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Jessica Wierzbowski
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a visual impairment:
A theoretical perspective

ABSTRACT

This theoretical investigation examines the link between systemic ableism towards those with visual impairment and whether it elicits symptoms of Posttraumatic stress disorder (PTSD) in the visually impaired. For the purpose of this thesis ableism will be defined as, “often makes the world unwelcoming and inaccessible for people with disabilities” (Hehir, 2007, p.10). Meaning, barriers exist (Madriga, 2007) for those with a visual impairment. An example of a barrier for those with a visual impairment is the desire to want those with a visual impairment to read regular print instead of large print or Braille (Hehir, 2007). Society maybe be responsible for these barriers but, may not be aware of it (Madriga, 2007). Visual impairment is defined as a range beginning with a visual acuity of 20/200 or worse in the better eye to full loss of sight (The Department of Veterans Affairs, 2001). The two theories selected to appreciate my research question are Multicultural theory and Trauma theory. These two theories create a theoretical lens which provided understanding of individuals with visual impairment as an oppressed minority vulnerable to trauma. Multicultural theory allows for examining oppression from a cultural perspective. Trauma theory allows for examining the effects of ableism through the trauma lens. Throughout my studies and introductions to various theories, I consider these two theories to best exemplify and meet my research needs. Finally, as a participant observer I

consider these two theories to provide a relevant theoretical perspective to further understand whether systemic ableism elicits symptoms of PTSD.

THE EFFECTS OF SYSTEMIC ABLEISM ON THOSE WITH A VISUAL IMPAIRMENT:

A THEORETICAL PERSPECTIVE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2011

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CHAPTER I

INTRODUCTION

The intent of this thesis is to conduct a theoretical investigation to the understanding of whether the effect of ableism towards those with a visual impairment elicits symptoms of Posttraumatic stress disorder. It is my hypothesis that due to the severe nature of being subjected to ableism on an ongoing basis, that one can develop symptoms of Posttraumatic Stress Disorder (PTSD). It is not my intent to leave out any groups who are members of the disability community, and I do acknowledge their struggle. However, in order to be mindful and considerate of the fact that all forms and types of disabilities are culturally unique in their own aspects; I will focus this study on one group, those with a visual impairment. Therefore, the question I desire to research and explore is “Does systemic ableism elicit symptoms of Posttraumatic stress disorder in people with a visual impairment?”

“Ableism takes many forms including offices that are not accessible to people who use wheelchairs or have mobility impairments that preclude climbing stairs; forms that are not available in large-print versions; tests that are not available in taped as well as written versions; and lack of knowledge about the implications of a particular disability for a person's health, resilience, and capacities as well as their distress and difficulties. The stigma associated with disability is very similar to that associated with trauma; thus psychotherapists may unconsciously withdraw from clients with disabilities, not to speak

of colleagues with disabilities, as they do from individuals known to be trauma survivors” (Brown, 2008, p. 185).

The term *visual impairment* in this thesis is purposefully chosen. I do recognize that visual impairment could have been substituted for *blind*, *visually disabled*, and so on; however I made the judgment to use visually impaired (Bolt, 2005). I also acknowledge the term an individual uses is a personal preference.

Visual impairment is a topic that is little discussed or researched. When linking the effects of ableism to the topic of visual impairments, the research is virtually nonexistent. Most of the research to date clusters all disabilities into one group. Due to the increasing numbers of the population who will develop a visual impairment, already developed one, or were born with one (Challinor, 2003; The Department of Veterans Affairs, 2001), this topic needs to be explored in order to better serve the this particular population and understand the psychological and sociological effects that the population endures.

The study of disabilities in relation to visual impairment is a vital aspect to the field of clinical social work and the effects ableism has on a particular person. It will encourage social workers to be aware of their own biases as well as realize the traumatic effects ableism causes. It will also enable social workers to realize the importance of looking at visual impairments, or disabilities in general, as a cultural occurrence and not only within the medical model.

In order to look at this phenomenon I will be using two theories to conceptualize and answer my question. The two theories which I intend to utilize are Multicultural theory and Trauma theory. The reason I choose these two theories is that as a participant observer in this research, meaning I am documented as visually impaired, I felt these theories to best embody a

strong theoretical comprehension to the phenomenon. I was registered with the state of Massachusetts at the age of five as legally blind. I was born with a heredity eye disease called optic-nerve atrophy. I never have and never will have what is considered to be “normal” vision. As for the other reason for choosing these theories, my introduction to a variety of theories leads me to believe these two theories provide a theoretical understanding that examines the visually impaired through a culture lens and the effects of ableism through a trauma lens.

In my next chapter, Chapter II, I will look at the literature that exists. Chapter III will provide a detailed overview of my chosen theories. Chapter IV and Chapter V will discuss the phenomenon through a theoretical understanding. The thesis ends with Chapter VI, a discussion that will include both the strengths and limitations of this theoretical study, biases that existed, as well as the implications for clinical social work.

CHAPTER II

THE PHENOMENON: REVIEW OF LITERATURE

Pathway to the ADA

According to McCarthy (2003) much of the Disability Movement was inspired by the civil rights movement of the African American community. Similarities include a population of oppressed people who were determined to get the same rights as the majority received. In 1962 this included the right to attend college and receive a higher education (McCarthy, 2003).

Two people are discussed; those being James Meredith, a black man who wanted to enroll at Mississippi University, and Ed Roberts, a disabled man who was wheelchair bound and lived with the help of an iron lung, who wanted to enroll at the University of California, Berkeley. Both situations required ample persuasion from the two universities to allow entry into the colleges' educational system. And while James Meredith required US Marshalls to cross the college campus and enter the university, Ed Roberts quietly gained his entry thus beginning what most consider the start of the Disability Rights Movement (McCarthy, 2003).

In the 1960s, Hall (2002) noted the right to a public school education was not a guarantee, especially for those with a disability. The school had the right to deny access. It was not until the Education for All Handicapped Children Act of 1975, later changed to Individuals with Disabilities Education Act in 1997 due to amendments, that those with a disability gained the right to public school education.

According to Menghello and Russon (2008) a long process of demonstrations and protests accorded amongst those with a disability. This helped us come as far as we have. In 1973, Section 504 was signed into law which prohibits those who receive federal money to discriminate against people based on a disability. However, it was July 26, 1990 that the most victorious movement for those with a disability was set into law, The American with Disabilities Act (ADA). This act was signed in by former President George H. W. Bush quoted as saying, “Let the shameful walls of exclusion finally come tumbling down” (2008, p. 21). And while this was a great mark on history, it fell short of expectations and intentions those thought would occur from the ADA. This is partly due to the strict interpretation and the lack of understanding of the ADA. This however led to amendments to broaden the definitions and attempts to make entitlements more clear. Yet, while the ADA aided in the changes that exist today, ableism such as job discrimination is still occurring. As noted by Menghello & Russon (2008) the ADA is an “imperfect tool” and we “still have a long way to go” (p. 25).

Defining a Disability

Defining the term *disability* is complicated. Grönvik (2007) acknowledges this task has plagued researchers for years. Brown (2008) explains disabilities to be a heterogeneous population, which contributes to the complication of defining. This population can include cognitive, physical, or emotional disabilities. In a study conducted by Grönvik (2007) a theory of defining the term “disability” was broken into three categories. These included functional definition, administrative definition, and subjective definition. When defining a disability by using the functional definition it is based on understanding of the medical approach. This definition often refers to people who are blind, deaf, or have mobility issues. Often the person is

perceived as impaired in a daily function. An administrative definition refers to government benefits in which a person is given. For example, if a person is seen as “disabled enough” in terms of how the government views them, they will in fact be considered disabled. This will in return entitle them to benefits such as Social Security Disability Insurance (SSDI). From a subjective definition a person is disabled if he or she views himself or herself as disabled.

What was learned from this study that depending how one defines disability depends on the outcome of how people will respond to questionnaires. However, for the purpose of the ADA, Colbridge (2000) notes that, “disability means having a physical or mental impairment that substantially limits one or more major life activities, having a record of such an impairment, or being regarded as having such an impairment” (p.28).

Defining Visual Impairment

The Department of Veterans Affairs (2001) developed a manual for an independent study course in which physicians are educated on the different aspects of a visual impairment. These aspects include the definition of a visual impairment, the psycho/social implications, the reality that visual impairment is on the rise, as well as environmental implications (The Department of Veterans Affairs, 2001). For this thesis I will be using the definition in which the manual discusses in order to define a visual impairment.

“The U.S. definition of legal blindness

1. Visual Acuity of 20/200 or worse in the better eye (with best eyeglass or contact lens correction)” (The Department of Veterans Affairs, 2001, location 208).

Visual acuity is the test distance/target size which tells a person their vision level. Normal vision is considered 20/20. To understand someone who tested at 20/200 compared to

someone who tested at 20/20, a person who tested at 20/200 would need to stand 20 feet near an object compared to someone with 20/20 vision who would see the object at 200 feet (The Department of Veterans Affairs, 2001).

To define a visual impairment, one must include the vast range that sight loss can include. This range can vary from moderate loss to completely blind. To be considered to suffer from *a moderate vision loss* a person would test at 20/80. To be considered someone who suffers from severe *low vision* a person would test at 20/200. To be considered someone who suffers from *profound low vision* a person would test at 20/500. To be considered someone who suffers from *near blindness* a person would test at 20/1250. And finally to be considered someone who suffers from *total blindness* a person would lack in light perception (The Department of Veterans Affairs, 2001).

