilities realize that it is the contact between the disabled and the able bodied , who are of equal status, combined with disability information that has the greatest impact. Reportedly, the number of years of education is the only variable significantly correlated with positive Attitudes Toward persons with disabilities (Yuker, 1994). Demographic variables such as gender were not strongly associated with positive attitudes toward persons with disabilities (Yuker, 1994).

2.7 The Counseling Relationship and Attitudes

According to Wallach and Strupp (1960), attitudes may influence clinical judgment, treatment planning, and therapist's effectiveness. These researchers support the concept that emotional and attitudinal factors in the therapist may have an important bearing upon clinical evaluations. Parloff (1956), found that counselors identified most satisfactorily to those clients who most clearly approximated clients who were considered to be ideal. Similarly, Wallach & Strupp (1960), reported that the counselor's attitude toward the client was

significantly correlated with the nature of therapy, treatment frequency and length, and the kinds of issues expected in therapy.

According to Sue, Arredondo, and McDavis (1992), counselors may form initial impressions early in the clinical process. These impressions may be associated with counselor attitudes. These early impressions are resistant to change (Sue, Arredondo, & McDavis, 1992). The research suggests that counselors may often seek to confirm initial hypotheses about their clients, and that they may ignore evidence that contradicts their initial beliefs (Sue, Arredondo, & McDavis, 1992). Studies report systematic biases between both expert and novice counselors (Eddy, 1990).

Morrow and Diedan (1992) posit a view of clinical bias, which assumes that bias is elicited by a single client attribute, for example blindness, while other client attributes are de-emphasized or ignored. Similarly, other models view clinical bias as being due to heuristics or short cuts taken by counselors in evaluating information selectively on the basis of stereotypes and misconceptions (Lopez, 1989). Theory and research indicate that negative attitudes of counseling professionals may have detrimental impacts on the therapeutic process (Lopez, 1989). Counselors who work with students with disabilities may hold subtle negative attitudes or misconceptions, which could lead to tension, difficulties establishing a therapeutic bond, premature termination, or possibly focus on inappropriate treatment themes (Nathanson, 1979).

2.8 Counselor Attitudes

Nathanson (1979) reported that counselors are not immune to negative attitudes toward persons with disabilities. The author presented seven syndromes or points of view, which reflect affectively, based counter transference reactions that may impede the psychotherapy process. They include: 1. sole focus on the label of disability, 2. pity, 3. rescuing, 4. paternalism, 5. avoidance, 6. awe at the courageousness of the client, and 7. anxiety. Therapists with ambiguous or negative attitudes may experience anxiety, discomfort, presume limitations, and become less effective in working with people with disabilities (Huitt & Elston, 1991). Biklen (1988) reported that negative attitudes can significantly bias clinical judgment and there by impair all areas of treatment planning and outcome. Similarly, unexamined attitudes toward persons with disabilities may also affect counselor effectiveness (Cook, 1992; Cook, Kunce, & Getsinger, 1976).

Research has focused on assessing the attitudes of rehabilitation counselors and correlating their attitudes to various demographic variables. For example, sex, age, type of training, level of experience, and contact (Carney & Cobia, 1995; Elston & Snow, 1986; Garske & Thomas, 1990; Goodyear, 1983; Huitt & Eliston, 1991). Additionally, only a few studies have examined the attitudes of counselors who are not rehabilitation counselors (Elliot, Frank, & Brown-Duffeck, 1988; Constantine, 2002). In addition, Palmerton and Frumpkin, (1969a), is one of the few studies, which has explored college counselors'

attitudes toward clients with disabilities.

According to Lombana (1989), persons with disabilities are referred regularly to counseling professionals for psychotherapy. Unfortunately, little research has focused on the relationship between the psychotherapist and the client with a disability (Lombana, 1989). Some studies have examined the attitudes of mental health practitioners toward clients with disabilities. For example, Elliot, Frank, and Brownlee-Duffeck (1988) investigated whether trainees would expect individuals with a spinal cord injury to be depressed and mourn their condition. They had 69 doctoral students to rate their expectations of depression (measured by the Beck Depression Inventory) after viewing a videotape of a person in varied conditions of disability. Condition 1: spinal cord injury, no disability and Condition 2: affect; depression, no depression. Findings indicate that the presence of a spinal cord injury did not moderate the assessment of depression.

Additionally, Constantine (2002) investigated the impact of counselor attitudes and training on the conceptualization of clients with disabilities. Community mental health counselors were assigned to view either an able-bodied or a disabled client intake video. After viewing the video, participants rated the client's functional level and prioritized treatment concerns. Participants also completed the ATDP Scale, and a demographic questionnaire, which assessed level of training and contact with disability matters. Findings indicated that assessment of client functioning level did not significantly vary between

counselors viewing the able bodied and disabled consumer video. Findings did show that counselors with training on disability issues held more positive attitudes toward people with disabilities.

Next, Palmerton and Frumpkin (1969b), examined 81 college counselors' knowledge, contact, and attitudes toward students with disabilities. Attitudes were assessed using the ATDP Scale. Findings indicated that knowledge about disabilities and attitudes were not related. Nevertheless, attitudes and prior contact with people with disabilities were related. Counseling professionals with favorable attitudes were likely to be those who enjoyed their contact with people with disabilities and did not find it easy to avoid contact.

2.9 Rehabilitation Programs

Rehabilitation programs for blind persons endeavor to restore individuals to their normal lives and focus on training individuals to become independent (Dodd, et al, 1991; Ferguson, 2001; Jones, 1996; Kemp, 1981; Tringo, 1970). In actuality, rehabilitation may leave blind clients marginalized and dependent, thereby, fulfilling the expectations of the dominant sighted culture (Dodd, et al, 1991; Ferguson, 2001; Kemp 1981; Tringo, 1970; Van-Hesselt, 1983). Training blind individuals to function independently without sight and without the services of sighted individuals in an environment without the infrastructure to support independence for blind people is a flawed goal. Research indicates that rehabilitation systems have a deficit and functional limitations view toward disability (Ferguson, 2001).

Rehabilitation agencies would be more effective in their services if they viewed people with disabilities through an asset paradigm (Carter-Davis, 2000). In the case of adventitiously blind people, rehabilitation would be more cogent if the emphasis was placed on strategies that fostered, supported and encouraged interdependence (Walker, 1999). Viewing disabled persons from a deficit and a functional limitations prospective builds and expands the rehabilitative industrial complex and creates an institutionalized barrier to educational and employment opportunities for adventitiously blind people (Vaughan, 1998; Walker, 1999, 2001)

2.10 Rehabilitation Counselors

Research on attitudes of rehabilitation counselors concludes that many counselors hold negative and stereotypical beliefs toward clients with disabilities (Chubon, 1982; Kaplan, 1982). Similarly, Goodyear (1983) found that rehabilitation counselors hold attitudes that are stereotypical toward persons with disabilities. These attitudes are primarily in reference to disability type. In their study, 40 rehabilitation counselors were surveyed on their attitudes toward consumers with alcoholism, paraplegia, mental retardation, and schizophrenia. Attitudes were measured using a semantic differential scale. Results indicated that counselors' attitudes toward people with disabilities differ according to the category of the disability (Goodyear, 1983).

Carney and Cobia (1995), found that type of counseling training did influence counselors'-in-training attitudes toward people with disabilities.

Attitudes of master's level students enrolled in rehabilitation, school, and community counselor education programs were measured using the ATDP scale. Findings showed that counselors-in-training demonstrated positive attitudes (Carney & Cobia, 1995). Findings revealed that there were significant differences in attitudes toward persons with disabilities, by counseling program.

Rehabilitation counseling students reported the most positive attitudes, then school counseling students and finally community counseling majors. The researchers found no differences between counselors-in-training based on level of training, age, or sex (Carney & Cobia, 1995).

Additionally, Garske & Thomas (1990) investigated the attitudes of graduate students in rehabilitation counseling. Specifically, the researchers examined the relationship of graduate students' attitudes toward persons with disabilities to self-esteem and prior contact to persons with disabilities. They found that students showed positive attitudes toward persons with disabilities and positive self-esteem.

Further, students' attitudes toward individuals with disabilities were found to be positively correlated to self-esteem. However, no significant relationship was found between attitudes and prior exposure to persons with disabilities.

Rumrill, Millington, Webb and Cook (1998), investigated whether inclusion of a disability label (namely insulin-dependent diabetes mellitus) affected the employment expectations of prospective rehabilitation counselors toward a fictitious client. Using an experimental analog design, employment expectations

were used as a differential indicator of rehabilitation professionals' attitudes toward people with diabetes. Findings indicated that the diabetes label had no significant effect on the participants' ratings of the fictitious client, indicating the absence of any negative attitudinal bias.

2.11 Agency Counseling

Next, individuals with disabilities meet the standards of a minority group: social stigma, identifiably with a particular group, inferior status, and pejorative treatment (Atkinson & Hackett, 1988). Persons with disabilities are typically marginalized and viewed through stereotypical perceptions as with ethnic, racial, or religious minority groups (Livneh, 1988). As a minority subgroup, many people with disabilities share in common the issues they are confronted with, as well as institutionalized barriers in the world they must overcome.

In a special issue of *Journal of Counseling and Development* devoted to counseling persons with disabilities, an article intended as an update on people with disabilities emphasized school and rehabilitation counseling (Pagan & Jenkins, 1989). Notably, absent within the entire issue were self-concept issues, relationship issues, and cross-cultural approaches. Wright (1988) suggested that as counseling professionals we need to become sensitized to contributing inadvertently to disabling myths about particular groups. Individuals with disabilities may be in psychotherapy sessions, couples sessions, groups, and classes. They lead multifaceted lives, and their counseling issues are not primarily limited to academic, career, and health issues. Lombana (1989)

reports that when a rehabilitation counseling client should need long term counseling, he or she will be referred to community counselors. Hohenshil and Humes (1988) suggested that with the exception of rehabilitation counseling, counselors in agency and school settings have not devoted a significant portion of their resources to the provision of comprehensive services for the disabled. Many counselors who desire to provide effective services for the disabled would require reorientation as well as retraining (Hohenshil & Humes, 1988). The authors suggest that mental health counselors and psychologists may not be prepared to recognize important disability group themes (Hohenshil & Humes, 1988). The counseling profession that now recognizes the importance of training counselors to work with members of ethnic minority groups, must now recognize the need to train counselors to work with persons with disabilities (Hohenshil & Humes, 1988).

2.12 Multicultural Counseling Issues

Theories associated with Multicultural counseling acknowledge the importance of counselor awareness to differences between the client and counselor. Important differences may include: values, world view, communication styles, language, power, and perceived locus of control (Horner, Vandersluis, Alexander, Bashey, Clarke, & Peterson, 1984; Pedersen, 1976, 1988; Sue & Sue 1990). It is essential that counselors have disability issues included in their awareness. When disability issues remain outside of awareness, counselors may impose their values upon a client, create biased treatment plans,

or ignore major themes often central to persons with disabilities.

Because the common bias many times recognizes people with disabilities, as their disability, people with disabilities tend to value their capabilities and wholeness over limitations (Matthews, 1983; Zola, 1984). It is important that counselors see their clients as whole persons and as a total system, without ignoring their disabilities (Carlton & Maxwell, 1987; Cobb & Brown, 1987). The conscious or unconscious use of disabling language, i.e., "the handicapped", "crippled" may harm both the bonding process and lower the client's sense of self-worth (Harvey, 1989; Hulnick & Hulnick, 1989; Humes, Szymanski, & Hosenshil, 1989; Matthews, 1983). Counselors who ignore the disability, impair the communication with the client, and may suggest that the therapist considers these issues unimportant, irrelevant to the therapy, or too anxiety provoking to investigate (Horner et al., 1984; Nathanson, 1979; Sue & Sue, 1990).

Some researchers maintain that the European-American value system of a beautiful body, work productivity, and financial success, may be different to the values held by a person with disabilities (Ponterotto & Casas, 1991). Many individuals view their disability as a divine gift that affords a new path to a more rewarding life and clarified value priorities (Hulnick, & Hulnick, 1989). The world view of client's may include fatalism, a sense of external control, environmental barriers, dependency and learned helplessness. On the other hand, another client's world view may include independence, optimism, and a sense of internal control (Hulnick & Hulnick, 1989).

Due to communication disorders, nonverbal processes, or interpersonal dynamics, atypical communication styles may develop during the counseling session (Harvey, 1989; Telford & Sawrey, 1977). Interpersonal dynamics associated with disability issues may affect communication processes due to an imbalance of power between the client and the counselor. The counselor is in the position of expert healer, by default the client's position becomes that of a person that needs healing. Typically, clients are referred to counseling by third parties, i.e., parents, schools or agencies. Clients may be aware of possible dual loyalties of the counselor, and feel hesitant to fully disclose his or her feelings (Harvey, 1989, Thoreson & Kerr, 1978).

Research has indicated that treatment plans are impacted by counselor attitudes toward client cultural group membership (Ponterotto & Casas, 1991; Sue & Sue, 1990). Treatment plans may be inappropriately developed due to biases and attempts to fix the client so that they fit into the counselor's cultural system or world view (Pedersen, 1988). Counselor attitudes toward certain group memberships may impact decision making regarding a client's appropriateness for treatment (Wright, 1988). According to Thomas & Althen (1989), there may be difficulty with accurate diagnosis when nontraditional belief systems exist.

Additionally, there may be more similarities than differences between persons with and without disabilities. Therefore, these two groups may share similar counseling needs (Cobb & Brown, 1987; Hulnick & Hulnick, 1989;

McDowell, Coven, & Eash, 1984). Many researchers present concerns that counseling may focus too heavily on adjusting the individual to the disability, as oppose to adjusting society to the individual (Pagan & Wallace, 1988; Humes et al. 1989). Shontz (1984) reports a shifting from searching for specific mental traits associated with individuals with disabilities, to a focus on the physical and social environments that create handicaps for people with disabilities.

According to Lindemann (1981) adaptation to physical disability may range from optimal, positive self-actualizing to negative, embittered retreat. For disabled people, the developmental process is often burdened by others' ignorance, impatience, and uninformed benevolence (Lindemann, 1981). Many times the problem is the reaction evoked in others by the disability (Scott, 1982). Humes et al. (1989) stated, "disability is a multifaceted construct that involves individual and environmental dimensions and affects and is affected by individual perceptions (including expectations) and interpersonal interactions" (p. 145). Other than being unemployed, the issues synonymous with many individuals with disabilities, due to negative societal attitudes, include: discrimination and alienation, barriers to positive self-concept and healthy separation and individuation, and physical, sensory, cognitive difficulties within the traditional psychotherapy process. Fenderson (1984) emphasizes the impact of societal discrimination as a mental health issue. His work focused on the ongoing need for disability research by psychologists in this area.

Ladieu-Leviton, Adler, and Dembo (1984) examined the difference between the effect of non-participation and the impact of non-acceptance that individuals with disabilities experience, stemming from others' negative attitudes and misconceptions, (i. e., unable to kick field goals in a sporting activity (soccer), and/or not being invited to the sporting activity at all). The researchers maintain that all persons experience non-participation in various situations, primarily without emotional affect, however repeated experiences of non-acceptance often result in feelings of rejection. Evans and Dingus (1987) reported that persons with physical or perceptual disabilities are at higher risk of loneliness. They suggest that this may be due to alterations in the social environment, which may deplete social resources. They offer models for the treatment of loneliness. Comparatively, Lombana (1988) reports that suicide rates among adolescents and children are higher in the disabled population than the able-bodied population and teaching coping skills to children with disabilities will help inoculate them from internalizing the rejection that occurs with some peers.

Although individual reactions to rejection are varied, for many persons with disabilities, experiences of and feelings of alienation are present. According to Aubrey & Lewis (1983), many counseling professionals are ill prepared to work with issues of discrimination and alienation. According to Asch & Rousso (1985), within the field of psychoanalysis, discrimination toward the disabled has been institutionalized, through the standardized rejection of individuals with identifiable

disabilities. Jureidini (1988) suggest a contraindication using psychoanalysis as a treatment for individuals with disabilities based on assumed lack of ego strength.

Self concept and self-esteem are important constructs for teens in adolescents. Some school counseling literature that looks at working with children and adolescents with disabilities focuses on the importance of self concept issues (Battle, 1984; Goldberg, 1984; Hosie, Patterson, & Hollingsworth, 1989; Lefebvre & Arndt, 1988; Telford & Sawrey, 1977). The development and facilitation of a healthy self-concept is typically an important emphasis of the therapy in counseling children with disabilities (Cobb & Brown, 1983). When discussing disruptions in the normal socialization process, it is suggested that disabled children will have issues with self-concept (Battle, 1984). The author indicates that children with “handicaps” will have less experience in social relationships than able bodied children. Battle believes that with the passage of time, the child will become deeply concerned about his or her physical disability. Further Battle suggests that the disabled child will not be sufficiently isolated or sheltered to prevent them from learning about the negative values applied to persons with disabilities within an able bodied society. Therefore, the disabled child may tend to deprecate his or her own worth against the able bodied standard (Battle, 1984).

In his essay on the rehabilitation of the disabled adolescent, Goldberg (1984) suggests that healthy adolescent development should present rebellion as oppose to passivity. Physical dependence on caregivers and limited power

restrict the ability of children with disabilities to pull away from parents (Goldberg, 1984). For teens with disabilities, identity development including sexual identity, can be especially difficult amid a culture that emphasizes able bodiedism and physical beauty.

Receiving accurate information and counseling about sexual issues may be difficult for both adolescents and adults (Griffith, Trieschmann, Hohmann, Cole, Tobis, & Cummings, 1984; Hohmann, 1984). Hohmann (1984) indicated that by default assumption, the disabled client's sexual drive and sexuality are none existent. In counseling, anxiety can be intensified by negative attitudes, misapprehensions, and misunderstandings (Hohmann, 1984).

Reframing disability to a positive challenge, and focusing on individual strengths is an important part of counseling this population (Hulnick & Hulnick 1989). Allowing clients to experience intense levels of emotional pain while grieving their disability can also be an important feature of therapy (Jureidini, 1981). In general, researchers suggest sensitivity to the areas of discrimination, alienation, self concept, and the importance of attending to issues associated with people with disabilities, (i.e., communication).

