SELF-ACCEPTANCE, PSYCHOLOGICAL WELL-BEING AND PSYCHOSOCIAL ADJUSTMENT AMONG ADULTS WITH LATE-ONSET DISABILITY IN ADDIS ABABA

BY

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This work is dedicated to my late older brother, lost recently, who faced blindness in adulthood and struggled to accept it.

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Acronyms and Abbreviations

CBT	Cognitive Behavioral Therapy
CRPD	Convention on the Rights of Persons with Disabilities
ICF	International Classification of Functioning, Disability and Health
IRB	Institutional Review Board
NGO	Non-Governmental Organization
REBT	Rational Emotive Behavior Therapy
UN	United Nations
WHO	World Health Organization

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Abstract

Adults who acquire disabilities later in life often face profound challenges to self-acceptance, psychological well-being, and social adjustment, yet research on these internal psychological processes remains limited in Ethiopia. This study examined self-acceptance, psychological well-being, and psychosocial adjustment among 410 adults with late-onset disabilities in Addis Ababa. A quantitative descriptive design was employed, and simple random sampling was used. Data were collected using the Acceptance of Disability Scale-Revised, the Psychosocial Adjustment to Illness Scale-Short Form, and the Psychological Well-Being scale. Data were analyzed using descriptive statistics, Pearson correlations, one-way ANOVA, and ANCOVA with SPSS version 27.

The findings revealed moderate levels of self-acceptance, psychological well-being, and psychosocial adjustment difficulties. Autonomy was the lowest-scoring dimension of well-being. Significant correlations were found among all three constructs. One-way ANOVA revealed significant group differences for employment status, income level, duration of disability, and disability type. Employment status emerged as the strongest predictor, with employed participants reporting better outcomes than unemployed and retired participants. Income showed a consistent dose-response relationship, and longer duration was associated with better outcomes. Participants with visual disabilities reported lower well-being and greater adjustment difficulties than those with physical disabilities. Education was not significant for any outcome. ANCOVA results confirmed that employment status and disability type remained significant predictors after controlling for duration and income. These findings highlight the critical role of employment and economic factors in shaping adaptation outcomes. The study concludes that while adults with late-onset disabilities demonstrate resilience, many continue to struggle with autonomy, vocational functioning, and the effects of stigma and poverty. Recommendations include prioritizing employment-focused interventions, addressing economic marginalization, and developing targeted support for individuals with visual disabilities.

Chapter One

Introduction

1.1. Background of the study

Disability is a complex phenomenon arising from the multifaceted relationship between a person's health status and various contextual factors, including environmental barriers and cultural perceptions that may impede full participation in daily living (World Health Organization [WHO], 2001). Within the International Classification of Functioning, Disability and Health (ICF) framework, disability is conceptualized not merely as a "disease of the individual" but as a dynamic interaction involving bodily functions, activities, participation, and environmental influences (WHO, 2001).

While congenital disabilities become integrated into an individual's developing identity early in life, those acquired later in adulthood often profoundly disrupt an established sense of self, identity, and social roles (Papadimitriou, 2008). Traumatic injury, progressive neurological disorders, chronic diseases, or age-related declines are common triggers, and whether the loss of function occurs abruptly or gradually, the psychological adjustment to new functional limitations involves a significant cognitive transition—a renegotiation of self-perception, loss of independence, and risk of social marginalization (Livneh & Antonak, 2005).

Self-acceptance is a fundamental psychological construct that refers to an individual's overall positive attitude toward themselves, including acknowledgment and acceptance of both strengths and limitations without excessive self-criticism or denial (Rogers, 1961; Ryff, 1989). Within the context of disability, self-acceptance extends beyond general self-esteem to encompass the specific process of integrating disability into one's identity, acknowledging

functional limitations while maintaining a sense of personal worth and dignity (Groomes & Linkowski, 2007; Smart, 2009). For adults with late-onset disabilities, self-acceptance is particularly challenging because it requires reconciling a pre-disability identity with a post-disability reality (Charmaz, 1995; Papadimitriou, 2008). Unlike individuals with congenital disabilities who develop their identity alongside their impairment, adults with acquired disabilities must actively reconstruct their self-concept after having already established life roles, careers, and relationships (Livneh & Martz, 2019).

International research has consistently demonstrated that self-acceptance is a critical predictor of positive psychological outcomes among persons with disabilities, with higher self-acceptance being associated with lower depressive symptoms, reduced anxiety, greater life satisfaction, and better social functioning (Chan et al., 2020; Joshanloo, 2021; Keyes et al., 2020). Self-acceptance also serves as a buffer against internalized stigma, when individuals accept their disability, they are less likely to internalize negative societal attitudes and more likely to maintain positive self-regard (Smart, 2009; Scior, 2017).

Psychological well-being is a multidimensional construct that encompasses positive mental functioning, including autonomy, self-acceptance, personal growth, purpose in life, environmental mastery, and positive relationships with others (Ryff, 1989; Ryff & Keyes, 1995). For adults with late-onset disabilities, psychological well-being is often compromised by the sudden disruption of established life patterns, loss of independence, and the challenges of adapting to functional limitations (Ryff, 2014; Livneh & Martz, 2019).

Autonomy loss is particularly significant, as individuals may become dependent on others (Krupa et al., 2022), while environmental mastery is challenged by inaccessible infrastructure (Breffka et al., 2023). However, personal growth can be a source of resilience (Papadimitriou, 2008; Charmaz, 1995).

Psychosocial adjustment refers to the ongoing process of adapting emotionally, psychologically, and behaviorally to significant life changes, such as the acquisition of a disability (Livneh, 2001; Livneh & Antonak, 2005). Successful psychosocial adjustment involves integrating changed abilities into daily life, maintaining social roles and relationships, sustaining occupational functioning, and preserving psychological well-being despite functional limitations (Livneh & Martz, 2019).

Theoretical models describe a progression through phases; shock, denial, anger, depression, and eventually adaptation and acceptance, though individuals may move through these phases nonlinearly and at different paces (Livneh & Antonak, 2005). Psychosocial adjustment encompasses several key domains: vocational/activity environment, domestic environment, extended family relationships, and social environment (Derogatis, 1986). For adults with late-onset disabilities, psychosocial adjustment is particularly challenging because it requires adapting to changes in multiple life domains simultaneously. Work roles may be disrupted, often leading to financial strain and loss of identity (Krupa et al., 2022). Domestic responsibilities may shift, with family members assuming caregiving roles (Tekola et al., 2020). Social relationships may change, as friends may withdraw and opportunities for community participation may be restricted by inaccessible environments (Breffka et al., 2023).

These three constructs are closely interconnected and mutually reinforcing (Livneh & Martz, 2019; Ryff, 2014). Self-acceptance facilitates both psychological well-being and psychosocial adjustment (Chan et al., 2020; Smart, 2009; Livneh, 2001), while psychological well-being supports adjustment through autonomy and positive relationships (Ryff & Singer, 2020). Conversely, successful psychosocial adjustment—maintaining work, family, and social participation—promotes well-being by providing identity, purpose, and social

connection (Krupa et al., 2022; Breffka et al., 2023). Understanding these interrelationships is essential for designing effective interventions that support successful adaptation.

Despite growing recognition of disability as a social and psychological phenomenon, significant gaps remain in the Ethiopian context. Much existing research derives from Western settings with established rehabilitation and support systems (Scior, 2017; Goodley, 2021). In Ethiopia, studies have highlighted stigma, social exclusion, and lack of infrastructure (Breffka et al., 2023; Tekola et al., 2020), but understanding of internal psychological processes, self-acceptance, identity reconstruction, and psychosocial adjustment, remains scarce.

Prior Ethiopian studies (Aster, 2010; Mihiret, 2020) have examined socio-demographic factors and psychosocial distress but have not systematically explored the interrelationships among self-acceptance, psychological well-being, and adjustment. Breffka et al. (2023) identified stigma-related participation barriers but did not explore internal dimensions, while Tekola et al. (2020) focused on parents of children with disabilities rather than adults with late-onset disabilities themselves. This study addresses these gaps by examining self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa, utilizing quantitative methods to explore both the levels of these constructs and their interrelationships

1.2. Statement of the problem

When a disability strikes someone as an adult, it often disrupts a life as we know it, making life difficult, often disrupting one's sense of self, independence and dream and purpose. People struggle not only with physical adversity but with emotional confusion as they navigate to redefine who they are in the space that their new life took advantage of. As such

upheaval often produces painful emotions such as embarrassment, hopelessness, or persistent mourning (Papadimitriou, 2008). There is increasing empirical evidence from Ethiopia that highlights the challenges that society and structure place on people with disabilities such as deep-seated stigma, social exclusion, and lack of infrastructure (Breffka et al., 2023; Tekola et al., 2020).

These academic gaps resonate deeply with observations from the researcher's own community. In the neighborhood where the researcher lives, people have been witnessed struggling profoundly after acquiring disabilities later in life, neighbors who once worked, provided for their families, and moved freely through their daily lives now confined to their homes, isolated, and visibly distressed. The shame in their eyes when they cannot perform basic tasks, the way they withdraw from social gatherings, and the hopelessness that creeps in when they realize that their former roles and identities have been stripped away are deeply troubling. What strikes the researcher most is the variation in their experiences: some individuals eventually find peace and purpose despite their limitations, while others remain trapped in grief and self-rejection.

These personal encounters have raised critical questions about whether the existing literature adequately captures the psychological dimensions of this transition, particularly in the Ethiopian context where cultural beliefs about disability, limited rehabilitation services, and pervasive stigma create unique challenges. The observations have also highlighted a critical gap: while researchers have documented structural barriers and stigma, there is little understanding of the internal psychological processes, self-acceptance, psychological well-being, and psychosocial adjustment that determine how adults navigate this devastating transition.

Understanding of internal psychological processes such as self-acceptance, identity reconstruction, and psychosocial adjustment remains scarce, particularly for adults who acquire disabilities later in life. Aster (2010) and Mihiret (2020) demonstrated an intricate interplay of socio-demographic factors with psychosocial distress but did not systematically examine how adults psychologically manage the transition to disability. Similarly, Breffka et al. (2023) identified key measures of meaningful participation linked to disability-related stigma, showing that persons with disabilities face significant barriers to involvement in community-based inclusive development programs due to misconceptions about disability causation and societal beliefs about their capabilities.

Krupa et al. (2022) noted that these struggles limit the capacity of persons with disabilities to exercise their rights under the UNCRPD. Tekola et al. (2020) advanced understanding of stigma but focused on parents of children with developmental disorders rather than adults who acquire disabilities later in life. The attention paid to external challenges has typically failed to engage with internal dimensions, self-acceptance, identity reconstruction, and emotional regulation, which are crucial components of psychological health. While some quantitative data describe stigma and functionality (e.g., Takele et al., 2024), few studies have systematically examined the interrelationships among self-acceptance, psychological well-being, and psychosocial adjustment in this population. As a result, little research exists on how adults who develop disabilities later in life, especially in Addis Ababa, negotiate self-acceptance and regain psychosocial balance.

Rehabilitation programs and initiatives risk failing because external obstacles are addressed while the crucial internal processes that promote successful adaptation are neglected. The anticipated findings of this study will contribute to the academic discourse of social psychology but will also shape practical interventions in the form of policies, rehabilitation

and community programs aimed towards inclusivity in Ethiopia. Finally, this research sought to contribute to the psychological and social aspects of late-onset disabilities to enhance well-being, autonomy and social inclusion of persons with disability in Ethiopia.

1.3. Research Questions

1. What are the overall levels of self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa?
2. What are the relationships between self-acceptance, psychological well-being, and psychosocial adjustment?
3. Are there significant mean differences in self-acceptance, psychological well-being, and psychosocial adjustment across socio-demographic groups (employment, income, education, gender, age) and disability-related groups (type of disability, duration since onset, cause of disability)?

1.4. Research Objectives

1.4.1. General Objective:

To examine self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa using a quantitative approach.

1.4.2. Specific Objectives:

- To assess the overall levels of self-acceptance, psychosocial adjustment, and psychological well-being among adults with late-onset disabilities in Addis Ababa.

- To examine the relationships between self-acceptance, psychosocial adjustment, and psychological well-being.
- To compare mean differences in self-acceptance, psychological well-being, and psychosocial adjustment across socio-demographic and disability-related groups (including employment status, income level, disability type, duration since onset, and cause of disability)

1.5. Significance of the study

There are several ways in which this study is of great academic, practical, policy and social significance.

Academics and Researchers benefit from this study as it contributes to the disability literature by directing attention from structural and functional dimensions of disability toward the psychological aspects that lie within individuals, such as self-acceptance, mental health, and how adults with late-onset disabilities adapt socially and emotionally. The findings provide empirical evidence from the Ethiopian context, filling a significant gap in the literature that has predominantly focused on Western or high-income settings.

Researchers gain knowledge about the interrelationships among self-acceptance, psychological well-being, and psychosocial adjustment, which can inform future theoretical developments and empirical investigations. Additionally, the study provides validated data using standardized instruments (ADS-R, PAIS-SF, and PWB scale) in the Ethiopian context, offering a foundation for comparative studies and further research on disability and psychological adaptation in resource-limited settings.

Mental Health Professionals, Rehabilitation Specialists, Social Workers, and Community Program Managers benefit from practical, actionable insights that can inform comprehensive, individualized interventions. They gain a deeper understanding of how individuals negotiate

identity shifts, construct emotional resilience, and maintain mental wellness following the acquisition of a disability. This knowledge enables them to design and implement evidence-based programs that address not only physical rehabilitation but also the psychological dimensions of adaptation. Specifically, professionals can use the findings to develop counseling approaches that target self-acceptance, group-based interventions that foster peer support, and culturally and spiritually sensitive therapeutic methods that resonate with Ethiopian clients. Rehabilitation specialists can better understand which subgroups (e.g., unemployed individuals, those with visual disabilities, those with shorter duration since onset) require more intensive psychological support, allowing for more efficient allocation of limited resources.

Individuals Living with Late-Onset Disabilities benefit directly from this study as it contributes to empowering their lives and supporting social transformation by providing real-life insights into the experiences of adults with late-onset disabilities. By illuminating the path to self-acceptance and mental health, the research contributes to efforts to decrease internalized stigma, combat negative cultural attitudes, and increase inclusion. Individuals gain validation that their struggles are recognized and understood, and they may benefit from improved services and interventions informed by the findings. Ultimately, this reinforces the dignity, self-esteem, and full participation of disabled people in Ethiopian society, contributing to a more inclusive and respectful community environment.

Policymakers, Government Bodies, and Non-Governmental Organizations benefit from practical information that can inform the development and implementation of inclusive policies and services appropriate to local conditions. The identification of employment and income as critical predictors of self-acceptance, psychological well-being, and psychosocial adjustment provides strong evidence for policies that promote vocational training, workplace accommodations, and affirmative action in hiring practices. The finding that visual

disabilities are associated with lower well-being and greater adjustment difficulties highlights the need for targeted policies addressing information access, rehabilitation services, and stigma reduction for this specific population. The study's emphasis on autonomy and environmental mastery as areas of particular challenge supports the need for investment in accessible infrastructure, community-based rehabilitation, and independent living support. These policy recommendations align with Ethiopia's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and contribute to the realization of disability rights and inclusion.

Disability Advocacy Organizations and Community-Based Organizations benefit from evidence that strengthens their advocacy efforts. The findings provide data that can be used to advocate for increased funding for mental health services, rehabilitation programs, and employment initiatives for persons with disabilities. Organizations can use the results to design peer support programs, self-acceptance workshops, and community awareness campaigns that address both internal psychological processes and external structural barriers. The identification of specific subgroups at greatest risk enables organizations to target their resources more effectively and tailor their interventions to the needs of different disability types and demographic groups.

The Broader Ethiopian Society benefits as the study contributes to decreasing stigma, challenging negative cultural attitudes, and promoting inclusion of persons with disabilities. By increasing understanding of the psychological challenges faced by adults with late-onset disabilities, the research fosters empathy and reduces misconceptions about disability causation and capabilities. This contributes to a more inclusive society where persons with disabilities are valued, respected, and enabled to participate fully in social, economic, and community life. The study's emphasis on the relationship between employment, income, and adaptation outcomes also contributes to broader poverty reduction and economic

development goals by highlighting the importance of economic inclusion for persons with disabilities.