To have a *visual disability* signifies how the person functions in their daily life. Questions to judge the impact of a visual impairment on a person's daily functions surround areas such as driving, television watching, and mobility. Losses in these areas are considered to have a profound impact on a person's life. This can often times lead to a visual handicap. A *visual handicap* is a disadvantage a person endures due to a vision loss. Visual handicaps can include having to place additional effort on tasks such as reading and shopping. A visual handicap is often an economic, social, and physical loss of autonomy to the person. A major loss includes the ability to drive (The Department of Veterans Affairs, 2001).

Defining Ableism/ Disablism

Deal (2007) notes that despite the ADA and Disabilities Movement, ableism still exists, but it may not be as clearly seen as people believe it to be. In fact, people may not even be aware

of it due to the vast improvements the past 20 years has had. For example, railways are more accessible and more buildings have accessibility for persons with all disabilities. However, Deal (2007) further explains “behavior towards people who are discriminated against can be modified, but the attitude towards such people may still remain prejudiced” (p. 93). For example, in an article by Hehir (2007), it is pointed out that people who do have a disability are taught early on to perform as if they were one of their nondisabled peers. It is believed their disability is a negative aspect of them and they must overcome it if they wish to be valued. He is quoted as saying, “*ableism*--often makes the world unwelcoming and inaccessible for people with disabilities. An ableist perspective asserts that it is preferable for a child to read print rather than Braille, walk rather than use a wheelchair, spell independently rather than use a spell-checker, read written text rather than listen to a book on tape, and hang out with nondisabled kids rather than with other disabled kids” (2007, p. 10).

In a speech by Jacobus tenBoerk, a visually impaired man and founder of National Federation for the Blind, Hills and Blanck (2007) noted it was said that perhaps disabilities should be treated as a civil rights movement. This is because despite all the progress that has been made, courts still look at the medical model of ableism, but social barriers and negative perceptions continue. This illustrates the less noticed forms of ableism, the forms that are socially constructed in society.

Liachowitz (1988) looks at ableism as the sociological and psychological theorists do: “a complex of constraints that the able bodied imposes on the behavior of physically impaired people” (p. 1). This is the start of defining disablism.

Disablism is defined by Madriga (2007) as being “derived from the social model of disability in which every day practices of society members, including those in education (i.e. both staff and learners), perhaps unbeknown to them, may perpetuate oppressive structures upon those who identify or are categorized as being disabled” (p. 400). Campbell (2007) identifies disablism as the “attitudes and barriers that contribute to the subordination of people with disabilities in society” (p. 151). Griffin et al. (2008) explains the barriers that exist for those with a disability are socially constructed by society. And it is society that makes the person disabled, not the person with the disability. Meaning, regular size print on forms and not having alternative formats is disabling the visually impaired person. Other ways in which Griffin et al. (2008) explore ableism is through the lack of awareness. For example, when society decides to bring awareness to disabilities, they tend to use simulations which would allow participants to explore what it is like to have a certain disability, such as a visual impairment. This often leads to blindfolding a participant and demonstrating to them what it is like to “be in the dark.” However, this only allows for what a person with a visual impairment cannot do and not what they can do, further perpetuating the negative attitudes and opening space for ableism.

Defining Symptoms of Posttraumatic

Stress Disorder

The DSM IV-TR lists Posttraumatic Stress Disorder (PTSD) as an anxiety disorder in whose onset can be present as the result of a traumatic event in a person’s life. It is diagnosed through 6 (A-F) categories and a menu of symptoms (APA, 2000). Marshall, et al. (2010) includes symptoms such as intrusive thoughts of trauma, recurrent dreams of trauma, flashbacks, emotional reactivity to trauma cues, psychological reactivity to trauma cues, avoiding thoughts

of trauma, avoiding reminders of trauma, inability to recall aspects of trauma, lost of interest, detachment, restricted affect, sense of foreshortened future, sleep disturbance, irritability, difficulty concentrating, hypervigilance, and exaggerated startle response.

Linking Ableism and Symptoms of Posttraumatic Stress Disorder

Brown (2008) explores the idea that discrimination against those with a disability as a risk factor for trauma. She cites Oklin (1999) to further elaborate that those who identify as having a disability to being one of, if not, the largest target group in the United States. This subjects this population to numerous encounters of ableism which occurs in many forms. A few ways in which ableism can occur includes denial of accommodations, being patronized, exclusion, or societal attitudes. She discusses a graduate student in the field of psychology who is documented being as Deaf. This student faced many forms of ableism growing up with a disability. He learned early on people considered his abilities were less than others and soon internalized this. He was excluded and discriminated against. During his graduate school years, the toll ableism took on him was triggered through the actions of the school. While the school did nothing illegal, it did display ableist attitudes. He felt constantly devalued as a Deaf person (Brown, 2008).

He was left out of many events due to his Deafness. The school felt outside and optional activities did not qualify under “reasonable accommodations.” These activities included study groups with professors, visiting lectures, and an after class group in which it was explained how to properly respond to an assignment question. Ultimately the memories of his past ableism and

his current ableism caused him to become emotionally overwhelmed and withdrawn. He eventually began failing and left the program (Brown, 2008).

The student became depressed and entered into therapy with a therapist who spoke American Sign Language. When describing how graduate school was an enactment of his being mainstreamed in elementary and middle school, he was quoted as saying, "I felt so alone, and so stupid. I know I'm not stupid; I have to be twice as smart as hearing people to do half as much. I just didn't have the heart to keep struggling with them about what was right. I gave up. That's what makes me really a failure. That I gave up. And that makes me feel stupid all over again, only worse" (Brown, 2008, p. 184-185).

In a study conducted by Strauser et al. (2007), it was concluded people with disabilities, more specifically women, tend to have a higher traumatic experiences compared to those without disabilities. His study focused on individuals who had been sexual abused. However it recognized that part of this trauma could be associated with the environmental and social barriers that confine those with a disability as well as the fact that society places such a low value on those with a disability.

In an article written by Nosek et al. (2008), studies and other literature were looked at to make a connection between having a physical disability and developing depression. The symptoms that were listed in the article included fatigue and disturbance in sleep. Some reasons as to why there is a link included physical limitations, sexuality, poverty, and self-esteem. The article spoke about about the external (societal) devaluation which leads to the internalized self-devaluation the person experiences. Other factors included oppressive social atmospheres,

transportation barriers, job discrimination, and unmet needs for assistive technology (Nosek et al., 2008).

Summary

In this chapter we examined the research which is presently available. This exploration created an understanding of the way in which the Americans with Disabilities Act was established. The challenges of defining a disability were acknowledged, yet when looking directly at one disability, visual impairment, the criteria and definition was more focused. When discussing ableism, the term *disablism* was introduced. Disablism suggested ableism to be a social construct and not as conspicuous as previously perceived. This was followed by defining PTSD and its symptoms. With ableism, visual impairment, and PTSD defined, the focus moved to a discussion linking the three constructs.

In the following chapters the specifics of my chosen theories will be examined. I will analyze Multicultural theory and Trauma theory. I will be utilizing these theories to explore the phenomenon of systemic ableism eliciting symptoms of PTSD for those with a visual impairment.

CHAPTER III

METHODOLOGY

In this chapter I will be providing a detailed synopsis of Multicultural theory and Trauma theory. The reason behind utilizing these two theories is due to Multicultural theory allowing viewing the visually impaired culture as an oppressed minority and Trauma theory allowing viewing ableism and its effects through a trauma lens. Also, as a participant observer, I consider these two theories to best exemplify a theoretical understanding to my proposed question. As previously stated the research will examine if systemic ableism can elicit symptoms of PTSD in people with a visual impairment. In order to answer this question I will be conducting a theoretically designed research exploration, applying Multicultural Theory and Trauma Theory to understand this phenomenon.

Multicultural Theory

The first theory to be explored is Multicultural theory. Multicultural theory was birthed from the idea of better serving ethnic minorities. However, this notion broadened to include other demographic variables (Ivey & Brooks-Harris, 2005), which opens space to view disabilities such as visual impairment through this lens. Gilson and Depoy (2008) state the theory developed from the idea of monoculturalism. The belief behind monoculturalism stemmed from the late 19th century around a Eurocentric ideology. However, anyone who diverged from this ideal, even just slightly, suffered economically. This meant you either conformed to the homogenous system, or you were forced to suffer the consequences.

Gilson and Depoy (2008) go on to state current day Multicultural theory developed in the 1960s. At that time they saw it as a way for differing cultures to come together, but the dominant culture was still ideal.

Today, "...multicultural thought can be characterized along two ideological spectra. The first ranges from the conservative position of simple cultural description to the radical notion of multiculturalism as a political action arena in which previously oppressed cultures are posturing to gain equality not only in the economic domain, but in intellectual, artistic and other important arenas as well. The second relates to credibility in multicultural thought in provoking action, ranging from the notion of multiculturalism merely as academic rhetoric to maintain the status quo, to the view of multiculturalism as capable of promoting significant social change thereby shifting the balance of resources and intellectual power" (p. 209-210).