2.13 Education

The next step in the developmental process for blind adults may be marked by the challenge of higher education. Blind people must be indefatigable in their pursuits of higher education, because the university environment may be

hostile and unwelcoming toward persons with disabilities (Enright, Conyers, & Syzmanski, 1996; Newman, 1976; Wiseman, Emry, & Morgan, 1988).

Achieving acceptance to a university or college for most people is a major accomplishment. Blind people as well as their families have overcome their own fears and biases toward blindness. Fortunately, a few exceptional members of this population have survived and overcome the oftentimes toxic debilitating and demoralizing institution of rehabilitation and demeaning and incompetent rehabilitation counselors, and enter higher education. Research indicates that due to the severity of the condition of blindness, rehabilitation counselors are reluctant to steer clients towards college and university enrollment (Dixon, 1983; Newman 1976). Research also indicates that college professors and admissions boards are reluctant to admit students who are blind (Newman, 1976). It appears as if rehabilitation counselors and university professors, believe that, even if blind students could complete the academic requirements to obtain a college degree, employment opportunities are so limited that college admission should be restricted (Newman, 1976; Siller & Chapman, 1967).

The college and university experience holds forth opportunities for academic growth and social interactions. Adventitiously blind students are academically integrated and socially isolated at most universities (Enright, et al., 1996). Data indicate that blind and disabled students who are academically integrated, but socially isolated, tend not to complete their academic programs due to feelings of isolation and alienation (Enright, et al, 1996). The experiences

of college students with disabilities may be instructive in that feelings of social isolation experienced in the university environment may reflect feelings experienced by disabled persons in the larger society (Vaughan, 1998). The research suggests that able-bodied students tend to be uncomfortable with students, who are blind or disabled in social situations (Enright, et al., 1996; Stovall & Sedlacek, 1981 & 1983; Wiseman, et al, 1988).

The impacts of attitudinal barriers faced by blind adults at the university level are environmental and situational, public and private, institutional and individual, professional and personal (Walker, 1999). According to Siller and Chapman (1967) university faculty members believe that blindness presents the worse disability for college work. Research indicates that blind and disabled students need and desire to be included and integrated into the college environment and experience (Newman, 1976; Siller & Chapman, 1967). The university environment does not provide adequate equal access to written materials, bulletin boards, library materials and databases, social events, sporting events, and campus wide programs, facilities, and services (Enright, et al., 1996; Newman 1976; Siller & Chapman, 1967). It appears that institutionalized attitudinal barriers are the greatest challenges for blind and disabled people in terms of completing their college educations and obtaining substantial gainful employment (Black, 1970; Jones & Koestler, 1983; McBroom, 1995; Wacker, 1976). Successful completion of a university education does not eliminate the barriers to growth and access to opportunities for this population. In

fact, congenitally blind and adventitiously blind individuals may face their greatest challenges outside of rehabilitation and higher education, given that 70 to 75% of disabled persons are unemployed (World Institute on Disabilities, 1998).

In spite of institutionalized attitudinal barriers in the environment, blind and visually impaired people adjust, grow, develop, and become conscious of the nature of disability in society. Like race, disability is socially constructed, with economic and political consequences (Anderson & Collies, 1992; Jones, 1996). There maybe challenges and issues with the identity development of this population. An identity development model for blind or visually impaired persons is needed to map and chart identity development for this demographic. An identity development model may assist individuals to become conscious of external and internal biases towards blind people, and prepare them to survive and overcome attitudinal barriers experienced in an oppressive, disabling environment (Walker, 2001).

Additionally, the literature review reflects the need for counselors and counselors in training to have a tool that describes the stages of development that a blind or visually impaired client may go through, both to approximate where they are at a glance, and to challenge, encourage or facilitate growth as appropriate. An identity development instrument may assist counselors with seeing those who live in this environment without sight, from a new perspective. In addition, an identity development model may assist counselors with recognizing the unique environmental challenges experienced by blind and

visually impaired persons, when processing life issues (Walker, 2001), (see Appendix M Emerging Theories).

Based on the professional literature, there appears to be a paucity of studies that investigate the difference between counselor attitudes and contact with persons who are blind or visually impaired. Research shows that the counselor's attitude can have a powerful influence on the counseling intervention; therefore, it is essential to investigate them, (Cory, 1991). Therefore, this investigation will ask the following research questions and test the following research hypotheses.

2.14 Research Questions

The following research questions will be asked in this study:

1. What is the relationship between counselors in training attitudes toward persons who are blind or visually impaired, and their degree of contact with this population, as measured by the ATDP-B and the CDP Scales?

2. Is there a difference due to the graduate school status (MS or PhD) of counselors in training, in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B Scale?

3. Is there a difference due to the type of experiences or level of involvement (1. none, 2. casual/ incidental, 3. work associated, or 4. direct personal/intimate) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

4. Is there a difference due to the type of involvement/work experience (0. none, 1. as an employee, 2. as a colleague/coworker, 3. as a supervisor/employer) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

5. Is there a difference due to the gender of counselors in training in their attitudes towards and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

6. Is there a difference due to the age (1. 30 – younger, 2. 31-40, 3. 41-50, 4. 51-above) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

7. Is there a difference due to the race of counselors in training in their attitudes toward and the degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

8. Is there a difference due to the disability status (disabled or non-disabled) of counselors in training in their attitudes toward and the degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

9. Is there a difference due to the blindness education (1. no blindness education or 2. yes blindness education) of counselors in training and their

attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales?

2.15 Hypotheses

1. There will be a positive correlation between counselors in training attitudes toward persons who are blind or visually impaired, and their degree of contact with this population, as measured by the ATDP-B and the CDP Scales.

2. There will be no difference due to the graduate school status (MS or PhD) of counselors in training in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B Scale.

3. There will be a difference due to the type of experiences or level of involvement (1. none, 2. casual/incidental, 3. work associated, or 4. direct personal/intimate) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

4. There will be a difference due to the type of involvement/work experience (0. none, 1. as an employee, 2. as a colleague/coworker, 3. as a supervisor/employer) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

5. There will be no difference due to the gender of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

6. There will be no difference due to the age (1. 30 – younger, 2. 31-40, 3. 41-50, 4. 51-above) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

7. There will be no difference due to the race of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

8. There will be no difference due to the disability status (disabled or non-disabled) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

9. There will be a difference due to the blindness education (1. no blindness education or 2. yes blindness education) of counselors in training and their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

CHAPTER 3

Method

This national counselor study was approved by North Carolina State University's Institutional Review Board (IRB) (see Appendixes A and B). The instruments in this study were obtained from the Psychology Department of Hofstra University (see Appendixes C and D). This investigation was conducted during the spring semester of 2008. Counselor education program directors and professors across the nation were emailed a national counselor invitation for distribution to their graduate level counselor education students (see Appendix E). Because data was collected anonymously online, counselors in training browsed to <http://ceres.cals.ncsu.edu/nationalcounselor> to register their participation in this investigation (see Appendix F). Participants gave their voluntary consent to be a part of this study (see Appendix G). They then completed the demographic data form and the instruments (see Appendixes H, I, J, K, and L). The respondents were surveyed as to their honest opinion about individuals who live with vision loss.

3.1 Participants

There were 300 counselors in training, from across the nation, who participated in this study. The participants were drawn from CACREP approved counselor education programs nationwide. The participants were all graduate students. There were 215 (72%) master's students and 85 (28%) PhD students. The gender of the counselors in training included in this study consisted of 240

(80%) females and 60 (20%) males. The ages of the counselors in training participants were in one of four categories: group one: ages 29-younger, n=137 (46%), group two: ages 30-40, n=102 (34%), group three: 41-50. n=42 (14%), or group four: ages 51-above, n=19 (6%). In the racial group categories there were n=221 (74%) White, n=43 (14%) African American, n=20 (7%) Hispanic, and n=16 (5%) participants that were either Asian, Indian, or another race. The disability status of the counselors in training participants, included n=285 (95%) with no disability and n=15 (5%) who indicated that they had a disability. Among the 300 participants, n=201 (67%) indicated that they had received no education about blindness in their academic programs and n=99 (33%) reported that they had received some education about persons living with vision loss.

Counselors in training were surveyed as to their involvement and type of experience they had with persons who are blind or visually impaired. In the involvement category, n=102 (34%) participants indicated that they had (1) no involvement or experience with persons who are blind or visually impaired. There were n=113 (38%) participants who indicated that they had (2) casual/incidental experience with this population. There were n=44 (15%) participants who indicated that they had (3) work associated experience with persons who are blind. And, there were n=41 (14%) participants who indicated that they had (4) direct personal/intimate involvement with persons who are visually impaired. In the type of involvement, work experience category respondents indicated their type of experience with persons who are blind or

visually impaired in the following four groups: group (1): no work experience, n= 266 (89%) participants; group (2): as the employee of a person who is blind or visually impaired, n=10 (3%); group (3): as a colleague/coworker, n=17 (6%); and group (4): as a supervisor/employer, n=7 (2%).

3.2 Variables of Interest

The variables of interest in this study include the Attitude Towards Disability scale (ATDP-B) and the Contact with Disabled Persons scale (CDP). The other variables include: counselors in training graduate school status (MS/PhD), involvement and experience of counselors in training with blind or visually impaired people, in the context of (1) no involvement, (2) casual/incidental involvement, work associated involvement, and more direct personal/intimate involvement, such as friends or family. Also type of involvement/work experience is considered. In addition, the demographic variables of gender, age, race, and disability status (disabled or non disabled) and blindness education were considered. The work experience category included: 0. None, 1. as the employee of a persons who is blind or visually impaired, 2. as a colleague/coworker of a person who is blind or visually impaired, and 3. as a supervisor/employer of a person who is blind or visually impaired.

3.3 Instruments

A demographic data sheet, the Attitude Toward Disabled Persons Scale ATDP-B and the Contact with Disabled Persons Scale CDP were used as the

instruments for this study. The ATDP-B was modified by the researcher for purposes of clarification and use in this study. The terms “blind or visually impaired” replaced instances and appearances of the word “disabled,” in the modified version. Similarly, the CDP scale was modified by the researcher for purposes of clarification and foci in this study. The terms “blind or visually impaired” replaced instances and appearances of the word “disabled,”.

3.4 Demographic Data Form

The Demographic Data Sheet was developed by the researcher for use in this study. Face validity of this instrument was established by a review of professionals within the counseling profession.

3.5 ATDP-B Scale

The Attitudes Toward Disabled Persons Scale (ATDP), was developed by Yuker, Block & Campbell in 1960. This study used a researcher modified version of the ATDP form B to assess counselors in training attitudes toward persons who are blind or disabled, (Yuker & Block, 1986). Three versions of the Attitudes Toward Disabled Persons Scale (ATDP, form O, form A, and form B) have been developed by Yuker and associates, in order to provide flexibility and to permit the use of the instruments in various research designs (Yuker & Block, 1986). Form O is the original form and contains 20 items (Yuker, Block, & Campbell, 1960). Forms A and B contain 30 items each (Yuker, Block, & Young, 1970). According to the test manual, all three versions (Forms O, A, and B) are comparable to each other and can be utilized interchangeably (Yuker &

Block, 1986). Face validity for instrument items was established from an initial pool of 300 questions that were analyzed by psychologists and administered to undergraduate students at Hofstra University.

According to the test manual, the intent of the development of the ATDP was an effort to offer a reliable, valid, and objective measure of attitudes toward disabled persons with physical disabilities. The Attitude Towards Disabled Persons scale was developed to measure attitudes held by both disabled and able bodied persons (Yuker & Block, 1986). The scale was designed to measure the attitudes of able bodied people towards disabled people and the attitudes of disabled people towards other disabled people, or themselves. The Attitudes Toward Persons with Disabilities instrument can be utilized as an individual or group measure. Research participants respond to test items by indicating their agreement or disagreement with statements on the instrument according to the six item Likert scale that ranges from -3 I Disagree Very Much to +3 I Agree Very Much as reflected in Table 3.1.

Table 3.1 ATDP-B Likert Scale

+AGREE		-DISAGREE	
+3	I Agree Very Much	-1	I Disagree A Little
+2	I Agree Pretty Much	-2	I Disagree Pretty Much
+1	I Agree A Little	-3	I Disagree Very Much

The ATDP Scale form B consists of 30 items with a six item Likert tool response system as depicted in the Table 3.1 above. The Likert tool ranges from "+3 I agree very much" to "-3 I disagree very much" for each item. The total score is interpreted in terms of perceived differences between disabled and able bodied persons (Yuker & Block, 1986). Therefore, relatively high scores indicate the respondents perceive individuals with disabilities as similar to able bodied persons and low scores indicate the respondent perceives individuals with disabilities as different from able bodied persons. Low scores imply negative attitudes and high scores imply positive attitudes towards persons with disabilities. The ATDP Scale takes approximately 15 minutes to complete.

Range. The ATDP-B ranges between 0 and 180. Scores between 0 and 90 indicate rejecting attitudes towards persons with disabilities. Scores that range between 91 and 180 indicate accepting attitudes towards persons with disabilities.

Reliability and Validity. Yuker and Block (1986) reported that the ATDP has been utilized in over 325 studies, about 110 of them published in the 1980's. Thus, the reliability and validity of this scale has been widely tested and established. Four procedures have been used in assessing the reliability of the ATDP: test-retest reliability, split-half reliability, parallel-forms reliability, and stability-equivalence reliability.

Reliability. According to the test manual, the reliability coefficient of the ATDP Scale is .80 (Yuker, 1986). Within a six-week period, the test developers

conducted two investigations using the test-retest method to assess and determine reliability for the ATDP-B. Results yielded a range of values from .83 to .85 with a median of .84. The results of the test-retest method at 4 months for the ATDP-B reported a median of .71 (Yuker & Block, 1986).

Reliability of the ATDP-B was assessed using the split-half method across ten different studies. Using the split-half method, odd and even numbered items were scored separately. The results yielded reliability scores ranging from .72 to .91 with a median reliability coefficient of .82 (Yuker & Block, 1986). The reliability coefficients for the ATDP form B refer to, the extent to which measurements made with this instrument, are consistent. First, the test-retest measures of reliability range from .83 to .85 with a median of .84. Then, the split-half method reliability range from .72 to .91 with a median of .82. Next, the parallel-forms correlations range from a low of .57 to a high of .83 with the medians clustering around .68. And finally, the stability-equivalent reliability correlations range from .41 to .76 with a median for forms A and B of .73 and .83 for forms O and B (Yuker & Block, 1986).

Validity. Most test manuals report various types of validity, chief among them are content validity, predictive validity, concurrent validity, and construct validity. The researchers reported construct validity for this measure. They indicate that construct validity is the most meaningful and basic type of validity. Construct validity is based on a theory that postulates a set of associations between an instrument and other variables. According to the test manual, all

three forms (O, A, and B) of the ATDP are valid with disabled and able bodied populations. This instrument correlates highly with other instruments that measure attitudes toward the disabled population. The median validity of the ATDP correlation is .80, consistent with the reliability median of .80. The validity median correlation of .80 is present when correlated with other instruments of similar length. Additionally, the test manual reports that the correlations range from .19 to .34 when the instruments are different. Correlations average +.32 with instruments that measure attitudes toward specific disabilities, for example blindness. The +.32 correlation suggests common variance and infers that there are differences between attitudes toward disabled people and attitudes toward individuals with specific disabilities. The researchers established convergent validity by correlating the ATDP with other instruments that measure attitudes toward persons with disabilities. Individual correlations of validity ranged from .98 to .09. The relationships were predicted to be positive, negative, and orthogonal. Because most of the predictions were confirmed, the ATDP may be considered a valid measure of attitudes toward disabled persons (Yuker & Block, 1986). Finally, according to the test manual, the ATDP's validity has been established through its wide acceptance and use. The ATDP scale is often referred to as the preferred tool to measure attitudes toward the disabled population.

Instructions ATDP-B Modified. Participants were asked to complete all thirty items on the ATDP-B (Modified) with a rating that corresponds to their feelings about persons who are blind or visually impaired. Participants answered

+3 I agree very much, +2 I agree pretty much, +1 I agree a little: or -1 I disagree a little, -2 I disagree pretty much, -3 I disagree very much.

Scoring. According to the test manual, the ATDP requires four steps for scoring:

1. Use positive or negative to change the sign of some of the test items on form B. The researcher changed item answers on items *1, *3, *4, *6, *7, *10, *12, *13, *22, *26, and *28 from negative to positive or from positive to negative, for example when scoring, change -3 to +3 or +2 to -2 on questions *4 and *28.
2. Total all items including the changed starred items.
3. Change the sign of the sum to positive or negative, for example change -47 to +47 or +42 to -42, then add to the constant in step four.
4. The final step required that a constant of 90 points be added to the negative or positive sum. The yield is a resulting theoretical ATDP-B score that ranges from 0 to 180, for example $+47 + 90 = 137$ ATDP-B score, or $-42 + 90 = 48$ ATDP-B score (Yuker & Block, 1986).

Relatively high scores indicate accepting attitudes toward persons with disabilities and relatively low scores indicate negative attitudes toward disabled people.

3.6 CDP Scale

The Contact with Disabled Persons scale was developed by Yuker and Hurley, 1987. According to the researchers, there was no psychometrically adequate instrument for measuring contact with disabled persons in existence at the time of development. The CDP scale was developed to provide a unidimensional instrument that is psychometrically adequate. The CDP scale is a 20 item questionnaire that measures contact with disabled persons without regard to associated attitudes. Participants indicate their response on a Likert scale indicating their level of contact with disabled persons, from 1 never, 2 once or twice, 3 a few times, 4 often, or 5 very often.

Range. The CDP scores range between 20 and 100. Scores that range between 20 and 60 indicate low contact. And, scores that range between 61 and 100 indicate high contact.

Reliability. The test developers reported that reliability data was collected from over 200 people. They reported a corrected median split-half reliability coefficient of .93 and report a median alpha coefficient of .92.

Validity. The researchers reported that validity was examined by correlating CDP scores with scores on the Attitude Towards Disabled Persons Scale. The developers reported ten correlation coefficients ranging from $-.26$ to $+.40$ with a median correlation of $+.10$ for this instrument. They report that the strength of the coefficients were weakened or attenuated due to the limited scores on either the CDP or the ATDP. Further, the developers maintain that the

range of correlations indicates the complexity of the association between contact and attitudes toward the disabled population. The CDP Scale was created to offer a reliable and valid assessment quality and quantity of an individual's prior contact with persons who are disabled. According to the test developers it is appropriate and valid to change the term disabled to a specific disability, for example blind.