Students and Future Researchers benefit from this study as it provides a comprehensive example of quantitative research on disability and psychological well-being in the Ethiopian context. The methodological approach, including the use of standardized instruments, regression analysis, and variance analysis, serves as a model for future studies. The findings generate research questions and directions for investigation, including longitudinal studies tracking adaptation over time, qualitative studies exploring identity reconstruction in depth, and comparative studies examining differences between early-onset and late-onset disabilities or across different regions of Ethiopia.

1.6. Scope of the study

This study investigated adults aged 18 and above living in Addis Ababa who developed disabilities during their adult life. It considers psychological, social, and cultural aspects of self-acceptance, mental well-being, and psychosocial adjustment post-disability acquisition.

In this study, the challenges these individuals face head-on, they offer their answers through their coping strategies and what they need, in addition to the role that societal attitudes and beliefs about disability, cultural and structural elements play in shaping their identity, mental health and overall path of adjustment.

The focus is specifically on those with disabilities on the physical, sensory or mobility side post-adolescents, as they arise after that time. It deliberately excludes the person with congenital, childhood onset, or intellectual disabilities, because they form from developmental trends and psychological adjustment processes that are far different than those experienced in adults with disabilities. They are considered "not considered in the research"

by the text because they do not include physical, sensory or mobility-related disabilities. On a geographical level, the research is restricted to Addis Ababa, thus the results may represent the particular urban sociocultural and delivery mode of services dynamics in the city.

1.7. Limitations of the Study

There are a few limitations to be aware of here. First of all, the cross sectional design implies that we cannot infer causality between self-acceptance, adjustment and well-being as being related. Second, the sample was only taken from Addis Ababa and the results could not be generalised to rural areas of Ethiopia where cultural beliefs and access to services may vary. Third, all the measures were dependent on self-reports, so could be subject to social desirability bias.

Moreover, they did not represent those with congenital, childhood-onset, and intellectual disabilities, and the findings may not hold for those groups. Finally, these moderate adjusted R^2 values (25% for self-acceptance and 28% for well-being) point to other unmeasured factors such as the quality of social support, spirituality, or coping styles that may affect the outcomes too.

1.8. Operational Definitions of Key Terms

Late-Onset Disability: For the purpose of this study, late-onset disability refers to a physical, mobility, visual, or hearing impairment acquired at or after the age of 18 years. Participants were included only if their disability onset occurred during adulthood (≥18 years) and if they had lived with the disability for at least one year prior to data collection. Disabilities resulting from injury, chronic illness, neurological conditions, or other causes were included. Congenital disabilities (present from birth) and disabilities acquired before the age of 18 were excluded. The presence of disability was confirmed through self-report, and functional

limitation was assessed using the Psychosocial Adjustment to Illness Scale (PAIS-SF), which measures the extent to which the condition interferes with daily activities, work, and social participation.

Self-Acceptance: For the purpose of this study, self-acceptance is defined as the extent to which an individual with a late-onset disability acknowledges their limitations without devaluing their self-worth, integrates their disability into their overall identity, and maintains a positive attitude toward themselves despite functional changes. This study measured self-acceptance using the Acceptance of Disability Scale-Revised (ADS-R), a 32-item instrument that assesses four dimensions: enlargement of scope of values (finding meaning beyond physical ability), subordination of physique (placing less importance on physical appearance and function), containment of disability (limiting the impact of disability to specific areas rather than allowing it to dominate all aspects of life), and transformation from comparative status to asset values (valuing oneself based on personal qualities rather than comparison with able-bodied others). Higher scores on the ADS-R indicate greater self-acceptance.

Psychosocial Adjustment: A process involving emotional, psychological, and behavioral adaptations in response to significant life changes, such as acquiring a disability. It encompasses self-acceptance, social participation, and psychological well-being, enabling individuals to maintain identity continuity and life satisfaction (Livneh, 2001).

Psychological Well-Being: A state of positive mental functioning characterized by autonomy, self-acceptance, personal growth, purpose in life, environmental mastery, and positive relationships. Psychological well-being is both an outcome and a facilitator of self-acceptance and psychosocial adjustment among persons with disabilities (Ryff, 1989; Ryff & Keyes, 1995).

Chapter Two

Literature Review

2.1. Conceptualization of Study Variables

This section presents the conceptualization of the three key study variables: self-acceptance, psychological well-being, and psychosocial adjustment. Each variable is defined, its theoretical foundations are discussed, and its relevance to adults with late-onset disabilities is examined. The section also addresses the interrelationships among these variables and the socio-demographic and disability-related factors that influence them.

2.1.1. Self-Acceptance

Self-acceptance is a fundamental psychological construct that refers to an individual's overall positive attitude toward themselves, including acknowledgment and acceptance of both strengths and limitations without excessive self-criticism or denial (Rogers, 1961; Ryff, 1989). Within humanistic psychology, Carl Rogers (1961) conceptualized self-acceptance as a core component of psychological health, arguing that individuals who accept themselves unconditionally are better able to achieve personal growth, authentic functioning, and meaningful relationships. Rogers emphasized that self-acceptance involves recognizing one's inherent worth as a human being regardless of personal shortcomings, failures, or limitations. This unconditional positive regard toward oneself enables individuals to face reality openly, acknowledge their weaknesses without defensive denial, and pursue self-improvement without self-condemnation.

Within the context of disability, self-acceptance extends beyond general self-esteem to encompass the specific process of integrating disability into one's identity—acknowledging functional limitations while maintaining a sense of personal worth and dignity (Groomes & Linkowski, 2007; Smart, 2009). Smart (2009) argued that self-acceptance among persons with disabilities involves a transformation in how individuals perceive themselves, shifting from viewing disability as a defining deficit to recognizing it as one aspect of a multifaceted identity. This transformation requires individuals to confront societal stigma, challenge internalized negative beliefs, and develop criteria for self-evaluation that are not based solely on physical abilities or social comparisons.

The Acceptance of Disability Scale-Revised (ADS-R) conceptualizes self-acceptance through four interrelated dimensions (Groomes & Linkowski, 2007). The first dimension, enlargement of scope of values, involves finding meaning and purpose beyond physical ability and appearance. Individuals who achieve this dimension of acceptance shift their focus from what they have lost to what remains meaningful in their lives, discovering new sources of fulfillment, purpose, and contribution. The second dimension, subordination of physique, refers to placing less importance on physical appearance and function relative to other personal qualities. This involves recognizing that physical capabilities do not determine one's worth as a person and that qualities such as character, kindness, intelligence, and creativity are equally or more important. The third dimension, containment of disability, involves limiting the impact of disability to specific areas rather than allowing it to dominate all aspects of life. Individuals who achieve this dimension recognize that while disability affects certain activities or domains, it does not have to define their entire existence or prevent them from finding satisfaction in other areas. The fourth dimension, transformation from comparative status to asset values, means valuing oneself based on personal qualities rather than comparison with able-bodied others. This involves moving away from measuring

oneself against societal standards of normalcy and instead recognizing one's unique strengths, contributions, and worth as an individual.

For adults with late-onset disabilities, self-acceptance is particularly challenging because it requires reconciling a pre-disability identity with a post-disability reality (Charmaz, 1995; Papadimitriou, 2008). Unlike individuals with congenital disabilities who develop their identity alongside their impairment from an early age, adults with acquired disabilities must actively reconstruct their self-concept after having already established life roles, careers, relationships, and personal goals (Livneh & Martz, 2019). This process often involves grieving the loss of former abilities, mourning disrupted life plans, and gradually developing new sources of meaning and purpose (Marini et al., 2016). Papadimitriou (2008) described this process as "re-embodiment," where individuals must learn to inhabit and identify with a body that functions differently than before. This re-embodiment involves not only physical adaptation but also psychological integration—developing a new sense of self that incorporates disability without being defined by it.

The process of achieving self-acceptance following late-onset disability is often gradual and nonlinear. Livneh and Antonak (2005) proposed that individuals typically progress through phases of shock, denial, anger, bargaining, depression, and eventually acceptance, though they may move through these phases at different paces and may revisit earlier phases during times of stress or change. This model acknowledges that self-acceptance is not a single event but an ongoing process that unfolds over time, influenced by personal characteristics, social support, and environmental factors.

International research has consistently demonstrated that self-acceptance is a critical predictor of positive psychological outcomes among persons with disabilities. Higher self-acceptance is associated with lower depressive symptoms, reduced anxiety, greater life satisfaction, and

better social functioning (Chan et al., 2020; Joshanloo, 2021; Keyes et al., 2020). Self-acceptance also serves as a buffer against internalized stigma—when individuals accept their disability, they are less likely to internalize negative societal attitudes and more likely to maintain positive self-regard (Smart, 2009; Scior, 2017). This buffering effect is particularly important in contexts where disability is highly stigmatized, as internalized stigma can compound the challenges of adaptation and undermine psychological well-being.

However, self-acceptance does not develop uniformly across all individuals. Research has identified several factors that influence the trajectory of self-acceptance, including employment status, income, social support, duration since disability onset, and cultural beliefs about disability causation (Livneh & Martz, 2019; Yeo & Moore, 2003). Individuals who are employed and financially secure tend to report higher self-acceptance because work provides identity validation, social connection, and a sense of contribution (Krupa et al., 2022). Similarly, those with longer duration since onset often demonstrate greater acceptance, suggesting that acceptance is a gradual process that unfolds over time (Livneh & Antonak, 2005). Social support from family, friends, and peers with disabilities can facilitate self-acceptance by providing validation, reducing isolation, and offering models of successful adaptation (Chan et al., 2020).

In the Ethiopian context, self-acceptance among adults with late-onset disabilities is influenced by cultural beliefs that often attribute disability to spiritual causes such as curses, divine punishment, or karmic retribution (Tekola et al., 2020). These beliefs can create significant barriers to self-acceptance by fostering shame, guilt, and internalized stigma. Individuals may struggle to accept their disability when they believe it represents divine punishment or reflects negatively on their character or family. However, religious and spiritual frameworks can also support self-acceptance by providing meaning-making

resources, community support, and a sense of purpose beyond physical functioning (Marini et al., 2016). Understanding these cultural dynamics is essential for developing effective interventions that support self-acceptance in the Ethiopian context.

2.1.2. Psychological Well-Being

Psychological well-being is a multidimensional construct that encompasses positive mental functioning, including autonomy, self-acceptance, personal growth, purpose in life, environmental mastery, and positive relationships with others (Ryff, 1989; Ryff & Keyes, 1995). Unlike subjective well-being, which focuses on happiness and life satisfaction, psychological well-being (often termed eudaimonic well-being) emphasizes the realization of human potential, meaningful engagement with life, and the pursuit of authentic goals (Ryff & Singer, 2008, 2020). This distinction is important because it recognizes that well-being involves more than feeling good—it involves functioning well, living in accordance with one's values, and contributing to something beyond oneself.

Ryff's (1989) multidimensional model of psychological well-being identifies six distinct but interrelated dimensions that together constitute positive psychological functioning. The first dimension, autonomy, refers to the capacity to make independent decisions, resist social pressure, and regulate one's behavior according to personal values rather than external expectations. Autonomous individuals are self-determining, able to evaluate themselves by personal standards, and capable of resisting societal pressures to conform. The second dimension, environmental mastery, involves the ability to manage daily activities, navigate one's environment, and create contexts that suit personal needs. Individuals with high environmental mastery are competent in managing their affairs, able to choose or create environments that support their well-being, and effective in handling everyday challenges.

The third dimension, personal growth, reflects the sense of continued development, openness to new experiences, and realization of one's potential over time. Individuals who score high on personal growth see themselves as growing and expanding, are open to new experiences, and feel they are developing as a person.

The fourth dimension, positive relations with others, encompasses the experience of warm, trusting, and meaningful relationships with others. This involves empathy, intimacy, and the capacity for deep connection, as well as the ability to give and receive affection.

The fifth dimension, purpose in life, is the belief that life has meaning, direction, and goals that provide motivation and engagement. Individuals with high purpose in life have goals and objectives that give their lives meaning, feel there is purpose in their current activities, and believe their lives have direction. The sixth dimension, self-acceptance, as already discussed, involves positive evaluation of oneself including acknowledgment of both strengths and limitations.

For adults with late-onset disabilities, psychological well-being is often compromised by the sudden disruption of established life patterns, loss of independence, and the challenges of adapting to functional limitations (Ryff, 2014; Livneh & Martz, 2019). The loss of autonomy is particularly significant—individuals who previously managed their own lives may become dependent on others for daily activities, leading to feelings of helplessness, loss of control, and reduced self-efficacy (Krupa et al., 2022). This loss of autonomy can be particularly distressing for adults who have spent years developing independence and self-reliance. Environmental mastery is also challenged, as inaccessible infrastructure, limited transportation options, and barriers to employment restrict participation and independent functioning (Breffka et al., 2023; Shakespeare, 2018). Individuals may find themselves

unable to navigate their environments effectively, leading to frustration, dependence, and reduced quality of life.

Positive relations with others can be both challenged and strengthened by disability. Social relationships may change as friends and acquaintances withdraw due to discomfort, stigma, or uncertainty about how to interact with someone with a disability (Breffka et al., 2023). However, disability can also deepen existing relationships and create new connections with other individuals with disabilities who provide understanding and support (Mohammed et al., 2023). The quality of social support is crucial—individuals with strong, supportive networks tend to maintain higher psychological well-being than those who experience social isolation or rejection.

Personal growth, however, can be a source of resilience for some individuals with late-onset disabilities. Many report that their disability experience has led to new insights, changed priorities, and a deeper appreciation for life (Papadimitriou, 2008; Charmaz, 1995). This "post-traumatic growth" is more likely to occur when individuals have supportive social networks, access to rehabilitation services, and opportunities for meaningful engagement (Marini et al., 2016). Purpose in life may also be redefined—individuals may find new purposes related to advocacy, supporting others with disabilities, or pursuing previously neglected interests and relationships.

Importantly, psychological well-being is not solely determined by individual characteristics—it is profoundly influenced by social and structural factors. Individuals with disabilities who are unemployed, living in poverty, or experiencing social isolation consistently report lower psychological well-being than those who are employed, financially secure, and socially connected (Keyes et al., 2020; Joshanloo, 2021). This highlights the importance of addressing both individual and structural factors in promoting psychological

well-being among adults with disabilities. In Ethiopia, where many adults with disabilities face unemployment, poverty, and social exclusion, these structural factors likely have a significant negative impact on psychological well-being (Breffka et al., 2023; Krupa et al., 2022).

2.1.3. Psychosocial Adjustment

Psychosocial adjustment refers to the ongoing process of adapting emotionally, psychologically, and behaviorally to significant life changes, such as the acquisition of a disability (Livneh, 2001; Livneh & Antonak, 2005). Successful psychosocial adjustment involves integrating changed abilities into daily life, maintaining social roles and relationships, sustaining occupational functioning, and preserving psychological well-being despite functional limitations (Livneh & Martz, 2019). This process is not merely about accepting limitations but about actively constructing a new life that accommodates disability while maintaining meaning, purpose, and connection.

Theoretical models of psychosocial adaptation describe a progression through phases—shock, denial, anger, depression, and eventually adaptation and acceptance—though individuals may move through these phases nonlinearly and at different paces (Livneh & Antonak, 2005). Shock is typically the initial response to the onset of disability, characterized by emotional numbness, confusion, and disorientation. Denial follows as individuals struggle to process the reality of their situation, sometimes refusing to acknowledge the permanence or severity of their disability. Anger may emerge as individuals confront the injustice of their situation, directing frustration at themselves, others, or God. Depression often accompanies the grieving process as individuals mourn their losses and confront the implications of their disability for their future. Finally, adaptation and acceptance involve recognizing the reality

of the disability without being overwhelmed by it and developing new sources of meaning and purpose.

Successful adjustment is influenced by multiple factors, including personal characteristics such as coping styles, resilience, and self-efficacy; social factors such as support networks, family functioning, and community attitudes; and structural factors such as access to rehabilitation, employment opportunities, and accessible environments (Marini et al., 2016). Individuals who employ adaptive coping strategies—such as problem-focused coping, seeking social support, and finding meaning in their experience—tend to adjust more successfully than those who rely on avoidance, denial, or self-blame. Resilience, or the ability to bounce back from adversity, also facilitates adjustment by enabling individuals to maintain positive functioning despite challenges. Self-efficacy, or belief in one's ability to manage challenges, supports adjustment by motivating individuals to take active steps toward adaptation.