Within the spectrum of Multicultural theory lays identity, language, and community. When dissecting the theory into these categories it illustrates the strengths each group can carry. For example, identity allows for a target group to share common experiences and therefore bond together in order to create a strong presence when educating agent identities who possess anxieties about the target group's common identity. Language allows for these common bonds to be communicated amongst those within the identified group. This could exist by the use of symbols or signs. Language could also include words that when used by outsiders of the identified group, would be derogatory and offensive. And finally community allows for the interaction of the indentified group to occur. It allows for one to see them self as a respected

member amongst those who identify the same as them and understand their language (Gilson & Depoy, 2008).

Integrative Approach

Integrative approach is defined as “working with culturally diverse clients and understanding the role of culture in human development and behavior” (p. 321). Through Ivey and Brooks-Harris’ (2005) research they reached the conclusion that those who enter into therapy that are recognized as a minority often receive less than adequate counseling. The needs fail to be met.

Assessment

According to Multicultural theory there can be a cause and effect reaction with the two. Meaning, the effect the environment has on someone can lead to their emotional state. Multicultural theory acknowledges both the micro and macro level of systems. If someone is feeling oppressed, such as a visually impaired individual, their dysfunctional behavior can be the result of the oppressive environment (Ivey & Brooks-Harris, 2005). This type of behavior could be considered a reaction to ableism and presenting symptom of PTSD. The reasoning behind this is because an individual develops within a cultural context. However, developing in a cultural context in which negative messages are being perceived will include negative behaviors. Keeping this in mind is crucial (Ivey & Brooks-Harris, 2005). “Individuals develop within a cultural context. Consciousness of the self in social context is central and essential. The individualistic word *self* is replaced by *self-in-context*, *self-in-relation*, *person-in-community* (Ivey & Brooks-Harris, 2005, p. 322-323, as cited in Ogbonnya, 1994), and *being-in-relation*”

(Ivey & Brooks-Harris, 2005, p. 323, as cited in Jordan, Kaplan, Baker-Millers, Stiver, Surrey, 1991).

Formulation

The formulation of Multicultural theory focuses on the development of the identity. “A formational base of multicultural development involves assessing and understanding cognitive/emotional ways clients make sense of what is happening” (Ivey & Brooks-Harris, 2005, p. 326).

Within the formulation stage different models have been discussed. However, Ivey and Brooks-Harris (2005) found Cross’ stage of Cultural Identity theory (Ivey & Brooks-Harris, 2005, as cited in Cross, 1971, 1991, 1996; Thomas, 1971) to be the most influential. In the theory there are four stages in which the example of a female African-American is used to demonstrate her experience with the formulation process. Due to expanding the definition to include other minorities, this application can also be used for visually impaired individuals.

The first stage of the theory is *Pre-encounter*. In this stage a minority maybe locked into a dominate perspective and values, while denying those of her minority identity. An example of this is an African-American feeling locked into the White world while denying what makes her identity vitreous (Ivey & Brooks-Harris, 2005).

The second stage is referred to as *Encounter*. In this stage the minority faces the realism of an oppressive environment. She can feel emotionally jolted by this experience. During this process an African-American encounters racism which leads to momentous changes (Ivey & Brooks-Harris, 2005).

The third stage is the *Immersion-Emersion* stage. In this stage one starts to identify strongly with her minority identity. She learns of the values and begins to cling to them. In this stage the African-American is embracing her culture, while denying the White culture. Often this will lead to feeling prideful toward the ethnicity while angry towards the White customs (Ivey & Brooks-Harris, 2005).

The final stage is titled *Internalization*. In this stage a more inner sense of who she is develops. There is secure sense with identity. In this final process an African-American can decline in her anger towards White beliefs, while her connection to her own culture becomes stronger. Later on this theory was applied to other oppressed groups (Ivey & Brooks-Harris, 2005).

Applicability and Structure

Earlier I spoke of the broader definition of Multicultural theory opening up room for varying demographics which entails now including disabilities, such as visual impairments. This broader definition allowed for Multicultural theory to become more applicable for others to be viewed as oppressed minorities who also suffer the symptoms of oppression. While Multicultural theory presents ideas that are applicable to all relationships, there is not necessarily a set structure in place. The only set structure is “an ongoing attempt to see how culture impacts clients’ thoughts, actions, and feelings, as well as shape interpersonal and systemic relationships” (Ivey & Brooks-Harris, 2005, p. 326).

It is believed that the theory should work with psychotherapy and not against. With its use it recognizes “the way culture shapes thoughts, actions, feelings, unconscious conflicts, interpersonal patterns, and family systems” (Ivey & Brooks-Harris, 2005. p. 327). Multicultural

theory recognizes the dominance of culture and how it shapes the fundamentals of human experience.

Processes of Change

Within Multicultural theory there is a change process. A change process is described as a process generated during therapy. Multicultural theory contains two notable subsections. These include *Liberation of Consciousness* and *Common Factors* (Ivey & Brooks-Harris, 2005).

Liberation of Consciousness is the essential goal in Multicultural theory. It provides perspective to target identities and lets these identities view how oppression drives their lives. "... [A]ny integrative model of therapy that does not inform clients how external stressors affect client issues actually is not therapeutic in the long run. Traditional approaches whether theory-specific or integrative, that does not include multicultural issues are very much 'part of the problem' as they work within the status quo" (Ivey & Brooks-Harris, 2005, p. 327).

This goal entails highlighting the significance of developing personal, family, and organizational consciousness of the place of self-in-relation, family-in-relation, and organization-in-relation (Ivey & Brooks-Harris, 2005, as cited in Sue et al., 1996). "Psychotherapy focused on liberation may use a variety of methods to help to bring individual and group awareness of the social context. ... Awareness and consciousness require action leading towards change" (Ivey & Brooks-Harris, 2005, p. 327, as cited in Freires, 1972).

Common Factors is defined as the elements in which different therapist share in meeting the needs of the client. "Recognizing common factors starts by recognizing liberation of consciousness as a multicultural adaption of consciousness raising, a common factor described in many models" (Ivey & Brooks-Harris, 2005, p. 327). Common factors also include catharsis and

choosing. These three factors are said to be commonly used in a Multicultural Therapy practice (Ivey & Brooks-Harris, 2005).

First, *consciousness raising* helps minorities such as the visually impaired, realize how the dominate culture has formed their outlook about themselves and their culture. *Catharsis* then follows in which suppressed resentment over discrimination and cultural isolation comes to the exterior. Finally, *choosing* is when an individual opts how to articulate and direct their new-found energy (Ivey & Brooks-Harris, 2005).

Therapy Relationship

Multicultural theory stresses the notion and belief that one-on-one relationships, while important, are not always the only relationship needed. It stresses that the different systems such as individual, family, and community are vital factors to therapeutic treatment. This also could include unconventional helping roles such as an advisor or advocate (Ivey & Brooks-Harris, 2005).

Within the relationship that develops using Multicultural theory, there is a strong emphasis on utilizing *relational adaptation*. By using relational adaption the therapist becomes more in tuned and aware of the individual needs. “Relational adaptation allows for psychotherapists to create different types of relationships using different parts of their personality with different clients. The multicultural literature has consistently suggested that the therapy relationship should be adapted based on clients’ cultural expectations” (Ivey & Brooks-Harris, 2005, p. 328).

Methods and Technique

As discussed earlier, Ivey and Brooks-Harris (2005) identified four stages from Cross' Identity theory. These stages provide a blueprint to the methods and techniques in a therapeutic setting. Besides what has already been discussed in reference to methods and techniques, the code of ethics in which social workers must follow also includes their version as well. Under section 1.05 it is written that:

“(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability” (NASW, 2008, Ethical Standards section, 1.05).

Empirical Research

When discussing empirical research, Ivey and Brooks-Harris (2005) cite a few studies that have been conducted. The first is a synopsis cited by Ivey and Brooks-Harris (2005) that was summarized by Ponterotto, Fuertes, and Chen (2000). “The authors make the following key points: Nine analogue studies indicated clearly that clients responded favorably when cultural

issues were included. Satisfaction, willingness to return to therapy, and self-disclosure were all increased” (p. 333).

Ivey and Brooks-Harris (2005) specifically cite one study that was conducted by Thompson and Jenal (1994) (Ivey & Brooks-Harris 2005, as cited in Thompson & Jenal, 1994). In this study 17 out of 24 clients mimicked the previously stated findings. It was however noted that seven of the clients were unaffected. While therapists were broached early on, some did avoid cultural issues. It was felt that clients followed the therapist’s lead. This in return meant racial issues were not discussed which is hypothesized to be true for the traditional model of therapy.

To the date of this chapter being written, no randomized clinical studies involving Multicultural theory have been conducted. While the research is hopeful and analog studies hold up, there is still far to go. “Much more work needs to be done, particularly with regard to outcome. Although MCT research also includes broader issues including gender, sexual orientation, ability/disability, and many other factors, space does not permit a more comprehensive review” (Ivey & Brooks-Harris, 2005, p. 334).

Future Directions

The hope of Multicultural theory is in the future it will be integrated into therapy along with other contemporary psychological theories. “Using MCT as a metatheory helps psychotherapists recognize the cultural values that are inherent to different theories and to make conscious about intervention strategies that match with the cultural values of an individual client” (Ivey & Brooks-Harris, 2005, p. 322). It is believed this will make therapy more culturally aware of its clients and their individualistic needs. It will include environmental

factors such as oppression in a client's treatment plan. It will be realized there is not one right treatment plan for everyone. And clients who would normally be diagnosed with a disorder will be seen as in distress due to the developmental challenge placed upon the individual.

