CHAPTER-1

INTRODUCTION

1.1 Background of the problem:

Though the percentage of visually impaired children is very less in society, their problem of living life is very tough. The definition of vision impairment by the Centers for Disease Control and Prevention (CDC) says a visually impaired person’s eyesight cannot be corrected to a “normal level”.

It may be said that visual impairment is the functional limitation of the eye or eyes or the vision system. This leads to–

1: Loss of visual acuity and inability of the person to see objects as clearly as a healthy person

2: Loss of visual field meaning inability of an individual to see as wide an area as the average person without moving the eyes or turning the head.

3: Photophobia – inability to look at light

4: Diplopia – double vision

5: Visual distortion or distortion of images

6: Visual perceptual difficulties or difficulties of perception

7: Or any combination of the above features
Low visual acuity

The CDC and the World Health Organization suggest that low visual acuity means vision between 20/70 and 20/400 with the best possible correction, or a visual field of 20 degrees or less.

Blindness

Blindness is defined as a visual acuity worse than 20/400 with the best possible correction, or a visual field of 10 degrees or less.

Legal blindness in the US means visual acuity of 20/200 or worse with the best possible correction, or a visual field of 20 degrees or less.

Measuring visual acuity

Visual acuity is measured by use of a Snellen’s chart. The chart consists of random letters and numbers of various sizes set at a distance of 6 feet. The best possible vision if 6/6. Visual field is the width of the vision without moving or turning the head. It is measured in degrees.

Causes of vision impairment

Vision may be impaired due to multiple reasons. These could be due to eye damage, failure of the brain to receive and read the visual cues sent by the eyes etc.

Underlying diseases may also cause visual impairment. The commonest cause is diabetic retinopathy, age-related macular degeneration, formation of cataracts and raised pressure within the eyes leading to glaucoma.
Who does visual impairment affect?

Although impairment of vision can occur at any point in life, it is more common among the elderly. Sometimes visual impairment may be inherited. It manifests at birth or in childhood in such cases. Common conditions are retinitis pigmentosa, genetic or developmental abnormalities etc.

These children with partial or complete impairment are often developmentally delayed especially in gross and fine motor skills. Visually impaired adults struggle with gainful employment and day to day activities.

How many people are visually impaired?

Some estimates suggest the approximately 10 million people in the United States are blind or visually impaired. Some sources suggest that one million adults over the age of 40 are blind, and 2.4 million are visually impaired. It is estimated that as the elderly population swells over the years, the number of adults with vision impairments is expected to double. Figures also show that only 46% of working-age adults have vision impairments and 32% of legally blind adults of working age are gainfully employed.

In this context, the role of parents of visually impaired children is become much critical, because each and every stage their help is needed to their wards. Parents are the main referral source of information. They always think and work about their children so the parents are found always under stress and emotionally disturbed. They feel that disability of their children is curse for them. This situation creates stress and disturbs their mood constantly.
1.2 Concept included in the study:

As concerned to parents of visually impaired children two psychological problems are associated. These are stress and their mood state. Their description is as follows.

1: Visual Impairment:

According to world health organization, any handicap person going through the above stages. If anyone has low vision, eyeglasses, contact lenses, medicine, or surgery may not help. Activities like reading, shopping, cooking, writing, and watching TV may be hard to do. The leading causes of low vision and blindness in the United States are age-related eye diseases. Other eye disorders, eye injuries and birth defects can also cause vision loss.

Whatever the cause, lost vision cannot be restored. It can, however, be managed. A loss of vision means that you may have to reorganize your life and learn new ways of doing things. If you have some vision, visual aids such as special glasses and large print books can make life easier. There are also devices to help those with no vision, like text-reading software and Braille books.
Definition

In India, the broad definition of visual impairment as adopted in the persons with Disabilities (Equal Opportunities, protection of Rights and Full Participation) Act, 1995 as well as under the National Programme for Control of Blindness (NPCB) is given below:

Blindness: refers to a conditions where a person suffers from any of the following conditions, namely:

* Total absence of sight; or

* Visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye even with correction lenses; or

* Limitation of the field of vision subtending an angle of 20 degree or worse.

For deciding the blindness, the visual acuity as well as field of vision have been considered.

Low Vision:

The person with Disability Act, 1995 also recognizes low vision as a category of disability and defines it as follows:

“Person with low vision” means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device”. 
This definition is incomplete as it inadvertent omits quantification of the acuity as well as the field of vision as is done in the case of the WHO definition. It is desirable to modify this definition and the following quantification should be added.

Low vision are those who suffer visual acuity between 20/200 to 70/200 (Snellen) or 6/18 to 6/60 in the better eye after the best possible correction or a field of vision between 20 to 30 degrees”.

The WHO working definition of Low Vision (WHO, 1992) is as follows.

“A person with low vision is one who has impairment of visual functioning even after treatment, and/or standard refractive correction, and had a visual acuity of less than 6/18 to light perception or a visual field of less than 10 degrees from the point of fixation, but who uses, or is potentially able to use, vision for the planning and/or execution of a task”

The points emphasized are that is significantly reduced vision visual performance is affected but that there still is vision that can be used. This last point is very important: if there is usable vision, training to use that vision might be possible. In addition, this person is not labeled blind.

The WHO working definition has been adopted since WHO Consultation in 1992. This working definition is solely used for reporting purposes and should not be used for eligibility of services.

The importance of the functional definition lies in the ‘label’ people is given. Someone with a visual acuity of 2/60 can have useful vision, for
example, for mobility. However, he or she will be labeled blind person. The consequence is this person is than treated as if he/she is a blind. This ignores the usable vision. There should be a difference between legal blindness and functional blindness or low vision.

The WHO standard definition defines as visual acuity of less than 3/60 in the better eye with the best possible correction as compared to that of 6/60 in India. The WHO functional definition, however, considers blindness starting at light perception or when a person has no usable vision. Similarly, a person with visual acuity better than 3/60 but equal or less than 6/60 is graded as “blind” in India, while WHO grades him as low vision.

In India a person with <6/60 is legally blind, which enables to receive certain services and financial benefits. However, a person who is legally blind can still have useful vision to do certain tasks, as can be seen in the working definition. This refers to the fact that they still have functional vision, which is the use of vision for a particular purpose.