Psychosocial adjustment encompasses several key domains that reflect the multiple dimensions of daily life affected by disability (Derogatis, 1986). The vocational or activity environment domain involves the ability to maintain work roles, daily activities, and meaningful contributions. Disability often disrupts employment, leading to financial strain, identity loss, and reduced social connection (Krupa et al., 2022). Adjustment in this domain involves finding new ways to contribute, whether through adapted employment, volunteering, or other meaningful activities. The domestic environment domain involves the capacity to manage household responsibilities and family relationships. Disability may shift domestic roles, with family members assuming caregiving responsibilities and individuals with disabilities experiencing reduced independence (Tekola et al., 2020). Adjustment involves negotiating new family roles and maintaining positive family relationships despite changes.

The extended family relationships domain involves the quality of connections with relatives and in-laws. Extended family support can buffer against isolation, but stigma and misunderstanding can also strain these relationships (Mohammed et al., 2023).

The social environment domain involves the ability to maintain friendships, engage in community activities, and participate in social life. Disability can lead to social withdrawal, isolation, and exclusion, making adjustment in this domain particularly challenging (Breffka et al., 2023).

For adults with late-onset disabilities, psychosocial adjustment is particularly challenging because it requires adapting to changes in multiple life domains simultaneously (Livneh & Martz, 2019). Work roles may be disrupted, often leading to financial strain and loss of identity. Domestic responsibilities may shift, with family members assuming caregiving roles and individuals with disabilities experiencing reduced independence. Social relationships may change, as friends and acquaintances may withdraw due to discomfort or stigma, and opportunities for community participation may be restricted by inaccessible environments. The complexity of these simultaneous changes can be overwhelming, leading to chronic stress and difficulties in adjustment.

In the Ethiopian context, psychosocial adjustment is complicated by cultural beliefs that attribute disability to spiritual causes, which can lead to stigmatization, family shame, and social exclusion (Tekola et al., 2020). These beliefs can impede adjustment by fostering guilt, shame, and internalized stigma, making it difficult for individuals to accept their disability and engage fully in social life. However, the collectivist nature of Ethiopian society also provides potential resources for adjustment—extended family networks often provide practical and emotional support, reducing social isolation (Mohammed et al., 2023). The balance between family support (which can buffer against distress) and loss of autonomy

(which can undermine well-being) is a particularly important dynamic in the Ethiopian context (Aster, 2010). Understanding these cultural dynamics is essential for understanding psychosocial adjustment in Ethiopia.

2.1.4. Late-Onset Disability

Disability is a universal human experience that affects millions of people worldwide. According to the World Health Organization (2019), over one billion people, approximately 15% of the global population, live with some form of disability. However, the experience of disability is not uniform. One of the most significant distinctions in disability research is between early-onset disability (present from birth or acquired during childhood) and late-onset disability (acquired during adolescence or adulthood). This distinction is critical because the timing of disability onset fundamentally shapes an individual's psychological development, identity formation, and social integration.

Early-onset disabilities include congenital conditions (present at birth) and disabilities acquired during childhood or adolescence. Examples include cerebral palsy, spina bifida, congenital limb differences, childhood-onset visual or hearing impairments, and developmental disabilities such as autism spectrum disorder (Shakespeare, 2018). For individuals with early-onset disabilities, the impairment becomes integrated into their developing sense of self from an early age. They typically grow up learning to navigate the world with their disability as a constant feature of their identity. As Papadimitriou (2008) notes, children with congenital disabilities often develop adaptive strategies organically as they learn basic life skills, and their self-concept incorporates disability as a natural, though sometimes challenging, aspect of who they are. However, early-onset disability is not without psychological challenges. Children and adolescents with disabilities face stigma, social exclusion, and barriers to education and participation (Scior, 2017). Nevertheless, their

psychological adaptation process differs from those who acquire disabilities later in life because they have not experienced a sudden loss of previously held abilities, roles, or identities (Livneh & Antonak, 2005).

Late-onset disabilities are acquired after an individual has already established their adult identity, life roles, career paths, and social relationships. Common causes include traumatic injury (e.g., spinal cord injury, traumatic brain injury), progressive neurological conditions (e.g., multiple sclerosis, Parkinson's disease), chronic illnesses (e.g., diabetes-related amputation, stroke), and age-related degeneration (e.g., macular degeneration, hearing loss) (Livneh & Martz, 2019). The experience of late-onset disability is often described as a "biographical disruption" (Charmaz, 1995). Unlike those with early-onset disabilities who develop their identity alongside their impairment, adults with late-onset disabilities must reconcile their pre-disability self with their post-disability reality. This process typically involves grieving the loss of former abilities, roles, and future aspirations. As Papadimitriou (2008) explains, individuals with late-onset disabilities must engage in a process of "re-embodiment," learning to inhabit and identify with a body that functions differently than before.

The psychological impact of late-onset disability can be profound. Common emotional responses include shock, denial, anger, depression, and eventually, adaptation and acceptance (Livneh & Antonak, 2005). However, not all individuals reach full acceptance; some remain stuck in chronic grief or internalized stigma (Smart, 2009). The presence of supportive social networks, access to rehabilitation services, and personal resilience factors significantly influence the adaptation trajectory (Marini et al., 2016).

Several key differences distinguish early-onset from late-onset disability. First, identity formation differs fundamentally. Early-onset disability becomes embedded in developing

self-concept, while late-onset disability disrupts an already established identity, requiring active reconstruction (Charmaz, 1995; Papadimitriou, 2008). Second, grief and loss are more pronounced in late-onset disability because individuals have experienced life without the impairment and can directly compare their pre-disability and post-disability functioning (Livneh & Martz, 2019). Third, social roles are more deeply disrupted in late-onset disability, as adults may lose their jobs, careers, parenting capacities, or marital roles that were already established (Krupa et al., 2022). Fourth, coping strategies differ; individuals with early-onset disabilities often develop lifelong adaptive coping mechanisms, while those with late-onset disabilities must learn new coping strategies later in life, sometimes without adequate support (Marini et al., 2016).

In Ethiopia, the distinction between early-onset and late-onset disability is particularly important. Traditional beliefs about disability often attribute it to spiritual causes such as curses or divine punishment (Tekola et al., 2020). For adults who acquire disabilities later in life, especially suddenly through injury, these beliefs may intensify self-blame, shame, and internalized stigma. Furthermore, Ethiopia has limited rehabilitation and mental health services, making the psychological transition to disability even more challenging for adults who must suddenly navigate a new identity with minimal professional support (Breffka et al., 2023; Mohammed et al., 2023).

While research on disability in Ethiopia has grown in recent years, most studies have focused on structural barriers, stigma, and access to services. There remains a significant gap in understanding the internal psychological processes—self-acceptance, identity reconstruction, and psychosocial adjustment—that enable or hinder successful adaptation to late-onset disability (Aster, 2010; Mihiret, 2020). This study addresses that gap by focusing specifically on adults who acquired disabilities after the age of 18, examining how they navigate self-

acceptance, psychological well-being, and psychosocial adjustment within the Ethiopian context.

2.2. Theoretical Foundations of Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment

Self-acceptance, psychological well-being, and psychosocial adjustment are fundamental constructs of people managing late-onset disability. Positive emotion regulation and social support help those experiences develop so that it prevents the onset of problems and enhances emotional state(s); and it is related more to a sense of personal identity rather than the situation. Self-acceptance, defined as accepting strengths and limitations without excessive self-criticism, represents the social dimension of healthy human adjustment, followed by the broader psychological, cognitive, and social aspects of an individual's adaptation to life transition related to disability (Joshanloo, 2021; Livneh & Martz, 2019; Ryff, 1989). These constructs (for example, the following factors) are closely associated with psychological well-being: autonomy, self-esteem, life satisfaction, and social performance (in this context positive socio-demographic adjustment; Ryff & Singer, 2020).

They include, but are not limited to, humanistic psychology, cognitive-behavioral approaches, positive psychology, and psychosocial adaptation models. The Humanistic Theory proposes that, in order for personality development, acceptance of people, etc., to happen, unconditional positive regard, genuine feelings, and empathy are the primary factors (Rogers, 1961).

In modern applications, it is suggested that accepting, validating and supporting situations may aid individuals with disabilities in becoming resilient, making adaptive changes to self-

identity and achieving psychosocial adjustment (Hirsch et al., 2021). From this stance, acceptance of self is the necessary first step to adjustment and well-being.

Cognitive-Behavioral Theory (CBT) also supports this view by recognizing irrational self-beliefs and internalized stigma as impediments to accepting and integrating oneself into life. Those with disabilities may adopt inappropriate thought processes which are detrimental to adjustment and impact their psychological health and well-being. CBT-based strategies (e.g., cognitive restructuring, rational-emotive strategies) allow challenging this cognitive processing and beliefs by modifying them to support self-acceptance and good psychosocial outcomes (David et al., 2018; Vázquez et al., 2020). Empirical evidence shows that CBT interventions can lower depressive symptoms, enhance coping strategies and facilitate general adjustment among persons with disabilities. Positive Psychology (Ryff & Singer, 2020) has framed self-acceptance as a significant aspect of psychological well-being.

With a focus on strengths, resilience, meaning making and growth, particularly in populations facing adversity. Research shows that people with a higher self-acceptance are more likely to practice adaptive coping strategies, present higher psychological well-being, and experience positive psychosocial adjustment after their initial disability (Keyes et al., 2020; Joshanloo, 2021).

Adjustment to chronic illness and disability is specifically addressed by Psychosocial Adaptation Theory (Livneh & Martz, 2019). It suggests that people experience phases of shock, denial, anger, depression, and ultimately adaptation. Effective adjustment is influenced by internal mechanisms or characteristics such as resilience, coping styles, and self-efficacy and external constructs such as social support, accessibility, and inclusive settings. Theories that have emerged in recent times demonstrate the importance of mediating

factors such as cultural narratives, spirituality and systemic barriers in the adjustment process (Goodley, 2020; Breffka et al., 2023).

Finally, Identity Reconstruction Theories highlight the disruption that late-onset disability places upon personal identity and roles in life and the necessity to form a coherent sense of self that includes new limitations, to maintain dignity, a sense of purpose, as well as psychological well-being. As Papadimitriou (2021) and Crisp (2020) explain, adaptation is a critical act of active meaning construction in which people interpret their identity, redefine the roles they play, and look for new potentialities, which are beyond loss of a prior function and quality (adaptive work).

2.3. Relationships among Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment

Understanding the dynamic interrelationships among self-acceptance, psychological well-being, and psychosocial adjustment is essential for developing effective interventions and support programs for adults with late-onset disabilities. These three constructs do not operate in isolation—they are mutually reinforcing, with changes in one domain likely to influence the others (Livneh & Martz, 2019; Ryff, 2014).

2.3.1. Relationship between Self-Acceptance and Psychological Well-Being

Self-acceptance is a foundational component of psychological well-being within Ryff's (1989) multidimensional framework. The relationship between self-acceptance and psychological well-being is both conceptual and empirical—theorists have long argued that accepting one's strengths and limitations is essential for positive mental functioning (Rogers, 1961; Ryff & Singer, 2008). Empirical studies consistently demonstrate that individuals with

greater self-acceptance report higher psychological well-being across dimensions including autonomy, environmental mastery, and purpose in life (Joshanloo, 2021; Keyes et al., 2020).

For adults with late-onset disabilities, the relationship between self-acceptance and well-being is particularly significant. When individuals accept their disability and integrate it into their self-concept, they are better able to maintain positive self-regard, pursue meaningful goals, and sustain social relationships—all of which contribute to psychological well-being (Chan et al., 2020; Smart, 2009). Conversely, failure to achieve self-acceptance often leads to internalized stigma, shame, and negative self-evaluation, undermining psychological well-being and increasing vulnerability to depression and anxiety (Scior, 2017; Marini et al., 2016). The temporal direction of this relationship is likely bidirectional: self-acceptance facilitates psychological well-being, but well-being may also promote self-acceptance by enabling individuals to maintain positive outlooks and adaptive coping (Ryff & Singer, 2020).

2.3.2. Relationship between Self-Acceptance and Psychosocial Adjustment

Self-acceptance is a critical prerequisite for successful psychosocial adjustment to disability (Livneh & Antonak, 2005; Livneh & Martz, 2019). Psychosocial Adaptation Theory posits that acceptance of disability represents the final stage in the adaptation process—individuals who achieve acceptance have successfully integrated their disability into their identity and can therefore engage fully in work, family, and social life (Livneh, 2001).

The mechanisms linking self-acceptance to psychosocial adjustment are multiple. First, self-acceptance enables individuals to acknowledge their limitations realistically without devaluing themselves, allowing them to make practical adjustments to daily activities while maintaining self-worth (Smart, 2009). Second, self-acceptance reduces internalized stigma—

when individuals accept their disability, they are less likely to internalize negative societal attitudes and more likely to engage confidently in social interactions (Scior, 2017). Third, self-acceptance facilitates goal-setting and purposeful activity—individuals who accept their disability can focus on what they can do rather than what they cannot, enabling them to identify meaningful roles and contributions (Charmaz, 1995; Papadimitriou, 2008).

The relationship between self-acceptance and psychosocial adjustment is also supported by Identity Reconstruction Theory, which posits that successful adaptation to disability involves reconstructing one's self-concept to incorporate new functional limitations while maintaining identity continuity (Charmaz, 1995; Papadimitriou, 2008). Self-acceptance represents the successful outcome of this reconstruction process—individuals who achieve acceptance have developed a coherent post-disability identity that enables meaningful social participation.

2.3.3. Relationship Between Psychological Well-Being and Psychosocial Adjustment

Psychological well-being and psychosocial adjustment are closely interconnected, with each influencing and reinforcing the other. Individuals with higher psychological well-being—characterized by autonomy, environmental mastery, positive relationships, and purpose in life—are better equipped to navigate the challenges of disability-related adjustment (Ryff & Singer, 2020; Keyes et al., 2020).

The relationship operates through several mechanisms. Autonomy supports psychosocial adjustment by enabling individuals to make independent decisions about their lives, seek needed services, and advocate for their needs (Krupa et al., 2022). Environmental mastery directly facilitates adjustment by enabling individuals to manage daily activities, navigate barriers, and create supportive environments (Shakespeare, 2018). Positive relationships provide social support, reduce isolation, and buffer against stress during the adjustment

process (Tekola et al., 2020). Purpose in life provides motivation to engage in meaningful activities, maintain social roles, and pursue goals despite functional limitations (Charmaz, 1995).

Conversely, successful psychosocial adjustment—maintaining work roles, family relationships, and social participation—promotes psychological well-being. Employment provides identity, purpose, social connection, and financial security, all of which enhance well-being (Krupa et al., 2022). Family relationships provide emotional support and a sense of belonging (Tekola et al., 2020). Social participation provides opportunities for meaningful engagement and reduces isolation (Breffka et al., 2023). When adjustment fails—when individuals lose jobs, experience family conflict, or become socially isolated—psychological well-being suffers.

2.3.4. The Triadic Relationship

The three constructs—self-acceptance, psychological well-being, and psychosocial adjustment—form a mutually reinforcing triadic relationship. Self-acceptance supports psychological well-being (through positive self-regard and reduced stigma) and psychosocial adjustment (through realistic self-assessment and identity integration). Psychological well-being supports self-acceptance (through positive outlook and adaptive coping) and psychosocial adjustment (through autonomy, environmental mastery, and social engagement). Psychosocial adjustment supports self-acceptance (through meaningful roles and social validation) and psychological well-being (through participation, connection, and purpose). Understanding these interrelationships has important implications for intervention, as programs that target only one domain may have limited effectiveness if the other domains are not addressed.