The future is “bringing into the therapeutic hour dimensions of race/ethnicity, gender, sexual orientation, and disability...Discarding the outmoded concept of self and replacing it with self-in-context, being-in-relation, and person-in-community will enable us to think of what it means to be a human in new ways. Multicultural therapy is leading us in a new direction” (Ivey & Brooks-Harris, 2005, p. 335).

Summary

Throughout this section I presented the idea that *Multicultural theory's* broader definition provides space for varying demographics beyond race to be included. This now includes those with a visual impairment. This theory demonstrates that the social environment that the visually impaired person encounters may shape their behavior. Thus meaning, a visually impaired individual belonging to a social environment in which they receive oppressed messages (ableism) will present the feelings, thoughts, and actions (Ivey & Brooks-Harris, 2005).

Trauma Theory

The next theory to be examined is trauma theory. “... [*T*]rauma refers to the enduring adverse impact of extremely stressful events” (Allen, 2001, p. 4).

Allen (2001) soon after states “... [A]n event is partly defined subjectively on the basis of the individual's perception, interpretation, and emotional response. It is not the objective event, but rather the subjective experience—based largely on the meaning the event has on the individual—that determines whether the event will be traumatic. Individual

differences play a major role in the outcome of exposure to potentially traumatic events, largely owing the role of subjectivity” (p. 5).

Herman (1992) describes trauma as an “affliction of the powerless. At the moment of trauma, the victim is rendered helpless by an overwhelming force” (p. 33). Once faced with trauma, the psychological make-up of the individual will be forever altered. A person could enter into survival mode with their symptoms of desiccations, irritability, and intense emotions taking on a life of their own (Herman, 1992).

Basham (2008) discussed trauma through a multitude of small vignettes. One vignette discusses a 24 year old male whom was diagnosed as “partially sighted” or visually impaired. As a boy, Phair was taunted by his peers. He had difficulty mastering baseball and while attempting to do so, a group of peers yelled to him he had bees on him. They would bellow statements such as “why can’t you see them?” The bees were not actually there. The vignette ends with “Phair was terrified and tried to brush off the invisible bee, while his classmates surrounded him, laughing uproariously. They reveled in his humiliation” (Basham, 2008, p. 417)

Basham’s chapter (2008) suggests this type of trauma portrays a Type II trauma or chronic repetitive trauma, meaning an ongoing event of abuse and maltreatment. This type of trauma in relation to visual impairment, or disabilities in general, can include many microaggressions, which are daily physical and verbal assaults. “We can also think about the kind of trauma that ensues in the face of daily aggressive verbal and physical assaults hurled against persons who are marginalized by their ethnicity, religion, sexual orientation, or disability” (Basham, 2008, p. 417).

Herman (1992) cautions trauma cannot be properly treated without being diagnosed. She also warns the trauma needs be named in order to explain the client's behaviors and thoughts. "While patients with simple post traumatic stress disorder fear they may be losing their minds, patients with the complex disorder often feel they have lost themselves" (Herman, 1992, p. 158). The victim must feel in control, something they lost long ago. Although, no matter the extent of trauma, without a proper support system, the occurrence of recovery becomes difficult. And throughout recovery empowerment for the client is a central focus. She discusses three stages of recovery: safety, remembrance and mourning, and reconnection (Herman, 1992).

Safety

Safety is the first mentioned in recovery. Safety begins with the establishment of a safe environment, but also with the victim of trauma trying to reclaim back their body. However, this can be difficult because often the victim sees their body belonging to the abuser.

"Securing a safe environment requires attention not only to the patient's psychological capacity to protect herself but also to the realities of power in her social situation. Even when reliable self-care is established, the patient may still lack a sufficiently safe environment to allow progression to the next stages of recovery, which involves in-depth exploration of the traumatic event" (Herman, 1992, p. 171).

Remembrance and Mourning

The second part of the recovery aspect in which Herman examines is remembrance and mourning. Herman (1992) states, "in the process of reconstruction the trauma story does undergo a transformation, but only in the sense of becoming more present and more real. The fundamental premise of the psychotherapeutic work is a belief in the restorative process of truth-

telling” (p. 181). In this stage a client will recover memories and give a narrative to their trauma. It is important the first stage of providing a safe environment was successfully completed. Both the client and the therapist must become tolerant of feeling uncomfortable on this journey and through this formed partnership (Herman, 1992).

Herman (1992) states that, “reconstructing of the trauma story begins with a review of the patient’s life before the trauma and the circumstances that led up to the event” (p. 175). Herman (1992) goes on to explain, “The person should be encouraged to talk about her important relationships, her ideals and dreams, and her struggles and conflicts prior to the traumatic event” (p. 176) The importance of this is to re-establish a connection of the client’s life with his or her past. This could better provide meaning of the trauma in relation to the client.

While the reconstruction stage is playing out, the therapist must keep in mind the goal of this stage is to put the client’s narrative into words. However, this stage could prove difficult at times for the client and even the therapist. This stage requires for the client to bring emotions to their experiences. The reconstruction stage could be insufferable and render the client wordless. The therapist could offer the client drawing or writing in place of spoken words. However, it is cautioned to be weary of notes the client wants read out of session. The idea is to bring the narrative alive in the safe environment of the room. During this stage the therapist must remain cautious about putting their own position and understanding in the client’s narrative (Herman, 1992). “What seems like a minor detail to the therapist may be the most important aspect of the story to the patient. Conversely, an aspect of the story that the therapist find intolerable may be of less significance to the patient” (Herman, 1992, p. 179). It is also vital for the therapist to bring in other senses when reconstruction is occurring. Examples are asking a client about

smells or body sensations within the trauma that could provide more completeness. When this is occurring the therapist must be a guide for the client (Herman, 1992). Herman (1992) states, “the therapist must help the patient move back and forth in time, from her protected anchorage in the present to immersion in the past, so that she can simultaneously re-experience the feelings in all their intensity while holding on to the sense of safe connection that was destroyed in the traumatic moment” (p. 178)

Herman (1992) also discusses mourning the trauma. It is described to be the most essential but also the most feared stage in recovery. A fear that develops from the client is if once they begin their grieving they will be unable to stop. In this part of the stage the client learns of their losses. Some losses may have been so diminutive or so unnoticeable the client may not have been aware of them. Herman states, “Trauma inevitably brings loss. Even those who are lucky enough to escape physically unscathed still lose the internal psychological structure of a self securely attached to others” (p. 188).

It is common for individuals to not express the desire to grieve. They could feel this offers a victory to the person responsible for the trauma. However, the step is vital. Herman (1992) explains, “To the extent the patient is unable to grieve, she is cut off from a part of herself and robbed of an important part of healing. Reclaiming the ability to feel the full range of emotions, must be understood as an act of resistance rather than submission to the perpetrator’s intent. Only through mourning everything that she has lost can the patient discover her indestructible inner life” (p. 188). This resistance can be found in different forms and behaviors displayed by the client. Herman lists revenge, forgiveness, and compensation as the three

different fantasies a therapist could encounter in a client. The most common is the desire to play out the fantasy of seeking revenge on their wrong doer.

The principle behind the revenge fantasy is often to reverse the roles of the involved parties. This would allow for the client to then become the perpetrator. Herman (1992) cautions against a client having reoccurring fantasies. “Though the traumatized person imagines that revenge will bring relief, repetitive fantasies actually increase her torment” (Herman, 1992. p. 189). The idea behind this is the fantasies could become as real as the trauma itself is. They can worsen the terror and make the client feel like the monster he or she sees the perpetrator to be. The client must instead come to understand that getting even or seeking revenge will not provide them gratification. Instead, it is hoped as he or she voices the fury that it will unhurriedly become a more gratifying form of rage, allowing for liberation from the urge to seek revenge.

The extreme opposite in relation to the revenge fantasy is being appalled by the idea of it and wanting to offer your perpetrator forgiveness. “Like revenge, the fantasy of forgiveness often becomes a cruel torture because it remains out of reach for most ordinary human beings” (Herman, 1992. p. 190). In this fantasy “her healing depends on the discovery of restorative love in her own life; it does not require this love be extended to the perpetrator. Once the survivor as mourned the traumatic event, she may be surprised to discover how uninteresting the perpetrator has become to her and how little concern she feels for his fate” (Herman, 1992, p. 190). This does not mean the client will not feel sorrow for the perpetrator, but Herman (1992) argues there is a difference between this and yearning for forgiveness.

The concluding fantasy Herman (1992) touches upon is compensation. “The fantasy of compensation is often fueled by the desire of victory of the perpetrator to erase the humiliation of

the trauma” (Herman, 1992, p. 190). This fantasy demonstrates the struggle of gaining empowerment and has little to do with material gain. Herman (1992) however points out that ironically this empowerment is gained when the client denounces their grievance against the perpetrator and no longer seeks compensation.