For India or other developing countries, it is essential to maintain the legal definition of blindness at the level of visual acuity of 6/60 (20/200 Snellen) or less and field of vision of 20 degree or less. Already the travel concessions, scholarship and other benefits are very meager, if “perception of light” to “no perception of light” is considered blindness, a large of persons who are at present availing these concessions would fall outside the eligibility criteria and thus remain bereft of these benefits. Alternatively, if these
concessions are extended to all the persons with low vision in the acuity range of 6/18 to “perception of light” as defined by WHO, the appropriate Government may not be able to meet the demand due to financial constraints. For India and other developing countries, it is desirable to maintain the definition of blindness as adopted in the Persons with Disability Act, 1995, i.e. visual acuity of 6/60 (20/200) or less and field of vision of 20 degree and less and to consider all the persons in the range of acuity of 6/18 to 6/60 (20/60 to 20/200) as persons with low vision.

Thus the recommended definition for low vision in Indian context should be “Low vision are those who suffer visual acuity between 20/200 to 70/200 (Snellen) or 6/18 to 6/60 in the better eye after the best possible correction.

One - Eyed Person: - There is a controversy regarding the inclusion or one-eyed person in the category of blindness. The definition of blindness adopted in India exclude people with impairment only in one eye from the purview of blindness. Even in medical parlance, disability is synonymous to the physical impairment and the level of such impairment has been prescribed for certifying a person to be disabled. Generally, the impairment of 40 percent or more is considered a handicap. As percentage of impairment in the case of a no-eye person is only 30 percent, according to the approved definition in medical parlance, a person with one good eye in not a blind person. In short, a person
with one good eye is not a blind person. In short, a person with visual impairment of 40 per cent or more is considered a blind person.

The Committee of the Ministry of Social Justice and Empowerment on Recommendation of Standard Definition of Disability recommended that one eye-eyed person should be excluded from the other categories of visual impairment so that facilities and concessions available to severely and profoundly visually impaired persons are not eroded. The committee, however, felt that loss of one eye would not be considered as a disqualification on medical grounds unless a particular post is of such a technical nature that it requires of a person to have the coordinated use of both eyes or dimensional vision.

**Persons with Deaf-blindness**

Deaf blindness is a condition presenting other difficulties than those caused by deafness and blindness. It is an ‘umbrella’ term which can include children and adults who may suffer from varying degrees of visual and hearing impairment, perhaps combined with learning difficulties and physical disabilities, which can cause:

* Severe communication

* Developmental, and

* Educational problems.

It includes children and adults who are:
* Blind and profoundly deaf
* Blind and severely or partially hearing
* Partially sighted and profoundly deaf
* Partially sighted and severally or partially hearing

(Source: Contact (1993) A Resource for Staff Working with Children who are Deaf and Blind, Edinburgh: Moray House)

2: Stress:

Stress is a term that refers to the sum of physical, mental and emotional strains or tensions on a person. It also represents feelings of stress that result from interactions between people and their environment, which are perceived as straining or exceeding their adaptive capacities and threatening their well-being. In addition, stress has wide psychological and physical effects such as cardiovascular problems, musculoskeletal problems, headaches, gastrointestinal problems, sleep disturbance and depression (Ghaleb, 2008).

Stress is derived from the Latin word “strainger” (to draw tight) and was popularly used in the seventeenth century to mean “hardship, straits; adversity or affliction” In physical science, the term stress refers to the internal force generated within a solid body by the action of any external force.

In ancient Greece, Hippocrates, The “father of medicine.” clearly recognized the existence at healing power of nature mod up of inherent bodily mechanism for restoring health after exposure to pathogens. The nineteenth
century French physiological Bernard enormously advanced the subject by pointing out that the internal environment of a living organism must remain fairly constant despite changes in the external environment. (Schechter 1993)

Every human being has own understanding of stress, because all demands of adaptability do evoke the stress phenomenon. Selye (1974) beautifully summarized the nature of stress in the following words.

Every body knows what stress is and yet in so many different contents that there is confusion regarding the exact meaning of the term few definitions of stress are given below and they are useful according to scope and clarity.

“Stress is a any condition that disturbs normal functioning.’’

(Arnold, 1980)

“Stress refers to physiological, behavioral and cognitive responses to events appraised as threatening or exceeding one’s coping responses and options”.

(Selye 1974)

“Stress is the state of an organism where he perceives that his well-being is endangered and that he must divert all his energies to its protection.”

(Coper and Appley, 1964)

“Stress is a dynamic state within an organism in response to a demand for adaptation.”

(Wolff. 1968)
“Stress is stimulus or situation to which man reacts with learned coping mechanism activated by homeostasis principle and fuelled by energies which are in finite supply.”

(Captan, 1964, marsh and copper 1979)

“Stress is defined in terms of tolerance, stressful environment which are those that are outside the normal tolerance limit of daily function at extreme level; stimulation might be perceived as pain.”

(McGrath, 1974)

Perhaps, no construct in psycho-social research has been more difficult to define than stress. Therefore, there is clearly no satisfactory definition of stress which encompasses the social. Psychological and biological issues as they certain to individual Stress is multifaceted in nature and stress response arousal involves every set of organs and tissues in our body. Thoughts and feelings are clearly intertwined with these physiological processes.

The most recent development in scientific psychology has been concerned with the psychology of emotions. The emotional life was considered better than the rational life because it was directly connected with the body. These theorists of antiquity and feeling at all us psychological problem attribute them to a Lower type of soul. The whole direction at our schooling in ethical problems and problem of correct behavior has been. Until very recently schooling in emotional inhabitation, the child must learn to control his love and his hates, his fears and rages, his moods of excitement and depression despite
the fact that civilization requires emotional control and emotional inhabitation
most at us who are honest with ourselves realize that were in not for the
promise of certain emotional satisfaction. Life would be scarcely worth living
at all.

No doubt many points in the older views regarding emotions were
basically sound. It is obvious to everyone that, must be curbed at sometimes
and redirected at others the modern view breaks with the order per scientific
view not at all another question of ethics but rather and question as to the
nature of the emotions. Emotions are today considered as natural phenomenon
exactly as worthy at psychological study as any other form at behavior.