Instructions for the CDP Modified. Participants were asked to choose an answer between 1 and 5. The numbers indicated the following: 1 = never; 2 = once or twice; 3 = a few times; 4 = often; 5 = very often.

Scoring. According to Yuker and Hurley, 1987, scores on the CDP scale can range from 20 to 100. The low score 20 indicates a total lack of contact while the high score of 100 indicates the maximum amount of contact. Both negative and positive items are scored the same. The researcher summed the items. The total indicates the CDP score. The CDP measures the extent of contact with disabled persons rather than whether that contact is positive or negative. Higher scores reflect greater contact while lower scores reflect less contact.

According to Yuker and Hurley, 1987, correlations between the CDP scale and the ATDP scale are moderate, but expected. They indicate that the moderate correlation is consistent with prior research that suggests that although contact with disabled people is a dominant influence on attitudes toward this population, other factors such as education and information are equally important

variables (Yuker & Hurley, 1987). The developers maintain that the CDP scale is a reliable, valid and useful assessment of intergroup contact.

3.7 Materials

Informed Consent. Participants completed the informed consent agreement by clicking “I agree”.

Demographic Data. Participants. The participants completed the demographic data form by indicating or typing their answers.

Surveys. Participants completed a modified versions of the ATDP-B and the CDP scales online by choosing the answers they agreed with.

3.8 Data Collection/Procedures

The 300 participants accessed the study’s website at ceres.cals.ncsu.edu/nationalcounselor. They were presented with the national counselor’s welcome page. To participate in this study, counselors in training clicked on the link “informed consent agreement.” Then, the participants agreed to the informed consent form, and completed the demographic data form, the modified versions of the ATDP-B and the CDP scales. These completed materials were collected by the principal investigator via the online website, ceres.cals.ncsu.edu/nationalcounselor. Colleagues and professors associated with the principal investigator and the dissertation committee members were recruited to encourage counselors in training to participate in this national study. Directors of CACREP approved counselor education programs from around the nation were contacted via email by the principal investigator to recruit research

participants. The directors of counselor education programs were sent a national counselor invitation.

3.9 Design

This investigation assessed counselors in training attitudes towards and contact with persons who are blind or visually impaired. This study used a correlation and a comparative research design.

3.10 Data Analysis

The hypotheses were tested at the .05 level of significance. The data was analyzed with the statistical software package for the Social Sciences, SPSS. A Pearson correlation coefficient was computed to infer the relationships between the variables for the first hypothesis. The Pearson correlation coefficient is the most commonly used correlation statistic. The strength and direction of the linear relationship between two variables is measured by this statistical correlation. The Pearson correlation coefficient is a number that ranges between -1 and +1 which measures both the strength and the direction of the relationship between two variables.

The strength of the correlation is indicated and represented by the magnitude of the number. No relationship is indicated by a correlation coefficient of zero. Conversely, a perfect correlation is represented by a correlation coefficient of -1 or +1. The direction of the correlation is indicated by the signs (+/-). A positive direction, indicated by a positive (+) sign means that an increase on one variable suggests that there is a tendency for the other variable to

increase. A negative coefficient represented by the negative (-) sign means and suggests that as values on one variable increase, values on the other tend to decrease, meaning, they tend to go in opposite directions (Anastasi, 1988).

An Analysis of Variance (ANOVA) and Independent Sample t test were computed to test the differences between the variables. The Independent Samples t test compared the mean scores of the groups on the variable. The t test assessed whether the means of 2 of the variable groups differed from each other. The analysis of variance was used to determine the degree of difference or similarity between two or more of the variable groups.

CHAPTER 4

Results

Chapter 4 reports the significant results of this nationwide counselor study, which investigated counselor attitudes towards persons who are blind or visually impaired. The data was anonymously collected online, from counselors in training, in CACREP approved counselor education programs, across the nation via the study's website, <http://ceres.cals.ncsu.edu/nationalcounselor>. There were 300 counselors in training that participated in this investigation. A correlation, Analysis of Variance (ANOVA's), and independent sample t test were computed to test the hypotheses. The variables included the graduate status, the involvement/experience, the type involvement/work experience, the gender, the race, the disability status, and the blindness education of counselors in training. These variables were tested against the Attitude Toward Persons with Disabilities-B scale (ATDP-B) and the Contact with Disabled Persons (CDP) scale. A 95% confidence interval was used throughout this investigation (alpha level .05). The ATDP-B and CDP means results are reported first in the descriptive table for 4.1.

Descriptive Statistics

4.1 ATDP-B & CDP Means

Table 4.1 below displays the mean ATDP-B and CDP results for the variables. The ATDP-B means and the CDP means show that the 300 counselor in training participants held rejecting attitudes and had low to no contact with persons who are blind or visually impaired. The mean ATDP-B score was 63.13 indicating rejecting attitudes held by counselors in training towards persons who are blind or visually impaired, and the mean CDP score was 36.39 indicating low contact by counselors in training with members of this population.

Secondly, master's participants had a higher ATDP-B mean than PhD participants did. However, PhD participants had a slightly higher CDP score than master's participants. It appears that participants with higher attitude scores had lower contact scores, and those with lower attitude scores had higher contact scores. Therefore, as attitudes increased in a positive direction, contact appeared to have decreased. Alternatively, as participant contact with this population increased, their attitudes appeared to have decreased in a negative direction.

Next, in the involvement/experience variable, participants who had no experience with persons who are blind or visually impaired, had the highest ATDP-B mean score, while participants who had direct personal/intimate involvement had next to the lowest ATDP-B score. The next highest ATDP-B mean score was in the casual/incidental category. Moreover, the lowest ATDP-B

mean score was work associated. It appears that counselors in training who had no experience with people who are blind or visually impaired had higher attitudes than those with direct personal/intimate involvement.

Next, work associated contact had the highest CDP mean and no experience had the lowest contact mean. Direct personal/intimate and casual/incidental followed the highest contact score. As expected, those with greater contact had higher CDP scores than those with no experience with persons who are blind. Additionally, as attitudes increased contact decreased, and as contact increased attitudes decreased.

Next, the item for type of involvement/work experience had four categories. The highest attitude mean was no work experience and the lowest ATDP-B mean was as an employee. Colleague/coworker and supervisor/employer ATDP-B means followed the highest category in terms of their ATDP-B means. The lowest attitude score and contact score was in the category, as an employee for each. As attitude increased for participants in the as supervisor/employer category, contact scores also increased. It appears that counselors in training had better attitudes when they had no work experience than when they had experience working as an employee for persons who are blind or visually impaired. Finally, the participants appeared to have greater contact and higher attitude scores when they were in authority, than they were subordinate to members of this population.

Next, in the item for gender, the female participants had higher ATDP-B mean scores than the male participants did. However, the male participants had higher CDP mean scores than the female participants. As attitudes increased, contact decreased, and as attitudes decreased, contact increased.

Then, in the item for age, there were four groups. Participants in the 51 and above age group had higher ATDP-B mean and CDP mean scores than any other age group. Participants in the 29 and younger and 41 to 50 age groups had similar attitude scores. The lowest attitude score was found in the age group 30 to 40. Next, the lowest CDP mean was in the age group 41 to 50. The next highest contact means age groups were 29 and younger and 30 to 40. It appears that as the age of participants increased, their attitude and contact increased with this population.

Next, the race item was also divided into 4 groups. Hispanic participants had the highest ATDP-B mean scores and the lowest CDP mean scores. Participants who were White or African American had the next highest mean scores on the ATDP-B and the CDP scales. While the Asian, Indian, and other group participants had the lowest score on the ATDP-B, they had the highest mean score on the CDP scale. With the Hispanic participants, as attitudes increased contact decreased. Conversely, with the Asian, Indian, and other group participants, as contact-increased attitudes decreased. The White and African American participants appeared to be constant in the hierarchy of attitude and contact means for the race groups.

Then, in the disability item, there were two groups. Participants with no disability had higher ATDP-B scores and lower contact scores than participants with a disability. Participants, who indicated that they had a disability, had lower attitude scores and higher contact scores. Consistent with the other means, as attitude increased contact decreased and as contact decreased attitude scores increased.

Finally, the blindness education item had two categories. The majority of the participants had no education about blindness in their graduate programs. They had higher ATDP-B scores than CDP scores and lower CDP scores than ATDP-B scores. The participants who had received education about blindness, in their academic programs, had lower attitude scores and higher contact scores. Again, as attitude scores increased, contact scores decreased. Conversely, as contact scores increased, attitude scores decreased.

Table 4.1 ATDP-B and CDP Means for the variables

Item	n	Percentage	ATDP-B <i>M</i>	CDP <i>M</i>
Correlation	300	100%	63.13	36.39
Graduate Status	300	100%	62.62	36.54
MS	215	72%	63.80	36.20
PhD	85	28%	61.44	36.88
Involvement/Experience	300	100%	61.24	37.52
1. None	102	34%	67.83	32.75
2. Casual/Incidental	113	38%	63.78	36.73
3. Work Associated	44	15%	55.36	40.77
4. Direct Personal/Intimate	41	14%	58.00	39.83
Type Involvement/Work Experience	300	100%	58.65	41.69
0. None	266	89%	64.02	35.70
1. As Employee	10	3%	55.00	33.30
2. As Colleague/Coworker	17	6%	55.29	40.47
3. As Supervisor/ Employer	7	2%	60.29	57.29
Gender	300	100%	63.04	37.31
Male	60	20%	62.87	38.83
Female	240	80%	63.20	35.78
Age	300	100%	63.94	38.46
1. 29-Younger	137	46%	64.41	35.55
2. 30-40	102	34%	60.28	36.11
3. 41-50	42	14%	64.21	34.90
4. 51-Above	19	6%	66.84	47.26
Race	300	100%	62.98	36.01
1. African American	43	14%	58.56	36.00
2. White	221	74%	63.61	36.62
3. Hispanic	20	7%	72.20	33.40
4. Asian, Indian, Other	16	5%	57.56	38.00
Disability	300	100%	57.58	38.61
No Disability	285	95%	63.75	36.14
Yes Disability	15	5%	51.40	41.07
Blindness Education	300	100%	62.65	37.13
No Blindness Education	201	67%	64.08	34.96
Yes Blindness Education	99	33%	61.21	39.30

Inferential Statistics

4.2 Correlation

Hypothesis: 1. There will be a positive correlation between counselors in training attitudes toward persons who are blind or visually impaired, and their degree of contact with this population, as measured by the ATDP-B and the CDP Scales.

Table 4.2 depicts the Pearson Correlation between ATDP-B and CDP scores. The researcher conducted a Pearson correlation with counselor ATDP-B and CDP scores to determine the relationship between counselors in training ($N=300$) attitudes and contact with persons who are blind or visually impaired. The participants had an mean ATDP-B score of 63.13, $M=63.13$, $SD=25.65$, and a mean CDP score of 36.39, $M=36.39$, $SD=16.81$. These scores indicate that counselors in training held rejecting attitudes and had low contact with persons are blind or visually impaired. The correlation was not significant, $r=-.08$, $p>.05$, $p=.16$. There was no significant association between counselor attitudes and contact with persons who are blind or visually impaired as measured by the ATDP-B and the CDP scales. This hypothesis was not confirmed.

Table 4.2 ATDP-B CDP Pearson Correlation

N	95% Confidence Interval		variance	Std error mean	SD	M	r	p
ATDP-B								
300	60.22	66.05	657.922	1.481	25.650	63.13	-.081	.16
CDP								
300	34.48	38.30	282.500	.970	16.808	36.39	-.081	.16

4.3 Graduate Status

Hypothesis: 2. There will be no difference due to the graduate school status (MS or PhD) of counselors in training in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B Scale.

Table 4.3 reports the ANOVA for graduate school status for the ATDP-B and CDP scores. The researcher conducted an ANOVA to determine the difference between the graduate school status (MS or PhD) of counselors in training in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B scale. The ANOVA result indicated no significant difference between graduate status and ATDP-B scores, $df=1$ ATDP-B, 298 CDP, $F=.52$, $p=.47$. There was no difference between the graduate school status of counselors in training and their attitudes towards persons who are blind or visually impaired, as measured by the ATDP-B scale. According to the ANOVA, this hypothesis was confirmed.

Table 4.3 Graduate Status ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B S within-group error	1	.52 (341.977)	341.977	.47
Within Participants				
ATDP-B Group error	298	(658.982)	196376.689	

Table 4.4 reports independent sample t test results for graduate school status and ATDP-B scores. The result of the t test indicated no significant difference between graduate school status and ATDP-B scores, $df=145.55$, $M=63.80$ MS, 61.44 Ph.D., $SD=25.18$ MS, 26.88 Ph.D., $t=.70$, $p=.49$. There was no statistically significant difference between the graduate school status of counselors in training and their attitudes towards persons who are blind or visually impaired. This hypothesis was confirmed.

Table 4.4 Graduate Status T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper	Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B									
MS	215	145.55	-4.318 9.056	1.717	2.369	25.18	63.80	.70	.49
Ph.D.	85			2.915		26.88	61.44		

4.4 Involvement/Experience

Hypothesis: 3. There will be a difference due to the involvement/experience (1. none, 2. casual/incidental, 3. work associated, or 4. direct personal/intimate) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.5 describes the ANOVA for counselor involvement/experience. The researcher conducted an ANOVA to determine the difference due to the involvement/experience (1. none, 2. casual/incidental, 3. work associated, or 4. direct personal/intimate) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. The ANOVA result indicated a significant difference between counselor involvement/experience and their ATDP-B and CDP scores, between group $df=3$ ATDP-B, 3 CDP; within group $df=296$ ATDP-B, 296 CDP: $F=3.12$ ATDP-B, 3.26 CDP, $p=.03$ ATDP-B, $p=.02$ CDP. There was a difference due to the involvement/experience of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales. According to the ANOVA, this hypothesis was confirmed.

Table 4.5 Involvement/Experience ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	3	3.12	6036.849	.03
CDP	3	3.26	2697.970	.02
S within-group error (ATDP-B)		(2012.283)		
error (CDP)		(899.323)		
Within Participants				
ATDP-B	296		190681.818	
CDP	296		81769.400	
Group error (ATDP-B)		(644.195)		
Group error (CDP)		(276.248)		

Table 4.6 reports results of the independent sample t test for involvement/experience groups 1 and 3 and ATDP-B and CDP scores. The ATDP-B $df=108.28$, $M=67.83$ 1. none, $M=55.36$ 3. work associated, $SD=26.85$ 1. none, $SD=19:06$ 3. work associated, $t=3.11$; the CDP $df=69.40$, $M=32.75$ 1. none, $M=40.77$ 3. work associated, $SD=15.32$ 2. none, $SD=18.58$ 3. work associated, $t=2.52$, the t test was significant at alpha .05, $p<.05$, $p=.002$ for ATDP-B and $p=.01$ for CDP. There was a difference due to the involvement/experience (1. none, 3. work associated) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. According to the independent sample t test, this hypothesis was confirmed.

Table 4.6 Involvement/Experience Groups 1 and 3 T Test

Group	n	df	95% Confidence Interval of the diff. Lower/Upper	Std Error M	Mean diff.	SD	M	t	p	
ATDP-B										
1. None	102	108.28	4.512	20.427	2.659	12.470	26.85	67.83	3.11	.002
3. Work Associated	44				3.008		19.96	55.36		
CDP										
1. None	102	69.40	-14.381	-1.675	1.517	-8.028	15.32	32.75	-2.52	.01
3. Work Associated	44				2.800		18.58	40.77		

Table 4.7 reports results of the independent sample t test for involvement/experience groups 1 and 4 and ATDP-B and CDP scores. The ATDP-B $t=1.81$, the CDP $t=-2.50$, the t test was not significant, $p=.07$ for ATDP-B and was significant for CDP, $p=.01$. According to the independent sample t test, this hypothesis was not confirmed with the ATDP-B ($p=.07$), however, this hypothesis was confirmed with the CDP ($p=.01$). There was no difference due to the involvement/experience (1. none, 4. direct personal/intimate) of counselors in training, in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B. Conversely, there was a significant difference due to the involvement/experience (1. none, 4. direct personal/intimate) of counselors in training, in their degree of contact with people who are blind or visually impaired, as measured by the CDP scale. This hypothesis was confirmed ($p=.01$).

Table 4.7 Involvement/Experience Groups1 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. None	102	66.639	-0.997	20.664	2.659	9.833	26.851	67.83	1.81	.07
4. Direct Personal /Intimate	41				4.729		30.283	58.00		
CDP										
1. None	102	74.010	12.722	-1.446	1.517	-7.084	15.321	32.75	-2.50	.01
4. Direct Personal /Intimate	41				2.388		15.294	39.83		

Table 4.8 reports results of the independent sample t test for involvement/experience groups 2 and 3 and ATDP-B and CDP scores. The ATDP-B $t=2.24$, the CDP $t=-1.25$, the t test was significant, $p=.03$ for ATDP-B and not significant for CDP, $p=.22$. There was not a difference due to the involvement/experience (2. casual/incidental, 3. work associated) of counselors in training, in their degree of contact with people who are blind or visually impaired, as measured by the CDP scale. According to the independent sample t test, this hypothesis was not confirmed with respect to the CDP ($p=.22$). However, there was a difference due to the involvement/experience (2. casual/incidental, 3. work associated) of counselors in training, in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B scale. According to the independent sample t test, this hypothesis was confirmed with the ATDP-B ($p=.03$).