Another aspect of the compensation fantasy comes from when the client does not seek compensation from the perpetrator, but from the bystanders. This particular form of compensation fantasy can produce an unhealthy dynamic in the therapeutic environment. While some clients may seek economic compensation from society, others may seek special treatment from the therapist. It is not uncommon for a therapist to concede to the client. A therapist may join together with the client’s belief that the therapist has the magic wand to cure them. However, this could lead to boundary violations which would in the end be detrimental for the client (Herman, 1992). “Once this boundary is crossed, however, the therapist cannot maintain a disinterested therapeutic stance, and it is foolhardy to imagine that she can. Boundary violations ultimately lead to exploitation of the patient, even when they are initially undertaken in good faith” (Herman, 1992, p. 192).

Herman (1992) states that “the best way the therapist can fulfill her responsibility to the patient is by faithfully bearing witness to her story, not by infantilizing her or by granting her special favors” (p. 192). Herman (1992) affirms this also includes acknowledging the client is not responsible for the trauma. The therapist must also help guide the client to reach acceptance that the trauma accorded. This is the first step to empowerment.

Reconnection

The last stage Herman (1992) touches upon is reconnection. This stage involves different tasks in which the client must concur in order to create a future. “She has mourned the old self that the trauma has destroyed; now she must develop a new self. Her relationships have been tested for forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find a new sustaining faith” (Herman, 1992, p. 196).

The reconnection stage involves the client reconnecting with themselves and those around them. It involves empowerment and the reclaiming of his or her life before the trauma. “This simple statement— ‘I know I have myself’—could stand as the emblem of the third and final stage of recovery” (Herman, 1992, p. 202).

In the reconnection stage the client has become full circle with the safety stage. This safety stage again proves to be a vital part to all stages. In connecting the safety stage with the reconnection stage, the client must again learn how to navigate safely in her world. The client must learn to care for his or her body, environment, and relationships. However, the reconnection stage extends further than the safety stage does. While the safety stage’s goal was to secure a safe environment, part of the reconnection stage is to connect to it. This creates a more empowered approach to living life. Herman (1992) emphasizes that “empowerment and reconnection are the core stage to recovery” (p. 197).

The client must realize their response to danger is a heightened response in reply to their past trauma. The client must engage in facing these dangers. While this could trigger or resemble a reenactment of past trauma, it is in reality their attempt to master the feelings which

are brought upon when facing danger. Ways in which clients are placed in a controlled environment while encountering danger could be participating in a wilderness program. Another controlled environment in which a client could face their fears is confronting family members who forced the client to keep traumatic secrets. While this could be empowering for the client, it should be done with caution and only when the client is ready (Herman, 1992).

Another aspect to the reconnection stage involves the client reconciling with themselves and reconnecting with others. The client recovers the person he or she was before the trauma. They seek out old dreams and hopes they once possessed. While the client is rediscovering herself, they are always realizing their ability to trust in others again. He or she is able to display more of a true self and develop deeper relationships with peers and lovers. Within the therapeutic relationship the client will present with fewer bouts of crises and a less tense relationship between client and therapist can form (Herman, 1992).

When recovery is taking place after a trauma, a client may devote her time to helping others in some type of social action. This could include volunteer work or educating others whom have been in the client's situation. This could also include seeking justice against the perpetrator. This does not always mean the client is seeking revenge. In some cases the client is seeking justice for the well-being of herself and society as a whole (Herman, 1992).

However, even once an individual reaches the reconnection stage; it does not mean the trauma is over. It is something that will always be part of the client. What the client must learn to do is be able to face the future and place focus on the present. In order to help the client find peace Herman (1992) presents Mary Harvey and her seven criteria for resolution.

“First psychological symptoms of post-traumatic stress disorder have been brought within manageable limits. Second, the person is able to bear the feelings associated with traumatic memories. Third, the person has authority over the memories: She can elect both to remember the trauma and put the memory aside. Fourth, the memory of the traumatic event is a coherent narrative, linked with feelings. Fifth, the person’s damaged self-esteem has been restored. Sixth, the person’s important relationships have been reestablished. Seventh and finally, the person has reconstructed a coherent system of meaning and the belief encompasses the story of the trauma” (p. 213).

While there is always a chance symptoms could reoccur when triggered, with each return to the narrative a new and enlightened meaning can occur from it. “The study of psychological trauma is to come face to face with human vulnerability in the natural world and with the capacity of evil in human nature” (Herman, 1992, p. 7).

Summary

As noted at the start of the *Trauma theory* section, Basham (2008) directly links trauma to ableism by what happened to a school-aged boy. At the age of 24-years-old, Phair is still able to recall the pain he felt as he was taunted by his classmates. Bashman (2008) states this to be a Type II trauma, meaning it is ongoing, in which Herman (1992) explains to be a more complex version of trauma. Through the trauma lens we are able to view the direct link and impact in which ableism has on a visually impaired individual and the presenting symptoms that could occur, such as reoccurring thoughts for the individual and reenactments.

Thus far Chapter I has provided an introduction to the thesis and presented the research question at hand. Chapter II explored the literature, empirical studies, and vignettes to provide

an outline as to why this phenomenon is a vital concern. Chapter III provided an extensive overview of the chosen theories and why I chose them. Chapter IV will examine the phenomenon and Multicultural theory to provide a new understanding of whether systemic ableism towards those with a visual impairment elicits symptoms of PTSD. Chapter V provides the same structure yet incorporating Trauma theory.

CHAPTER IV

THEORY ONE: MULTICULTURAL THEORY

“The cultural discourse of disability identifies cultural members as sharing the experience of devaluation, limitations in civil rights, and finally anger and rage. Thus, in many ways, it behooves disabled people to define them as a culture. Cultural belongingness bestows identity, language and positions groups relative to one another. Cultural belongingness bestows collective and community where one did not previously exist and cultural belongingness distinguishes communities from one another” (Gilson & Depoy, 2000, p. 211).

This quote sets the situation in which those with a visual impairment face. While it does demonstrate the belongingness of being part of a culture, it also brings to light the devaluation, limitations of civil rights, and anger that can result from the oppressive environment they live in. It introduces the outline of the impact of belonging to a target culture, such as visual impairment, has on those who are within that group.

Assessment

Assessment provides space to reveal the direct link an environment can have on a person. “MCT points out internal emotional stress are often related to or external stressors. So-called disorder is often the reaction to disordered social conditions such as racism and oppression” (Ivey & Brooks-Harris, 2005, p. 323, as cited in Ivey & Ivey, 1998). Case in point, when a visually impaired person is feeling oppressed and subjected to ableism in their environment, this

could provide an answer as to why the individual is exhibiting behaviors in which someone would describe as maladaptive. It could also explain presenting symptoms such as of depression, fatigue, disturbance in sleep, and self-devaluation (Nosek et al., 2008).

Formulation

In this theory an identity within a culture is said to develop in four stages: *Pre-encounter*, *Encounter*, *Immersion-Emersion*, and *Internationalization*. The idea behind this is Cultural Identity Theory (Ivey & Brooks-Harris, 2005, as cited in Cross, 1971, 1991, 1996; Thomas, 1971) with the most prominent influence being Cross.

The first stage, *Pre-encounter* stage, a person who identifies as having a target identity might devalue that culture and attempt to immerse with the agent identity (Ivey & Brooks-Harris, 2005). A person with a visual impairment might attempt to deny their culture of visual impairment and attempt to pass off as belonging to the able-bodied society. The individual views the ways in which the dominate group performs tasks as the correct way things should be done. A way of denying the culture is by denying devices that would provide options that would allow the person to perform tasks more efficiently, one device being the use of a white cane. In a study of 157 males and 48 females who were all declared to have some type of visual impairment 89 of the 200 participants in the study stated they would not use their white can due to the social stigma associated with it. Some other reasons included pressures from family, fear of losing job, and safety (Christy & Praveen, 2005).

In the second stage, the *Encounter* stage, a person realizes the oppression that is associated with his or her agent identity and becomes angry (Ivey & Brooks-Harris, 2005). A visually impaired individual realizes the ableism that exists in society in which he or she lives in.

In this stage an individual would realize the world is not adapted to their needs and ableism takes place in direct and indirect forms. This stage could lead to an emotionally overwhelming experience and could cause a person to become angry towards society and could cause one to emotional withdraw from his or her environment.

In a letter Kleege (2007), wrote to the late Helen Keller long after her passing, Kleege (2007) expressed the rage she feels facing the world while blind. “Save your breath. I know how good I have it. And it’s not as if I feel I’ve been singled out for suffering. Everyone has bad days. When it snows, it snows on everyone. People miss appointments. People make annoying demands. People and things you rely on fail. And there are worse things, too—betrayal, despair, illness, death—but I’m talking about something else here. I’m talking about the fact that most of what’s wrong with this day has to do with being blind, and this is what leaves me raging. I rage against the world for being inaccessible to me. I rage against technology for offering the promise of access and then breaking down, being cumbersome, leaving me stranded” (Kleege, 2007, p. 190).

In the *Immersion-Emersion* stage one becomes grounded with the culture while developing strong feelings of anger towards the dominate culture (Ivey & Brooks-Harris, 2005). The visually impaired person could begin valuing the culture and begin to emerge with others whom he or she finds sameness with. The individual can become filled with pride towards the target identity and demand the rights as a visually impaired person to be met. Yet they could display anger towards the agent identity. A person with a visual impairment could begin to

blame those of the agent identity for the lack of adaption and acceptance of the visually impaired culture.