As the age grow young and old both may regress to infancy, to escape
reality, becoming depended on others for care. Thus the emotional disturbances
such as anxiety, depression, aggression, conflict, fatigue at Quilt feeling,
among youths may be seen commonly in several cases. Some common
emotional states are described here.

Important contribution of different theorists in the development of the
concept of stress is listed below.

**The Yerkes Dodson law:**

The Yerkes Dodson law was first formulated in 1908 This Law
postulates that, up to a point, arousal increases performance. After an optimal
arousal peak, however permanent goes down as arousal continue to rise
(Schafer 1992)
**Walter-cannon; fight or flight.**

Walter cannon (1932), considered stress to be a disturbance of homeostatic under condition of lack of oxygen, cold heat and the like he emphasized the Role of the sympathetic nervous system during periods of disturbances. He identified the fight or fight response, the body’s mobilization to face external threat.

**Hans selye: The general Adaptation syndrome.**

Selye coined stress syndrome as general Adaptation syndrome (GAS) and it is made up of three stages.

1) Alarm Reaction; The organism’s reaction when it is suddenly exposed to diverse stimuli to which it is not adapted. The reaction has two phases stock phase and counter shock phase.

2) Stage of Resistance - The organism’s full adaptation to the stressor and the consequent improvement or disappearance of symptoms.

3) Stage of exhaustion; sine adaptability is finite, exhaustion in exorable follows if the stressor is sufficiently sever and prolonged, Symptoms reappear and if stress continues unabated death occurs. Holmes and Rahe: Stress as a Result of Clustering of life events:-

In 1960s, Holmes and Rahe noticed that illness seemed to increase during times of rapid personal change. Holmes and Rahe developed a rank ordering of life events in terms of average stressfulness among several
thousand respondents, Lazarus and colleagues (1984) has recently extended the view that minor adjustment may have more negative impaction well-being of individual.

Stress was originally referred to as a biological reaction to a stressful stimulus. Selye (1946) found that when an individual is exposed to extreme heat or cold, they exhibit a set of bodily reactions. This he referred to as stress. However, today, when people are working longer hours, have more demands on their time from family and work as well as changes in the use of technology, individuals commonly use the word 'stress'; 'I've had a very stressful day'. The concept of stress has almost become an accepted part of everyday working life. This type of stress generally refers to individuals also feeling under pressure. It is when the feelings of stress start to have negative effects on the individual and their working and family life that problems may ensue. The level of stress that can be coped with by each individual is very different. According to Lazarus (1993), stress represents a relationship between a person and their environment, which they perceive as significant to their well-being as the demands exceed the individual's coping resources. These differences in perception have been explained by the Cognitive Activation Theory of Stress (CATS), in which an individual's response to the stress stimuli is dependent on their expectation of responses they have in order for them to cope with the situation. If the coping mechanism is expected to provide positive results, the stress experienced by the individual will be reduced. If a lack of coping is expected to produce negative results, then ill health may manifest.
The way in which the body responds to stress is due to the person seeing a threat to their well-being. As a threat arises an individual's sympathetic nervous system is activated, which increases blood pressure and heart rate. Pupils are dilated and there is a reduction in pain sensitivity and an increase in our attention. These changes prepare an individual for fight or flight. The fight or flight response dates back to prehistoric times where individuals had to be aggressive to ward off predators and the flight response involved fleeing from predators. Although this does not occur in organizations, the notion still exists. The fight response can be seen when individuals become involved in confrontations and the flight response may be evidenced by an individual withdrawing from a situation. For example, an individual is involved in conflict with a peer at work. This has been a result of a misunderstanding regarding project deadlines. The issues have become very confrontational. If the individual is to 'fight', they would put forward their argument and stand their ground. If the individual decided to adopt the position of 'flight', they would withdraw from the situation to avoid a confrontation.

Work-related stress is a complex issue and is estimated to cost the UK in excess of £530 million and 14 million working days per year (Health and Safety Executive, 2007). A study by Smith, Wadsworth, Davey Smith and Peters (2000), which investigated the scale of occupational stress in a randomized sample of 17,000 people from Bristol, UK, found that over 20% of individuals (4,000) reported that they had high or extremely high levels of
stress at work as a result of stressful working conditions that impaired their mental and physical health.

Stress at work, according to Melhuish (1978), can be described in four different ways, dependent on the level of pressure felt by the individual.

1 Hypo-stress. Stress can be caused by boredom or too little pressure being felt by the individual. This can manifest itself in depression, frustration and indifference.

2 Eu-stress. When an individual feels optimum pressure they can thrive in the work situation. Eu-stress is where stress is a motivating factor and encourages an individual to perform to their highest ability.

3 Hyper-stress. Stress becomes so extreme that stress reactions occur. Such reactions can vary from person to person. Symptoms when a person is in this state of stress can include feeling out of control, panic, and feeling that they are unable to cope with the situation.

4 Distress. Distress is a symptom of continuous stress. This can have a negative impact on both the individual and the organization. The individual can experience physical and mental health problems and may voluntarily leave the organization.

Theories of stress fall into two main camps: the interactional stress theory and the transactional stress theory.
Interactional Stress Theory:

The interactional stress model has been directed by two main models. The first is the demand control model, also referred to as the job-strain model (Karasek, 1979), and the effort-reward imbalance model (Siegrist, 1996). The job-strain model's focal point is on the interaction between the work environment and the worker's autonomy in making decisions. The model allows for four job types.

1 High strain jobs. These are characterized by high demands and low levels of control. This type of job is the most risky to an individual's health.

2 Active jobs. These are characterized by high demands and high controls. This type of job is less risky to an individual's health.

3 Low job strain. These are characterized by low demands and high controls. This is characterized by below average levels of job strain.

4 Passive jobs. These are characterized by low level of demands and controls. Average levels of job strain may be shown as this type of job can be demotivating.