Table 4.8 Involvement/Experience Groups 2 and 3 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
2. Causal/ Incidental	113	93.343	.956	15.874	2.250	8.415	23.916	63.78	2.24	.03
3. Work Associated	44				3.008		19.955	55.36		
CDP										
2. Causal/ Incidental	113	74.043	-10.509	2.415	1.636	-4.047	17.390	36.73	-1.25	.22
3. Work Associated	44				2.800		18.576	40.77		

4.5 Type of Involvement/Work Experience

Hypothesis: 4. There will be a difference due to the type of involvement/work experience (0. none, 1. as a employee, 2. as a colleague/co-worker, 3. as a supervisor/employer) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.9 describes the ANOVA for counselors in training type of involvement/work experience and ATDP-B and CDP scores. The researcher conducted an ANOVA to determine the difference between the type of involvement/work experience (0. None, 1. As an Employee, 2. As a Colleague/Co-Worker, or 3. As a Supervisor/Employer) of counselors in training, and their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. The ANOVA result indicated no significant difference between work experience and ATDP-B scores, $p=.39$. This hypothesis was not confirmed with respect to

counselor work experience and attitude towards people who are blind as measured by the ATDP-B scale. However, the ANOVA result indicated a significant difference between counselor work experience and CDP scores, $p=.01$. This hypothesis was confirmed with respect to counselor work experience and contact as measured by the CDP scale.

Table 4.9 Type Involvement/Work Experience ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	3	1.00	1969.769	.39
CDP	3	4.35	3563.272	.01
S within-group error (ATDP-B)		(656.590)		
error (CDP)		(1187.757)		
Within Participants				
ATDP-B	296		194748.898	
CDP	296		80904.098	
Group error (ATDP-B)		(657.935)		
Group error (CDP)		(273.325)		

4.6 Gender

Hypothesis: 5. There will be no difference due to the gender of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.10 reports the ANOVA result for gender and ATDP-B and CDP scores. The ANOVA results indicate no significant difference, $p=.93$ ATDP-B and $p=.21$ CDP. There was no difference due to the gender of counselors in training

in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. This hypothesis was confirmed.

Table 4.10 Gender ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	1	.01	5.333	.93
CDP	1	1.59	447.741	.21
S within-group error (ATDP-B)		(5.333)		
error (CDP)		(447.741)		
Within Participants				
ATDP-B	298		196713.333	
CDP	298		84019.629	
Group error ATDP-B		(660.112)		
Group error CDP		(281.945)		

Table 4.11 reports the independent sample t test for gender. There was no statistically significant difference between the gender of counselors in training and their attitudes towards or contact with persons who are blind or visually impaired as measured by the ATDP-B and the CDP scales, $df=97.96$ ATDP-B, $df=84.57$ CDP, $M=62.87$ Male ATDP-B, $M=63.20$ Female ATDP-B, $M=38.83$ Male CDP, $M=35.78$ Female CDP, $SD=23.75$ Male ATDP-B, $SD=26.15$ Female ATDP-B, $SD=18.21$ Male, CDP, $SD=16.42$ Female CDP, $t=97.96$ ATDP-B, $t=84.57$ CDP, $p=.92$ ATDP-B, $p=.24$ CDP. This hypothesis was confirmed.

Table 4.11 Gender T Test

Groups	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. Male	60	97.96	-7.279	6.612	3.066	-.333	23.75	62.87	97.96	.92
2. Female	240				1.688		26.15	63.20		
CDP										
1. Male	60	84.57	-2.074	8.182	2.351	3.054	18.21	38.83	84.57	.24
2. Female	240				1.060		16.42	35.78		

4.7 Age

Hypothesis: 6. There will be no difference due to the age (1. 30 – younger, 2. 31-40, 3. 41-50, or 4. 51-above) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.12 reports the ANOVA results for age and ATDP-B and CDP. The ANOVA results indicate no significant difference between the age of counselors in training and their attitudes towards people who are blind or visually impaired, $p=.56$ ATDP-B. This hypothesis was confirmed with respect to age and ATDP-B scores. The ANOVA results for age and CDP score indicated a statistically significant difference between the age of counselors in training and their contact with persons who are blind or visually impaired, $p= .03$ CDP. There was a significant difference between counselors' age and the amount of contact they had with persons who are blind or visually impaired. According to the ANOVA for age and CDP scores, this hypothesis was not confirmed.

Table 4.12 Age ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	3	.69	1361.205	.56
CDP	3	2.94	2444.311	.03
S within-group error ATDP-B		(453.735)		
error CDP		(814.770)		
Within Participants				
ATDP-B	296		195357.462	
CDP	296		82023.059	
Group error ATDP-B		(659.991)		
Group error CDP		(277.105)		

Table 4.13 reports the independent sample t test results for ATDP-B and CDP scores (groups 1. 29-younger and group 4. 52-above). The result indicated no significant difference between age and ATDP-B scores, $t=-.39$, $p=.70$ ATDP. This hypothesis was confirmed with respect to the ATDP-B scale. The result indicated a significant difference between age and contact scores, $t=-2.37$, $p=.03$ CDP. There was a significant difference between counselors' age and contact with the blind population. This hypothesis was not confirmed with respect to the CDP scale.

Table 4.13 Age Groups 1 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. 29-Younger	137	22.28	-15.343	10.477	1.988	-2.433	23.269	64.41	-.39	.70
4. 51-Above	19				5.904		25.734	66.84		
CDP										
1. 29-Younger	137	21.47	-22.005	-1.426	1.444	-11.716	16.896	35.55	-2.37	.03
4. 51-Above	19				4.739		20.658	47.26		

Table 4.14 reports the independent sample t test for age and ATDP-B and CDP (2. 30-40 and 4. 51-above). The result for ATDP-B and age indicated no difference between counselor age and attitude towards people who are blind or visually impaired $t=-1.01$, $p=.32$. This hypothesis was confirmed for age and ATDP-B. The result for CDP and age indicated a difference between counselor age and contact with persons who are blind or visually impaired $t=-2.23$, $p<.05$, $p=.04$. There was a statistically significant difference between the age of counselors in training and amount of contact they had with the blind population. According to the results, this hypothesis was not confirmed with respect to age and contact.

Table 4.14 Age Groups 2 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
2. 30-40	102	26.621	-19.955	6.839	2.778	-6.558	28.058	60.28	-1.01	.32
4. 51-Above	19				5.904		25.734	66.84		
CDP										
2. 30-40	102	22.273	-21.520	-.790	1.598	-11.155	16.137	36.11	-2.23	.04
4. 51-Above	19				4.739		20.658	47.26		

Table 4.15 reports the independent sample t test results for age and ATDP-B and CDP scores (age groups 3 and 4). The results for ATDP-B were not significant $t=-.36$, $p>.05$, $p=.72$. This hypothesis was confirmed with respect to age and attitude. The results for CDP were significant $t=-2.34$, $p<.05$, $p=.03$. There was a significant difference between age and contact for counselors in training with the blind population. According to the results, this hypothesis was not confirmed with respect to counselor age and contact with the blind population.

Table 4.15 Age Groups 3 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
3. 41-50	42	36.652	-17.306	12.050	4.194	-2.628	27.179	64.21	-.363	.719
4. 51-Above	19				5.904		25.734	66.84		
CDP										
3. 41-50	42	26.926	-23.180	-1.536	2.313	-12.358	14.991	34.90	-2.343	.027
4. 51-Above	19				4.739		20.658	47.26		

4.8 Race

Hypothesis: 7. There will be no difference due to the race of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.16 reports the ANOVA results for race and ATDP-B and CDP scores. There was no statistically significant difference between the race of counselors in training and their attitudes towards and contact with persons who are blind or visually impaired as measured by the ATDP-B and the CDP scales. The ANOVA results indicated no significant difference at alpha .05, $p > .05$, $p = \text{ATDP-B } .20$, $p = \text{CDP } .84$. This hypothesis was confirmed.

Table 4.16 Race ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	3	1.575	3090.173	.20
CDP	3	.279	238.498	.84
S within-group		(1030.058)		
error ATDP-B		(79.499)		
error CDP				
Within Participants				
ATDP-B	296		193628.493	
CDP	296		84228.872	
Group error		(654.150)		
ATDP-B				
Group error		(284.557)		
CDP				

Table 4.17 reports the independent sample t test for race groups (1. Black/African American and 2. White). The t test results indicated no statistical significant $t=-1.06$ ATDP-B, $t=-.23$ CDP; $p=.30$ ATDP-B, $p=.82$ CDP. This hypothesis was confirmed.

Table 4.17 Race Groups 1 and 2 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. Black	43	53.711			4.481	-5.048	29.386	58.56	-1.06	.30
2. White	221		-14.612	4.515	1.633		4.273	63.61		
CDP										
1. Black	43	62.687			2.418	-.620	15.855	36.00	-.23	.82
2. White	221		-5.974	4.734	1.154		17.153	36.62		

Table 4.18 reports the independent sample t test for race groups (1. Black/African American and 3. Hispanic). The t test results indicated no statistical significant $t=-1.63$ ATDP-B, $t=.68$ CDP; $p=.11$ ATDP-B, $p=.50$ CDP. This hypothesis was confirmed.

Table 4.18 Race Groups 1 and 3 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. Black	43	34.813			4.481	-13.642	29.386	58.56	-1.63	.11
3, Hispanic	20		-30.630	3.347	7.065		31.597	72.20		
CDP										
1. Black	43	44.375			2.418	2.600	15.855	36.00	.68	.50
3, Hispanic	20		-5.055	10.255	2.930		13.104	33.40		

Table 4.19 reports the independent sample t test for race groups (1. Black/African American and 4. Other). The t test results indicated no statistical significant $t=.13$ ATDP-B, $t=-.37$ CDP; $p=.90$ ATDP-B, $p=.72$ CDP. This hypothesis was confirmed.

Table 4.19 Race Groups 1 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. Black/AA	43	32.515	-14.321	16.313	4.481	.996	29.386	58.56	.13	.90
4. Other	16				6.044		24.177	57.56		
CDP										
1. Black/AA	43	22.831	-13.241	9.241	2.418	-2.000	15.855	36.00	-.37	.72
4. Other	16				4.864		19.456	38.00		

Table 4.20 reports the independent sample t test for race groups (2. White and 3. Hispanic). The t test results indicated no statistical significant $t=-1.19$ ATDP-B, $t=1.02$ CDP; $p=.25$ ATDP-B, $p=.32$ CDP. This hypothesis was confirmed.

Table 4.20 Race Groups 2 and 3 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
2. White	221	21.078			1.633	-8.594	24.273	63.61	-1.19	.25
3. Hispanic	20		-23.671	6.483	7.065		31.597	72.20		
CDP										
2. White	221	25.296			1.154	3.220	17.153	36.62	1.02	.32
3. Hispanic	20		-3.262	9.702	2.930		13.104	33.40		

Table 4.21 reports the independent sample t test for race groups (2. White and 4. Other). The t test results indicated no statistical significant $t=.97$ ATDP-B, $t=-.28$ CDP; $p=.35$ ATDP-B, $p=.79$ CDP. This hypothesis was confirmed.

Table 4.21 Race Groups 2 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
2. White	221	17.263	-7.150	18.421	1.633	6.044	24.273	63.61	.97	.35
4. Other	16				6.044		24.177	57.56		
CDP										
2. White	221	16.732			1.154	-1.380	17.153	36.62	-.28	.79
4. Other	16		-11.940	9.180	4.864		19.456	38.00		

Table 4.22 reports the independent sample t test for race groups (3. Hispanic and 4. Other). The t test results indicated no statistical significant $t=1.57$ ATDP-B, $t=-.81$ CDP; $p=.13$ ATDP-B, $p=.43$ CDP. This hypothesis was confirmed.

Table 4.22 Race Groups 3 and 4 T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
3. Hispanic	20	33.952			7.065	14.638	31.597	72.20	1.57	.13
4. Other	16		-4.259	33.534	6.044		24.177	57.56		
CDP										
3. Hispanic	20	25.239			2.930	-4.600	13.104	33.40	-.81	.43
4. Other	16		-16.289	7.089	4.864		19.456	38.00		

4.9 Disability Status

Hypothesis: 8. There will be no difference due to the disability status (disabled or non-disabled) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.23 reports the ANOVA for disability and ATDP-B and CDP. The ANOVA results indicated no significant difference between the disability status of counselors in training and their scores on the ATDP-B and CDP scales, $p > .05$, $p = \text{ATDP-B } .07$, and $p = \text{CDP } .27$. This hypothesis was confirmed.

Table 4.23 Disability Status ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	1	3.330	2173.754	.07
CDP	1	1.223	345.335	.27
S within-group error ATDP-B		(2173.754)		
error CDP		(345.335)		
Within Participants				
ATDP-B	298		194544.912	
CDP	298		84122.035	
Group error ATDP-B		(652.835)		
Group error CDP		(282.289)		

Table 4.24 reports the independent sample t for disability and ATDP-B and CDP. The CDP results indicated no significant difference between counselor disability status and contact with people who are blind as measured by the CDP, $t = -1.02$, $p > .05$, $p = .32$. There was no difference as to the counselors in

training disability status and their contact with persons who are blind or visually impaired. This hypothesis was confirmed. Conversely, the ATDP-B results were significant, $t=2.67$, $p<.05$, $p=.02$. There was a statistically significant difference between the disability status of counselors in training and their attitudes towards blind or visually impaired people as measured by the ATDP-B. According to the independent sample t test, this hypothesis was not confirmed with respect to disability status and attitude.

Table 4.24 Disability Status T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. No Disability	285	2.671			1.534	12.351	25.903	63.75	2.67	.02
2. Yes Disability	15		2.623	22.079	4.362		16.894	51.40		
CDP										
1. No Disability	285	-1.019			.991	-4.923	16.724	36.14	-1.02	.32
2. Yes Disability	15		-13.682	3.836	4.727		18.309	41.07		

4.10 Blindness Education

Hypothesis: 9. There will be a difference due to the blindness education (1. no blindness education or 2. yes blindness education) of counselors in training and their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

Table 4.25 reports the ANOVA for blindness education. The results indicated no statistical significants with blindness education and ATDP-B scores, $p=.36$. This hypothesis was not confirmed with attitudes and blindness education. However, the results indicated a statistically significant difference between contact and blindness education, $p=.04$. This hypothesis was confirmed with counselor in training contact with persons who are blind or visually impaired and their blindness education.

Table 4.25 Blindness Education ANOVA

Source	df	F	η	p
Between Participants				
ATDP-B	1	.828	545.395	.36
CDP	1	4.490	1253.864	.04
S within-group error ATDP-B		(545.395)		
error CDP		(1253.864)		
Within Participants				
ATDP-B	298		196173.272	
CDP	298		83213.506	
Group error ATDP-B		(658.300)		
Group error CDP		(279.240)		

Table 4.26 reports the independent sample t test for blindness education. The t test results indicated no statistical significant difference between attitudes and blindness education, $t=.89$, $p=.38$ ATDP-B. This hypothesis was not confirmed as to blindness education and attitudes. However, the results indicated a statistically significant difference between contact and blindness education, $t=-2.01$, $p=.04$ CDP. This hypothesis was confirmed with contact and blindness education. Counselors in training showed a difference between their contact scores on the CDP scale and the amount of blindness education they had received.

Table 4.26 Blindness Education T Test

Group	<i>n</i>	<i>df</i>	95% Confidence Interval of the diff. Lower/Upper		Std Error Mean	Mean diff.	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
ATDP-B										
1. No B/E	201	183.410			1.767	2.867	25.046	64.08	.89	.38
2. Yes B/E	99		-3.498	9.233	2.700		26.863	61.21		
CDP										
1. No B/E	201	169.417			1.110	-4.348	15.736	34.96	-2.01	.04
2. Yes B/E	99		-8.630	-.066	1.863		18.541	39.30		

CHAPTER 5

Discussion

The principal investigator conducted this national counselor study to examine counselor attitudes towards persons who are blind or visually impaired. The majority of the counselors in training in this investigation were found to hold negative attitudes and to have had low contact with persons who are blind or visually impaired.

Counselor attitudes and contact were measured by the Attitudes Toward Persons with Disabilities Scale (ATDP form B) and the Contact with Disabled Persons Scale (CDP) (Yuker & Block, 1986; Yuker & Hurley, 1987). First, the Attitudes Towards Disabled Persons Scale form B (ATDP-B), scores range between 0 and 180. Secondly, rejecting attitude scores, towards people who are blind or visually impaired, range between 0 and 90. Finally, accepting attitude scores, towards people who are blind or visually impaired, range between 91 and 180. Then, the Contact with Disabled Persons (CDP), scores range between 20 and 100. Next, low contact scores with people who are blind or visually impaired range between 20 and 60, and finally, high contact scores with this population range between 61 and 100. The results found that counselors in training had an ATDP-B mean score of 63.13 and a CDP mean score of 36.39 for the 300 participants. These findings are consistent with generally negative attitudes and low contact based on avoidance behaviors towards blind or visually impaired people, found in the general culture (Yuker & Block, 1986).

Additionally, the counselors in training ATDP-B means in this study, fall drastically below the normative ATDP-B means found in 83 studies, reported by Yuker and Block, 1986. These researchers reviewed 83 studies that used the ATDP form B. They found that the ATDP-B mean scores ranged between 102.0-126.6 for females and 87.6-126.8 for males. The CDP was normed with 238 participants with a mean score of 60.33 (Yuker & Hurley, 1987). The difference in these findings may be explained by the difference in the degree of contact, involvement, familiarity and education that participants had with persons with disabilities. Where Yuker and Block, 1986, and Yuker and Hurley, 1987, normed their data with professional rehabilitation counselors and rehabilitation counselors in training, the counselors in training in this study, may not have had the same level of exposure with people who are blind, visually impaired or disabled.

Additionally, respondents indicated little to no academic training that would prepare them to work effectively with this population. Among the 300 participants in this study, 201 (67%) indicated that they received no blindness education in their academic programs. The remaining 99 participants (33%) indicated that they had received some blindness education within their academic programs, (see Table 4.1). In the blindness education category, the mean ATDP-B score was 64.08 and the mean CDP score was 34.96 for participants who indicated that they had received no education about blindness. For the participants who indicated that they had received education about blindness, the mean ATDP-B score was 61.21 and the mean CDP score was 39.30. While the contact scores

improved for respondents who received formal blindness education in their academic programs, the attitudes score did not improve. Respondents who received education about blindness had a lower ATDP-B score (61.21) than respondents who indicated no blindness education (64.08).

Nevertheless, participants with or without formal academic blindness education had rejecting attitude scores on the ATDP-B (63.13) and low to no contact scores on the CDP (36.39), which suggests that the current level of blindness education in Counselor Education programs is inadequate to prepare counselors in training to advocate for and work effectively with this population. In addition, the current blindness education received by counselors in training, has not served as an impetus to move counselors in training from rejecting attitudes and low contact with persons who are blind or visually impaired, to accepting attitudes and more contact with this population.