2.4. Conceptual Framework

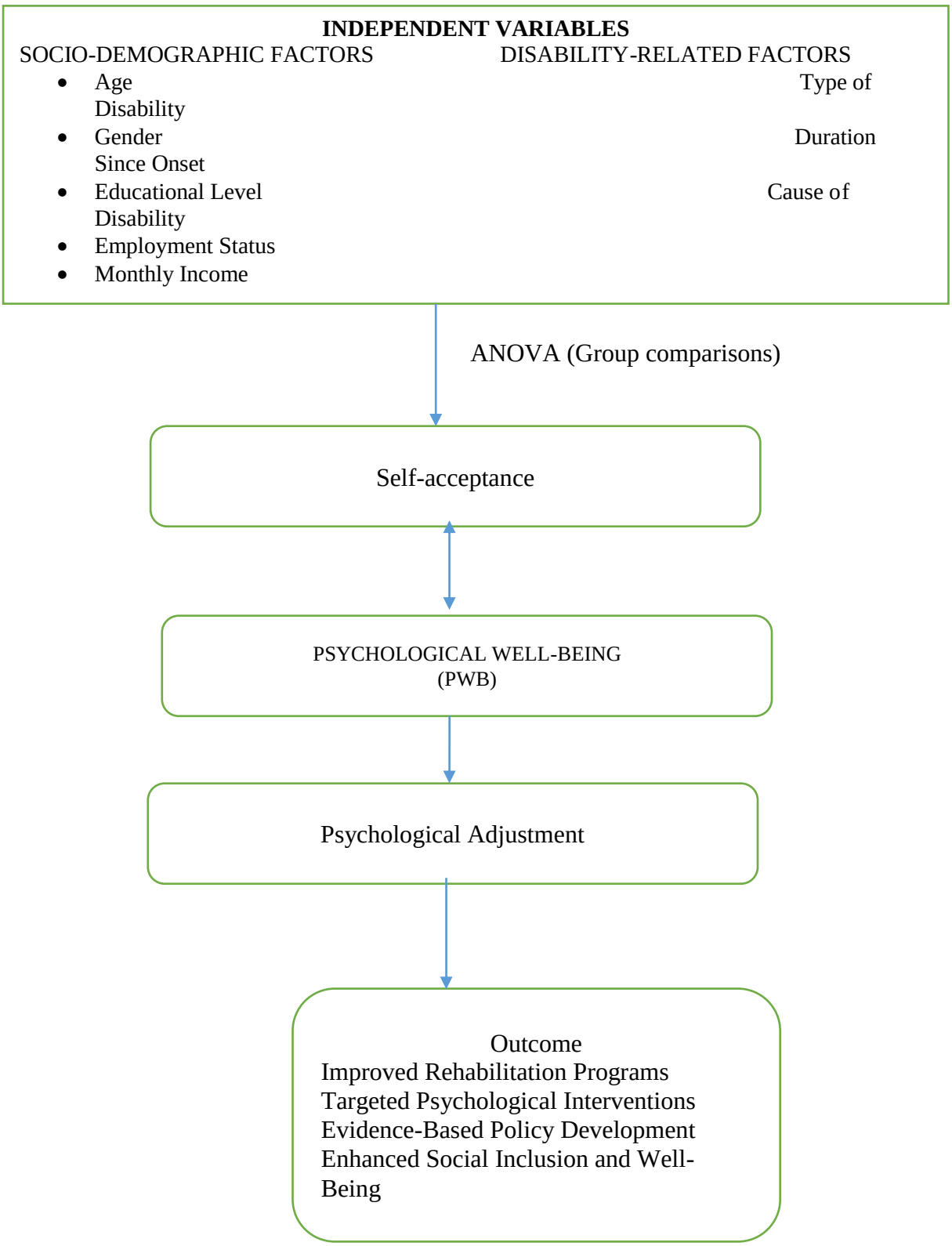


Figure 1: Conceptual Frame work adapted from (Tekola et al., 2020; Mohammed et al., 2023) and modified by the researcher.

Chapter Three

Research Methodology

3.1. Research Approach and Design

This study adopted a quantitative research approach with a descriptive study design. A quantitative approach was selected because the research objectives required measuring the levels of self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities, examining the relationships between these variables, and comparing mean differences across socio-demographic and disability-related groups. Quantitative methods are appropriate when the researcher seeks numerical data that can be analyzed statistically to identify patterns and describe the characteristics of a population (Creswell & Plano Clark, 2018). The use of standardized instruments (ADS-R, PAIS-SF, and PWB scale) allowed for reliable and comparable measurement across the 410 participants.

The design is descriptive because the study aimed to describe the current levels of self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa. Descriptive research is designed to systematically describe a population, situation, or phenomenon, answering questions about what, where, when, and how (Creswell & Plano Clark, 2018). This design was appropriate because the study sought to provide a comprehensive description of the three psychological constructs and their variations across different socio-demographic and disability-related groups, rather than manipulating variables or establishing causal relationships.

The descriptive design also allowed the researcher to examine the relationships between the three core variables through correlation analysis and to compare mean differences across groups using analysis of variance (ANOVA) and analysis of covariance (ANCOVA).

Specifically, the study described the levels of self-acceptance, psychological well-being, and psychosocial adjustment among participants, examined how these variables relate to each other, and compared mean scores across categories of employment status, income level, disability type, duration since onset, and cause of disability. This descriptive and comparative approach enabled the researcher to provide a detailed account of the psychological experiences of adults with late-onset disabilities in the Ethiopian context.

The descriptive design was appropriate for this study because the research questions focused on describing the current levels of the three variables, examining their interrelationships, and comparing group differences. However, it is important to note that this design does not allow for causal inferences; it can only describe, identify associations, and compare group differences, not determine whether one variable causes changes in another (Creswell & Plano Clark, 2018).

3.2. Study area

This study was conducted in Addis Ababa, the capital city of Ethiopia. Addis Ababa is the largest city in Ethiopia, with an estimated population of over 5 million people according to the Ethiopian Statistical Service (2022). As the political, economic, and administrative center of the country, Addis Ababa hosts a diverse population from various regions of Ethiopia, representing different ethnic, linguistic, and cultural backgrounds. The city is divided into 11 sub-cities and 116 woredas (districts), each with its own administrative structure.

Addis Ababa was selected as the study area for several reasons. First, the city has the highest concentration of persons with disabilities in Ethiopia, making it feasible to recruit a sufficient sample size for quantitative analysis. Second, Addis Ababa hosts the majority of the country's rehabilitation centers, disability associations, and healthcare facilities that provide services to persons with disabilities. These include the Ethiopia Prosthetic and Orthotic Service, Alert

Hospital Physiotherapy Department, the Ethiopian National Association of the Blind (ENAB), the Addis Hiwot Center of the Blind (AHCB), the Ethiopian National Association of the Deaf (ENAD), the Ethiopian Federation of Persons with Disabilities (EFPD), and Tirunesh Beijing Hospital. These facilities provided access to eligible participants with late-onset disabilities.

3.3. Population of Study

This study focused on adults aged 18 years and above living with late-onset disabilities in Addis Ababa, Ethiopia. Late-onset disability was defined as a physical, mobility, visual, or hearing impairment acquired at or after the age of 18 years. Participants were included only if their disability onset occurred during adulthood (≥18 years) and if they had lived with the disability for at least one year prior to data collection. Disabilities resulting from injury, chronic illness, neurological conditions, or other causes were included. Congenital disabilities (present from birth) and disabilities acquired before the age of 18 were excluded.

Participants were recruited from three types of facilities in Addis Ababa: (1) rehabilitation centers, including the Ethiopia Prosthetic And Orthotic Service and the Alert Hospital Physiotherapy Department; (2) disability associations, including the Ethiopian National Association of the Blind (ENAB), the Addis Hiwot Center of the Blind(AHCB), the Ethiopian National Association of the Deaf (ENAD), and the Ethiopian Federation of Persons with Disabilities (EFPD); and (3) public healthcare facilities, including Tirunesh Beijing Hospital. The researcher contacted the administrative offices of these facilities to obtain permission and to access lists of eligible adults with late-onset disabilities.

The study specifically included adults with the following types of late-onset disabilities: physical/mobility disabilities (e.g., spinal cord injury, amputation, post-stroke mobility impairment), visual disabilities (e.g., blindness or low vision acquired in adulthood), and

hearing disabilities (e.g., deafness or hard of hearing acquired in adulthood). Other types of disabilities (e.g., cognitive or intellectual disabilities) were excluded because their psychological adaptation processes differ significantly from those with physical, visual, or hearing impairments.

3.4. Sampling Technique and Sample Size

3.4.1. Sample Size

The sample size was determined using **Cochran's formula** for cross-sectional studies (Cochran, 1977):

$$N = Z^2 \cdot P \cdot (1 - P) / d^2$$

where

- Z = 1.96 (confidence level of 95%)
- P = 0.5 (estimated proportion of the population with the characteristic of interest, which maximizes sample size)
- d = 0.05 (margin of error of 5%)

Substituting the values:

$$N = (1.96)^2 \cdot (0.5) \cdot (0.5) / (0.05)^2 = 384$$

Cochran's formula assumes that the target population is sufficiently large and homogeneous with respect to the characteristic being measured (Cochran, 1977). For this study, the target population was defined as all adults aged 18 years and above living with late-onset physical, mobility, visual, or hearing disabilities in Addis Ababa. According to data from the Ethiopian Federation of Persons with Disabilities and the Addis Ababa City Administration, this

population is large (estimated over 100,000) and no single facility or association contains all members. Therefore, the assumption of a large, single population was considered met.

To account for potential non-response and incomplete data, an additional 10% was added, yielding an estimated final sample size of approximately 420 participants. This adjustment ensured sufficient statistical power and reliability of the findings, while also enhancing the representativeness of the study population.

3.4.2. Sampling Technique

Simple random sampling was used to select participants for this study. This method was chosen because it satisfies the assumptions of Cochran's formula used to calculate the sample size, and it gives every eligible person an equal and independent chance of being selected (Cochran, 1977).

First, the researcher obtained complete lists of eligible adults with late-onset disabilities from each recruitment site (rehabilitation centers, disability associations, and healthcare facilities in Addis Ababa). Eligible participants were defined as adults aged 18 years and above who acquired a physical, mobility, visual, or hearing disability at or after age 18 and had lived with the disability for at least one year. From each list, participant names were assigned numbers, and a random number generator was used to select participants until the desired number from that site was reached. This method eliminates selection bias and ensures that the sample represents the diversity of adults with late-onset disabilities in Addis Ababa.

3.4. Data Collection Methods

Data were collected using a structured questionnaire designed to capture socio-demographic and disability-related information, including age, gender, marital status, educational level, employment status, monthly income, type of disability, duration since onset, and cause of disability.

Three standardized instruments were used to measure the core variables of the study. The Psychosocial Adjustment to Illness Scale-Short Form (PAIS-SF, 16 items) was used to assess psychosocial adjustment across four domains: vocational environment, domestic environment, extended family relationships, and social environment (Derogatis, 1986). The Acceptance of Disability Scale-Revised (ADS-R, 32 items) was used to evaluate the extent to which individuals accept their disability and integrate it into their self-concept across four dimensions: enlargement of scope of values, subordination of physique, containment of disability, and transformation from comparative status to asset values (Groomes & Linkowski, 2007). The Psychological Well-Being scale (PWB, 18 items) from the SPARQTools.org Measuring Mobility Toolkit was used to measure psychological well-being across six dimensions: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff, 1989).

All instruments were administered in Amharic. For participants with visual impairments, the researcher read the questionnaires aloud to ensure accessibility. Permission was secured from the copyright holders or developers of each instrument prior to data collection.

Three domains of the original PAIS-SR were omitted: Healthcare Orientation, Sexual Relationships, and Psychological Distress. This decision was based on cultural appropriateness, research focus, and to avoid conceptual overlap with the ADS-R which comprehensively measures internal psychological adaptation processes (Groomes & Linkowski, 2007). The remaining domains (Vocational/Activity Environment, Domestic

Environment, Extended Family Relationships, and Social Environment) directly capture the most salient and culturally relevant areas of community-based adjustment.

To enable meaningful interpretation, the researcher developed a standardized scoring classification. Mean scores for each scale were converted to percentage of maximum score and categorized as Low (≤ 50%), Moderate (> 50% to ≤ 75%), or Good/High (> 75%). For the PAIS-SF, where lower scores indicate better adjustment, the same structure was applied to difficulty level. Higher scores on the ADS-R and PWB indicate greater self-acceptance and psychological well-being, respectively, while higher scores on the PAIS-SF indicate greater psychosocial adjustment difficulties.

3.5. Data Analysis

The study achieved a response rate of 97.6%, with 410 out of the target 420 participants completing the quantitative questionnaire. Quantitative data analysis was conducted using SPSS version 27.

First, data cleaning and coding were performed. All questionnaires were checked for completeness, coded, and entered into the software.

Second, descriptive statistics were computed. Frequencies, percentages, means, and standard deviations were used to describe the socio-demographic characteristics of the participants and the scores on the three main scales (ADS-R, PAIS-SF, and PWB).

Third, bivariate analysis was performed. Pearson correlation coefficients were calculated to examine the relationships between self-acceptance, psychosocial adjustment, and psychological well-being.

Fourth, variance analysis was conducted. One-way analysis of variance (ANOVA) was used to compare mean scores on self-acceptance, psychological well-being, and psychosocial adjustment across categorical groups including employment status, income level, disability

type, duration since onset, and cause of disability. Post-hoc tests (Tukey HSD) were conducted to identify which specific groups differed significantly from each other. Effect sizes (partial η^2) were calculated to determine the practical significance of group differences. Analysis of covariance (ANCOVA) was used to control for potentially confounding variables (e.g., duration and income) while examining group differences on the outcome variables.

Additionally a pilot study was conducted prior to the main data collection to assess the clarity, comprehensibility, and applicability of the instruments in the Ethiopian context. The pilot study involved 30 adults with late-onset disabilities recruited from one disability association in Addis Ababa who were not included in the final sample. Participants were asked to complete the questionnaire and provide feedback on any items that were unclear, difficult to understand, or culturally inappropriate. The pilot study also helped estimate the average time required to complete the questionnaire.

Based on the pilot study feedback, minor adjustments was made to the wording of some items to enhance clarity and cultural relevance. The Amharic translation of the instruments was reviewed and refined to ensure accurate comprehension. The pilot study confirmed that the instruments were appropriate for the target population, with all participants able to complete the questionnaire within 45 to 60 minutes. The data from the pilot study were not included in the final analysis.

3.7. Ethical Considerations

The researcher treated all the information given by respondents confidentially without disclosing the respondents' identity and would not be used for any personal interest. The questionnaires were distributed only to voluntary participants. Furthermore, the Ethical clearance was obtained from IRS before proceeding to data collection.

Consent was documented through signed consent forms, and for participants with limited literacy, the data collector read the form aloud and obtained verbal or thumbprint consent.

In order to promote anonymity and confidentiality, identifying information was abstracted from transcripts and replaced with pseudonyms. All information, including demographic and statistical data, stored in password protected files and only the researcher had access to them. Particular sensitivity, respect and trauma-informed nature of individuals with late-onset disabilities, particularly, this vulnerable group of participant, was considered taking into account all potential outcomes of the research.

Chapter Four

Result

4.1. Sociodemographic profile

Table 1:

Sociodemographic variables

		Frequency	Percentage
Age	18-30	92	22.4
	31-50	185	45.1
	51-65	84	20.5
	Above 65	49	12
Gender	Male	213	52
	Female	197	48
Educational level	No formal education	133	32.4
	Primary	132	32.2
	Secondary	97	23.7
	College/University	48	11.7
Employment status	Employed	116	28.3
	Unemployed	213	52
	self employed	-	-
	Retired	81	19.8
Monthly income (in ETB):	<1000	148	36.1
	1001–3000	146	35.6
	3001-5000	67	16.3
	Above 5000	49	12
Type of disability	Physical/mobility	230	56.1
	Visual	111	27.1
	Hearing	34	8.3
	Other	35	8.5
Duration of disability	1–2 years	92	22.4
	3–5 years	185	45.1
	Above 5 years	133	32.4

Regarding age, nearly half of the participants (45.1%) were in the 31-50 year age range, indicating that middle adulthood, which is the peak period of work and family responsibilities, the most represented life stage among adults with late-onset disabilities in this sample.

In terms of employment, more than half (52.0%) of the participants were unemployed, a rate substantially higher than the national average, suggesting a strong link between late-onset disability and loss of work. Similarly, monthly income was concentrated at the lower end, with 71.7% of participants earning 3000 Birr or less, reflecting the economic marginalization associated with disability.

Regarding education, nearly two-thirds (64.6%) had no formal education or only primary schooling, which may limit access to information, rehabilitation services, and employment opportunities.

With respect to disability type, physical/mobility disabilities were the most common (56.1%), followed by visual disabilities (27.1%). Finally, in terms of duration, the majority (45.1%) had lived with their disability for 3-5 years, suggesting that most participants were neither newly disabled nor long-term accommodated, but rather in an intermediate phase of adaptation.