Later, the model also included social support as this was found to be a buffer to the experience of stress. However, there are disadvantages of this model. For example, it fails to consider external factors such as technological changes, legislative changes, globalization and economic changes. However, there is evidence in support of this model. A meta-analysis by Stansfeld and
Candy (2006) found that a combination of high demand levels and low decision autonomy was a risk factor for mental health problems.

The effort-reward imbalance model (ERIM) suggests that stress is caused by an imbalance between a person's effort and the reward they receive. Effort at work occurs due to a contract between the individual and the organization; rewards can represent money, career opportunities, job security and praise. If the effort is perceived as outweighing the rewards, emotional distress ensues that can lead to stress being experienced. There are two main conditions where emotional distress can manifest. First, if a work contract is poorly defined and the individual has little choice of alternative work opportunities; secondly, if the individual accepts the imbalance for strategic reasons and/or over-commits due to occupational demands. Over-commitment includes attitudes, behaviors and emotions. This model allows stress to be predicted including coronary heart disease. Stansfeld and Candy (2006) found that high effort and low reward was a risk factor for common mental health problems such as anxiety and depression. The interactional stress theory and associated models have now been superseded by the transactional stress theory.

**Transactional stress theory**

The transactional stress theory (Lazarus & Folkman, 1984) takes into account the changing relationship between the person and the working environment. This involves three interlinked processes:

1) Antecedent factors;
2) Cognitive perceptual processes that result in the emotional experience of stress;

3) Correlates of the experience such as impact on health.

This theory is based on an individual's subjective experience and their coping resources. The manifestation of stress, according to this theory, can be psychological, physiological, social or behavioral. The theory also recognizes individual differences in the perception of stress, thus explaining why one person may perceive an event or situation as stressful whereas another person may not. Much research has been carried out into causes of stress in the workplace and these are now discussed in more detail.

**Causes of stress**

The causes of stress have been the topic of research over many decades. As far back as 1967, the first Whitehall study of 18,000 men in the Civil Service was conducted, followed by a study in 1985 that included over 10,000 civil servants; one-third women and two-thirds men. Findings from these studies have been used to influence policy and help organisations with the development of appropriate policies and procedures to help improve well-being and the lives of employees. The main findings from the studies are reported by Cranwell-Ward and Abbey (2005) and are detailed below.

1 The social gradient. The studies showed that the organisation of work, the work climate, social influences and a lack of physical activity all play a part in the social gradient of health.
2 Demands and control at work. High demands and low control contribute to stress at work. As a person is promoted up the organisational hierarchy, the demands increase, whereas the lower down the hierarchy the less control a person has. People with lower control have higher sickness absence, mental health issues and heart disease.

3 Social support at work. Having supportive colleagues at work provides a buffer to stress and people who have strong social support have less sickness absence. Lack of social support is associated with stress at work.

4 Effort-reward balance at work. High effort without reward causes stress. The Whitehall study also found that this can relate to an increase in the risk of heart attack.

5 Job insecurity. Secure jobs have a very positive effect on health, well-being and satisfaction at work.

6 A healthy diet, exercise and quitting smoking reduce stress levels.

7 An active social life outside work can have a positive effect on an individual's health. This can include informal contact with friends and family and more formal involvement in groups and organizations.

8 Organizational change. Changes in management structure, management style and redundancy can all have a negative impact on an individual's health.

Organizational change in the last two decades has been dramatic. Globalization has had a dramatic impact on the world of work. This is due to an
increase in trade and competition across countries and the need for workers to be more mobile. This may also result in employees being more culturally diverse, as organizations may be located in different countries while still working together. Technological advances have also impacted on the workplace. The use of mobile technology such as smart phones that allow employers and employees 24/7 access to each other increases demands on individuals. Such variations in working practices may result in attitude changes towards work and job security. With an increase in redundancies and more outsourcing of work, individuals are not expecting a job for life, but have a constant sense of uncertainty that may lead to stress.

**Consequences of stress**

The Health and Safety Executive (2011b) states that physical effects of stress include heart disease, back pain, headaches, gastrointestinal problems as well as psychological effects including anxiety, depression, loss of concentration and poor decision-making. Depression and anxiety are the most common stress-related complaints seen by general practitioners, with 20% of the UK working population affected. Stress can also lead to negative behaviors that may impact on health including social withdrawal, aggressive behavior, alcohol/drug abuse and eating disorders.

When stress is prolonged burnout can occur. Burnout is defined by Pines and Aronson (1988) as 'a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations'. This
can be characterized by symptoms such as waking up as tired as when you went to sleep; lacking energy; evaluating oneself negatively; physical exhaustion; insomnia; and an increase in the use of drugs and alcohol. As well as individual consequences of stress there are also consequences to the organization including a reduction in productivity and quality, an increase in sickness absence and a higher turnover of staff. It is, therefore, important that interventions are put into place to deal with stress at work.

Coping with Stress

Research has focused on coping with stress from the individual employing their own coping methods to organizations implementing stress management programmes and, in severe cases, medical intervention. However, the way in which a person or organization copes is dependent on the causes of stress. These coping methods are now discussed.

Individual coping strategies

From an individual coping perspective, Billings and Moos (1981) outlined three general coping methods that individuals may employ.

Active Cognitive: The individual manages the appraisal of the stressful event. The individual changes the perception of their appraisal of the event by challenging irrational thoughts such as 'I can't do this on time' or 'I don't have the skills to carry out the task'. This allows the individual to cognitively restructure their perceptions of an event or situation to make it more positive.
Active Behavioral: The individual deals with the stressful situation they are faced with. The issue is addressed and colleagues support the individual in working through the stressors faced. Social support represents a coping strategy employed by the individual.

Avoidance: The individual avoids the stressful situation. Although the stressor is still present, it is avoided or ignored.

The option an individual may choose may depend on how confident they are in their ability to deal with the situation. This is known as self-efficacy. A person who has high self-efficacy is more confident and is better able to deal with stressful situations than those with low self-efficacy, as these individuals do not believe they can deal with the situation.

Other individual coping strategies also exist, such as:

  Reward substitution, where individuals stop seeing their work as a source of reward and see other activities or tasks they do as rewarding such as going to the gym, seeing family etc. Even those activities outside the workplace that may be boring or unpleasant should be viewed as rewarding. However, the realism of this can be questioned.