Negative attitude scores and low contact scores suggest that counselors in training are not familiar with persons who are blind or visually impaired. They may hold fears, misconceptions and biases towards this group. Because of their lack of contact and negative attitudes, they may not see members of this population as whole persons. They may not see them as complete and valuable members of the human family. Counselors, who hold negative attitudes towards potential client populations, may impair their own prescience. Blinded by negative attitudes, they may not see the hope and the glory of blind and visually impaired people.

From a theoretical perspective, counselors that hold rejecting attitudes toward persons who are blind or visually impaired, may view these individuals from a negative expectancy paradigm, such as the deficit, functional limitations, or minority perspective toward disability (Jones & Koestler, 1983; Jones, 1996). These views tend to focus upon the negative aspects of disability, as oppose to emphasizing the assets of individuals. Drawing from the possibilities of more positive theoretical frameworks such as Erickson's psychosocial development model, Cross' Negresence model, and Marcia's identity status model, the researcher offers a blind identity development model, (Walker Blind Identity Development Model, WBID), which may serve as an alternative perspective on the process of identity development for blind or visually impaired people, (see Appendix M Emerging Theories). This model may offer counselors a more constructive way of viewing members of this population, and contribute to the counseling relationship. Counselors may be able to view their clients who are blind or visually impaired, in dynamic and multi-dimensional ways, at different stages of their development, along a continuum, from adjustment, to dependence, to independence, to interdependence, rather than viewing visually impaired clients from the perspective of static negative attitudes and unexamined biases.

Moreover, the professional counseling relationship exists for the benefit of the client. Due to the sometimes byzantine, didactic, and dynamic eclectic application of psychological theory and the complex structure and nature of the

therapeutic interaction, the counseling relationship becomes a critical concern. In light of negative associated counselor expectations of persons with vision loss, the counseling relationship must be examined. Counselors who hold negative attitudes and biases towards their clients, distort and impair the therapeutic relationship (Cory, 1991). Poor blindness education, few opportunities to interact with this population, along with generally negative misperceptions about blind people in the environment, may contribute and be associated with negative attitudes.

The counseling relationship is the most important element in therapy. The expectation of the counselor toward the client, if negative, may influence or direct the application and the use of theory, and not allow growth-producing therapeutic relationships to form (Corey, 1991). Without a conscious awareness of unconscious biases and negative attitudes held towards persons who are blind or visually impaired, counselors could unwittingly obstruct their clients change and hamper their growth (Corey, 1991). Regardless of the counseling theory or intervention used, without positive accepting attitudes towards persons who are blind or visually impaired, counselors could limit their effectiveness with their visually impaired clients. Counseling interventions such as interventions that produce affective change, cognitive change, behavioral change, and interventions that produce social systems change, have limited utility if the counseling expectation and the counseling relationship is defective (Cormier & Hackney, 1993).

Based on professional literature associated with expectancy theory, counselor expectations and perceptions of clients who are blind or visually impaired may impact the process and outcome of therapy (Vroom, 1964; Highlen & Hill, 1984; Strohmer, Shivy, & Chiodo, 1990). Blind or visually impaired clients who come to counseling may be marginalized and vulnerable. However, they may have positive valence but low expectations of realistic positive outcomes. If counselors hold low expectations of people who are blind (negative valence), by virtue of rejecting attitudes held towards members of the blind population, desired therapeutic outcomes may be out of reach.

Intentional counselors must establish rapport, empathy, and trust, to have an effective working relationship with their clients that promote growth and change (Cory, 1991). Moreover, counselor expectations may play a large part in directing therapeutic outcomes. According to expectancy theory, valence is associated with behavior, attitude and outcome. There are three types of valence: negative valence, low expectations and belief that a chosen outcome cannot be achieved, therefore, minimum effort is expended, zero valence, outcomes in which we are indifferent to, and positive valence, outcomes we desire because there exists a high expectation that outcomes can be achieved, effort is readily extended (Vroom, 1964). Counselors who hold negative attitudes towards persons who are blind or visually impaired may have negative valence or negative expectations. These negative counselor expectations may contaminate the therapeutic relationship and lead to outcomes that are less than desirable.

Conversely, positive attitudes may reflect positive valence, thereby contributing to more effective therapy and more favorable outcomes (Corey, 1991; Vroom, 1964).

Without positive valence or positive counselor expectations, counselors may establish process rapport, process empathy, and process trust in the counseling relationship, instead of genuine authentic rapport, authentic empathy, and authentic trust, which is essential to effective counseling interventions. Process rapport, process empathy, and process trust, refer to the establishment of necessary elements in the counseling relationship that facilitate the technical migration through the process of counseling, but dilute desired outcomes, without effective change.

Conversely, authentic rapport, authentic empathy, and authentic trust, refer to the establishment of those necessary elements, in the counseling relationship, that facilitate the process of counseling, and promote effective change. Table 5.1 depicts counselor expectancy with negative valence, and Table 5.2 reflects counselor expectancy with positive valence.

Table 5.1 Counselor Expectancy: Negative Valence

Outcome = Process Rapport + Process Empathy + Process Trust
 Less than favorable

Table 5.2 Counselor Expectancy: Positive Valence

Outcome = Authentic Rapport + Authentic Empathy + Authentic Trust
 Favorable

Findings

First, the results in this study found no correlation between counselors in training and their attitudes toward and contact with persons who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. In addition, hypothesis one stated that there would be a positive correlation between counselors in training attitudes toward persons who are blind or visually impaired, and their degree of contact with this population, as measured by the ATDP-B and the CDP Scales. Although hypothesis one was not confirmed, the 300 counselors in training were found to have negative attitudes toward and have little to no contact with the 21.2 million individuals in the United States who live with vision loss. (afb.org).

These findings are consistent with generally negative attitudes found in society towards persons who are blind or disabled. The blind or disabled population tends to be marginalized and isolated in society. Therefore, opportunities for counselors in training to have contact with this population may be limited. Finally, these findings may reflect traditionally stereotypically negative views and attitudes held by people who are sighted toward persons who are blind or visually impaired (Ferguson, 2001; Goffman, 1963; Vaughan, 1998).

Next, the second hypothesis stated that there would be no difference due to the graduate school status (MS or PhD) of counselors in training in their attitudes toward people who are blind or visually impaired, as measured by the ATDP-B Scale. This hypothesis was confirmed. According to the ATDP-B scale,

these scores indicated rejecting attitudes towards members of the visually impaired population. Graduate school status was not an indicator of attitudes towards members of this population. Stigmatized views towards people who are blind or visually impaired held by persons who are sighted may explain these findings (Goffman, 1963).

Thirdly, hypothesis three stated that there would be a difference due to the involvement/experience (1. none, 2. casual/incidental, 3. work associated, or 4. direct personal/intimate) of counselors in training, in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. The results found a statistically significant difference between experience or level of involvement that counselors in training had with persons who have vision loss. These findings showed that the significant groups were 1. none and 3. work associated; 1. none and 4. direct personal/intimate; 2. casual/incidental and 3. work associated. This hypothesis was confirmed. Counselor attitudes were impacted with greater contact with this population, even though the contact score was below 60 and the attitude score was below 90.

First, the mean ATDP-B score for involvement/experience 1. none was rejecting and the mean CDP score was low, and the mean ATDP-B score for 3. work associated was negative and the mean CDP score was low. These scores indicated that counselors in training had negative attitudes and little to no contact with the visually impaired population. Additionally, although the majority of the

counselors in training had little to no work associated involvement with persons who are blind or visually impaired, they maintain negative attitudes towards this population. This may reflect unexamined biases that could be harmful to this population. Secondly, the mean ATDP-B score for 1. none was negative and the mean CDP score was low; the mean ATDP-B score for 4. direct personal/intimate was rejecting and the mean CDP score was low. Similarly, these scores indicate that the majority of counselors in training had negative attitudes and little to no direct personal or intimate contact with any person who was blind or visually impaired. These findings show that the counselors in training in this study are ill prepared to counsel with this population. Thirdly, the mean ATDP-B score for 2. casual/incidental was rejecting and the mean CDP score was low; the mean ATDP-B score for 3. work associated was negative and the mean CDP score was low. These findings also indicate that counselors in training had rejecting attitudes and little to no contact with this population. Finally, these findings show that counselors in training could benefit from greater contact and awareness of this population, in order to prepare and service them.

In conjunction, hypothesis three was confirmed with respect to contact and type of involvement/work experience. This hypothesis was not confirmed with respect to attitude and type of involvement work experience. In the type of experience work associated category, 1. as an employee and 3. as a supervisor/employer were significant. According to these findings, there was a difference when counselors in training had contact with persons who are blind or

visually impaired in the work environment. Because attitude and contact scores remain negative and low, these findings show that, the type of involvement with blind and visually impaired people in the work place alone was not enough to improve attitudes towards this population.

Next, the fifth hypothesis investigated the difference between the gender of counselors in training and their attitudes toward and contact with persons who are blind or visually impaired, as measured by the ATDP-B and CDP scales. The hypothesis stated that there would be no difference due to the gender of counselors in training and their attitudes toward and contact with persons who are blind or visually impaired, as measured by the ATDP-B and CDP scales. The results found no significant difference between attitude scores and contact scores. This hypothesis was confirmed. Gender was not found to be significant with respect to the gender of counselors in training and their attitudes toward and contact with members of this population. However, ATDP-B scores and CDP scores continued to reflect rejecting attitudes and little to no contact by counselors in training with persons who are blind or visually impaired in this study.

Then, hypothesis six stated that there would be no difference due to the age (1. 29 – younger, 2. 30-40, 3. 41-50, and 4. 51-above) of counselors in training in their attitudes toward and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. The ANOVA results for the age of counselors in training with ATDP-B and CDP

scores were rejecting and low indicating no statistically significant difference between age and attitudes. This hypothesis was confirmed as associated with attitudes and age. The age of counselors in training did not make a difference in the attitudes that they held towards the blind population. ATDP-B scores indicated that counselors in training held rejecting attitudes towards persons who are blind or visually impaired regardless to their age. However, there was a statistically significant difference between counselors in training age and their contact with persons who are blind or visually impaired. According to the ANOVA for age and CDP scores, this hypothesis was not confirmed as it relates to contact with this population. As age increased, contact appeared to increase.

Next, when independent t test were conducted to determine if there was no difference between counselors in training age and their ATDP-B and CDP scores, there were three significant age groups: 1. 29-younger & 4. 51-above; 2. 30-40 & 4. 51-above, and 3. 41-50 & 4. 51-above. There was no statistically significant difference found between attitude and age groups 1 & 4, 2 & 4, and 3 & 4. This hypothesis was confirmed with age and attitude scores for age groups 1 & 4, 2 & 4, and 3 & 4. There was no difference as to the age of counselors in training and their attitudes towards persons who are blind or visually impaired. Age was not a factor in determining the attitudes held by counselors in training towards this population. Conversely, the age and CDP scores were significant for age groups 1 & 4, 2 & 4, and 3 & 4. There was a difference found between contact scores and age groups 1 & 4, 2 & 4, and 3 & 4. This hypothesis was not

confirmed with respect to age and contact scores for age groups 1 & 4, 2 & 4, and 3 & 4.

Even though statistical significance was found with age and CDP scores for counselors in training, the mean scores on the ATDP-B and CDP scales for all age groups remained suppressed. For age group one: age 29 & younger and 51 & above, for age group two: age 30 to 40 and 51 & above, and for age group three: age 41 to 50 and 51 & above, the ATDP-B means were negative and the CDP means were low across each group. These findings show that the age of counselors in training was not associated with positive attitudes or a high degree of contact with members of this population. Counselors in training continued to have little to no contact and rejecting attitudes towards visually impaired persons across the constructs.

Next, hypothesis seven stated that there would be no difference due to the race of counselors in training in their attitudes toward and degree of contact with persons who are blind or visually impaired, as measured by the ATDP-B and the CDP scales. The results found no significant difference with respect to the race of counselors in training and their attitudes toward and contact with members of this population. This hypothesis was confirmed. Race was not found to be a factor with respect to counselors in training attitudes toward or contact with this group. Rejecting attitudes and low to no contact with persons who are blind or visually impaired, continued to be an issue for counselors in training in this study.

Subsequently, hypothesis eight stated that there would be no difference due to the disability status (disabled or non-disabled) of counselors in training in their attitudes towards and degree of contact with people who are blind or visually impaired, as measured by the ATDP-B and the CDP Scales.

The ANOVA results indicated no significant difference between the disability status of counselors in training and their scores on the ATDP-B and CDP scales. The disability status of counselors in training made no difference on their attitudes held or contact with members of the blind population. This hypothesis was confirmed.

Similarly, the independent sample t for disability and CDP findings indicated no significant difference between counselor disability status and contact with people who are blind as measured by the CDP. Disability status was not a factor in determining the amount of contact that counselors in training had with this population. This hypothesis was confirmed with respect to disability status and contact scores. Conversely, the findings showed that the ATDP-B results were significant. According to these findings, this hypothesis was not confirmed with respect to disability status and attitude. There was no difference found between disability status and attitudes held towards this population. The 285 (95%) participants who indicated that they had no disability, had a mean ATDP-B score that was rejecting and a mean CDP score that was low. The 15 (5%) participants that indicated that they had a disability, had a mean ATDP-B score that was negative and a mean CDP score that was low. These findings indicate

that attitude scores remained negative and contact scores remained low in all categories. According to these findings, the disability status of counselors in training was not associated with attitudes toward or contact with persons who are blind or visually impaired. In addition, these findings show that the counselors in training in this study, held stereotypically negative attitudes towards members of this population (Goffman, 1963). Moreover, counselors in training had limited contact, if any, with persons who are blind or visually impaired.

Finally, among the 300 counselors in training investigated in this study, 201 (67%) indicated that they received no blindness educational training, and 99 (33%) indicated that they had received some blindness educational training. The mean attitude and contact scores of counselors in training who had no blindness education was rejecting and low. The mean score for counselors in training who had received blindness education was also negative and low. These findings show that whether counselors in training received educational training associated with the blind population or not, their scores remained low on both the ATDP-B and the CDP scales.

In addition, hypothesis nine stated that there would be a difference between blindness education and counselors in training attitudes towards and contact with persons who are blind or visually impaired, as measured by the ATDP-B and CDP scales. The results of the ANOVA were mixed. Whereas, attitude scores were not significant for blindness education and the hypothesis was not confirmed, contact and blindness education was significant, and the

hypothesis was confirmed. The findings show that there was no difference due to attitudes and blindness education, but a statistically significant difference between contact and blindness education was found.

Similarly, the independent sample t test results were mixed. The results found no statistically significant difference between attitudes and blindness education. This hypothesis was not confirmed. However, there was a statistically significant difference between contact scores and blindness education. This hypothesis was confirmed as it relates to contact and blindness education. Nevertheless, the findings show that counselors in training held negative attitudes and had very little contact with persons who are blind or visually impaired.

These findings are alarming in terms of counselor preparedness to work with the visually impaired population. Education about the visually impaired population appeared to be negligible. Although, tremendous effort has been expended to prepare counselors in training to be multi-culturally competent, there appears to be a paucity of educational effort when it comes to blind or visually impaired persons in the nationally accredited counselor education programs.

Overall, these findings showed that the majority of counselors in training in this study, held negative attitudes towards and had little to no contact with members of the blind or visually impaired population. Attitudes and contact scores remained negative and low across all the variables. Although statistically

significant, no meaningful difference was found between counselors in training attitudes and their contact with the blind or visually impaired population. The graduate status, involvement/experience, type involvement/work experience, gender, age, race, disability status, or blindness education of the counselors in training, in this study were not found to be worthwhile factors in determining counselor attitudes or contact with this population. There was no correlation between attitude scores and contact scores for counselors in training as associated with those who live with vision loss. The lack of education about blindness, visual impairment, and persons who live with vision loss, may also be one of the most important findings and opportunities in this study.

The primary issue appears to be the difference between persons who are sighted and their attitudes towards persons who are blind or visually impaired. The counselors in training in this study were predominately sighted and had little to no knowledge about persons who are blind or visually impaired beyond myths, stereotypes, and misconceptions found in the general population. Education about persons who live with blindness or visual impairment could serve as an impetus to ameliorate some of the fears and negative attitudes that counselors in training hold towards this population. Integrating information and data about persons who are blind or visually impaired into counselor education program curriculum is essential to prepare counselors to effectively service this population. The potential for harm exist when counselors hold negative attitudes towards their clients. The findings in this study run counter to conventional

wisdom, about counselors and those who choose to train as counseling professionals, in terms of their attitudes held towards members of the blind population. Due to the potential generalizability of the findings in this study, caution is advised for counselors in training and counselors, if serving members of the blind or visually impaired population.

Limitations

Counselors in training nationwide were studied anonymously, via the world wide web. Due to the confidentiality and anonymous agreement with the participants in this study, the researcher was limited as to identifiable information about the participants. Information associated with the counselor education program, and university in which participants were enrolled, was not collected or available to the investigator. Caution is advised when generalizing the findings of this study.

Among the universe of counselors in training, enrolled in the approximately 270 CACREP approved counselor education programs, and universities across the nation, 300 participants, may be potentially considered a low response rate. Even though, the anonymity of the participants was protected, response bias is always a recommended caution when analyzing self-reported survey data. The findings showed that the majority of counselors in training in this study, attitudes and contact with the visually impaired population were rejecting and low. However, this study was a survey, not an actual

observation of counselor behavior in practice. Therefore, caution is advised in terms of generalizing these results to all counselors.

Data was collected about whether or not counselors in training received any blindness education or training about visually impaired people, in their academic programs. This investigation is limited as to the amount, type, or duration of the training received. Further, the level of disability awareness in general was not investigated.

Implications

The findings of this national counselor study show that counselors in training are unfamiliar with persons who are blind or visually impaired. They also show that counselors in training may not have dealt with their own unfinished business and biases towards this population. The implications of this study may call for attention to be given to counselors in training attitudes and contact with the blind and visually impaired population in the area of policy, education, and practice. Policy institutions and organizations should consider strengthening standards as it relates to the requirement of more effective education about persons who are blind, visually impaired or disabled. From a multicultural prospective, counselor education programs should consider strengthening course work and guest lecture opportunities, as a matter of required education for counselors in training. In practice, counselors should continuously receive training and seek out opportunities for professional development and continuing education in the areas of blindness and low vision.