The sociodemographic data provide critical context for interpreting the findings of this study. The high unemployment rate (52.0%) and low income levels (71.7% earning ≤ 3000 Birr) highlight the economic marginalization faced by adults with late-onset disabilities in Addis Ababa. These economic challenges likely contribute to the moderate levels of self-acceptance and psychological well-being observed in this sample, as employment and income are known to provide identity validation, social connection, and access to resources that facilitate adaptation. The predominance of physical/mobility disabilities (56.1%) and visual disabilities (27.1%) allows for meaningful comparisons across disability types, while the varying duration since onset (from 1-2 years to over 5 years) enables examination of how adaptation

may change over time. The low educational attainment (64.6% with no formal or only primary education) suggests that many participants may face barriers to accessing information about rehabilitation services, disability rights, and available support programs, which may further impede their psychological adjustment. Collectively, these sociodemographic characteristics underscore the need for targeted interventions that address both economic empowerment and psychological support for adults with late-onset disabilities in Ethiopia.

4.2. Levels of self-acceptance, psychological well-being and psychological adjustment.

4.2.1. Levels of Self-Acceptance

The overall levels of the three core variables, mean scores, standard deviations, and percentage of maximum scores were calculated for each scale and subscale. A scoring classification was developed by the researcher for this study, where scores were categorized as Low (≤ 50% of maximum score), Moderate (> 50% to ≤ 75%), or Good/High (> 75% of maximum score). For the PAIS-SF, where lower scores indicate better adjustment, the same percentage structure was applied to difficulty level (i.e., ≤ 50% = low difficulty/good adjustment, > 50% to ≤ 75% = moderate difficulty, > 75% = high difficulty/poor adjustment).

As shown in Table 3, the mean score on the Acceptance of Disability Scale-Revised (ADS-R) was 78.42 (SD = 11.35) out of a possible range of 32 to 128, representing 61.3% of the maximum score. This indicates that participants, on average, have made meaningful progress toward accepting their disability but continue to experience some internal conflict regarding their condition. The standard deviation of 11.35 suggests considerable individual variation, with some participants scoring substantially higher or lower than the mean.

4.2.2. Levels of Psychosocial Adjustment

The mean score on the PAIS-SF was 28.65 (SD = 6.71) out of a possible range of 0 to 48, representing 59.7% of the maximum difficulty score, which falls within the moderate difficulty range. Among the four domains assessed, the Vocational/Activity Environment domain showed the highest difficulty (M = 6.12 out of 9, 68.0% of maximum), indicating that work and daily activity limitations are the most challenging areas for participants.

The Domestic Environment domain showed moderate difficulty (M = 5.89 out of 15, 39.3% of maximum), falling within the low difficulty range. The Extended Family Relationships domain showed the lowest difficulty (M = 3.98 out of 12, 33.2% of maximum), also in the low difficulty range. The Social Environment domain showed moderate difficulty (M = 5.06 out of 12, 42.2% of maximum), at the upper end of low difficulty. These results suggest that participants struggle most with vocational activities, while family relationships serve as a relative source of support.

4.2.3. Levels of Psychological Well-Being

The mean total score on the Psychological Well-Being (PWB) scale was 72.14 (SD = 15.82) out of a possible range of 18 to 126, representing 57.3% of the maximum score, which falls within the moderate range. At the subscale level, participants scored highest on Self-Acceptation (M = 14.65 out of 21, 69.8% of maximum, moderate) and Personal Growth (M = 12.87 out of 21, 61.3% of maximum, moderate).

The lowest scores were observed on Autonomy (M = 10.58 out of 21, 50.4% of maximum), which falls at the lower boundary of the moderate range, and Environmental Mastery (M = 10.92 out of 21, 52.0% of maximum, moderate). The low autonomy score is particularly noteworthy, as it indicates that participants experience substantial difficulty in making

independent decisions and directing their own lives. The Purpose in Life subscale (M = 11.67 out of 21, 55.6% of maximum) and Positive Relations with Others subscale (M = 11.45 out of 21, 54.5% of maximum) both fell within the moderate range. (Table 2).

Table 2:

Levels of Self-Acceptance, Psychosocial Adjustment and Psychological Well-Being

Variable/Domain	**Mean (M)**	**Standard Deviation (SD)**	**Possible Range**	**% of Maximum**	**Interpretation**
Acceptance of Disability (ADS-R)	78.42	11.35	32 – 128	61.3%	**Moderate**
Psychosocial Adjustment (PAIS-SF)	28.65	6.71	0 – 48	59.7%	**Moderate Difficulty**
Vocational/Activity Environment	6.12	1.85	0 – 9	68.0%	**Moderate Difficulty**
Domestic Environment	5.89	2.01	0 – 15	39.3%	**Low Difficulty**
Extended Family Relationships	3.98	1.92	0 – 12	33.2%	**Low Difficulty**
Social Environment	5.06	1.94	0 – 12	42.2%	**Low Difficulty**
Psychological Well-Being (PWB)	72.14	15.82	18 – 126	57.3%	**Moderate**
Self-Acceptance Subscale	14.65	3.51	3 – 21	69.8%	**Moderate**
Autonomy Subscale	10.58	3.22	3 – 21	50.4%	**Moderate (Low)**
Environmental Mastery Subscale	10.92	3.18	3 – 21	52.0%	**Moderate**
Personal Growth Subscale	12.87	3.45	3 – 21	61.3%	**Moderate**
Positive Relations Subscale	11.45	3.30	3 – 21	54.5%	**Moderate**
Purpose in Life Subscale	11.67	3.48	3 – 21	55.6%	**Moderate**

4.3. Relationship between self-acceptance, Psychological well-being and Psychological adjustment

The second research objective aimed to explore how self-acceptance, psychosocial adjustment, and psychological well-being are interconnected. To investigate these relationships, a Pearson correlation was performed (refer to Table 3). The results showed a moderate, positive, and statistically significant correlation between self-acceptance (ADS-R) and psychological well-being (PWB), with $r\ (408) = .52$, $p < .001$. This suggests that participants who embraced their disability tended to report greater overall psychological well-being.

In terms of correlations a moderate, negative significance found between self-acceptance (ADS-R) and problems in psychosocial adjustment (PAIS-SF), $r = -.45$. This suggests those with high self-acceptance faced fewer problems with adjustment in society, or less adjustment in general. On the other hand, people with lower self-acceptance generally have problems in work, home, and society. Furthermore, there was a strong, negative and statistically significant relationship between psychosocial adjustment (PAIS-SF) and psychological well-being (PWB) $r(408) = -.61$, $p < .001$. As expected, participants with more psychosocial challenges also reported substantially lower levels of psychological well-being.

Table 3:

Pearson Correlations between Self-Acceptance, Psychological Well-Being And Psychological Adjustment

Variable	**1. Self-Acceptance (ADS-R)**	**2. Psychosocial Adjustment (PAIS-SF)**	**3. Psych. Well-Being (PWB)**
1. Self-Acceptance	1	-.45**	.52**
2. Psychosocial Adj.	-	1	-.61**
3. Psych. Well-Being	-	-	1
****. Correlation is significant at the 0.01 level (2-tailed). N = 410.**			

These correlational findings provided empirical support for the conceptual framework of the study, demonstrating that self-acceptance is a key psychological resource that was positively associated with well-being and negatively associated with adjustment difficulties.

4.4. Group Differences in Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment

4.4.1. One-Way ANOVA Results

To examine group differences, one-way analysis of variance (ANOVA) was conducted for each of the three outcome variables across the categorical independent variables. Table 4 presents the ANOVA results including F-values, degrees of freedom, p-values, and effect sizes (partial η^2).

Table 4:

Summary of One-Way ANOVA Results Comparing Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment across Socio-Demographic and Disability-Related Groups

Variable	Factor	F-value	Df	P-value	Partial η²
Self-acceptance (ads-r)					
	Employment status	18.42	2, 407	**<.001**	.083
	Income level	12.87	3, 406	**<.001**	.087
	Disability type	2.15	3, 406	.094	.016
	Duration	8.94	2, 407	**<.001**	.042
	Education	1.87	3, 406	.134	.014
Psychological well-being (pwb)					
	Employment status	22.56	2, 407	**<.001**	.100
	Income level	15.34	3, 406	**<.001**	.102
	Disability type	7.82	3, 406	**<.001**	.055
	Duration	6.45	2, 407	**.002**	.031
	Education	2.01	3, 406	.112	.015
Psychosocial adjustment (pais-sf)					
	Employment status	19.87	2, 407	**<.001**	.089
	Income level	11.23	3, 406	**<.001**	.077
	Disability type	4.56	3, 406	**.004**	.033
	Duration	7.34	2, 407	**.001**	.035
	Education	1.65	3, 406	.176	.012

For self-acceptance, significant group differences were found for employment status, income level, and duration of disability. Employment status showed a significant effect on self-acceptance, $F(2, 407) = 18.42$, $p < .001$, partial $\eta^2 = .083$. Post-hoc comparisons revealed that employed participants ($M = 84.12$, $SD = 10.21$) scored significantly higher than unemployed participants ($M = 74.28$, $SD = 12.45$, $p < .001$) and retired participants ($M = 76.45$, $SD =$

11.89, p = .012). No significant difference was found between unemployed and retired participants (p = .342). Income level also showed a significant effect on self-acceptance, F(3, 406) = 12.87, p < .001, partial η^2 = .087. Post-hoc comparisons revealed that participants earning above 5000 Birr (M = 86.34, SD = 9.87) scored significantly higher than those earning less than 1000 Birr (M = 72.56, SD = 12.34, p < .001). Participants earning 3001-5000 Birr (M = 82.15, SD = 10.56) also scored significantly higher than the lowest income group (p = .015). However, the difference between the 1001-3000 Birr group (M = 76.89, SD = 11.23) and the lowest income group was not statistically significant (p = .091). Duration of disability significantly influenced self-acceptance, F(2, 407) = 8.94, p < .001, partial η^2 = .042. Participants with duration >5 years (M = 82.56, SD = 10.87) scored significantly higher than those with 1-2 years duration (M = 74.23, SD = 12.56, p < .001). The 3-5 year group (M = 78.45, SD = 11.23) showed intermediate scores that did not differ significantly from the 1-2 year group (p = .084). Disability type and education did not show significant differences for self-acceptance.

For psychological well-being, significant group differences were found for employment status, income level, disability type, and duration of disability. Employment status showed a significant effect on psychological well-being, F(2, 407) = 22.56, p < .001, partial η^2 = .100. Post-hoc comparisons revealed that employed participants (M = 79.45, SD = 14.32) scored significantly higher than unemployed participants (M = 67.23, SD = 15.67, p < .001) and retired participants (M = 70.12, SD = 14.89, p = .008). No significant difference was found between unemployed and retired participants (p = .089). Income level showed a significant effect on psychological well-being, F(3, 406) = 15.34, p < .001, partial η^2 = .102. Participants earning above 5000 Birr (M = 84.56, SD = 13.45) scored significantly higher than those earning less than 1000 Birr (M = 64.23, SD = 16.78, p < .001). Participants earning 3001-5000 Birr (M = 78.34, SD = 14.56) scored significantly higher than the lowest income group

($p < .001$). Even participants in the 1001-3000 Birr range ($M = 72.45$, $SD = 15.23$) scored significantly higher than those earning less than 1000 Birr ($p = .008$). Disability type significantly influenced psychological well-being, $F(3, 406) = 7.82$, $p < .001$, partial $\eta^2 = .055$. Participants with physical disabilities ($M = 76.34$, $SD = 14.23$) scored significantly higher than those with visual disabilities ($M = 65.87$, $SD = 16.45$, $p < .001$). Participants with hearing disabilities ($M = 71.23$, $SD = 15.12$) did not differ significantly from those with physical disabilities ($p = .087$), but scored significantly higher than those with visual disabilities ($p = .034$). Duration of disability significantly influenced psychological well-being, $F(2, 407) = 6.45$, $p = .002$, partial $\eta^2 = .031$. Participants with duration >5 years ($M = 76.34$, $SD = 14.56$) scored significantly higher than those with 1-2 years duration ($M = 68.12$, $SD = 16.23$, $p = .001$). The 3-5 year group ($M = 72.45$, $SD = 15.34$) showed intermediate scores that did not differ significantly from either extreme ($p > .05$). Education did not show significant differences for psychological well-being.

For psychosocial adjustment (PAIS-SF), where higher scores indicate greater adjustment difficulties, significant group differences were found for employment status, income level, disability type, and duration of disability. Employment status significantly influenced psychosocial adjustment difficulties, $F(2, 407) = 19.87$, $p < .001$, partial $\eta^2 = .089$. Unemployed participants ($M = 32.45$, $SD = 6.78$) reported significantly greater adjustment difficulties than employed participants ($M = 24.12$, $SD = 5.89$, $p < .001$). Retired participants ($M = 28.34$, $SD = 6.23$) also reported significantly greater difficulties than employed participants ($p = .003$). The difference between unemployed and retired participants was not significant ($p = .089$). Income level showed a significant association with psychosocial adjustment, $F(3, 406) = 11.23$, $p < .001$, partial $\eta^2 = .077$. Participants earning above 5000 Birr ($M = 23.45$, $SD = 5.67$) reported significantly fewer difficulties than those earning less than 1000 Birr ($M = 32.12$, $SD = 7.12$, $p < .001$). Participants earning 3001-5000 Birr ($M =$

26.34, SD = 6.12) reported significantly fewer difficulties than the lowest income group (p = .001). Even the 1001-3000 Birr group (M = 29.45, SD = 6.56) reported significantly fewer difficulties than the lowest income group (p = .021). Disability type significantly influenced psychosocial adjustment, $F(3, 406) = 4.56$, $p = .004$, partial $\eta^2 = .033$. Participants with visual disabilities (M = 32.45, SD = 6.78) reported significantly greater adjustment difficulties than those with physical disabilities (M = 27.12, SD = 6.23, p = .003). Participants with hearing disabilities (M = 29.56, SD = 6.45) did not differ significantly from those with physical disabilities (p = .078). Duration of disability significantly influenced psychosocial adjustment, $F(2, 407) = 7.34$, $p = .001$, partial $\eta^2 = .035$. Participants with duration >5 years (M = 26.12, SD = 6.12) reported significantly fewer difficulties than those with 1-2 years duration (M = 31.45, SD = 7.23, p < .001). The 3-5 year group (M = 28.56, SD = 6.56) reported significantly fewer difficulties than the 1-2 year group (p = .012). Education did not show significant differences for psychosocial adjustment.

4.4.2. Post-Hoc Comparisons (Tukey HSD)

Post-hoc Tukey HSD tests were conducted to identify which specific groups differed significantly from each other for variables with significant ANOVA results. These pairwise comparisons provide detailed insight into the nature of group differences, revealing which subgroups within each categorical variable had significantly higher or lower scores on the outcome measures.

For self-acceptance by employment status, post-hoc comparisons revealed a clear pattern of differences. Employed participants (M = 84.12, SD = 10.21) scored significantly higher on self-acceptance than unemployed participants (M = 74.28, SD = 12.45, p < .001), indicating that individuals who maintained employment after disability onset reported substantially greater acceptance of their condition. Similarly, employed participants scored significantly

higher than retired participants (M = 76.45, SD = 11.89, p = .012), suggesting that retirement, whether voluntary or disability-related, is associated with lower self-acceptance compared to continued employment. However, the difference between unemployed and retired participants was not statistically significant (p = .342), indicating that both groups experienced similarly lower levels of self-acceptance relative to employed individuals.

For self-acceptance by income level, post-hoc comparisons demonstrated a dose-response relationship, with higher income consistently associated with greater self-acceptance. Participants earning above 5000 Birr (M = 86.34, SD = 9.87) scored significantly higher than those earning less than 1000 Birr (M = 72.56, SD = 12.34, p < .001). Similarly, participants earning 3001-5000 Birr (M = 82.15, SD = 10.56) scored significantly higher than those in the lowest income category (p = .015). However, the difference between the 1001-3000 Birr group (M = 76.89, SD = 11.23) and the lowest income group was not statistically significant (p = .091), indicating that the benefits of higher income for self-acceptance may only become apparent at income levels above a certain threshold.

For psychological well-being by employment status, post-hoc comparisons revealed a similar pattern to that observed for self-acceptance. Employed participants (M = 79.45, SD = 14.32) scored significantly higher on psychological well-being than unemployed participants (M = 67.23, SD = 15.67, p < .001). Employed participants also scored significantly higher than retired participants (M = 70.12, SD = 14.89, p = .008), suggesting that the transition out of work, whether through unemployment or retirement, is associated with lower psychological well-being. The effect size and significance levels for employment status on psychological well-being were even stronger than those observed for self-acceptance.