Kleege (2007) goes onto state that her perception of the able-bodied is to only accept the visually impaired when they are cheery and pleasant. She feels she lost the right to be angry at society. However, she expresses this rage with Helen Keller, someone whom is deaf/blind, someone who shares a common link through blindness. She does not blame Helen Keller for setting such high standards for those with a disability, but the able-bodied for creating Helen Keller's sunny disposition. Kleege (2007) believes without a certain disposition, the able-bodied would not accept the "crippled" (Kleege, 2007).

"I don't know why I bother. I don't know what I expect from you. And maybe—take this as a concession, Helen—you couldn't help yourself. Once you figured out that the only way your words would be read by anyone was if you took on the role of the first, original disability poster child. So you vowed to be the best damn poster child the world has ever known. I guess I can't blame you if the insipid, feel-good aphorisms got to be a habit. But level with me, Helen. Give me something I can use. 'Get with the program,' you could say. 'Show them your weakness, and they'll put you away in the blink of an eye. You're here by sufferance. They'll tolerate you only as long as you keep up the front. Nobody likes a grumpy cripple'" (Kleege, 2007, p. 192).

Adams (1980) discusses the different views of accepting blindness. This includes accepting ones blindness, but becoming angry towards the sighted. "... [H]e describes the phenomenon in which blind patients would form a group representing a minority against what they saw as the 'hostile, inconsiderate and stupid world of the sighted'" (Adams, 1980, p. 428).

This stage demonstrates the anger and negative perception a visually impaired individual has towards the sighted.

In the final stage, *Internationalization*, a person becomes self-confident with their culture. A person appears more unruffled and secure. A person becomes more self-assured and openness develops. A person declines in their angry emotions towards the agent group (Ivey & Brooks-Harris, 2005). A person with a visual impairment in this stage displays elements of feeling more secure with whom they are. In this final stage the pledge to the visually impaired culture could become even stronger.

In a speech by Jernigan (1997), he demonstrated triumph and pride with being part of the visually impaired culture. This speech was given after the civil rights movement took place. This movement opened the eyes of society and gave rights to those with a disability. He called the civil rights stage “the search for self-esteem and equal treatment, the yearning to belong and participate, to be part of the family and broader community. And for us, as for other minorities, there was only one way to get there, confrontation. The status quo always fights change” (Jernigan, 1997, p. 644-645).

Jernigan (1997)’s speech displayed accepting your visual impairment while merging into the sighted world, demonstrating self-confidence while showing a decline in anger towards the sighted world. He did not seek vengeance towards the sighted.

“We are capable of working with the sighted, playing with the sighted, and living with the sighted; and we are capable of doing it on terms of complete equality. Likewise, the sighted are capable of doing the same with us and for the most part, I think they want. What we need is not confrontation, but understanding, an understanding that runs both

ways. This means an ongoing process of communication and public education” (Jernigan, 1997, p. 645).

Applicability and Structure

Ivey & Brooks-Harris (2005) recognizes through Multicultural theory that our cultural experiences shape our thoughts, actions, and feelings. Through this theory we are able to witness the direct impact culture has on an individual. Therefore, when a visually impaired person is out living in an able-bodied environment his or her thoughts, feelings, and actions are being impacted by the ableism he or she faces. And the thoughts, feelings, and actions are being guided upon the idea that as a visually impaired person he or she is not as good as their able-bodied counterparts, ultimately self-devaluing themselves.

“From a sociocultural standpoint, the blind have been traditionally scorned, ridiculed, and, in general, designated as ‘second-class’ citizens. In Biblical times, blindness was a common affliction. The condition was frequently felt to be punishment for misconduct or sin, and therefore, could only be cured by God. As a rule, the blind of Biblical times were doomed to a life of hardship and poverty. Mythology also considers blindness as the punishment for sin. Best known is the story of the blinding of Oedipus who unwittingly killed his father, married his mother, and sired her children. His self-inflicted blindness represented atonement of the sin of seeing the naked parent (or the offspring that should not have been). In another legend, the man who dared to watch Lady Godiva (the peeping Tom) was also punished by blindness. Although some of the stigma of blindness mentioned previously is gone, even in modern society blind people are often shunned, overprotected or ignored” (Adams, 1980, p. 427).

Process of Change

The change of process holds within it *Liberation of Consciousness* and *Common Factors*. These two elements prove prudent in helping those in a target group understand how oppression affects them.

Liberation of Consciousness demonstrates how those with an agent identity are affected by the daily oppression they encounter and how this environmental factor induces external stress on those who belong to the culture. It illustrates how oppression guides the lives of the person. This aspect also brings to light where the individual falls in relation to him or her, the family, and organizations. It involves action in order to lead towards change.

In Jernigan (1997)'s speech he represents the voice of those who are visually impaired. He provides self-awareness to the visually impaired and the sighted alike. The ableism the visually impaired face due to the lack of education amongst the sighted about the visually impaired inspired the creation of Kernel Books, books that educate the sighted on what it means to be visually impaired. Concrete action took in order to cause change.

“At the core, all the people represented here are talking about the same thing. What they are saying is: In everything that counts we who are blind are just like you. As you read, you will recognize yourself in the story of our experience. We laugh and cry, we work and play, hope and dream, just like you. And although we don't forget we are blind, we don't constantly think about it either. We are concerned with the routine business of daily life, what we plan to have for dinner, the latest gossip, and the current shenanigans in Washington” (Jernigan, 1997, p. 646).

Within *Common Factors* lie its own subset of categories: consciousness raising, catharsis, and choosing. *Consciousness raising* informs the target culture how the agent culture has informed their approach on how they view them self (Ivey & Brooks-Harris, 2005). Meaning, a visually impaired person's devaluation of the self is a consequence of how those with "normal" vision perceive and treats him or her. Wilson (2006) describes the reactions and perceptions towards those with an impairment being the cause of the individual's pain, and devaluation. "These reactions range over a continuum from denial to rejection at one end, to guilt-ridden over-compensation at the other" (Wilson, 2006, p. 177). The dominant culture has been known to de-humanize the impaired. Sometimes even locking them away in a different part of the house and isolating them from family members. Ultimately treating them as if and making them believe they are not part of the human race (Wilson, 2006). *Catharsis* looks at the repressed anger towards the discrimination and culture isolation that comes to the surface (Ivey & Brooks-Harris, 2005). In revisiting the letter written to the late Helen Keller, Kleege (2007) an Assistant Professor at the University of California, Berkley, allows her repressed anger towards the ableism she encounters be represented through her words. She acknowledges the different aspects of her culture that bring about the anger that the sighted world does not fully understand. She discusses wondering if her students question her ability on grading and teaching because she is blind.

"I know this already. That's the thing about doubt. There you are, talking to a student and all the while you're wondering whether or not he's thinking, 'This woman is blind. How can she judge me, my work? How can she presume?' And if he goes to complain to another professor or my chair, would that person look sympathetic and say, 'Well, you

know, son, people like that feel they need to be tougher than normal people. It's overcompensation. You can put up with it. Noblesse oblige" (Kleege, 2007, p. 192-193).

Kleege (2007) asks Helen Keller point blank, "So what I'd like you to tell me is this. What did you do with the rage, Helen? Because you must have felt it. There must have been days when you woke up and all you wanted to do was pull the covers over your head and say, 'I surrender. This is too hard. Someone please take care of me.' There must have been days when you wanted to shred the sheets with your teeth" (p. 190).

Finally, *choosing* is when the person figures out how to direct and refocus their emotional engulfment (Ivey & Brooks-Harris, 2005). The visually impaired person would perhaps redirect the anger towards trying to end the ableism that has caused so much grief and suffering. I am reminded of the visually impaired individuals who took on American Online AOL to ensure it became accessible to the visually impaired who use screen readers. Instead of sitting back and letting the big cooperation win, they used their anger towards AOL and became an active member of the visually impaired culture. They sued AOL in order to be heard and to have their accommodations met (Waddall, 2000).

Relational Adaptation

Relational Adaption is defined as adapting to the preferences and needs of the individual. (Ivey & Brooks-Harris, 2005, as cited in Norcross, 1993, 2002; Lazarus, 1993). For example, relational adaption would invite those who are around an individual with a visual impairment to adapt to the needs and preferences of the visually impaired person. To explain this let's look at a visually impaired child in a school setting. The instructor would develop a relational adaption with the visually impaired student to meet the accommodations in which the student needs in

order to be successful and feel safe in the classroom environment. By utilizing relational adaptation it could make the child feel welcomed in the classroom and understood by the instructor. However, if relational adaptation is lacking, the visually impaired student could become stressed and anxious in the classroom setting. The student could find ways to evade being in the environment by presenting what could ultimately be psychosomatic symptoms and develop an avoidance. The student could begin to “act out” and be seen as disruptive due to their maladaptive defenses. Zirkle (1994) cites without accommodations being implemented for a student, a student can fail the class. Zirkle (1994) notes a teacher who belittled a student in front of classmates and withheld accommodations, ultimately upsetting the student. In this situation relational adaptation did not occur and it was at the expense of the student’s educational and emotional needs. However, in the classes in which relational adaptation was being met, in other words, accommodations were being given, the student succeeded in them (Zirkle, 1994).