  Positive comparison is another way to make you feel better. This involves comparing the stressful situation with another situation that was even worse and which you coped with or, alternatively, making comparisons with people who are worse off than you.
Optimistic action appears to be a more proactive approach and more realistic than the other two approaches as it involves bringing about change. The change is not made all at once, but in small stages. An individual would list all the issues they have with a current situation and then rate them on how serious they perceive each component. Individuals start with the least serious items and change them, which makes them feel more positive about the situation and allows them to deal with the more serious items on the list.

**Organizational strategies**

As can be seen, by the individual coping strategies, individuals are required to change either their behavior or their cognitive thought processes. What this approach does not include is that organizations may be able to make changes to working practices or policies that may remove the stress altogether. For example, for work overload, time management training for staff may help reduce stress levels. This will enable the individual and the organization to assess time spent on each task and reduce the time, change the way the work is carried out or reduce the amount of work to be carried out in order to reduce overload. Delegation is another way to manage workload. There is a limit to the amount of work any individual can do on their own. Delegation allows an individual to pass some of their work to another person who is qualified and skilled to carry out the task. Including checkpoints at certain stages of the job allows the delegator to maintain control of the work as well as ensuring the work is being completed to the standard required. Checkpoints enable the
individual undertaking the task to ask any questions or raise any concerns they may have. Managers can also set realistic deadlines. This allows an individual to complete tasks that they are reasonably able to complete and reduces the stress felt by individuals when they are unable to meet unrealistic deadlines. Managers can also reduce role conflict by providing employees with clear definitions of their roles and responsibilities as well as providing them with the opportunity to participate in decisions that affect their jobs. Organizations can aid in the reduction of stress, but individuals also need to implement coping methods to deal with their feelings of stress.

Where individuals are not able to cope with stress at work and the organization cannot make changes to relieve the stress, stress-reduction interventions (Cox, Leather and Cox, 1990) maybe implemented. Interventions maybe implemented at three main levels.

Primary Level:

Involves organizations changing the source of stress such as clarifying an individual's role if there is uncertainty, ensuring a good person-job fit, providing training on new jobs or new technology.

Secondary Level:

Involves providing the individual with stress management training. This would involve individuals managing their symptoms of stress through relaxation and educating them on the process of stress.
Tertiary Level:

Involves health promotion and workplace counseling. This is employed when the previous two levels have failed and may involve medical help.

3: Mood States:

The theoretical foundation of mood states is correlated to the attribution theory. Peak arousal for optimal athletic performance is a function of both positive and negative effect. The extent are variations in performance of athletes related to the variations in their moods various from one performance to the next cannot because of state acquisition and loss, but might at least partly be explained by concomitant changes in the performers mood states in other words performance variation may be related to what mood the athlete may be in at the time of that particular performance and may or may not affect their ability to consistently perform at their best.

The term positive affect refers to a pleasure, engagement or the extent to which a person avows a zest of life which includes states such an enjoyment, happiness, excitement, enthusiasm, and uptimes, on the contrary the term negative affect refers to negative feelings such as unhappiness, upset or unpleasantly aroused (Watson & Tellegen 1985) and including states such as anxiety, fear, tension and stress.

A positive mood which has states of high arousal and high pleasure has been linked to range of performance related behavior (Baron. 1990, forgas 1998, staw & Barsade, 1993) for example, anxiety has been linked for many
years to a negative state of around has been linked for many years to a negative state of arousal. Today that thought has changed Some athletes claim that high Levels of anxiety promote a zone of optimal functioning (Williams & Lerance 1992) hence allowing athletes to view anxiety as something that should be faced constructively rather that avoided at all costs (hesti & sewell, 1999) In contrast, negative mood such as displeasure or lethargy (Low arousal) has a negative association with performance and possibly inhibits full function of the athletes. for example in extreme cases the inability to cope with persistent bouts of acute (sudden) stress in sport may Lead to decreased motivation emotional distress poor athletic performance out eventual psychological burnout and withdrawal from competitive sport (Anshell 1996; Although acute stress is inherent in competitive sport, athletes can reduce its impact on their emotions and performance by using effective coping strategies (Anshal, Brown & Brown 1993).

For the present research, researcher has considered following states of moods of the parents of visual impairment children.

1: Anxiety

2: Depression

3: Regression

4: Fatigue

5: Guilt
6: Extraversion

7: Arousal

Following is the brief explanation of each concept.

1: Anxiety:

Anxiety is an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth, physical complaints. It is the subjectively unpleasant feelings of dread over anticipated events. Anxiety is not the same as fear, which is a response to a real or perceived immediate threat; whereas anxiety is the expectation of future threat. Anxiety is a feeling of fear, worry, and uneasiness, usually generalized and unfocused as an overreaction to a situation that is only subjectively seen as menacing. It is often accompanied by muscular tension, restlessness, fatigue and problems in concentration. Anxiety can be appropriate, but when experienced regularly the individual may suffer from an disorders.

People facing anxiety may withdraw from situations which have provoked anxiety in the past. There are different types of anxiety. Existential anxiety can occur when a person faces negative feelings. Anxiety can be either a short term 'state' or a long term "trait". Anxiety disorders are a group of mental disorder characterized by feelings of anxiety and fear, whereas trait anxiety is a worry about future events. Anxiety disorders are partly genetic but
may also be due to drug use including alcohol, as well as withdrawal from certain drugs. They often occur with other mental disorders.

Anxiety is distinguished from fear, which is an appropriate cognitive and emotional response to a perceived threat and is related to the specific behaviors of fight-or-flight response, defensive behavior or escape. It occurs in situations only perceived as uncontrollable or unavoidable, but not realistically so. David Barlow defines anxiety as "a future-oriented mood state in which one is ready or prepared to attempt to cope with upcoming negative events," and that it is a distinction between future and present dangers which divides anxiety and fear. Another description of anxiety is agony, dread, terror, or even apprehension. In positive psychology, anxiety is described as the mental state that results from a difficult challenge for which the subject has insufficient coping skills.