Counselors in training indicate a willingness and a desire to help people by virtue of choosing counseling as a profession. They are uniquely situated to be effective advocates and change agents for this population, with the proper training and awareness. Disability awareness training is strongly suggested for counselors in training. Based upon the number of participants in this study, these findings show an interest on the part of counselors in training for more information in education about persons living with vision loss.

This study offers and makes a contribution to the professional literature as it relates to attitudes towards and contact with people who are blind or visually impaired. Further, the findings in this study call attention to an area of need in counselor education programs, practice, and policy. The findings in the study present an opportunity to strengthen disability awareness in counselor education programs across the nation.

Future Research

Finally, future research might investigate the impact of blindness education on counselors in training in terms of their attitudes towards persons who are blind or visually impaired. In addition, future research might also investigate the impact of a disability awareness course about blindness and blind people, and the impact on the attitudes of counselors in training. Moreover, opportunities for counselors in training to interact with persons who are blind or visually impaired may be extended and studied. Additionally, future research may investigate professional counselors in practice in terms of attitudes towards and contact with persons with vision loss.

REFERENCES

- Albrecht G. Walker V. Levy J. Social distance from the stigmatized: a test of two theories. *Soc Sci Med.* 1982;16:1319–1327.
- Allen, M. (1990). Adjusting to visual impairment. *Journal of Ophthalmic Nursing & Technology.* v9 47-51.
- American Foundation for the Blind, (2007). Blindness Statistics
<http://www.afb.org/section.asp?sectionID=15#content> Retrieved September 30, 2007.
- American Foundation for the Blind, (2008).
<http://www.afb.org/Section.asp?SectionID=15&DocumentID=4398>
Retrieved September 20, 2008.
- Anastasi, A. (1988). *Psychological Testing Sixth Edition.* Prentice Hall, New Jersey.
- Antonak, R. F., & Livneh, H. (1988). *The measurement of attitudes toward people with disabilities.* Springfield: Charles C. Thomas.
- Asch, A., & Rousso, H. (1985). Therapists with disabilities: theoretical and clinical issues. *Psychiatry.* 48. 1-12.
- Atkinson, D. R., & Hackett, G. (Eds.). (1988). *Counseling non-ethnic american minorities.* Springfield: Thomas.
- Aubrey, R. F., & Lewis, J. (1983). Social issues and the counseling profession in the 1980s and 1990s. *Counseling and Human Development,* (10), 1-15.

- Authorized King James Version. (1977). Holy Bible Heritage Edition Langley Park, Maryland: International Bible, Inc.
- Battle, C. U. (1984). Disruptions in the socialization of a young, severely handicapped child. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological and social impact of disability (2nd ed.) (pp. 67-85). New York: Springer.
- Bauman, M. K. & Yoder, N. M. (1966). Analysis of employer interviews. In Placing the blind and visually handicapped in clerical and service Fields. Washington, DC: Department of HEW.
- Belgntve, F. (1984). The effectiveness of strategies for increasing social interaction with a physically impaired person, Journal of Applied Social Psychology, 14, 147-161.
- Biklen, D. (1988). The myth of clinical judgment. Journal of Social Issues, 44, 127-140.
- Black, D.E. (1970). The hiring policies of selected Iowa businesses and industries with respect to employment of blind persons. Doctoral Dissertation, University Microfilms. Inc. Arbor, Michigan.
- Blank, P. D. (1991). The emerging work force: empirical study of the Americans with disabilities act. The Journal of Corporation Law, 16, 693-801.
- Block and Young, 1070 - Must find
- Carlton, C. M., & Maxwell, R. N. (1987). Counseling physically challenged men. In M. Scher, M. Stevens, G. Good, & G. A. Eichenfield (Eds.), Handbook

- of counseling and psychotherapy with men (pp. 360-371). Newbury Park: Sage.
- Carney, J., & Cobia, D.C. (1995). Relations of characteristics of counselors-in-training to their attitudes toward persons with disabilities. Rehabilitation Counseling Bulletin. 38. 72-76.
- Carter-Davis, M. J. (2000). College students with learning disabilities: questioning the deficit model. Doctoral dissertation. North Carolina State University. Raleigh, North Carolina.
- Cholden, L.S. (1958), A Psychiatrist Works with Blindness. Selected Papers By Louis S. Cholden, M.D. New York: The American Foundation for the Blind, 119 pp.
- Chubon, R. A. (1982). An analysis of research dealing with the attitudes of professionals toward disability. Journal of Rehabilitation. 48. 25-30.
- Cimarolli, V. R., & Boerner, K. (2005). Social support and well-being in adults who are visually impaired, Journal of Visual Impairment and Blindness, 99.
- Cobb, H. C., & Brown, D. T. (1987). Counseling and psychotherapy with handicapped children and adolescents. In H. T. Prout, & D. T. Brown (Eds.), Counseling and psychotherapy with children and adolescents: theory and practice for school and clinic settings (pp. 391-424). Brandon, Vermont: Clinical Psychology Publishing Company.

- Comer, R. J. & Piliavin, J. A., (1975) The effects of physical deviance upon face interaction: the other side. Journal of Personality and Social Psychology, 23, 67-69.
- Constantine, M. G., (2002) Racism attitudes, white racial identity attitudes, and multicultural counseling competence in school counselor trainees. *Counselor Education and Supervision*, v41, n3, 162-174.
- Cook, D. (1992). Psychosocial impact of disability. In R. M. Parker & E. D. Szymanski (Eds.), Rehabilitation Counseling: Basics and Beyond. Austin, IX: Pro-Ed, Inc.
- Cook, D. (1998). Psychosocial impact of disability, 3rd edition. Editor Randall M. Parker, Alston, Texas.
- Cook, D. W., Kunce, J. T., & Getsinger, S. H. (1976). Perceptions of the disabled and counseling effectiveness. Rehabilitation Counseling Bulletin. 20. 470-475.
- Cormier, L. S., & Hackney, H. (1993). The professional counselor: A process guide to helping (2nd ed.). Needham Heights, MA: Allyn & Bacon.
- Cross, W. E. (1971). Negro-to-Black conversion experience. Black World, 20, 13-27.
- Cross, W. E. (1991). Shades of black: Diversity in African-American Identity. Philadelphia: Temple University Press.

- Dale, B. (1992). Issues in traumatic blindness. *Journal of Visual Impairment and Blindness*. V86(3X 140-142.
- Danforth, S. (2001). A pragmatic evaluation of three models of disability in special education, *Journal of Developmental and Physical Disabilities*, vol. 13, no. 4.
- Davis, L. (1997). Constructing normalcy. The Disability Studies. New York, New York: Rutledge.
- Dixon, J. P. (1983). The spatial child. Springfield, IL: Charles C. Thomas.
- Dodd, A., Ferguson, E. (1994). The Concept of Adjustment: A Structural Model, Vol. 88, Issue 6.
- Dodds, A.G., Bailey, P., Pearson, A., & Yates, L. (1991). Psychological factors in acquired visual impairment: the development of a scale of adjustment. Journal of Visual Impairment and Blindness. v85(7). 306-310.
- Eddy, E. M. (1990). Clinical decision making: From theory to practice -anatomy of a decision. Journal of the American Medical Association. 263. 441-443.
- Elliott, T. R., Frank, R. G., & Brownlee-Duffeck, M. (1988). Clinical inferences about depression and physical disability. Professional Psychology: Research and Practice. 19. 206-210.
- Elston, R. R., & Snow, B. M. (1986). Attitudes toward people with disabilities as expressed by rehabilitation professionals. Rehabilitation Counseling Bulletin. 30. 284-286.

- Enright, M.S., Conyer, L.M. & Szymanski, E.M. (1996). Career and career-related educational concerns of college students with disabilities. Journal of Counseling & Development. 75. 103-114.
- Erikson, E. H. (1974) Dimensions of a New Identity: The 1973 Jefferson Lectures. New York: W.W. Norton.
- Erikson, J. M. (1997) The Life Cycle Completed Extended Version with New Chapters on the Ninth Stage of Development, New York: W. W. Norton
- Esses, V. M., & Beaufoy, S. L. (1994). Determinants of attitudes toward people with disabilities. Journal of Social Behavior and Personality. 9,. 43-64.
- Evans, R. L., & Dingus, Q. M. (1987). Serving the vulnerable: models for treatment of loneliness. Journal of Social Behavior and Personality. 2., 249-256.
- Fenderson, D. A. (1984). Opportunities for psychologists in disability research. American Psychologist. 39. 524-528.
- Ferguson, R. J. (2001). *We know who we are, a history of the blind in challenging educational and socially constructed policies, a study in policy archeology*, Gaddo Gap Press, San Francisco, CA.
- Fichten, C.S., & Amsel, R. (1986). Trait attributions about college students with a physical disability: Circumplex analyses and methodological issues. Journal of Applied Social Psychology, 16, 410-427.

- Garske, G. G., & Thomas, K. R. (1990). The relationship of self-esteem and contact to attitudes of students in rehabilitation counseling toward persons with disabilities. Rehabilitation Counseling Bulletin. 34, 67-71.
- Gething, L. (1991). Generality versus specificity of attitudes toward people with disabilities, British Journal of Medical Psychology. 64, 55-64.
- Giarratana-Oehler, J. (1976). Personal and professional reactions to blindness from diabetic retinopathy. New Outlook for the Blind. v7Q(6). 237-239.
- Goffman, E. (1963). Stigma, notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Goodyear, R. K. (1983). Patterns of counselors' attitudes toward disability groups. Rehabilitation Counseling Bulletin. 27, 181-184.
- Gordon, P. A., Lam, C. S., & Winter, R. (1997). Interaction strain and persons with Multiple Sclerosis: Effectiveness of a social skills program. Journal of Applied Rehabilitation Counseling. 28, 5-11.
- Griffith, E., Trieschmann, R. B., Hohmann, G. W., Cole, T. M., Tobis, J. S., & Cummings, V. (1984). Sexual dysfunctions associated with physical disabilities. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological and social impact of disability (2nd ed.) (pp. 220-232). New York: Springer.
- Harlan, S. L. & Robert, O. M. (1998). The social construction of disability in organizations: why employers often fervently resist reasonable accommodation. Work and Occupations, 25, 397-399.

- Harvey, M. A. (1989) . Psychotherapy with deaf and hard-of-hearing persons: a systemic model. Hillsdale, New Jersey: Erlbaum.
- Highlen, P. S., & Hill, C. E. (1984). Factors affecting client change in individual counseling: Current status and theoretical speculations. In S. D. Brown & R. W. Lent (Eds.), The handbook of counseling psychology. New York: John Wiley.
- Hohenshil, T. H., & Humes, C. W. (1988). Roles of counseling in ensuring the rights of the handicapped. In D. R. Atkinson, & G. Rackett (Eds.), Counseling non-ethnic american minorities (pp. 133-150). Springfield: Thomas.
- Hohmann, G. W. (1984). Reactions of the individual with a disability complicated by a sexual problem. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological & social impact of physical disability (2nd ed.) (pp. 223-224). New York: Springer.
- Hopkins-Best, M. (1987). The effect of students' sex and disability on counselors' agreement with postsecondary career goals. The School Counselor. 35. 28-33.
- Horner, D., Vandersluis, K., Alexander, A. A., Bashey, H., Clarke, C., & Peterson, D. (1984). Cross-cultural counseling. In G. Althen (Ed.), Learning Across Cultures (pp. 30-50), Washington, DC: National Association for Foreign Student Affairs.

- Huitt, K., & Elston, R. R. (1991). Attitudes toward persons with disabilities expressed by professional counselors. Journal of Applied Rehabilitation Counseling. 22. 42-43.
- Hulnick, M. R., & Hulnick, H. R. (1989). Life's challenges: curse or opportunity? Counseling families of persons with disabilities. Journal of Counseling & Development. 68. 166-170.
- Humes, C. W., Szymanski, E. M., & Hosenshil, T. H. (1989). Roles of counseling in enabling persons with disabilities. Journal of Counseling & Development. 68, 145-150. Springer.
- Jones, R. & Koestler, F.A. (1983). Breaking traditions: education and career opportunities for blind and visually impaired women. Journal of Visual Impairment and Blindness. 77. 271-294.
- Jones, S. R. (1996). Toward inclusive theory: Disability as social construction. NASPA Journal 33(4). 347-354.
- Jureidini, J. (1988). Psychotherapeutic implications of severe physical disability. American Journal of Psychotherapy. 62. 297-307.
- Kaplan, S. (1982). Rehabilitation counselor's attitudes toward their clients. Journal of Rehabilitation, 18(4), 28-30.
- Katz, I., Glass, R. G., & Bailey, J. (1988). Attitudinal ambivalence and behavior toward people with disabilities. In H. E. Yuker (Ed.), Attitudes toward persons with disabilities (pp. 47-57). New York: Springer.

- Kemp, N.J. (1981). Social psychological aspects of blindness: a review. Current Psychological Reviews. VI(I), 69-89.
- Kleinschmidt, J. J. (1999). Older adults' perspectives on their successful adjustment to vision loss. *Journal of Visual Impairment and Blindness*, 93, 69-81.
- Ladieu-Leviton, G., Adler, D. L., & Dembo, T. (1984). Studies in adjustment to visible injuries: social acceptance of the injured. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological and social impact of disability (2nd ed.) (pp. 148-155). New York: Springer.
- Lefebvre, A. M., & Arndt, E. M. (1988). Working with facially disfigured children: a challenge in prevention. Canadian Journal of Psychiatry. 33. 453-458.
- Livneh, H. (1988). A dimensional perspective on the origin of negative attitudes toward persons with disabilities. In H. E. Yuker (Ed.), Attitudes Toward Persons with Disabilities (pp. 35-46). New York, NY: Springer.
- Lombana, J. H. (1989). Counseling persons with disabilities: Summary and projections. Journal of Counseling & Development. 68. 177-179.
- Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. Psychological Bulletin. 106.184-203.
- Lowenfeld, B. (1957). The visually handicapped child in school. New York: The John Day Company.

- Makas, E. (1988). Positive attitudes toward disabled people: Disabled and nondisabled persons' perspectives. *Journal of Social Issues*, 44, 49-61.
- Marinelli, R. P., & Dell-Orto, A. E. (1999). The Psychological and Social Impact of Disability (4th ed.). New York: Springer.
- Matthews, G. F. (1983). Voices from the shadows; women with disabilities speak out. Toronto: Women's Educational Press.
- Matson, F. (1990). Walking alone and marching together: a history of the organized blind movement in the united states. 1940-1990. Baltimore, Maryland: National Federation of the Blind.
- McBroom, L. W. (1995). Transition to work following graduation from college: experiences of employees with visual impairments and their employers. Mississippi State University. Mississippi State Rehabilitation Research and Training Center on Blindness and Low Vision, p. 91.
- McDowell, W. A., Coven, A. B., & Eash, V. C. (1984). The handicapped: special needs and strategies for counseling. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological impact of physical disability (2nd ed.) (pp. 279-287). New York: Springer.
- Miller, M. (1992). The effects of disability-related information on employment decisions regarding persons with disabilities. (Doctoral dissertation. University of Oregon, 1992), Dissertation Abstracts international.

- Morrow, K. A., & Deidan, C. T. (1992). Bias in the counseling process: How to recognize and avoid it Journal of Counseling and Development. 70. 571-577.
- Nathanson, R. (1979). Counseling persons with disabilities: are the feelings, thoughts, and behaviors of helping professionals helpful? Personnel and Guidance Journal. 58., 233-237.
- National Federation of the Blind (2007). Voice of the Nation's Blind <http://www.nfb.org/default.asp> Retrieved September 30, 2007.
- Newman, J. (1976). Faculty attitudes toward handicapped students. Rehabilitation Literature. v37n7. 195-197.
- Pagan, T. K., & Jenkins, W. M. (1989). People with disabilities: an update. Journal of Counseling & Development. 68. 140-144.
- Pagan, T. K., & Wallace, A. (1988). Who are the handicapped? In D. R. Atkinson, & G. Hackett (Eds.), Counseling non-ethnic american minorities (pp. 117-132). Springfield: Thomas.
- Palmerton, K. E., & Frumkin, R. M. (1969a). College counselors' attitudes toward education considered a determinant of attitudes toward disabled persons Perceptual and Motor Skills. 28. 441-442.
- Palmerton, K. E., & Frumkin, R. M. (1969b). College counselor knowledge about and attitudes toward disabled persons. Perceptual and Motor Skills. 657-658.

- Parloff, M. B. (1967). Goals in psychotherapy: Mediating and ultimate. In A. R. Mahrer (Ed.), *The goals of psychotherapy*, pp. 5-19. Englewood Cliffs, NJ: Prentice-Hall.
- Patterson, J.B. & Witten, B. (1986). Myths concerning persons with disabilities. *Journal of Applied Rehabilitation Counseling*. 18. 42-44.
- Pavot, W. G. & Diener, E. (1993). Review of the satisfaction with life scale, *Psychological Assessment*, 5, pp. 164-172).
- Pedersen, P. (1976). The field of intercultural counseling. In P. Pedersen, W. J. Lonner, & J. G. Draguns (Eds.), Counseling across cultures (pp. 17-41). Honolulu: East-West Center, University of Hawaii.
- Pedersen, P. (1988). *A handbook for developing multicultural awareness*. Alexandria: American Association for Counseling and Development.
- Prevention of blindness and priorities for the future (2008)
[whqlibdoc.who.int/bulletin/2001/issue3/79\(3\)244-248.pdf](http://whqlibdoc.who.int/bulletin/2001/issue3/79(3)244-248.pdf) Retrieved September 19, 2008.
- Ponterotto, J. & Casas, M. (1991) Handbook of racial ethnic minor selling research. Springfield, IL: Charles C. Thomas.
- Rogers, C.R. (1951). Client-centered therapy. Boston: Houghton Mifflin.
- Rumrill, P. D., Millington, M. J., Webb, J. M., & Cook, B. G. (1998). Employment expectations as a differential indicator of attitudes toward people with insulin-dependent diabetes mellitus. Journal of Vocational Rehabilitation. 10. 271-280.