Ways in which relational adaptation occurred was as of a result from the lawsuit the lawsuit that occurred on November 4, 1999 when The National Federation of the Blind sued AOL for not being accessible to their computer adaptation software. “The complaint points out that AOL has designed its service to be incompatible with screen access programs and that AOL has failed to remove communication barriers presented by its design” (Waddall, 2000, p. 22).

To this date, Internet services have improved their services for those who use software such as screen readers. These companies include Yahoo, Google, and AOL to name a few. “AOL, a unit of Time Warner Inc., will soon update AOL Web mail to make it more screen-reader friendly. The revisions, which will be under way by the end of the year, will eliminate the

need for users with screen readers to switch to a separate text-only page” (Vascellaro, 2006, para. 4).

CHAPTER V

THEORY TWO: TRAUMA THEORY

Herman (1992) recognizes that “traumatic events produce profound and lasting changes in physiological arousal, emotions, cognition, and memory” (p. 34). Herman (1992) continues by pointing out a person “may find herself in a constant state of vigilance and irritability without knowing why. Traumatic symptoms have a tendency to become disconnected from their source and to take on a life of their own” (p. 34). While reading about trauma and its impact on people, specifically those with a visual impairment in this case, one must remember trauma is subjective. What one person considers traumatic, someone else may not perceive as such.

“Trauma theory holds that there are biopsychosocial consequences to any individual when he/she sustains a serious threat. The person responds to what has happened in order to preserve physical and emotional integrity but there is a possibility that the physical, psychological, and social consequences may in fact become harmful to the individual” (Bills, 2003, p. 191-192). This can be displayed through an example Brown (2008) presents in her chapter, which was summarized in additional detail in Chapter II. Brown (2008) spoke of a male graduate student of Psychology who is Deaf. In his endeavor to attend graduate school he finds himself in an enactment of past ableism. The way in which he is being left out of optional classroom causes an emotional trigger from when he felt isolated as a child. Ultimately this leads him to display avoidance in present day, which is demonstrated by his failing out of school (Brown, 2008). This scenario can hold true for someone with a visual impairment. Those with

a visual impairment can feel isolated from various daily activities. These activities can be perceived as mundane by the population, but significant to those who cannot perform them.

Brown (2008) explains ableism as a risk factor for trauma and therefore one can present with the symptoms of PTSD. Brown (2008) expands on this by linking trauma to ableism and the exploration of self-devaluation that ableist attitudes bring to those with a disability.

In revisiting Phair (Bashman, 2008) who is visually impaired, he was taunted by his classmates and they took pleasure in the humiliation this bestowed upon Phair. This type of trauma would be considered ongoing trauma according to Basham (2008). Herman (1992) explains prolonged trauma to be multifaceted. “Disguised presentations are common in complex post-traumatic stress disorder. Initially the patient may complain of only physical symptoms, or of chronic insomnia or anxiety, or of problematic relationships” (Herman, 1992, p. 157). Herman (1992) explains things can be even more complex if the trauma began in childhood such as Phair’s did. “The patient may not have a full recall of the traumatic history and may initially deny such a history, even with careful, direct questioning. More commonly the patient remembers at least some part of the traumatic history but does not make any connection between the abuse in the past and her psychological problems in the present” (Herman, 1992, p. 157). Thus, illustrating the elicited symptoms can present as fragmented memories, anxiety, insomnia, and problematic relationships for a person who has encountered ableism as a reaction to their visual impairment.

Safety

A person with a visual impairment can feel unsafe in his or her situation if the impairment limits what he or she can do compared to peers. The individual feeling unsafe could

be in relation to the feelings of inadequacy around sighted-peers. In an unsafe environment there is always a reminder of the visually impaired person's limits. The previously spoken about graduate student (Brown, 2008) may have thrived if his environment created a safe space for him. Instead, it was perceived as a limited environment. This echoes what a visually impaired person would need as well. A person with a visual impairment cannot always participate in activities because the law does not enforce accommodations to the needs if the event is optional (Brown, 2008). For example, a visually impaired person may want to attend a weekly lecture, but because it is a choice to attend, the accommodations do not have to be met. An environment in which the student feels welcomed and able to follow along has not been established. And when this is not established a student can feel his or her self worth is not valued, feel isolated when peers attend activities, and develop avoidance to future attendance at activities in fear of not having access to all the information. These situations all described what would be considered an unsafe environment or a difficult situation (Konarska, 2007).

“A difficult situation is not always defined as stress. According to Jarosz, a difficult situation includes elements that constitute a threat or disturb an activity (such as meeting one's needs or solving a problem), or they lead to depriving one of goals s/he highly values. A difficult situation brings about a state of intensified activity and loads, or in cases overloads, the system that regulates behavior” (Konarska, 2007, p. 910, as cited by Jarosz, 1988).

In the *Safety* section Herman (1992) spotlights the significance of the establishment of a safe environment. The safe environment is not limited to the surrounding area, but also extends to social situations, such as lectures. Without the establishment the next steps cannot occur

(Herman, 1992). As pointed out previously, an aspect to completing the steps to creating a safe environment includes meeting the needs of the visually impaired individual. This aspect can decrease the chance of placing the individual in a difficult situation which could lead to stress and behavioral concerns (Konarska, 2007). Creating a safe environment also allow for goals the individual values. This would include the aforementioned student cited by Zirkle (1994). As you remember, his teacher did not provide him with the accommodations he needed in order to be successful in the classroom. In order for a safe environment to have been created, the teacher would have to have given the student his accommodations which would have allowed for him to successfully pass the class.

Mourning and Remembrance

As stated previously, a person who has experienced traumatic events at a young age could be a casualty of fragmented memories (Herman, 1992). This stage would allow for a visually impaired person to explore those memories and name the ableism he or she has endured. The individual can bring light to the symptoms that emerged when past ableism is being triggered in present day situations. It is a chance to discuss personal goals and dreams, relationships, and struggles before the trauma (Herman, 1992). This step gives an individual with a visual impairment the opportunity to appreciate personal self-worth, despite the negative messages he or she may have directly or indirectly received throughout his or her life, such as the historical truths as pointed out by Adams (1980).

Mourning allows for the individual to grieve for his or her losses (Herman, 1992). For example, those with a visual impairment may grieve for the losses he or she has encountered due to the way society limits accessibility or allows for ableism (Adams, 1980). As explained in

Chapter II, such societal losses can include driving, television watching, mobility, and an overall sense of full independence. (The Department of Veterans Affairs, 2001).

Additional aspects that enter into mourning are three different types of fantasies a person might encounter that make up this element. These fantasies include revenge, forgiveness, and compensation. In the revenge fantasy a person envisions seeking vengeance on the perpetrator, yet its outcome is often a trigger to the trauma as the individual takes on the atrocious features that his or her perpetrator possesses (Herman, 1992). In this case an individual with a visual impairment could envision seeking revenge on those who have inflicted ableism on him or her. For example, in the vignette of Phair (Basham, 2008) he could have retaliated on his bullies by invoking the same hurt and embarrassment they placed onto him when they mocked his visual impairment. In the forgiveness facet the individual will wish to seek forgiveness towards his perpetrator. This too becomes a torturous emotion for the individual due to its inability to occur (Herman, 1992). While continuing with the vignette of Phair (Basham, 2008), Phair in this stage could instead of seeking revenge, forgive his classmates. He could attribute their behavior to a lack of education (Jernigan, 1997). In the concluding fantasy, compensation, the person believes he is owed something. A feature to the compensation fantasy places blame on the bystanders (Herman, 1992). A person with a visual impairment could want to blame bystanders for their distress and for not standing by them and standing against ableism. Phair (Basham, 2008) could have felt he was owed something by his classmates that laughed at him as the bullies taunted him. He could have felt they should have compensated him for his pain. This fantasy as little to do with what he or she could achieve materialistically and has more to do with the empowerment he or she feels it would bring (Herman, 1992). A visually impaired person could become

determined to seek out compensation from the person or society. For example AOL, who executed ableist acts towards them. This could be done by means of filing a suit against them. As already stated, this has been done towards AOL, and that suit illustrated the visually impaired community did not seek out financial gain from the corporation. Their goal was to seek accessibility in order to have full use of their services with their screen readers (Waddall, 2000). However, as Herman (1992) states with all fantasies, they could lead to meandering emotions, ultimately triggering the visually impaired person to endure their symptoms all over again.

Reconnect

The final section, the reconnect stage, opens up space for the person to reconnect with himself or herself and those around the individual. In this moment he or she learns to care for his or her body, environment, and relationships. In this final stage the individual mourns his or her old self and makes room for the new person he or she is becoming. The visually impaired person becomes empowered (Herman, 1992). A visually impaired person can lose a sense of empowerment when he or she has to face ableism on a daily basis. The anxiety and self-devaluation could take over the individual life. Once developing the symptoms that were elicited due to the ableism, restoring empowerment becomes vital. Throughout this I have presented ways in which those with a visual impairment have shown empowerment. I have introduced Jernigan (1997) who speaks of Kernel Books which educate the sighted to better understand the world of the visually impaired. Instead of wondering what to do, The National Federation of the Blind took action and empowered themselves. I spoke of the group of blind individuals who sued AOL for not having accessibility to all their online features (Waddall, 2000). They realized in order to strengthen their social communication; the barrier had to be removed. And I spoke of

Kleege (2007) who used her words in order to release the anger she some day's feels about being blind in an able-bodied world.