For psychological well-being by disability type, post-hoc comparisons revealed that participants with physical/mobility disabilities (M = 76.34, SD = 14.23) reported significantly

higher psychological well-being than those with visual disabilities (M = 65.87, SD = 16.45, p < .001). Participants with hearing disabilities (M = 71.23, SD = 15.12) did not differ significantly from those with physical disabilities (p = .087). However, participants with hearing disabilities scored significantly higher than those with visual disabilities (p = .034).

For psychosocial adjustment difficulties by disability type, participants with visual disabilities (M = 32.45, SD = 6.78) reported significantly greater adjustment difficulties than those with physical disabilities (M = 27.12, SD = 6.23, p = .003). Participants with hearing disabilities (M = 29.56, SD = 6.45) did not differ significantly from those with physical disabilities (p = .078), though the mean difference approached significance.

For duration of disability, post-hoc comparisons revealed consistent patterns across all three outcome variables. Participants who had lived with their disability for more than five years showed significantly better outcomes than those with only 1-2 years since onset across self-acceptance, psychological well-being, and psychosocial adjustment (p < .01 for all comparisons). The 3-5 year group showed intermediate scores on all outcomes, with some significant differences from the 1-2 year group, indicating that meaningful improvements in adaptation begin to emerge within the first few years but may take more than five years to become fully established. The significant differences between the >5 year group and the 1-2 year group across all outcomes suggest that, on average, individuals achieve meaningful improvements in adaptation over time.

4.4.3. ANCOVA Results (Controlling for Duration and Income)

To isolate the unique contribution of group membership while controlling for potentially confounding variables, Analysis of Covariance (ANCOVA) was conducted with duration and income as covariates.

Table 5:

Summary of ANCOVA Results for Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment by Employment Status and Disability Type, Controlling for Duration of Disability and Monthly Income

Dependent variable	Factor	F-value	Df	P-value	Partial η²
Self-acceptance	Employment Status	12.34	2, 405	**<.001**	.057
Self-acceptance	Disability Type	1.89	3, 404	.130	.014
Psychological well-being	Employment Status	15.67	2, 405	**<.001**	.072
Psychological well-being	Disability Type	5.23	3, 404	**.001**	.037
Psychosocial adjustment	Employment Status	14.22	2, 405	**<.001**	.066
Psychosocial adjustment	Disability Type	4.12	3, 404	**.007**	.030

For self-acceptance, employment status remained a significant predictor even after controlling for duration and income, $F(2, 405) = 12.34$, $p < .001$, with a moderate effect size of partial $\eta^2 = .057$. This indicates that approximately 5.7% of the variance in self-acceptance scores was uniquely explained by employment status, independent of the effects of duration and income. However, disability type did not show a significant effect on self-acceptance when duration and income were controlled, $F(3, 404) = 1.89$, $p = .130$, partial $\eta^2 = .014$, confirming the earlier ANOVA finding that disability type is not significantly associated with self-acceptance.

For psychological well-being, employment status remained a strong and significant predictor after controlling for duration and income, $F(2, 405) = 15.67$, $p < .001$, with a moderate effect size of partial $\eta^2 = .072$, indicating that 7.2% of the variance in psychological well-being was uniquely explained by employment status. Disability type also remained significant for psychological well-being after controlling for duration and income, $F(3, 404) = 5.23$, $p =$

.001, partial $\eta^2 = .037$, indicating that 3.7% of the variance in psychological well-being was uniquely explained by disability type, independent of the effects of duration and income.

For psychosocial adjustment, employment status remained a significant predictor after controlling for duration and income, $F(2, 405) = 14.22$, $p < .001$, with a moderate effect size of partial $\eta^2 = .066$, indicating that 6.6% of the variance in psychosocial adjustment difficulties was uniquely explained by employment status. Disability type also remained significant for psychosocial adjustment after controlling for duration and income, $F(3, 404) = 4.12$, $p = .007$, partial $\eta^2 = .030$, indicating that 3.0% of the variance in psychosocial adjustment difficulties was uniquely explained by disability type, independent of the effects of duration and income.

In all cases, the effect sizes were slightly reduced compared to the one-way ANOVA results, indicating that duration and income accounted for some of the variance that was previously attributed to employment status and disability type. However, both employment status and disability type remained statistically significant predictors for psychological well-being and psychosocial adjustment, while only employment status remained significant for self-acceptance. This pattern suggests that employment status has a robust and consistent effect on all three outcome variables that is not simply a reflection of income level or duration since onset, while disability type has a more limited but still meaningful effect on psychological well-being and psychosocial adjustment.

Chapter Five

Discussion

5.1. Levels of Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment

The first objective examined aggregate levels of the three constructs. The results indicated the participants had progressed in all three, but serious barriers to progress remain: moderate.

5.1.1. Self-Acceptance

The average ADS-R score indicated a moderate level of self-acceptance. This finding agrees with Humanistic Theory (Rogers, 1961), which posits that when people feel unconditionally positively toward themselves, and the condition is often not in Ethiopia, stigma continues to be an important issue (Tekola et al., 2020).

Self-acceptance is a central trait of eudaimonic well-being in Positive Psychology, and moderate scores suggest a trajectory toward greater psychological well-being (Ryff & Singer, 2008).

It has been argued from Cognitive-Behavioral Theory (David et al., 2018) that internalized stigma and irrational beliefs about disability can prevent levels of acceptance from achieving their full potential.

5.1.2. Psychosocial Adjustment

The average PAIS-SF score indicated moderate difficulties in adjustment.As per Psychosocial Adaptation Theory, it suggests (Livneh & Antonak, 2005; Livneh & Martz,

2019) that individuals can experience stages of shock to adaptation (which is why the middle of the model seems to be challenging).

The highest difficulty of participants was in Vocational/Activity Environment, while the lowest was in Extended Family Relationships. This vocational finding is in line with the Biopsychosocial Model (WHO, 2019) that emphasizes the impact of impairments and environmental barriers on limiting activities.

In Ethiopia, few job opportunities existed for individuals with disabilities (Breffka et al., 2023; Krupa et al., 2022). In extended family relationships, it is reported that the level of difficulty is lower reflecting the collectivist aspects of Ethiopian culture, as family networks of support (Tekola et al., 2020), however, this can cause dependency.

5.1.3. Psychological Well-Being

The average Psychological Well-Being (PWB) indicated a moderate level of well-being among participants. They scored the highest in Self-Acceptance (M = 14.65/21), followed by Autonomy (M = 10.58/21) and Environmental Mastery (M = 10.92/21).

Autonomy is defined as the ability to make your own choices according to Ryff's (1989) multidimensional model. The lower autonomy score indicates challenges related to physical access, financial dependence, and dependence on family support (Krupa et al., 2022; Mohammed et al., 2023). This is consistent with Aster (2010), who noted that older adults may feel more accepted as they age, but have greater difficulties gaining autonomy.

Based on the perspective of the Human Rights Model, our study (Degener & Quinn, 2022) found a low score on autonomy reveals the systemic issues that make it difficult to obtain that which the UN CRPD (United Nations, 2006) promises that can cover such as access and independent living.

5.2. Relationships between Self-Acceptance, Psychosocial Adjustment, and Psychological Well-Being

In conformity with theoretical expectation, major correlations were detected that corresponded to reviewed literature. There is a modest positive correlation between self-acceptance and psychological well-being.

According to Positive Psychology and Humanistic Theory, Ryff (1989) posits that self-acceptance is an important aspect of overall well-being. Rogers (1961) identified self-acceptance as one of the important aspects of psychological health, and Ryff and Singer (2008) identified self-acceptance as one of the main aspects of eudaimonic flourishing. In contrast, there was a moderate negative correlation between self-acceptance and psychosocial adjustment, which indicated that greater self-acceptance is associated with fewer difficulties for adjustment. This finding corroborated Psychosocial Adaptation Theory (Livneh & Antonak, 2005; Livneh & Martz, 2019), which posits that successful adaptation is dependent on inner variables such as self-acceptance.

Moreover, Identity Reconstruction Theory (Charmaz, 1995; Papadimitriou, 2008) argues that self-acceptance represents successful integration of disability into a person's identity. Psychosocial adjustment was significantly negatively correlated with psychological well-being.

Positive Psychology (Ryff & Singer, 2020; Keyes et al., 2020) interprets this as evidence for environmental mastery and positive relations being critical to well-being. In a similar fashion, the Biopsychosocial Model (WHO, 2019) frames functioning as dynamic interplay of health conditions and contextual factors. These results supported the conceptual framework (modified from Tekola et al., 2020; Mohammed et al., 2023) that self-acceptance is an important resource that facilitates psychosocial adjustment and well-being.

5.3. Group Differences in Self-Acceptance, Psychological Well-Being, and Psychosocial Adjustment

The third objective of this study was to compare mean differences in self-acceptance, psychological well-being, and psychosocial adjustment across socio-demographic and disability-related groups. The ANOVA and ANCOVA results revealed consistent patterns across the three outcome variables, with employment status, income level, duration of disability, and disability type emerging as significant predictors.

5.3.1. Employment Status

Employment status emerged as the strongest and most consistent predictor across all three outcome variables, and remaining significant in the ANCOVA after controlling for duration and income. Employed participants scored significantly higher on self-acceptance and psychological well-being and reported fewer adjustment difficulties than unemployed and retired participants. This finding is consistent with research demonstrating that employment provides identity validation, purpose, social connection, and financial security, all of which facilitate adaptation (Krupa et al., 2022; Breffka et al., 2023). The high unemployment rate in this sample (52.0%) is particularly concerning, as it suggests that a significant portion of adults with late-onset disabilities in Addis Ababa are missing out on these protective benefits.

The finding that retired participants also reported poorer outcomes than employed participants, but did not differ significantly from unemployed participants, suggests that retirement may be experienced as involuntary or premature for some individuals with disabilities. This is consistent with research suggesting that retirement due to disability can be particularly distressing, as it involves loss of identity and purpose without the planning or choice that characterizes normative retirement (Marini et al., 2016). The ANCOVA results

confirmed that the effect of employment status on all three outcomes remained significant even after controlling for duration and income, indicating that the benefits of employment extend beyond financial resources and may include psychological benefits such as structure, purpose, and social connection that are not fully captured by income alone.

From a policy perspective, these findings underscore the importance of employment-focused interventions for adults with disabilities. The Human Rights Model (United Nations, 2006; Degener & Quinn, 2022) requires governments to eliminate barriers to employment and provide reasonable accommodations to enable persons with disabilities to participate fully in the workforce. In Ethiopia, where unemployment among persons with disabilities is disproportionately high, targeted interventions such as vocational training, workplace accommodations, and affirmative action policies are urgently needed. The finding that employment remained significant after controlling for income suggests that interventions should address not only economic barriers but also psychological and social barriers to employment, such as stigma, discrimination, and lack of workplace accommodations.

5.3.2. Income Level

Income level showed a consistent dose-response relationship with all three outcome variables. Participants with higher income reported greater self-acceptance, higher psychological well-being, and fewer adjustment difficulties. This finding is consistent with research demonstrating that economic resources enable access to rehabilitation services, assistive devices, transportation, and social opportunities that facilitate adaptation (Yeo & Moore, 2003; Shakespeare, 2018). The dose-response relationship observed in this study suggests that even modest increases in income may improve adaptation outcomes. Participants earning 1001-3000 Birr reported significantly better psychological well-being and psychosocial adjustment than those earning less than 1000 Birr, suggesting that moving

out of extreme poverty has meaningful benefits. However, the finding that the 1001-3000 Birr group did not differ significantly from the lowest income group on self-acceptance suggests that meaningful improvements in self-acceptance may require income above a certain threshold.

These findings highlight the mutually reinforcing relationship between poverty and disability. Poverty restricts access to resources that could improve functioning and participation, while disability-related expenses further deplete financial resources (Shakespeare, 2018). Breaking this cycle requires comprehensive policies that address both economic empowerment and disability-related costs. In Ethiopia, where the majority of participants earned 3000 Birr or less, poverty likely compounds the challenges of adaptation and undermines the effectiveness of rehabilitation and support services. The finding that income effects remained significant for self-acceptance in the ANOVA but were controlled for in the ANCOVA suggests that income is an important but not the sole determinant of outcomes, and that interventions should address both economic and non-economic factors.

5.3.3. Disability Type

Disability type showed significant differences for psychological well-being and psychosocial adjustment but not for self-acceptance. Participants with visual disabilities reported significantly lower psychological well-being and greater adjustment difficulties than those with physical disabilities. This finding is consistent with research suggesting that visual impairments may present particular challenges in the Ethiopian context, including barriers to information access, mobility, and community participation (Ayele, 2020; Mihiret, 2020). The ANCOVA results confirmed that disability type remained significant for psychological well-being and psychosocial adjustment even after controlling for duration and income, indicating

that the challenges associated with visual impairment are not simply a reflection of economic disadvantage or time since onset.

The finding that visual disabilities were associated with poorer outcomes than physical disabilities may reflect several factors. First, visual impairment creates significant barriers to accessing written information, which is particularly problematic in a context where educational attainment is low and alternatives such as Braille or audio formats are limited. Second, navigating inaccessible streets and public transportation is particularly challenging for individuals with visual impairments, creating dependence on others and limiting social participation. Third, cultural beliefs about disability causation may be particularly stigmatizing for individuals with visual impairments, as spiritual explanations may be more salient for conditions that are visible and affect a primary sense (Tekola et al., 2020). The finding that disability type was not significant for self-acceptance suggests that while visual impairment poses practical challenges that affect well-being and adjustment, it does not necessarily impede the internal process of accepting one's disability.

The finding that hearing disabilities did not differ significantly from physical disabilities on most outcomes suggests that the challenges associated with hearing impairment may be less severe or more effectively managed than those associated with visual impairment. However, this finding should be interpreted with caution given the smaller sample size for hearing disabilities ($n = 34$). The trend toward significance for hearing disabilities on some outcomes suggests that a larger sample might reveal more consistent differences. From an intervention perspective, these findings suggest that individuals with visual disabilities may require targeted support to address their specific challenges, including access to information, mobility training, and stigma reduction initiatives. The Ethiopian government and disability

organizations should consider developing specialized programs for individuals with visual disabilities that address both practical barriers and psychological needs.

5.3.4. Duration of Disability

Duration of disability was consistently significant across all three outcome variables. Participants with longer duration since onset (more than five years) reported greater self-acceptance, higher psychological well-being, and fewer adjustment difficulties than those with shorter duration (1-2 years). This finding is consistent with Psychosocial Adaptation Theory (Livneh & Antonak, 2005; Livneh & Martz, 2019), which proposes that adjustment is a temporal process that unfolds over time. The finding that the 3-5 year group showed intermediate scores, with some significant differences from the 1-2 year group, suggests that meaningful improvements in adaptation begin to emerge within the first few years but may take more than five years to become fully apparent. This may reflect the time required to develop effective coping strategies, reconstruct identity, and find new sources of meaning and purpose (Charmaz, 1995; Papadimitriou, 2008).

The relatively small effect sizes for duration (η^2 ranging from .031 to .042) suggest that while time is important, other factors such as employment, income, and social support also play critical roles in facilitating adaptation. This finding highlights the need for interventions that address both the temporal nature of adaptation and the structural factors that influence outcomes. The ANCOVA results, which controlled for duration, confirmed that employment status and disability type remained significant predictors even after accounting for the effects of time, suggesting that these factors have unique contributions to outcomes beyond the natural passage of time.

The finding that individuals in the 1-2 year duration group consistently reported the poorest outcomes across all measures suggests that this period may be a critical window for intervention, when individuals are most vulnerable and may benefit most from psychological support, rehabilitation services, and peer support programs. Conversely, the finding that individuals in the >5 year duration group reported the best outcomes suggests that many individuals eventually achieve meaningful adaptation, though the process may be prolonged without adequate support. This underscores the importance of providing sustained, long-term support for adults with late-onset disabilities, rather than assuming that adaptation will occur naturally without intervention.

5.4. Integration with Ethiopian Context

The findings of this study must be understood within the Ethiopian context, where cultural beliefs, structural barriers, and limited resources shape the experience of disability. The moderate levels of self-acceptance observed in this study reflect both individual resilience and the pervasive stigma documented in recent Ethiopian research on disability (Breffka et al., 2023; Tekola et al., 2020). Cultural perspectives indicate that disability is commonly viewed through spiritual and religious lenses, which significantly impacts how individuals approach their self-acceptance process. The support provided by extended family relationships, reflected in the relatively low adjustment difficulties in this domain, is consistent with the collectivist nature of Ethiopian culture and aligns with Humanistic Theory (Rogers, 1961), which emphasizes the role of supportive relationships in strengthening well-being.