- Saramago, J. (1997) *Blindness*, translated from the Portuguese by Giovanni Pontiero from the 1995 *Ensaio sobre a Cegueira*. London: The Harvill Press, 1997
- Scott, D. S. (1981). Living with a physical handicap. In J. A. Downey, G. Riedel, & A. H. Kutscher (Eds.), Bereavement of physical disability; recommitment to life, health and function (pp. 148-150). New York: Arnold
- Scott, R. A. (1969). The making of blind men. A study of rehabilitation socialization, New York: Russell Sage Foundation.
- Shontz, F. C. (1984). Psychological adjustment to physical disability: trends in theories. In R. P. Marinelli, & A. E. Dell Orto (Eds.), The psychological and social impact of disability (2nd ed.) (pp. 39-63). New York: Springer.
- Siller, J. & Chapman, A. (1967). Attitudes of nondisabled toward the physically disabled. New York: New York University School of Education.
- Siller, J. & Chapman, A. (1970). Attitudes of nondisabled toward the physically disabled. New York: New York University School of Education.
- Stovall, C., & Sedlacek, W.E. (1981). Attitudes of male and female university students towards students with different physical disabilities. Maryland University. Counseling Center. Research Report No. 10-81. p. 15.
- Stovall, C., & Sedlacek, W. E. (1983). Attitudes of male and female university students toward students with different physical disabilities. Journal of College Student Personnel. v24. 325-330. York: New York University School of Education.

- Strohmer, D., Shivy, V., & Chiodo, A. (1990). Information processing strategies in counselor hypothesis testing: The role of selective memory and expectancy. *Journal of counseling psychology*, 37, 465-472.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992) Multicultural counseling competencies and standards: a call to the profession, Journal of Counseling & Development, v70. 477-485.
- Sue, D. W., & Sue, D. (1990). Counseling the culturally different (2nd ed.). New York: Wiley.
- Swain, J., French, S., and Cameron, C., (2003), Controversial Issues In A Disabling Society. Buckingham Open University Press.
- Telford, C. W., & Sawrey, J. M. (1977). The exceptional individual (3rd ed.). Englewood Cliffs: Prentice-Hall.
- Thomas, K., & Althen, G. (1989). Counseling foreign students. In P. Pedersen, J. Draguns, W. Lonner, & J. Trimble (Eds.), Counseling Across Cultures (pp. 205-241). Honolulu: East-West Center, University of Hawaii.
- Thomas, K. R. & Siller, J. (1999) Object loss, mourning, and adjustment to disability, *Psychoanalytic Psychology*, v16, 179-197.
- Thoreson, R. W. & Kerr, B. A. (1978). The stigmatizing aspects of severe disability: strategies for change. Journal of Applied Rehabilitation Counseling, 2, 21-26.

- Tringo, J. L. (1970). The hierarchy of preference toward disability groups. Journal of special education, 4, 295-306.
- Triandis, H. C. (1995). Individualism and collectivism, Boulder: CO, Wetview Press.
- Tuttle, D. W. (1984) Sources of Self-Esteem and the Adjusting Process, Springfield, Thomas, University of Northern Colorado, Greelev, Colorado
- Van-Hesselt, V.B. (1983). Social adaptation in the blind. *Clinical Psychological Review*. v3(1). 87-102.
- Vaughan, C. E. (1998). Social and cultural perspectives on blindness barriers to community integration. Springfield, Illinois: Thomas.
- Wacker, C.H. (1984). The socioeconomic of the blind male breadwinner. Journal of Visual Impairment and Blindness; v78 n3. p. 106.
- Wagner-Lampl, A. & Oliver, G.W. (1994). Folklore of blindness. Journal of Visual Impairment & Blindness, 267-276.
- Walker, C. L. (1999). Attitudinal barriers and the impact on the psychosocial identity development of adventitiously blind adults. Unpublished manuscript, North Carolina State University at Raleigh.
- Walker, C. L. (2001). Attitudinal barriers: Impact on the psychosocial identity development of blind adults. Unpublished manuscript, North Carolina University at Raleigh.
- Wallach, M. S., & Strupp, H. H. (1960). Psychotherapists' clinical judgments and attitudes toward patients. Journal of Counseling Psychology. 24. 316-323.

- Wang, V., & Rogolsky, S. (1970). Rehabilitation work with the blind; role of the helping professional in creating a family team. Cooperative Extension Services. University of Maryland, College Park, Maryland. P.22.
- Weiner, B. (1993). On sin versus sickness: A theory of perceived responsibility and social motivation. American Psychologist. 48, 957-965.
- Wiseman, R.L., Emry, R.A., & Morgan, D. (1988). Predicting academic success for disabled students in higher education. *Research in Higher Education*, 28, 255-269.
- World Health Organization (2004). Magnitude and causes of visual impairment <http://who.int/mediacentre/factsheets/fs282/en/> Retrieved September 30, 2007
- Wright, B. A. (1983). Physical Disability: A Psychosocial Approach. New York: Harper & Row.
- Wright, B. A. (1998). Attitudes and the fundamental negative bias: conditions and corrections. In H. E. Yuker (Ed.), Attitudes toward persons with disabilities (pp. 3-21). New York: Springer.
- Wright, T. J. (1988). Enhancing the professional preparation of rehabilitation counselors for improved services to ethnic minorities with disabilities. Journal of Applied Rehabilitation Counseling. 9(4), 4-10.
- Wyatt, G. G., & Parham, W. D. (1985), The inclusion of culturally sensitive course materials in graduate school and training programs. *Psychotherapy*, 22, 461-468.

- Yuker, H. E. (1994). Variables that influence attitudes toward people with disabilities. Journal of Social Behavior and Personality. 9. 3-22.
- Yuker, H. E. & Block, J. R. (1986) attitudes toward disabled persons scale manual, Yuker Research Center, Hofstra University, Hempstead, New York.
- Yuker, H. E., Block, J. R., & Campbell, W. J. (1960). A. scale to measure attitudes toward disabled persons (Human Resources Study No. 5). Albertson. New York: Human Resources Center.
- Yuker, H. E., Block, J. R., & Young, J. H. (1970). The measurement of attitudes toward disabled persons (Human Resources Study No. 3). Albertson, New York: Human Resources Center.
- Yuker and Hurley 1987 - Must Find
- Zola, I. K. (1984). Communication barriers between "the able-bodied" and "the handicapped." In R. P. Marinelli & A. E. Dell Orto (Eds.), The psychological impact of physical disability (2nd ed.) (pp. 139-147). New York: Springer.

APPENDICES

IRB EXEMPTION

From: "Joe Rabiega" <jrabieg@gw.fis.ncsu.edu>
To: <cwalker4@nc.rr.com>
Sent: Thursday, January 17, 2008 12:35 PM
Subject: IRB Exemption

Dear Mr. Walker,

The IRB has received and reviewed your protocol submission. After administrative review, the IRB office determined that the study is exempt from the federal regulations outlined in 45CFR46, which relate to the protection of human subjects, and qualifies for administrative approval. The study does not require further IRB review. If you make any changes to the study, you will need to contact the IRB office prior to implementing them. An official letter declaring the study exempt from 45CFR46, and administratively approving the study, is attached to this email. If you have any further questions, feel free to call me at 919.515.7515.

Thanks,

Joe

Joe Rabiega
IRB Coordinator
North Carolina State University
2701 Sullivan Drive, Room 245
Raleigh, NC 27695-7514
Telephone: 919- 515-7515
Fax: 919-515-7721

Appendix B

IRB APPROVAL

North Carolina State University is a land-grant
university and a constituent institution of
The University of North Carolina
Sponsored Programs and
Regulatory Compliance
Campus Box 7514
2701 Sullivan Drive
Raleigh, NC 27695-7514
919.515.2444
919.515.7721 (fax)

From: Joseph Rabięga, IRB Coordinator
North Carolina State University
Institutional Review Board

Date: January 17, 2008

Project Title: Counselor Attitudes Toward Persons Who Are Blind or Visually Impaired

IRB#: 20-08-01

Dear Mr. Walker:

The research proposal named above has received administrative review and has been approved as exempt from the policy as outlined in the Code of Federal Regulations (Exemption: 46.101.b.2). Provided that the only participation of the subjects is as described in the proposal narrative, this project is exempt from further review.

NOTE:

1. This committee complies with requirements found in Title 45 part 46 of The Code of Federal Regulations. For NCSU projects, the Assurance Number is: FWA00003429.
2. Review de novo of this proposal is necessary if any alterations/additions are made.

Sincerely,

Joseph Rabięga
NCSU IRB

HOFSTRA UNIVERSITY CORRESPONDENCE

From: "Ruth Mangels" <Ruth.Mangels@hofstra.edu>
To: "Walker" <walker4@nc.rr.com>
Sent: Thursday, October 12, 2006 12:42 PM
Subject: Re: ATDP

Dear Charles:

Thanks you for your e-mail regarding our monograph. You do not need our permission to use the Attitudes Towards Disabled Persons monograph as the monograph is in public domain. In reference to obtaining the monograph (which lists the forms O, A, or B) as well as scoring, reliability and validity information, you may obtain the monograph from the Psychology Dept. for \$10.00, payable to Hofstra University. The monograph contains valuable information regarding scales and the interpretation of the scales. The monograph contains 87 pages. Let me know what you wish to do and also let me know the subject of your dissertation. I like to mail you, under separate, some print outs, free of charge. Should you decide to request the monograph, please address your request to: Ms. Ruth Mangels, Yucker Research Center, Psych. Dept. Hauser Hall, Room 222, Hofstra University, Hempstead, NY 1154-91350. Hope to hear from you.
 All the best with your dissertation.

Ruth Mangels
 Yucker Research Center
 Psychology Dept.

>>> "Walker" <walker4@nc.rr.com> 10/08/06 2:24 PM >>>

Ms. Mangels,

My name is Charles Walker. I am a graduate student in the Department of Counselor Education at North Carolina State University. My dissertation research will include the Attitudes Towards Disabled Persons Scale developed by Yucker. It has been brought to my attention that your university is associated with this instrument. I am attempting to obtain the test manual and the test forms O, A, or B, as well as any permission needed to use the Attitudes Towards Disabled Persons Scale in my research. Please reply to me with any information or instructions that you may have regarding this request.

With kindest Regard
 Charles L. Walker
 walker4@nc.rr.com

INSTRUMENTS REQUEST

14 October 2006

Ms. Ruth Mangels
Hofstra University
Yuker Research Center
Psych. Dept. Hauser Hall
Room 222,
Hempstead, NY 1154-91350

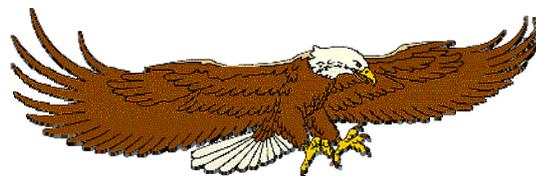
Dear Ms. Mangels:

Thank you for replying to my email. I am writing to order the Attitudes Toward Disabled Persons Scale developed by Yuker. The ATDP instrument will be used in my dissertation research entitled *Counselor attitudes toward Persons Who Are Blind Or Visually Impaired*. Additionally, the test manual or booklet along with any associated materials is requested. The print outs that you referred to would be appreciated as well. Please find enclosed my check in the amount of \$10.00 for the ATDP materials. Thank you for your assistance.

Best regards

Charles L. Walker

NATIONAL COUNSELOR INVITATION



NC STATE UNIVERSITY
DEPARTMENT OF COUNSELOR EDUCATION

For Distribution to Counselors In Training

TO: Counselor Educators
FROM: Charles L. Walker, Principal Investigator
Re: National Counselor Study
<http://ceres.cals.ncsu.edu/nationalcounselor>

National counselor,

You are cordially invited and asked to participate in a national counselor study <http://ceres.cals.ncsu.edu/nationalcounselor>. This study investigates counselor attitudes toward persons who are blind or visually impaired throughout the United States. This national counselor study will be conducted during the Spring Semester of 2008. This dissertation research extends to you an opportunity to be among 1000 counselors in training nationwide to offer your opinion and contribute to this important work.

To join us, please click here or point your browser to the National Counselor website <http://ceres.cals.ncsu.edu/nationalcounselor>. Please distribute this national counselor invitation to counselors in training at the masters and doctoral levels. Thank you in advance for your contribution to the professional literature and the body of knowledge.
<http://ceres.cals.ncsu.edu/nationalcounselor>

Cordially,
Charles L. Walker, Principal Investigator
nationalcounselor1k@nc.rr.com

NATIONAL COUNSELOR STUDY HOMEPAGE

<http://ceres.cals.ncsu.edu/nationalcounselor>

National Counselor Study



Welcome

Welcome Counselor and thank you for participating in this National Counselor Study. You are invited and privileged to be among 1000 Counselors NATIONWIDE to be involved in this important research. Of course, your participation is entirely voluntary and you may choose to withdraw at anytime. Your contribution will potentially add to the body of knowledge and enhance our efficacy as Counselors.

Moreover, your contribution may have a positive impact and help ameliorate some of the associated challenges of our clients. As busy Graduate students and professionals, I appreciate, respect, and value your time and opinions. The method of this study uses a completely anonymous and confidential data collection system. In an effort to protect privacy and insure confidentiality, personally identifiable information is not collected. Your identity is protected.

Briefly complete the informed consent agreement and the demographic questionnaire, then click submit and you are on your way. Effortlessly, communicate your opinions on two surveys with the click of your mouse, (the ATDP-B and the CDP Scales). Click submit at the end of these surveys. Conveniently, it should only take you 25 to 30 minutes from start to finish. Make written comments if you choose to, that's it, you are done. Now, let's get started!

[Click here](#)
Informed Consent Agreement
Thank you Counselor

Principal Investigator: C. L. Walker

Appendix G

INFORMED CONSENT AGREEMENT

North Carolina State University
INFORMED CONSENT FORM

for RESEARCH

Title of Study Counselor Attitudes Toward Persons Who Are Blind Or Visually Impaired

Principal Investigator Charles L. Walker Faculty Sponsors Dr. Edwin R. Gerler & Dr. Jose A. Picart

We are asking you to participate in a research study. The purpose of this study is to assess counselors in training preparedness to work with people who are blind or visually impaired.

INFORMATION

If you agree to participate in this study, you will be asked to 1. complete this informed consent agreement 2. complete a demographic questionnaire, 3. complete the Attitudes Towards Disabled Persons-B Scale, and 4. complete the Contact with Disabled Persons Scale. It should take you no more than 25 to 30 minutes to register your contribution to this study. Data will be collected for this research project during the Spring semester of 2008. This study is entirely web based, confidential and anonymous. Personally identifiable information is not collected.

RISKS

We do not anticipate or foresee any risk to you in this project. If you feel or become uncomfortable at any point during this project, you may withdraw from the research study without penalty or loss of benefit. For your convenience, your participation in this project can be contributed from any point wherein you have internet access. This access should ameliorate any discomfort you may experience.

BENEFITS

Your contribution and participation in this study may lead to knowledge gained that may help others. Additionally, your contribution to this study may add to the body of knowledge. We genuinely thank you for your participation and contribution to this research project. Unfortunately, no direct benefit in the form of compensation is available.

CONFIDENTIALITY

The information in the study records will be kept strictly confidential. Data will be stored securely in a password protected database. No reference will be made in oral or written reports which could link you to the study.

CONTACT

If you have questions at any time about the study or the procedures, you may contact the researcher, Charles L. Walker, at NCSU, Department of Counselor Education, 520 Poe Hall, Campus Box 7801, Raleigh, NC 27695-7801, or 919-881-7788, email: cwalker4@nc.rr.com or my faculty sponsors Dr. Edwin R. Gerler, NCSU, Department of Counselor Education, 520 Poe Hall, Campus Box 7801, Raleigh, NC 27695-7801, 919-515-2244, email: Edwin_gerler@ncsu.edu or Dr. Jose A. Picart, NCSU, Department of Counselor Education, Vice Provost, Diversity and African American Affairs, 201 Holladay Hall, Campus Box 7527, Raleigh, NC 27695-7527, 919-515-7966, email: jose_picart@ncsu.edu. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. David Kaber, Chair of the NCSU IRB for the Use of Human Subjects in Research Committee, Box 7514, NCSU Campus (919/515-3086) or Mr. Matthew Ronning, Assistant Vice Chancellor, Research Administration, Box 7514, NCSU Campus (919/513-2148)

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled.

CONSENT

"I have read and understand the above information. I have received or printed a copy of this form. I agree to participate in this study with the understanding that I may withdraw at any time without loss of benefit." By clicking "I agree" I give my informed consent to participate in this study. [Click here](#) [I agree](#) [I disagree](#)

Appendix H

DEMOGRAPHIC DATA QUESTIONNAIRE

Owner: Principal Investigator C. L. Walker

Neither your university name or your name is required to complete this form. Please provide answers that describe you most honestly. Feel free to add any additional comments on this form. Answer all questions and click submit to continue.

What is your graduate school status?

- Master's
- Doctoral

What Year?

What type of experience or type of involvement have you had with people who are blind or visually impaired? (If choice is Work Associated, indicate A, B, or C). Check all that apply.

- 1. None
- 2. Indirect Casual/Incidental
- 3. Work Associated
 - A. As an Employee
 - B. As a Colleague/Co-worker
 - C. As a Supervisor/Employer
- 4. Direct Personal/Intimate Relationship

Gender:

- 1. Male
- 2. Female

Age:

- 1. 29-Younger
- 2. 30-40
- 3. 41-50
- 4. 51-Above

Race:

- 1. African American/Black
- 2. White
- 3. Hispanic
- 4. Other

Do you have a disability?

- 1. Yes
- 2. No
- 3. If yes, please specify

Occupation:

Professional affiliations(ACA, APA, etc.):

Do you feel that your educational training has/will prepare/prepared you to work effectively as a counselor with people who are blind or visually impaired?

- 1. Yes
- 2. No

Submit

Appendix I

ATDP-B MODIFIED

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3 or -1, -2, -3 depending on how you feel in each case.