Fear and anxiety can be differentiated in four domains: (1) duration of emotional experience, (2) temporal focus, (3) specificity of the threat, and (4) motivated direction. Fear is defined as short lived, present focused, geared towards a specific threat, and facilitating escape from threat; while anxiety is defined as long acting, future focused, broadly focused towards a diffuse threat, and promoting excessive caution while approaching a potential threat and interferes with constructive coping.

Anxiety can be experienced with long, drawn out daily symptoms that reduce quality of life, known as chronic (or generalized) anxiety, or it can be
experienced in short spurts with sporadic, stressful panic attacks, known as acute anxiety. Symptoms of anxiety can range in number, intensity, and frequency, depending on the person. While almost everyone has experienced anxiety at some point in their lives, most do not develop long-term problems with anxiety.

The behavioral effects of anxiety may include withdrawal from situations which have provoked anxiety in the past. Anxiety can also be experienced in ways which include changes in sleeping patterns, nervous habits, and increased motor tension like foot tapping.

The emotional effects of anxiety may include "feelings of apprehension or dread, trouble concentrating, feeling tense or jumpy, anticipating the worst, irritability, restlessness, watching (and waiting) for signs (and occurrences) of danger, and, feeling like your mind's gone blank" as well as "nightmares/bad dreams, obsessions about sensations, a trapped in your mind feeling, and feeling like everything is scary."

The cognitive effects of anxiety may include thoughts about suspected dangers, such as fear of dying. "You may ... fear that the chest pains are a deadly heart attack or that the shooting pains in your head are the result of a tumor or aneurysm. You feel an intense fear when you think of dying, or you may think of it more often than normal, or can't get it out of your mind."
2: Depression:

Depression is a state of low emotional mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless. They may lose interest in activities that were once pleasurable, experience overeating or loss of appetite, have problems concentrating, remembering details or making decisions, and may contemplate, attempt or commit suicide. Fatigue, aches, pains, digestive problems or reduced energy may also be present.

Depressed mood is a feature of some psychiatric syndromes such as major depressive disorders, but it may also be a normal reaction to life events such as bereavement, a symptom of some bodily ailments or a side effect of some drugs and medical treatments.

Life event is a major cause of depression. Visual impairment is also a life event. Parents of visually impaired children have gone through the events. Adversity in childhood, such as bereavement, neglect, unequal parental treatment of siblings, physical abuse or sexual abuse, significantly increases the likelihood of experiencing depression over the life course.

Life events and changes that may precipitate depressed mood include childbirth, financial difficulties, job problems, a medical diagnosis (cancer, HIV, etc.), bullying, loss of a loved one, natural disasters, social isolation,
relationship troubles, jealousy, separation. Adolescents may be especially prone to experiencing depressed mood following social rejection.

Although depression may occur only one time during your life, usually people have multiple episodes of depression. During these episodes, symptoms occur most of the day, nearly every day and may include:

1: Feelings of sadness, tearfulness, emptiness or hopelessness
2: Angry outbursts, irritability or frustration, even over small matters
3: Loss of interest or pleasure in most or all normal activities, such as sex, hobbies or sports
4: Sleep disturbances, including insomnia or sleeping too much
5: Tiredness and lack of energy, so even small tasks take extra effort
6: Changes in appetite — often reduced appetite and weight loss, but increased cravings for food and weight gain in some people
7: Anxiety, agitation or restlessness
8: Slowed thinking, speaking or body movements
9: Feelings of worthlessness or guilt, fixating on past failures or blaming yourself for things that aren't your responsibility
10: Trouble thinking, concentrating, making decisions and remembering things
11: Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide
12: Unexplained physical problems, such as back pain or headaches

For many people with depression, symptoms usually are severe enough to cause noticeable problems in day-to-day activities, such as work, school, social activities or relationships with others. Other people may feel generally miserable or unhappy without really knowing why.

3: Regression:

Regression, according to psychoanalyst Sigmund Freud, is a defense mechanism leading to the temporary or long-term reversion of the ego to an earlier stage of development rather than handling unacceptable impulses in a more adult way. The defense mechanism of regression, in psychoanalytic theory, occurs when an individual's personality reverts to an earlier stage of development, adopting more childish mannerisms. Psychiatrist Joel Gold suggests that careful use of "ARISE" (Adaptive Regression in the service of the Ego) can sometimes yield creative benefits. To the extent that one is handling thoughts and impulses less like an adult, ARISE involves play, appreciation and primitive pleasures, and imagination.

Anna Freud (1936) ranked regression first in her enumeration of the defense mechanisms', and similarly suggested that people act out behaviors from the stage of psychosexual development in which they are fixated. For example, an individual fixated at an earlier developmental stage might cry or sulk upon hearing unpleasant news.
Michael Balint distinguishes between two types of regression: a nasty "malignant" regression that the Oedipal level neurotic is prone to... and the "benign" regression of the basic-fault patient. The problem then is what the analyst can do 'to ensure that his patient's regression should be therapeutic and any danger of a pathological regression avoided'.

Others have highlighted the technical dilemmas of dealing with regression from different if complementary angles. On the one hand, making premature 'assumptions about the patient's state of regression in the therapy...regarded as still at the breast', for example, might block awareness of more adult functioning on the patient's part: of the patient's view of the therapist '. The opposite mistake would be 'justifying a retreat from regressive material presented by a patient. When a patient begins to trust the analyst or therapist it will be just such disturbing aspects of the internal world that will be presented for understanding - not for a panic retreat by the therapist'.

Peter Blos suggested that 'revisiting of early psychic positions...helps the adolescent come out of the family envelope', and that 'Regression during adolescence thus advances the cause of development'. Stanley Olinick speaks of 'regression in the service of the other' on the part of the analyst 'during his or her clinical work. Such ego regression is a pre-condition for empathy'.

Jung had earlier argued that 'the patient's regressive tendency...is not just a relapse into infantilism, but an attempt to get at something necessary...the universal feeling of childhood innocence, the sense of security, of protection, of
reciprocated love, of trust'. Kris however was concerned rather to differentiate the way that 'Inspiration -...in which the ego controls the primary process and puts it into its service - needs to be contrasted with the opposite...condition, in which the ego is overwhelmed by the primary process'.