The low scores on autonomy highlight the tension between family support and the desire for independence. In Ethiopian culture, family support is expected and valued, but it can also limit autonomy and create dependence. This tension is particularly acute for adults with

disabilities, who may struggle to balance their need for support with their desire for independence (Aster, 2010). The strong associations between employment, income, and well-being mirror the harsh economic realities faced by many persons with disabilities in Ethiopia, where 52% are unemployed and 71.7% earn 3000 Birr or less. These findings underscore the importance of the Human Rights Model (United Nations, 2006; Degener & Quinn, 2022), which requires governments to eliminate barriers to economic participation.

The finding that visual disabilities were associated with poorer outcomes than physical disabilities may also reflect Ethiopian-specific factors. The limited availability of Braille materials, audio formats, and mobility training for individuals with visual impairments may compound the challenges they face. Additionally, cultural beliefs that attribute visual impairment to spiritual causes may be particularly stigmatizing, as the loss of sight is often perceived as a profound and visible disability that affects a primary sense (Tekola et al., 2020). These contextual factors highlight the need for culturally sensitive interventions that address both the practical and psychological needs of individuals with different types of disabilities.

The collectivist nature of Ethiopian society, while providing support through extended family networks, may also create challenges for autonomy and independence. The tension between family support and individual autonomy observed in this study reflects broader cultural dynamics in Ethiopia, where interdependence is valued and individual independence may be seen as less important than family cohesion (Mohammed et al., 2023). For adults with disabilities, this cultural dynamic may be particularly complex, as they may need to navigate the expectations of family members while also asserting their own desires for independence and self-determination. Interventions should be sensitive to these cultural dynamics, recognizing the value of family support while also promoting autonomy and independence where possible.

Chapter Six

Summary, Conclusion and Recommendations

6.1. Summary of Findings

This study examined self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa, Ethiopia. The findings revealed moderate levels across all three constructs, with participants scoring moderate percentages of the maximum on self-acceptance, psychosocial adjustment difficulties, and psychological well-being. Within psychological well-being, autonomy was the lowest-scoring dimension, while self-acceptance and personal growth were the highest. Pearson correlation analyses revealed significant relationships among the three constructs: self-acceptance was positively correlated with psychological well-being and negatively correlated with psychosocial adjustment difficulties, while psychological well-being was strongly negatively correlated with adjustment difficulties. One-way ANOVA results indicated significant group differences for employment status, income level, duration of disability, and disability type across the outcome variables, with effect sizes ranging from small to moderate. Employment status emerged as the strongest predictor, with employed participants reporting significantly better outcomes than unemployed and retired participants. Income level showed a consistent dose-response relationship, with higher income associated with greater self-acceptance, higher well-being, and fewer adjustment difficulties. Duration of disability was also significant, with participants who had lived with their disability for more than five years reporting better outcomes than those with shorter duration since onset. Disability type revealed that participants with visual disabilities reported significantly lower psychological well-being and greater adjustment difficulties than those with physical disabilities. Education was not significant for any outcome. ANCOVA results, controlling for duration and income,

confirmed that employment status remained a significant predictor of all three outcomes, and disability type remained significant for psychological well-being and psychosocial adjustment. These findings underscore the critical role of employment, economic resources, and disability type in shaping adaptation outcomes for adults with late-onset disabilities in Ethiopia.

6.2. Conclusions

Based on the findings of this study, several important conclusions can be drawn about self-acceptance, psychological well-being, and psychosocial adjustment among adults with late-onset disabilities in Addis Ababa, Ethiopia.

First, adults with late-onset disabilities in Addis Ababa experience moderate levels of self-acceptance, psychological well-being, and psychosocial adjustment. While participants have made meaningful progress in adapting to their disabilities, they continue to face significant challenges that prevent them from achieving optimal psychological functioning. Among the dimensions of psychological well-being, autonomy emerged as the lowest-scoring area, indicating that participants experience substantial difficulty in making independent decisions and directing their own lives. Family relationships served as a relative source of support, with extended family relationships showing the lowest adjustment difficulties, while vocational activities presented the greatest challenge, reflecting the high unemployment rate and economic marginalization faced by participants.

Second, self-acceptance is a key psychological resource that is positively associated with psychological well-being and negatively associated with psychosocial adjustment difficulties. The significant correlations among the three constructs confirm that they are interconnected and mutually reinforcing, with improvements in one domain likely to benefit the others. This finding supports theoretical frameworks including Humanistic Theory, Positive Psychology,

and Psychosocial Adaptation Theory, and highlights the importance of addressing self-acceptance in interventions aimed at promoting successful adaptation.

Third, socio-demographic and disability-related factors significantly influence adaptation outcomes. Employment status emerged as the strongest and most consistent predictor across all three outcome variables, with employed participants reporting greater self-acceptance, higher psychological well-being, and fewer adjustment difficulties than unemployed and retired participants. This finding remained significant even after controlling for duration of disability and income, indicating that the benefits of employment extend beyond financial resources. Income level showed a clear dose-response relationship, with higher income consistently associated with better outcomes across all measures, suggesting that economic resources enable access to rehabilitation services, assistive devices, and social opportunities that facilitate adaptation. Duration of disability was also significant, with longer duration associated with better adaptation, confirming that adjustment is a gradual process that unfolds over time. Disability type revealed that individuals with visual disabilities reported lower psychological well-being and greater adjustment difficulties than those with physical disabilities, while education was not significantly associated with any outcome.

Fourth, the Ethiopian context plays a critical role in shaping the adaptation experiences of adults with late-onset disabilities. The collectivist nature of Ethiopian society provides support through extended family networks, as reflected in the relatively low adjustment difficulties in the domain of extended family relationships. However, this family support may also limit autonomy, creating a tension between the benefits of interdependence and the desire for independence. Cultural beliefs that attribute disability to spiritual causes contribute to stigma and internalized shame, which impede self-acceptance and psychosocial adjustment. These contextual factors must be considered in designing interventions and policies.

Fifth, the study provides empirical support for the conceptual framework integrating Humanistic Theory, Positive Psychology, Psychosocial Adaptation Theory, Identity Reconstruction Theory, and the Biopsychosocial Model. The findings demonstrate that adaptation to late-onset disability is influenced by a complex interplay of psychological, social, cultural, and structural factors, and that successful adaptation requires addressing both internal psychological processes and external environmental barriers.

In conclusion, adults with late-onset disabilities in Addis Ababa face significant psychological and social challenges in their adaptation process. While they demonstrate resilience and have made progress in accepting their disabilities and maintaining psychological well-being, many continue to struggle with autonomy, vocational functioning, and the effects of stigma and poverty. Employment and economic resources are critical determinants of successful adaptation, and individuals with visual disabilities may require targeted support.

6.3. Recommendations

Based on the findings and conclusions of this study, the following recommendations are made for policy, practice, and future research.

Recommendations for Policy

- Given that employment status emerged as the strongest predictor of self-acceptance, psychological well-being, and psychosocial adjustment, with employed participants consistently reporting better outcomes than unemployed and retired participants, it is recommended that the Ethiopian government and relevant stakeholders prioritize employment-focused interventions for adults with disabilities. This includes implementing vocational training programs tailored to the needs of persons with disabilities, providing workplace accommodations to enable successful employment,

and enforcing affirmative action policies that require public and private employers to hire qualified individuals with disabilities. The government should also consider providing incentives for employers who hire persons with disabilities and establishing supported employment programs that provide ongoing assistance to individuals in maintaining their jobs.

- Given the clear dose-response relationship between income and all three outcome variables, with higher income consistently associated with better adaptation outcomes, it is recommended that policies be developed to address the economic marginalization of persons with disabilities. This includes expanding social protection programs, increasing disability allowances, and providing financial support for assistive devices and rehabilitation services. The government should also consider implementing poverty reduction programs that specifically target households with members who have disabilities, recognizing the mutually reinforcing relationship between poverty and disability.
- Given that participants with visual disabilities reported significantly lower psychological well-being and greater psychosocial adjustment difficulties than those with physical disabilities, it is recommended that targeted interventions be developed for individuals with visual impairments. This includes improving access to information through expanded Braille services, audio formats, and assistive technology; providing mobility training to enhance independence and community participation; and implementing stigma reduction campaigns that specifically address cultural beliefs about visual impairment. Rehabilitation programs should include psychological support components that address the unique challenges faced by individuals with visual disabilities.

Recommendations for Practice

- Given the significant correlations among self-acceptance, psychological well-being, and psychosocial adjustment, it is recommended that rehabilitation and mental health programs adopt holistic approaches that address all three constructs simultaneously. Interventions should include components that promote self-acceptance through counseling, peer support groups, and self-advocacy training; enhance psychological well-being through autonomy-building activities, goal-setting, and meaning-making interventions; and support psychosocial adjustment through vocational rehabilitation, social skills training, and community integration programs. A coordinated, multidisciplinary approach is essential for addressing the multiple dimensions of adaptation.
- Given the central role of self-acceptance in facilitating both psychological well-being and psychosocial adjustment, it is recommended that mental health professionals and rehabilitation specialists prioritize interventions that promote self-acceptance. This includes cognitive-behavioral approaches that challenge internalized stigma and irrational beliefs about disability; acceptance and commitment therapy that helps individuals develop psychological flexibility; and peer support programs that provide modeling and validation from others with similar experiences. Culturally sensitive approaches that address Ethiopian beliefs about disability causation are essential for effectiveness.
- Given that vocational difficulties were the most challenging domain of psychosocial adjustment, it is recommended that rehabilitation programs include a strong vocational component that addresses both job placement and psychological readiness for work. This includes vocational assessment, skills training, job placement assistance, and ongoing support to maintain employment. Programs should also

address the psychological barriers to employment, such as low self-efficacy, internalized stigma, and fear of discrimination, through counseling and peer support.

- Given the extended period required for adaptation, with participants who had lived with their disabilities for more than five years reporting significantly better outcomes than those with only one to two years since onset, it is recommended that support services be provided over the long term rather than only in the immediate post-onset period. This includes establishing ongoing peer support groups, providing periodic check-ins and booster sessions for psychological interventions, and ensuring that rehabilitation services are available throughout the adaptation process. Service providers should recognize that the first few years post-onset are a critical period of vulnerability and ensure that intensive support is available during this time.

Recommendations for Future Research

- Given the descriptive design of this study, which cannot establish causal relationships, it is recommended that future research employ longitudinal designs to track individuals over time from the onset of disability through the adaptation process. This would allow researchers to examine how self-acceptance, psychological well-being, and psychosocial adjustment evolve over time and to identify critical periods for intervention. Longitudinal studies would also enable researchers to examine the direction of causality among the three constructs and to identify factors that predict successful versus unsuccessful adaptation.
- Given that this study was conducted only in Addis Ababa, with its unique urban characteristics and relatively better access to services, it is recommended that future research be conducted in rural areas of Ethiopia where cultural beliefs, access to services, and economic conditions may differ substantially. Comparative studies across urban and rural settings would provide a more comprehensive understanding of

the factors that influence adaptation outcomes and would inform the development of contextually appropriate interventions.

- Given that the quantitative approach provided valuable information about levels and associations but could not capture the depth and richness of individual experiences, it is recommended that future research employ qualitative methods to explore the lived experiences of adults with late-onset disabilities in Ethiopia. In-depth interviews and focus groups could provide insight into the meaning-making processes, coping strategies, and cultural factors that shape adaptation, complementing the quantitative findings of this study.
- Given that this study included only physical, visual, and hearing disabilities, it is recommended that future research include other types of disabilities such as cognitive and intellectual disabilities to examine whether the patterns observed in this study generalize to other populations. Comparative studies across different disability types would help identify which groups face the greatest challenges and which interventions are most effective for different populations.
- Given that disability type emerged as a significant predictor of psychological well-being and psychosocial adjustment, it is recommended that future research examine in greater depth the specific challenges faced by individuals with visual disabilities in the Ethiopian context. This could include investigations of the role of stigma, access to information, mobility barriers, and cultural beliefs in shaping adaptation outcomes for this population, as well as intervention studies that test the effectiveness of targeted support programs.
- Given that education was not significantly associated with any outcome in this study, it is recommended that future research examine the relationship between education and adaptation more closely, including the potential mediating roles of employment,

income, and health literacy. Research could also explore whether the type or quality of education, rather than years of schooling, influences adaptation outcomes.

- Finally, given the moderate effect sizes observed in this study, which suggest that other unmeasured variables also contribute to adaptation outcomes, it is recommended that future research include additional variables such as social support quality, spirituality, coping strategies, and access to rehabilitation services. Examining the role of these factors would provide a more comprehensive understanding of the adaptation process and inform the development of more effective interventions.

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Appendix A: Informed Consent Form

Title of the Study: Self-Acceptance, Psychological Well-Being and Psycho-Social Adjustment among Adults with Late-Onset Disability In Addis Ababa

Introduction:

You are invited to take part in a research study. Please read this form carefully and feel free to ask any questions before agreeing to participate.

Purpose of the Study

This study aims to understand the psychological experiences and self-acceptance processes of individuals who acquired disabilities after adolescence in the Ethiopian context in Addis Ababa and its surrounding.

Procedures

If you agree to participate, you will be asked to take part in an interview lasting approximately 45–60 minutes. The interview will be recorded with your consent, and your responses will be used for academic analysis only.

Confidentiality

All data will be anonymized. Your name or any personal identifier will not appear in any reports or publications. Audio files and transcripts will be stored in a secure, password-protected system

Consent Statement:

☐ I have read and understood the information provided.

☐ I voluntarily agree to participate in this study.

Signature: _____

Appendix B: Questionnaire

Section I: Socio-Demographic and Disability-Related Information

1. Age: _____ years
2. Gender: ☐ Male ☐ Female ☐ Other
3. Marital status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed
4. Educational level: ☐ No formal education ☐ Primary ☐ Secondary ☐ College/University
5. Employment status: ☐ Employed ☐ Unemployed ☐ Self-employed ☐ Retired
6. Monthly income (in ETB): ☐ <1000 ☐ 1001–3000 ☐ 3001–5000 ☐ >5000
7. Type of disability: ☐ Physical/mobility ☐ Visual ☐ Hearing ☐ Other (specify) _____
8. Duration since onset: ☐ 1–2 years ☐ 3–5 years ☐ >5 years
9. Cause of disability: ☐ Injury ☐ Chronic illness ☐ Neurological condition ☐ Other

Section II: Psychosocial Adjustment (PAIS-SR Short Form, 16 Items)

This section asks about different areas of your life since your disability began. For each statement, please indicate how true it has been for you over the past month. Choose the number that best fits your experience:

0 = Not true, 1 = Sometimes true, 2 = Often true, 3 = Very true."

No	ITEM	0 = Not true	1 = Sometimes true	2 = Often true	3 = Very true.
Vocational/Activity Environment (3 items)					
1.	My disability has significantly affected my ability to work or do daily tasks.				
2.	I feel I can still contribute meaningfully to my household or community.				
3.	I feel valued in my current daily roles (work, home, volunteering, etc.).				
Domestic Environment (5 items)					
4.	My disability has created financial strain for my family.				
5.	Family communication has become more difficult since my disability.				
6.	I feel like a burden to my family because of my disability.				
7.	My disability has affected my ability to perform household tasks.				
8.	Family members are supportive and understanding of my situation.				
Extended Family Relationships (4 items)					
9.	I feel supported by my extended family (relatives, in-laws).				
10.	My disability has reduced my contact with relatives.				
11.	Relatives treat me with respect despite my disability.				
12.	I depend on extended family for physical or financial help more than before.				
Social Environment (4 items)					
13.	I participate in social gatherings as much as I did before my disability.				
14.	I feel comfortable interacting with people outside my family.				
15.	People in my community treat me differently because of my disability.				
16.	I have lost friends because of my disability.				

Section III: 32 items of the revised Acceptance of Disability Scale (ADS-R) as they appear in the Lithuanian version of the study.