+3:	I AGREE MUCH	-1:	I DISAGREE A LITTLE
+2:	I AGREE PRETTY MUCH	-2:	I DISAGREE PRETTY
MUCH			
+1:	I AGREE A LITTLE	-3:	I DISAGREE VERY
MUCH			

- _____ 1. Blind or visually impaired persons are usually friendly.
- _____ 2. People who are blind or visually impaired should not have to pay income taxes.
- _____ 3. Blind or visually impaired persons are not more emotional than other people.
- _____ 4. Blind or visually impaired persons can have a normal social life.
- _____ 5. Most blind or visually impaired persons have a chip on their shoulder.
- _____ 6. Blind or visually impaired workers can be as successful as other workers.
- _____ 7. Very few blind or visually impaired persons are ashamed of their disability.
- _____ 8. Most people feel uncomfortable when they associate with blind or visually impaired people.
- _____ 9. Blind or visually impaired people show less enthusiasm than nondisabled people.
- _____ 10. Blind or visually impaired people do not become upset any more easily than nondisabled people.
- _____ 11. Blind or visually impaired people are often less aggressive than normal people.
- _____ 12. Most blind or visually impaired persons get married and have children.
- _____ 13. Most blind or visually impaired persons do not worry more than Anyone else.
- _____ 14. Employers should not be allowed to fire blind or visually impaired employees.
- _____ 15. Blind or visually impaired people are not as happy as nondisabled ones.
- _____ 16. Severely blind or visually impaired people are harder to get along with than are those with minor disabilities.

- _____ 17. Most blind or visually impaired people expect special treatment.
- _____ 18. Blind or visually impaired persons should not expect to lead normal lives.
- _____ 19. Most blind or visually impaired people tend to get discouraged easily.
- _____ 20. The worst thing that could happen to a person would be for him/her to become severely injured or blind or visually impaired.
- _____ 21. Blind or visually impaired children should not have to compete with nondisabled children.
- _____ 22. Most blind or visually impaired people do not feel sorry for themselves.
- _____ 23. Most blind or visually impaired people prefer to work with other disabled people.
- _____ 24. Most blind or visually impaired persons are not as ambitious as other people.
- _____ 25. Blind or visually impaired persons are not as self-confident as physically normal persons.
- _____ 26. Most blind or visually impaired persons don't want more affection and praise than other people.
- _____ 27. It would be best if a blind or visually impaired person would marry another disabled person.
- _____ 28. Most blind or visually impaired people do not need special attention.
- _____ 29. Blind or visually impaired persons want sympathy more than other people.
- _____ 30. Most blind or visually impaired persons have different personalities than normal persons.

ATDP-B ORIGINAL

ATDP-B

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3: or -1, -2, -3: depending on how you feel in each case.

+3: I AGREE MUCH	-1: I DISAGREE A LITTLE
+2: I AGREE PRETTY MUCH	-2: I DISAGREE PRETTY MUCH
+1: I AGREE A LITTLE	-3: I DISAGREE VERY MUCH

-
- _____ 1. Disabled persons are usually friendly.
 - _____ 2. People who are disabled should not have to pay income taxes.
 - _____ 3. Disabled people are not more emotional than other people.
 - _____ 4. Disabled persons can have a normal social life.
 - _____ 5. Most physically disabled persons have a chip on their shoulder.
 - _____ 6. Disabled workers can be as successful as other workers.
 - _____ 7. Very few disabled persons are ashamed of their disabilities.
 - _____ 8. Most people feel uncomfortable when they associate with disabled people.
 - _____ 9. Disabled people show less enthusiasm than nondisabled people.
 - _____ 10. Disabled people do not become upset any more easily than nondisabled people.
 - _____ 11. Disabled people are often less aggressive than normal people.
 - _____ 12. Most disabled persons get married and have children.
 - _____ 13. Most disabled persons do not worry more than anyone else.
 - _____ 14. Employers should not be allowed to fire disabled employees.
 - _____ 15. Disabled people are not as happy as nondisabled ones.
 - _____ 16. Severely disabled people are harder to get along with than are those with minor disabilities.
 - _____ 17. Most disabled people expect special treatment.
 - _____ 18. Disabled persons should not expect to lead normal lives.
 - _____ 19. Most disabled people tend to get discouraged easily.
 - _____ 20. The worst thing that could happen to a person would be for him to be very severely injured.
 - _____ 21. Disabled children should not have to compete with nondisabled children.
 - _____ 22. Most disabled people do not feel sorry for themselves.
 - _____ 23. Most disabled people prefer to work with other disabled people.
 - _____ 24. Most severely disabled persons are not as ambitious as other people.
 - _____ 25. Disabled persons are not as self-confident as physically normal persons.

- _____ 26. Most disabled persons don't want more affection and praise than other people.
- _____ 27. It would be best if a disabled person would marry another disabled person.
- _____ 28. Most disabled people do not need special attention.
- _____ 29. Disabled persons want sympathy more than other people.
- _____ 30. Most physically disabled persons have different personalities than normal persons.

CONTACT WITH DISABLED PERSONS SCALE MODIFIED

Please place a number to the left of each statement indicating your answer to each question. Use a number from 1 to 5 to indicate the following: 1 = never; 2 = once or twice; 3 = a few times; 4 = often; 5 = very often.

-
- _____ 1. How often have you had a long talk with a person who is blind or visually impaired?
 - _____ 2. How often have you had brief conversations with persons who are blind or visually impaired?
 - _____ 3. How often have you eaten a meal with a person who is blind or visually impaired?
 - _____ 4. How often have you contributed money to organizations that help blind or visually impaired persons?
 - _____ 5. How often have blind or visually impaired persons discussed their lives or problems with you?
 - _____ 6. How often have you discussed your life or problems with a blind or visually impaired person?
 - _____ 7. How often have you tried to help blind or visually impaired persons with their problems?
 - _____ 8. How often have blind or visually impaired persons tried to help you with your problems?
 - _____ 9. How often have you worked with a blind or visually impaired client, student, or patient on the job?
 - _____ 10. How often have you worked with a blind or visually impaired co-worker?
 - _____ 11. How often has a blind or visually impaired person visited you in your home?
 - _____ 12. How often have you visited blind or visually impaired friends in their home?
 - _____ 13. How often have you met a blind or visually impaired person that you like?
 - _____ 14. How often have you met a blind or visually impaired person that you dislike?
 - _____ 15. How often have you met a blind or visually impaired person that you admire?
 - _____ 16. How often have you met a blind or visually impaired person for whom you feel sorry?
 - _____ 17. How often have you been annoyed or disturbed by the behavior of a person who is blind or visually impaired?
 - _____ 18. How often have you been pleased by the behavior of a blind or visually impaired person?
 - _____ 19. How often have you had pleasant experiences interacting with blind or visually impaired persons?
 - _____ 20. How often have you had unpleasant experiences interacting with blind or visually impaired persons?

CONTACT WITH DISABLED PERSONS SCALE ORIGINAL

Contact and Attitudes

149

Table 1. Contact with Disabled Persons (CDP) Scale

Please place a number to the left of each statement indicating your answer to each question. Use a number from 1 to 5 to indicate the following: 1 = never; 2 = once or twice; 3 = a few times; 4 = often; 5 = very often.

-
- _____ 1. How often have you had a long talk with a person who is physically disabled?
 - _____ 2. How often have you had brief conversations with persons who are physically disabled?
 - _____ 3. How often have you eaten a meal with a person who has a physical disability?
 - _____ 4. How often have you contributed money to organizations that help disabled persons?
 - _____ 5. How often have physically disabled persons discussed their lives or problems with you?
 - _____ 6. How often have you discussed your life or problems with a physically disabled person?
 - _____ 7. How often have you tried to help physically disabled persons with their problems?
 - _____ 8. How often have physically disabled persons tried to help you with your problems?
 - _____ 9. How often have you worked with a physically disabled client, student, or patient on the job?
 - _____ 10. How often have you worked with a physically disabled co-worker?
 - _____ 11. How often has a disabled friend visited you in your home?
 - _____ 12. How often have you visited disabled friends in their homes?
 - _____ 13. How often have you met a physically disabled person that you like?
 - _____ 14. How often have you met a physically disabled person that you dislike?
 - _____ 15. How often have you met a disabled person that you admire?
 - _____ 16. How often have you met a disabled person for whom you feel sorry?
 - _____ 17. How often have you been annoyed or disturbed by the behavior of a person with a disability?
 - _____ 18. How often have you been pleased by the behavior of a physically disabled person?
 - _____ 19. How often have you had pleasant experiences interacting with physically disabled persons?
 - _____ 20. How often have you had unpleasant experiences interacting with physically disabled persons?
-

EMERGING THEORIES

*Walker Blind Identity Development**Key Concepts*

Blind or visually impaired persons grow and develop within a sighted context that devalues their personhood because of the condition of blindness and attitudes towards those who are blind. Additionally, the situation for congenitally blind or adventitiously blind persons intersects around access issues, adjustment to blindness, rehabilitation, education, and employment. Relatedly, psychosocial and sociopolitical issues and challenges are associated with identity development for this population (Cross, 1991; Davis, 1997; Erikson, 1974; Ferguson, 2001).

Moreover, adventitiously blind persons come from a privileged sighted experience and have gone through the process of identity formation. Once these persons have become fortuitously blind, they are challenged with the process of identity development as visually impaired persons. The process of adjustment and identity development after acquired vision loss is difficult. The dominant sighted worldview is saturated with myths, stereotypes, prejudices, sympathy, avoidance behaviors and institutionalized attitudinal barriers towards blindness and those who are blind (Ferguson, 2001; Jones, 1996; Wagner-Lampl & Oliver, 1994). Since adventitiously blind persons come from a sighted experience, they typically have learned and hold the same stereotypical beliefs about blindness as

the dominant sighted society. Therefore, they must overcome and reframe their own internalized biased beliefs towards blindness as well as society's biased beliefs about blindness in order to develop an achieved identity.

For growth to occur from one stage of development to the other, individuals need to have both support and challenge to negotiate and balance developmental crises (Erikson, 1974). More often than not, congenitally blind and adventitiously blind persons face enormous challenges in the constructed and socially constructed environments without the adequate supports needed to promote growth and development (Erikson, 1997; Ferguson, 2001; Vaughan, 1998).

A model of identity development for persons who are blind or visually impaired would be useful for individuals who are blind, and counseling professionals. The identity development of blind people appears to move along a continuum from adjustment, to dependence, to independence, to interdependence. These stages of identity development are impacted negatively or positively depending upon the degree to which blind persons internalize the dominant worldview towards blindness (Ferguson, 2001; Jones, 1996; Kemp, 1981; Vaughan, 1998; Wagner-Lampl & Oliver, 1994). Congruent with these stages of identity development are the deficit, the functional limitations, the minority, and the social constructivist models of disability (Carter-Davis, 2000; Danforth, 2001; Ferguson, 2001; Jones, 1996). These models of disability serve as theoretical frameworks for the stages within the Walker Blind Identity

Development Model (Walker 1999). This identity development model is offered to individuals, families, rehabilitation counselors, educators, administrators, counselor education programs, professional counselors, counselors in training, employers, and institutions as a framework of identity development for persons who are blind.

Rationale

Currently, an identity development model for blind persons does not exist. Therefore, an identity development model may benefit those who are born blind or who become blind by providing an avenue by which their personhood can be reclaimed. Professional counselors, rehabilitation counselors, and other helping professionals could benefit from this identity development model by clarifying and understanding the barriers to identity development for people who are blind. Professionals could better perform essential advocacy roles by striving to ameliorate or eliminate attitudinal barriers for this population. Employers, educators and administrators could benefit from this model by understanding that the environments that they create both physical and attitudinal may cause visually impaired persons to be disabled. Therefore, a conscious awareness of how institutionalized attitudinal barriers restrict and limit employment and educational opportunities for visually impaired persons is critical to understand, if these professionals are to implement policies and procedures that benefit this population.

Theoretical Considerations

First, Erikson's psychosocial theory of identity development is considered to show how individuals move through or negotiate the stages of the Walker Blind Identity Development Model (WBID). Erikson suggests that when individuals successfully negotiate the crises of each stage, growth occurs.

Erikson's eight stages include:

1. trust vs. mistrust, hope emerges;
2. autonomy vs. shame and doubt, will emerges;
3. initiative vs. guilt, purpose emerges;
4. industry vs. inferiority, competence emerges;
5. identity vs. identity confusion, fidelity emerges;
6. intimacy vs. isolation, love emerges;
7. generativity vs. stagnation, care emerges; and
8. integrity vs. despair and disgust, wisdom emerges (Erikson, 1997).

Some of the stages in the WBID have features that are both syntonic and dystonic. As in Erikson's model, with support and challenge, successful negotiation from one stage to the next is achieved when the developmental crisis is met and individuals find a balance between the negative and positive elements within a given stage.

Next, the stages in the WBID adjustment, dependence, independence, and interdependence, correspond to foreclosure, diffusion, moratorium, and identity achievement of Marcia's (1993) identity status model. Individuals move

from limited narrowly defined ways of functioning to broader more accomplished ways of being. Individuals say "yes" to commitment and "yes" to the challenges and crises of development.

Additionally, Cross (1971, 1991) Nigrescence Model is used as a conceptual framework. Cross's model reflects the process of identity development as moving along a continuum from negative assumptions of identity prescribed, taught, and internalized from the dominant culture to broader more positive definitions and internalizations of identity. The five stages of the Nigrescence model are preencounter, encounter, immersion/emersion, internalization, and internalization/commitment.

Finally, the deficit, functional limitations, oppression, and social constructivists' views of disability are considered. The deficit model of disability contends that individuals are defective because they are disabled (Carter-Davis, 2000). The functional limitations view of disability believes that individuals are limited because of their disabilities. The oppression view of disability holds that individuals occupy a victim status because of their minority designation and the social constructivist view maintains that individuals with disabilities are disabled because of the environment (Danforth, 2001; Jones, 1996). Research, policy, and procedures are directed towards rehabilitation as opposed to liberation (Jones, 1996).

Stage 1: Adjustment

Birth: individuals who are born blind grow with blindness as the norm for their lives. They are taught by family and society that their blindness is abnormal. Being blind becomes associated with their identity and their status. They are taught that blind is abnormal, they are blind, therefore their personhood is abnormal.

Shock: individuals experience initial shock over loss of eye sight. Grief: individuals may experience grief, anger, denial, and depression over the loss of sight. Stereotypical attitudes towards blindness: individuals view blindness through the negative lens of the sighted world. They view their own blindness with internalized negative attitudes focusing upon the deficit and loss. Social withdrawal: individuals may feel fear and shame over the loss of sight. He/she may withdraw from former social interactions outside of family. Crisis over loss of independence: individuals may experience loss in the areas of employment/income, driving/travel, choices/decisions, role identity (i.e. family, community). Acceptance: individuals begin to accept blindness. They realize that they are blind and that they must live with blindness and that they can live with blindness. They find other ways to be and other ways to see. They discover their unique and deliberate creation, for the purpose of the reflection of glory.

Adjustment: individuals begin to explore independent living skills. The family/support system may foster individual's growth through support and challenge at this stage. Additionally, family encourages and allows individuals to

assert independence. Greater independence and assertiveness may result for blind individuals. Conversely, the family/support system may inhibit individuals growth at this stage, (family does not allow individuals to assert independence). Families may inhibit growth by being supportive, but not challenging or allowing individuals to be independent and assertive. This may result in skewed growth and hope deferred.

Stage 2: Dependence

In this stage, individuals continue to believe and act in stereotypical ways based on internalized prejudices towards blindness. They may experience learned helplessness and acquiescence of power to sighted persons. They may seek rehabilitation to learn independent living skills on their own or via encouragement of others. They may experience social isolation and may conform to dependent roles as defined by others. Individuals may approach rehabilitation with high hopes of finding validation, opportunity, meaning, and hope. Instead, they may find themselves in an institution designed by society to further teach them how to be in their stereotypical role. Most individuals may find that rehabilitation is only productive for a privileged few. Some blind or adventitiously blind persons may reject the debilitating qualities of rehabilitation and assert their own choices for further growth. These individuals move forward independently and make progress. Other individuals become entangled in the rehabilitation industrial complex and stay stuck at this stage in a continuing stage of foreclosure. On the other hand, they may reject pressures to conform to

dependent roles. This may lead to the beginning of assertiveness and personal power. Individuals may seek information and additional training beyond the rehabilitation prescription. They look for ways of independence that actually work for blind people.

Stage 3: Independence

Stereotypical attitudes towards blindness and persons who are blind are rejected. These individuals may join advocacy organizations. They may autonomously assert independence in making personal choices and confront attitudinal barriers in society assertively. They may function in more productive ways replacing anger with assertiveness. When blindness is accepted, role identity within one's family is clarified, and relationships become more meaningful. These individuals begin to accept assistance when needed and find creative ways to overcome the environmental obstacles. Individuals begin to understand that their lack of vision is an impairment and the environment causes them to be disabled.

Stage 4: Interdependence

At this stage, individuals ask for help when needed while maintaining self-respect. They choose to accept or reject assistance when offered and find a balance between independence and dependence. They continue to develop and maintain a successful identity, ergo, an achieved identity. Meaningful relationships are established. Individuals interact in socially meaningful ways. This leads to working together collaboratively with others to promote change that

is in the best interest of persons who are blind as well as other oppressed persons. Blind people clearly understand and see that disability is socially constructed and environmentally based. They understand that the unearned privilege of ableism leads to attitudinal barriers, environmental discrimination, and disabling conditions.

Table 1 Depicts the integration of developmental models with the WBID.

Walker Blind Identity Development Model

Theory Synthesis

Theorists	Stage 1	Stage 2	Stage 3	Stage 4
WALKER (WBID)	Adjustment	Dependence	Independence	Interdependence
ERIKSON (Psychosocial)	1. Trust v. Mistrust HOPE	3. Initiative v. Guilt PURPOSE	5. Identity v. Role Confusion FIDELITY	7. Generativity v. Stagnation CARE
	2. Autonomy v. Doubt WILL	4. Industry v. Inferiority COMPETENCE	6. Intimacy v. Isolation LOVE	8. Integrity v. Despair WISDOM
CROSS (Sociopolitical)	1. Pre-Encounter	2. Encounter	3. Immersion/ Emersion	4. Internalization 5. Internalization/ Commitment
MARCIA (Status)	Foreclosure	Diffusion	Moratorium	Achieved
CARTER-DAVIS JONES DANFORTH (Disability)	Deficit	Functional Limitations	Minority	Social Construction