4: Fatigue:

Fatigue is a state of awareness describing a range of afflictions, usually associated with physical and/or mental weakness, though varying from a general state of lethargy to a specific work-induced burning sensation within one's muscles. Physical fatigue is the inability to continue functioning at the normal levels of physical activity. It is ubiquitous in everyday life, but usually becomes particularly noticeable during heavy exercise. Mental fatigue, on the other hand, rather manifests in sleepiness.

Fatigue has two known forms; one manifests as a local, muscle-specific incapacity to do work, and the other manifests as an overall, bodily or systemic, sense of energy deprivation. Due to these two divergent facets of fatigue symptoms, it has been proposed to look at the causes fatigue from "central" and "peripheral" perspectives (Gandevia, 1992; Kent-Braun, 1999).

Mental Fatigue - In addition to physical, fatigue also includes mental fatigue, not necessarily including any muscle fatigue. Such a mental fatigue, in turn, can manifest itself either as decreased wakefulness or just as a general decrease of attention, not necessarily including sleepiness. In any case, this can be dangerous when performing tasks that require constant concentration, such as
driving a vehicle. For instance, a person who is sufficiently somnolent may experience micro sleeps. However, objective cognitive testing should be done to differentiate the neuro-cognitive deficits of brain disease from those attributable to tiredness.

**Physical fatigue** or muscle weakness (or "lack of strength") is a direct term for the inability to exert force with one’s muscles to the degree that would be expected given the individual’s general physical fitness. A test of strength is often used during a diagnosis of a muscular disorder before the etiology can be identified. Such etiology depends on the type of muscle weakness, which can be true or perceived as well as central or peripheral. True weakness is substantial, while perceived rather is a sensation of having to put more effort to do the same task. On the other hand, central muscle weakness is an overall exhaustion of the whole body, while peripheral weakness is an exhaustion of individual muscles.

There are seen to be two main types of physical fatigue; Central and Peripheral.

**Central Fatigue**: The central component to fatigue is generally described in terms of a reduction in the neural drive or nerve-based motor command to working muscles that result in a decline in the force output (Gandevia, 2001; Kay et al., 2001; Kent-Braun, 1999; Vandewalle et al., 1991). It has been suggested that the reduced neural drive during exercise may be a protective mechanism to prevent organ failure if the work was continued at the same intensity (Bigland-Ritchie & Woods, 1984; Noakes, 2000). The exact
mechanisms of central fatigue are unknown although there has been a great deal of interest in the role of serotonergic pathways (Davis, 1995; Newsholme et al., 1987; Newsholme et al., 1995).

**Peripheral Fatigue:** Fatigue during physical work is considered an ability for the body to supply sufficient energy to the contracting muscles to meet the increased energy demand. This is the most common case of physical fatigue-effecting a national average of 72% of adults in the work force in 2002. This causes contractile dysfunction that is manifested in the eventual reduction or lack of ability of a single muscle or local group of muscles to do work. The insufficiency of energy, i.e. sub-optimal aerobic metabolism, generally results in the accumulation of lactic acid and other acidic anaerobic metabolic by-products in the muscle, causing the stereotypical burning sensation of local muscle fatigue.

The fundamental difference between the peripheral and central theories of fatigue is that the peripheral model of fatigue assumes failure at one or more sites in the chain that initiates muscle contraction. Peripheral regulation is therefore dependent on the localized metabolic chemical conditions of the local muscle affected, whereas the central model of fatigue is an integrated mechanism that works to preserve the integrity of the system by initiating fatigue through muscle de-recruitment, based on collective feedback from the periphery, before cellular or organ failure occurs. Therefore the feedback that is read by this central regulator could include chemical and mechanical as well as
cognitive cues. The significance of each of these factors will depend on the nature of the fatigue-inducing work that is being performed.

5: Guilt:

Guilt is an emotional experience that occurs when a person realizes or believes—accurately or not—that he or she has compromised his or her own standards of conduct or has violated a moral standard and bears significant responsibility for that violation. It is closely related to the concept of sorrow.

Guilt is an important factor in perpetuating OCD symptoms. Guilt and its associated causes, merits, and demerits are common themes in psychology. Both in specialized and in ordinary language, guilt is an affective state in which one experiences conflict at having done something that one believes one should not have done (or conversely, having not done something one believes one should have done). It gives rise to a feeling which does not go away easily, driven by ‘conscience’. Sigmund Freud described this as the result of a struggle between the ego and the superego – parental imprinting. Freud rejected the role of God as punisher in times of illness or rewarde r in time of wellness. While removing one source of guilt from patients, he described another. This was the unconscious force within the individual that contributed to illness, Freud in fact coming to consider "the obstacle of an unconscious sense of guilt...as the most powerful of all obstacles to recovery." For his later explicator, Lacan, guilt was the inevitable companion of the signifying subject who acknowledged normality in the form of the Symbolic order.
Alice Miller claims that "many people suffer all their lives from this oppressive feeling of guilt, the sense of not having lived up to their parents' expectations....no argument can overcome these guilt feelings, for they have their beginnings in life's earliest period, and from that they derive their intensity." This may be linked to what Les Parrott has called "the disease of false guilt....At the root of false guilt is the idea that what you feel must be true." If you feel guilty, you must be guilty!

The philosopher Martin Buber underlined the difference between the Freudian notion of guilt, based on internal conflicts, and existential guilt, based on actual harm done to others.

Guilt is often associated with anxiety. In mania, according to Otto Fenichel, the patient succeeds in applying to guilt "the defense mechanism of denial by overcompensation...re-enacts being a person without guilt feelings."

When we see another person suffering, it can also cause us pain. This constitutes our powerful system of empathy, which leads to our thinking that we should do something to relieve the suffering of others. If we cannot help another, or fail in our efforts, we experience feelings of guilt. From the perspective of group selection, groups that are made up of a high percentage of co-operators outdo groups with a low percentage of co-operators in between-group competition. People who are more prone to high levels of empathy-based guilt may be likely to suffer from anxiety and depression; however, they are also more likely to cooperate and behave altruistically. This suggests that guilt-
proneness may not always be beneficial at the level of the individual, or within-group competition, but highly beneficial in between-group competition.