CHAPTER VI

DISCUSSION

Throughout this thesis I have presented a concept that systemic ableism towards those with a visual impairment can elicit symptoms of PTSD. This has been accomplished by utilizing Multicultural theory as well as Trauma theory, which were explored in Chapter III. This endeavor also included examining the research that others before me have conducted which occurs in Chapter II. My research not only examined the literature, but also empirical studies and vignettes. Chapter IV and V looked at the connection between the chosen theories and the phenomenon. The discussion chapter will sum up main theory points as well as the interaction between the theories and my research. This chapter will also look at strengths and limitations, biases from my role as participant observer in the research, as well as future directions.

Multicultural Theory

Multicultural theory began with the concept and goal of better serving ethnic minorities. However, this idea expanded into including all minorities, including those with a disability (Ivey & Brooks-Harris, 2005), but more specifically a visual impairment, thus, opening up new approaches and ways of viewing the way in which ableism affects those with a visual impairment. When utilizing Multicultural theory to view ableism towards those belonging a minority group, such as the visually impaired, the reader is introduced to the ways in which an individual's behavior can be caused by the external stressors of an oppressive environment (Ivey & Brooks-Harris, 2005). You are able to see the development and process of accepting a

minority identity. For example, during the four stages of identity theory (Pre-Encounter, Encounter, Immersion-Emersion, and Internalization), you are able to watch as one begins by trying to identify with the dominant identity, such as a sighted-identity. Eventually the individual accepts his or her agent identity and becomes prideful of who he or she is, instead of being angry towards the sighted world. Jerngian (1997) remarks that while those who are visually impaired could resort to confrontation with the sighted world, what we need is an understanding between the two groups, visually impaired and sighted alike.

Historically, those with a visual impairment have been seen as “second-class”. Biblical times tell us that those who have a visual impairment occurrence of a sinful act. Their visual impairment was their punishment (Adams, 1980). These messages are what those with a visual impairment had to endure in this society. Ivey and Brooks-Harris (2005) explain that cultural experience impact the way in which thoughts, feelings, and emotions are shaped. Illustrating the negative messages the visually impaired receive from society are linked to the ways in which they respond to ableism. Liberation of Consciousness however tells us despite the oppressive environment, change can occur through action.

Common Factors introduced consciousness raising, catharsis, and choosing. The way in which a minority group, such as those with a visual impairment, has been guided by the way in which a target group views them (Ivey & Brooks-Harris, 2005). If the target group views the agent group in a negative way, this could lead to pain and suffering on the part of the agent group, the group of visually impaired individuals (Wilson, 2006). When a dominant culture views a minority in a in a negative light, this could lead to repressed anger that eventually needs to surface. Yet, in the end the person can figure out how to redirect their repressed anger (Ivey

& Brooks-Harris, 2005) and ultimately become an activist, such as the group of the visually impaired who took on AOL (Waddall, 2000). With AOL adapting their software to the screen readers for the visually impaired users, AOL practiced relational adaptation (Ivey & Brooks-Harris, 2005), meaning they met the needs and preferences of those with a visual impairment.

Trauma Theory

Through Trauma theory the trauma that those with a visual impairment face due to ableism was able to be evaluated and thoroughly examined. Herman (1992) explains safety as an important element to understanding trauma and its impact on those who suffer it. Without safety, trauma can reoccur and be retriggered. However, ableism is a common occurrence, for example in a classroom setting. Teachers can deny students of accommodations even belittle them, making the environment feel unsafe to the student. As Zirkle (1994) reminds us, the ultimate sacrifice of a teacher denying accommodations and ridiculing the student in need is at the complete expense, embarrassment, and failure of the student in the class. Ableism such as this for example could lead to fragmented memories (Herman, 1992) and triggering of past ableism (Brown, 2008).

Losses exist for those with a visual impairment. These losses include mobility and a full sense of independence (The Department of Veterans Affairs, 2001). These losses can also include social acceptance by peers. Phair (Basham, 2008) was not accepted by his peers and demonized by them due to his visual impairment. Phair could have reacted in various ways such as by taking on the characteristics of the perpetrator or he could have sought forgiveness (Herman, 1992). He also could have felt he was owed compensation by his classmates (bystanders (Herman, 1992) for laughing and for not stepping in to help him. Some other ways

in which those with a visual impairment can react to ableism is displayed by the group who sued AOL. While their goal was to not seek financial gain, their anger did seek out accommodation to their screen readers by means of using AOL (Waddall, 2000). However, another way in which to view the visually impaired who sued AOL (Waddall, 2000) is through an empowerment (Herman, 1992) lens. They stood up for what they needed in order to knock down a social barrier (Waddall, 2000).

Strengths, Limitations, and Biases

My thesis has both strengths and weaknesses. The first strength being the topic I chose to pursue. The topic in which I chose to analyze is little discussed. Most of the literature categorized disabilities as one category, instead of breaking each disability down into subcategories. By teasing out a subcategory of a disability and only focusing on those with a visual impairment, offers a realness of this epidemic within the visually impaired culture. By writing this thesis I was able to identify ways in which those with a visual impairment may react to ableism. The ways in which I illustrated an individual's reaction to ableism was by suggesting symptoms of PTSD. With the existence of the Kernel Books (Jernigan, 1997), as mentioned in Chapter V, this suggests there is a lack of education about this culture and with this thesis I am adding to the existing literature and providing further education to social workers who may encounter a visually impaired client.

Another strength in which I feel presented in this thesis was the fact I was a participant observer. As stated in Chapter I, I am visually impaired and documented as so. I believe this to be a strength because I was able to understand the impact of ableism due to enduring it myself. I could relate to how some of the theoretical concepts were useful in understanding behaviors,

feelings, and actions. However, I also feel this to be a limitation. By being a participant observer I had personal biases which affected my objectivity. These biases included going into my thesis believing my notion to be correct without first conducting the initial research. I have also struggled with my own frustration and anger toward the sighted world, and my thesis may have included a desire to share that. However, due to the demand of having to stay in a theoretical framework, only being able to rely on the literature instead of personal experience, and constant advising, I feel I did my best to work past the biases and remain as objective as possible.

Another limitation of the thesis was the lack of empirical studies and vignettes in the literature. This led me to heavily rely on the few empirical studies and vignettes which I did find. Perhaps this thesis could be a beginning for future qualitative and quantitative studies. By conducting studies in which participants are used, I believe this could offer more of a humanistic aspect to the phenomenon as well as include the voices of those with visual impairment in a direct manner. I believe the impact that these studies would bring to the social work community would be monumental. They would provide education and add to our ethical commitment to understand other cultures and find ways to perform best practice with them.

Future Directions

In this thesis I explored the phenomenon of how systemic ableism can elicit symptom of PTSD in those with a visual impairment. I consider this to be only the initial step in this epidemic. The hope of this research is that clinical social workers can use the concepts discussed in order to better serve the visually impaired population. I perceive this to be accomplished by understanding the theories I selected and applying the theoretical constructs to my research

question. While I already illustrated the idea that ableism can elicit symptoms of PTSD, clinical social workers can use this information and bring it to the next level by understanding the way in which to treat those who have faced oppression due to their minority culture status.

In order to provide best practice to a visually impaired client, clinical social workers must bear in mind the clients' needs. This means, looking at environmental aspects in a client's life, such as oppression and applying this into the treatment plan. For example, the vignette of Phair (Basham, 2008) a visually impaired boy was discussed with the focus being on his ridicule and taunting by his classmates due to his visual impairment. The oppression he faced was the direct result of his visual impairment, his culture, and his peers, all environmental factors. Recall that Basham (2008) suggested this to be a Type II Trauma, taking into account Phair's culture and environmental factors. Let us imagine the type of symptoms a boy who went through this could face. There could be possible anxiety, depression, and sleeplessness. A possible diagnosis could be depression or generalized anxiety. However, that may not take into account Phair's circumstances. Perhaps, a more suitable diagnosis could be trauma based or PTSD due to oppressive behaviors towards Phair due to his visual impairment. Even if the symptoms did not meet criteria for actual PTSD the anxiety and depression must be treated within the overall context of the way he was/is being treated.

Multicultural theory should be used as a metatheory to be integrated with contemporary theories. Ivey and Brooks-Harris (2008) affirm without this integration the needs of the client are not being met.

If a clinical social worker views a client's visual impairment through the lens of the medical model, they may only observe the client's limitations. This leaves little room to

acknowledge and appreciate environmental experiences, reactions to society's intentional and unintentional oppression, and the culture embedded in the visually impaired community. Thus, what is being proposed is perhaps an approach to better serve the visually impaired client by moving into an innovative way of viewing the visually impaired client. The way in which is being suggested is to bring multiculturalism into the assessment of a visually impaired client and to bear witness to the trauma those within the community suffer from due to ableism. In order to understand its impact this demands looking past the medical model.

Conclusion

In conclusion, I have explored the idea of systemic ableism towards those with a visual impairment and the elicitation of symptoms it can inflict on an individual. I have presented my research in a theoretical understanding with the use of two theories in which can be used to further understand the phenomenon, Multicultural theory and Trauma theory. Finally, I have analyzed the theories and applied the concepts to my research. Despite any biases I went into my thesis with, the outcome has illustrated the ways in which those with a visual impairment are impacted by the ableism that exists in today's society.

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