6: Extraversion:

The trait of extraversion–introversion is a central dimension of human personality theories. The terms introversion and extraversion were popularized by Carl Jung, although both the popular understanding and psychological usage differ from his original intent. Extraversion tends to be manifested in outgoing, talkative, energetic behavior, whereas introversion is manifested in more reserved and solitary behavior. Virtually all comprehensive models of personality include these concepts in various forms. Examples include the Big Five Model, Jung’s Analytical Psychology, Hans Eysenck’s Three Factor Model, Raymond Cattels 16 personality factors, the Minnesota Multiphasic Personality Inventory and the Myers-Briggs Type Indicator.

Extraversion and introversion are typically viewed as a single continuum. So, to be high in one necessitates being low in the other. Carl Jung and the authors of the Myers-Briggs provide a different perspective and suggest that everyone has both an extraverted side and an introverted side, with one being more dominant than the other. Rather than focusing on interpersonal behavior, however, Jung defined introversion as an "attitude-type characterised by orientation in life through subjective psychic contents" (focus on one's inner psychic activity); and extraversion as "an attitude type characterised by concentration of interest on the external object" (the outside world).
Extraversion is "the act, state, or habit of being predominantly concerned with obtaining gratification from what is outside the self". Extraverts tend to enjoy human interactions and to be enthusiastic, talkative, assertive and gregarious. Extraverts are energized and thrive off of being around other people. They take pleasure in activities that involve large social gatherings, such as parties, community activities, public demonstrations, and business or political groups. They also tend to work well in groups. An extraverted person is likely to enjoy time spent with people and find less reward in time spent alone. They tend to be energized when around other people, and they are more prone to boredom when they are by themselves.

7: Arousal:

Arousal is a psychological state of being awake or reactive to stimuli. It involves the activation of the reticular activating system in the brain stem, the ANS and endocrine system, leading to increased heart rate and blood pressure and a condition of sensory alertness, mobility and readiness to respond.

There are many different neural systems involved in what is collectively known as the arousal system. Five major systems originating in the brainstem, with connections extending throughout the cortex, are based on the brain's neurotransmitters, acetylcholine, nor-epinephrine, dopamine, histamine, and serotonin. When these systems are stimulated, they produce cortical activity and alertness. The Noradrenergic system is a bundle of axons that originate in the neocortex, limbic system, and basal forebrain. Most of the neurons are
projected to the posterior cortex which is important with sensory information, and alertness. The activation of the locus coeruleus and release of norepinephrine causes wakefulness and increases vigilance. The neurons that project into the basal forebrain impact cholinergic neurons that results in a flood of acetylcholine into the cerebral cortex. The Acetylcholinergic system has its neurons located in the pons and in the basal forebrain. Stimulation of these neurons result in cortical activity, shown from EEG records, and alertness. All of the other four neurotransmitters play a role in activating the acetylcholine neurons. The neurons arise in the ventral tegmental area in the midbrain, and projects to the nucleus accumbens, the striatum forebrain, limbic system, and prefrontal cortex. The limbic system is important for control of mood and the nucleus accumbens signal excitement and arousal. The path terminating in the prefrontal cortex is important in regulating motor movements, especially reward oriented movements. The Serotonergic system which has almost all of its serotonergic neurons. This system projects to the limbic system as well as the prefrontal cortex. Stimulation of these axons and release of serotonin causes cortical arousal and impacts locomotion as well as mood. The last system is the histamnergic system. The neurons are located in the tuberomammillary nucleus of the hypothalamus. These neurons send pathways to the cerebral cortex, thalamus, and the basal forebrain, where is stimulate the release of acetylcholine into the cerebral cortex. All of these systems are very much linked and show similar redundancy. The pathways described are all ascending pathways, but there also arousal pathways that
descend. One example is the Ventrolateral Preoptic area which release GABA inhibitors, which interrupt wakefulness and arousal. Neurotransmitters of the Arousal system such as Acetylcholine and norepinephrine work to inhibit the Ventrolateral preoptic area.

1.3: Significance of the study:

Man is a social being and a person’s sense of identity is dependent on the manner it is perceived by others. We adapt and live based on constant feedback from the family, the community and friends. Feedback allows for the control and organization of actions and provides checks on behavior. The delivery of feedback is crucial and can have an important effect on one’s sense of identity, self-concept and esteem. Individuals who are blind or have low-vision must rely to a greater extent on auditory and tactile cues. While this type of information still allows for the discerning of moods, emotions and can help the individual make inferences about a person’s character and emotional state; it lacks the visual complement afforded by facial expressions. Morse (1983) observed that the blind are not very accurate at deducting and judging personal characteristics by voice alone. For this reason, communication must be clear, reliable and as redundant as possible.

Individuals who are blind or have low-vision must face the constant challenge of psychologically and socially adjusting to their disability. Tuttle (1987) defines adjustment as the process of responding to life’s demands and stresses. While there is no direct relationship between impairment and
psychopathological disorders (Harrington & McDermott, 1993), the heterogeneous nature of eye-conditions and the possible differences in family life, education, social and economic status suggest that adjustment is idiosyncratic – it is personalized, peculiar and dependent on the individual and his/her experience. In the paragraphs that follow, several aspects of psychosocial adjustment to blindness and low-vision will be presented and the role of the family, peers and the society in general will be discussed in relation to the formation of a positive self-concept and the development of high self-esteem. Throughout the discussion examples will be provided from the author’s research with students from Dorton College at the Royal London Society for the Blind (RLSB).

In this context their peer persons are their parents. These are important referral sources of information because they always face the problems. Hence, researcher has selects such problem for research purpose.

**Summary:**

The overall psychosocial adjustment of individuals with disabilities has been a topic of much interest but of considerable disagreement. The adjustment to life in a world that is essentially visual is a complex feat. Adjustment is inevitably tied in with issues of independence, sufficiency and control and will vary from person to person influenced by their character, previous experiences and support network. Research on psychosocial adjustment has incorporated a variety of questions ranging from the impact of progressive or immediate
visual loss, anxiety, the inability to work, avoidance and bullying to the role of support networks such as friends, families and charities. Hence, researcher incorporates stress and mood states of parents of visually impaired children in the present study.