The items are listed in the order they were presented in the questionnaire, along with their subscale notation in parentheses:

Twenty-two items on the ADS-R are reversed scored

NO	Item	1 = Strongly Disagree	2 = Disagree	3 = Agree	4 = Strongly Agree
1	With my disability, all areas of my life are affected in some major way. (C) R				
2	Having my disability, I am unable to do things like people without disabilities do. (T)R				
3	Disability or not, I am going to make a good in life. (E)				
4	Because of my disability, I have little to offer other people. (T)R				
5	Good physical appearance and physical ability are the most important things in life. (S)R				
6	A person with a disability is restricted in certain ways, but there is still much s/he is able to do. (E)				
7	No matter how hard I try or what I accomplish, I could never be as good as the person who does not have my disability. (T)R				
8	It makes me feel very bad to see all the things that people without disabilities can do that I cannot. (C)R				
9	The most important thing in this world is to be physically capable. (S)R				
10	Because of my disability, other people's lives have more meaning than my own. (T)R				
11	Because of my disability, I feel miserable much of the time. (C)R				
12	Though I have a disability, my life is full. (E)				
13	The kind of person I am and my accomplishments in life are less important than those of persons without disabilities. (T)R				
14	A physical disability affects a person's mental ability. (S)R				
15	Since my disability interferes with just about everything I try to do, it is				

	foremost in my mind practically all of the time. (C)R				
16	There are many things a person with my disability is able to do. (E)				
17	My disability in itself affects me more than any other characteristic about me. (C)R				
18	There are many more important things in life than physical ability and appearance. (E)				
19	Almost every area of life is closed to me. (T)R				
20	My disability prevents me from doing just about everything I really want to do and from becoming the kind of person I want to be. (C)R				
21	I feel like an adequate person regardless of the limitation of my disability. (E)				
22	My disability affects those aspects of life that I care most about. (C)R				
23	A disability such as mine is the worst possible thing that can happen to a person. (T)R				
24	You need a good and whole body to have a good mind. (S)R				
25	There are times that I completely forget that I have a disability. (E)				
26	If I didn't have my disability, I think I would be a much better person. (T)R				
27	When I think of my disability, it makes me so sad and upset that I am unable to do anything else. (C)R				
28	People with disabilities are able to do well in many ways. (T)				
29	I feel satisfied with my abilities and my disability does not bother me too much. (E)				
30	In just about everything, my disability is annoying to me so that I can't enjoy anything. (C)R				
31	Physical wholeness and appearance make a person who s/he is. (S)				
32	I know what I can't do because of my disability, and I feel that I can live a full life. (E)				

Subscale key:

- **(E)** = Enlargement of Scope of Values
- **(S)** = Subordination of Physique
- **(C)** = Containment of Disability
- **(T)** = Transformation from Comparative Status to Asset Values
- **R= reverse score**

Psychological Wellbeing (18 items)

Instructions: Circle one response below each statement to indicate how much you agree or disagree.

1. "I like most parts of my personality."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

2. "When I look at the story of my life, I am pleased with how things have turned out so far."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

3. "Some people wander aimlessly through life, but I am not one of them."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

4. "The demands of everyday life often get me down."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

5. "In many ways I feel disappointed about my achievements in life."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

6. “Maintaining close relationships has been difficult and frustrating for me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

7. “I live life one day at a time and don't really think about the future.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

8. “In general, I feel I am in charge of the situation in which I live.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

9. “I am good at managing the responsibilities of daily life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

10. “I sometimes feel as if I've done all there is to do in life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

11. “For me, life has been a continuous process of learning, changing, and growth.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

12. “I think it is important to have new experiences that challenge how I think about myself and the world.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

13. “People would describe me as a giving person, willing to share my time with others.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

14. “I gave up trying to make big improvements or changes in my life a long time ago”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

15. “I tend to be influenced by people with strong opinions”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

16. “I have not experienced many warm and trusting relationships with others.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

17. “I have confidence in my own opinions, even if they are different from the way most other people think.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

18. “I judge myself by what I think is important, not by the values of what others think is important.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

This survey accompanies a measure in the SPARQTools.org Measuring Mobility toolkit, which provides practitioners curated instruments for assessing mobility from poverty and tools for selecting the most appropriate measures for their programs.To get a copy of this document in your preferred format, go to "File" and then "Download as" in the toolbar menu.

Age: Adult

Duration: 3-5 minutes

Reading Level: 6th to 8th grade

Number of items: 18

Answer Format: 1 = strongly agree; 2 = somewhat agree; 3 = a little agree; 4 = neither agree or disagree; 5 = a little disagree; 6 = somewhat disagree; 7 = strongly disagree.

Scoring:

The Autonomy subscale items are Q15,Q17, Q18. The Environmental Mastery subscale items are Q4, Q8, Q9. The Personal Growth subscale items are Q11, Q12, Q14. The Positive Relations with Others subscale items are Q6, Q13, Q16. The Purpose in Life subscale items are Q3, Q7, Q10. The Self-Acceptance subscale items are Q1, Q2, and Q5.

Q1, Q2, Q3, Q8, Q9, Q11, Q12, Q13, Q17, and Q18 should be reverse-scored. Reverse-scored items are worded in the opposite direction of what the scale is measuring. The formula for reverse-scoring an item is:

((Number of scale points) + 1) - (Respondent's answer)

For example, Q1 is a 7-point scale. If a respondent answered *3* on Q1, you would re-code their answer as: (7 + 1) - 3 = 5.

In other words, you would enter a *5* for this respondents' answer to Q1.

To calculate subscale scores for each participant, sum respondents' answers to each subscale's items. Higher scores mean higher levels of psychological well-being.



አዲስ አበባ ዩኒቨርሲቲ

ትምህርትና እና ባህሪ ኮሌጅ

ሳይኮሎጂ የትምህርት ክፍል

አባሪ ሀ፡ ነጻ ፈቃድ መስጫ ቅጽ (Informed Consent)

በአዲስ አበባ ለአካለ መጠን የደረሱ በኋላ አካል ጉዳት የገጠማቸው ሰዎች ራስን መቀበል፣ ስነ-ልቦናዊ ደህንነት እና የስነ-ልቦና-ማኅበራዊ ማስተካከያን ዙሪያ ምርምር ጥናት ላይ እንድትሳተፉ ተጋብዘዋል። እባክዎ ይህንን ቅጽ በጥንቃቄ ያንብቡ እና ለመሳተፍ ከመስማማትዎ በፊት ማንኛውንም ጥያቄ ለመጠየቅ ነፃነት ይሰማዎት።

ይህ ጥናት በአዲስ አበባ በኢትዮጵያ ባለው ነባራዊ ሁኔታ ከጉርምስና በኋላ የአካል ጉዳተኛ የሆኑ ግለሰቦችን የስነ-ልቦና ልምድ እና ራስን የመቀበል ሂደቶችን ለመረዳት ያለመ ነው።

በዚህ ጥናት ውስጥ ያለውት ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ሲሆን ለመሳተፍ ሙሉ በሙሉ ፈቃደኛ አለመሆን ወይም መልስ መስጠት የማይፈልጓቸውን ጥያቄዎች መተው ይችላሉ። የሚሰጡት መልስ እና ማንነት ሚስጥራዊ ይቆያል። ምላሾችዎ ለትምህርታዊ ትንተና ብቻ ጥቅም ላይ ይውላሉ። የእርስዎ ስም ወይም ማንኛውም የግል መለያ በማንኛውም ሪፖርቶች ወይም ህትመቶች ውስጥ አይካተትም። ትክክለኛ መልስዎ ለዚህ ጥናት ስኬት በጣም ወሳኝ ነው።

መጠይቁ በግምት ከ45-60 ደቂቃዎች የቆይታ ግዜ ይኖረዋል።

የፍቃድ መግለጫ፡-

☐ የቀረበውን መረጃ አንብቤ ተረድቻለሁ።

☐ በዚህ ጥናት ለመሳተፍ በፈቃዴ ተስማምቻለሁ።

ፊርማ፡ _____

አባሪ ለ፡ መጠይቅ

ክፍል 1፡ አጠቃላይ መረጃ

1. ዕድሜ፡ _____ ዓመት
2. ጾታ፡ ☐ ወንድ ☐ ሴት
3. የትዳር ሁኔታ፡ ☐ ያላገባ/ት ☐ ያገባ/ት ☐ የተፋታ ☐ ባል/ሚስት የሞተባት/ት
4. የትምህርት ደረጃ፡ ☐መደበኛ ትምህርት አልተከታተልኩም ☐ የመጀመሪያ ደረጃ ☐ ሁለተኛ ደረጃ ☐ ኮሌጅ/ዩኒቨርሲቲ
5. የሥራ ሁኔታ፡ ☐ በደመወዝ ተቀጥሬ እሠራለሁ ☐ ሥራ አጥ ነኝ ☐ በግል ሥራ ላይ ነኝ ☐ ጡረታ ወጥቻለሁ
6. ወርሃዊ ገቢ (በብር)፡ ☐ ከ1000 በታች ☐ ከ1001 እስከ 3000 ☐ ከ3001 እስከ 5000 ☐ ከ5000 በላይ
7. የአካል ጉዳት ዓይነት፡ ☐ የአካል እንቅስቃሴ ችግር ☐ ዓይነሥውር ☐ መስማት የተሳነው ☐ ሌላ (እባክዎ ይጥቀሱ) _____
8. ጉዳቱ ከተከሰተ የቆየበት ጊዜ፡ ☐ ከ1-2 ዓመት ☐ ከ3-5 ዓመት ☐ ከ5 ዓመት በላይ
9. የአካል ጉዳት መንስኤ፡ ☐ አደጋ/ጉዳት ☐ ሥር የሰደደ ሕመም ☐ የነርቭ ሥርዓት በሽታ ☐ ሌላ

ክፍል 2፡ ስነ-ልቦናዊ እና ማኅበራዊ ልምምድ (PAIS-SR አጭር ቅጽ፣ 16 ጥያቄዎች)

ይህ ክፍል አካል ጉዳቱ ከተከሰተ በኋላ በሕይወትዎ ውስጥ ስላሉት የተለያዩ ጉዳዮች ይጠይቃል።

ለእያንዳንዱ ጥያቄ፣ ከልምድዎ ጋር በጣም የሚስማማውን ቁጥር ይምረጡ፦

0 = እውነት አይደለም፣ 1 = አንዳንድ ጊዜ እውነት ነው፣ 2 = ብዙ ጊዜ እውነት ነው፣ 3 = በጣም እውነት ነው

ተ.ቁ		0	1	2	3
የሙያ እና የተለያዩ እንቅስቃሴዎች					
1	የአካል ጉዳቴ የመሥራት ወይም የዕለት ተዕለት እንቅስቃሴዎችን የማከናወን ችሎታዬን በእጅጉ ተግዳሮት ፈጥሮብኛል				
2	አሁንም ለቤተሰቤ ወይም ለማህበረሰቤ ትርጉም ያለው አስተዋፅዖ ማድረግ እንደምችል ይሰማኛል				
3	አሁን ባለኝ የእለት ተእለት ሚና (ስራ፣ ቤት፣ በጎ ፈቃደኝነት፣ ወዘተ) ብርታት ይሰማኛል።				
የቤተሰብ ሁኔታ					

4	የእኔ አካል ጉዳተኝነት በቤተሰቦቼ ላይ የገንዘብ ችግር አስከትሏል ።				
5	አካል ጉዳተኝነት ካጋጠመኝ በኋላ ከቤተሰብ ጋር ያለኝ ግንኙነት በጣም ከባድ ሆኗል።				
6	በአካል ጉዳቴ ምክንያት ለቤተሰቦቼ ሸክም እንደሆንኩ ይሰማኛል ።				
7	የአካል ጉዳቴ የቤት ውስጥ ሥራዎችን የመሥራት ችሎታዬን ጎድቶታል።				
8	ቤተሰቦቼ የእኔን ሁኔታ ይደግፋሉ እና ይገነዘባሉ				
	የቤተሰብ ግንኙነት				
9	ዘመዶቼ እንደሚደግፉኝ ይሰማኛል። (አማቶቼን ጨምሮ)				
10	የአካል ጉዳቴ ከዘመዶቼ ጋር ያለኝን ግንኙነት ቀንሷል።				
11	የአካል ጉዳተኝነት ቢኖርም ዘመዶቼ በአክብሮት ይንከባከቡኛል ወይም ያስተናግዱኛል።				
12	ከዚህ ቀደም ከነበረው ይበልጥ ለአካላዊ ወይም የገንዘብ እርዳታ በዘመዶቼ እየተደገፍኩ ነው				
	ከባቢ				
13	ከአካል ጉዳተኛ ከመሆኔ በፊት እንደማደርገው በማኅበራዊ ሕይወት ላይ እሳተፋለሁ።				
14	ከቤተሰቤ ውጪ ካሉ ሰዎች ጋር በመገናኘቴ ምቾት ይሰማኛል።				
15	በማህበረሰቤ ውስጥ ያሉ ሰዎች በአካል ጉዳቴ ምክንያት በተለየ መንገድ ያዩኛል።				
16	በአካል ጉዳቴ ምክንያት ጓደኞቼን አጥቻለሁ።				

ክፍል 3፡ የአካል ጉዳተኝነትን መቀበልን የሚለካ መለኪያ (ADS-R) 32 ጥያቄዎች አሉት።

ተ.ቁ		1 በጣም አልስማማም	2 አልስማማም	3 እስማማለሁ	4 በጣም እስማማለሁ
1	በአካል ጉዳቴ ምክንያት እያንዳንዱ የሕይወቴ ክፍል በእጅጉ ተጎድቷል።(C) R				
2	በአካል ጉዳቴ ምክንያት ጉዳት አልባዎች ማድረግ የሚችሁትን ነገሮችን ማድረግ አልችልም። (T)R				
3	አካል ጉዳተኛ ብሆንም ባልሆንም ጥሩ ህይወት ይኖረኛል። (E)				
4	በአካል ጉዳቴ ምክንያት ለሌሎች ሰዎች የምሰጠው ነገር ጥቂት ነው። (T)R				
5	ጥሩ አካላዊ ገጽታ እና አካላዊ ብቃት በሕይወት ውስጥ በጣም አስፈላጊ ነገሮች				

	ናቸው። (S)R				
6	አካል ጉዳተኛ በተወሰኑ መንገዶች ቢገደብም፣ አሁንም ማድረግ የምችላቸው ብዙ ነገሮች አሉ። (E)				
7	ምንም ያህል ብጥር ወይም ባሳካሁት ውጤት፣ ከጉዳት አልባ ጋር እኩል መሆን አልችልም። (T)R				
8	ጉዳት አልባዎች እኔ ማድረግ የማልችላቸውን ነገሮች ሲያደርጉ ማየት በጣም ያሳዝነኛል።" (C)R				
9	በዚህ ዓለም ውስጥ በጣም አስፈላጊው ነገር አካላዊ ብቃት ያለው መሆን ነው ። (S)R				
10	በአካል ጉዳቴ ምክንያት፣ ከሌሎች ሰዎች ሕይወት ይልቅ የኔ ሕይወት ትርጉም ያለው አይመስለኝም።" (T) R				
11	በአካል ጉዳቴ ምክንያት፣ በአብዛኛው ጊዜ ሐዘን ይሰማኛል።" (C) R				
12	ምንም እንኳን የአካል ጉዳተኛ ቢሆንም ህይወቴ የተሞላ ነው። (E)				
13	እንደሰው ያለሁበት ሁኔታ እና በሕይወቴ ያስመዘገብኳቸው ውጤቶች ከጉዳት አልባዎች ያነሱ ናቸው። (T) R				
14	አካላዊ ጉዳት በአንድ ሰው የአዕምሮ ችሎታ ላይ ተጽዕኖ ያሳድራል። (S) R				
15	አካል ጉዳቴ ልሞክረው በምለው ነገር ሁሉ ላይ ጣልቃ ስለሚገባ፣ በተግባሩ ሁልግዜ በአእምሮዬ ውስጥ ይቀራል። (C) R				
16	አካል ጉዳተኛ ማድረግ የሚችላቸው ብዙ ነገሮች አሉ። (E)				
17	አካል ጉዳቴ ራሱ ከሌሎች ባህሪያቼ በላይ በእኔ ላይ ተጽዕኖ ያሳድራል።" (C) R				
18	ከአካላዊ ብቃት እና ገጽታ ይልቅ በሕይወት ውስጥ በጣም አስፈላጊ የሆኑ ብዙ ነገሮች አሉ። (E)				
19	ሁሉም የሕይወት ዘርፎች ማለት ይቻላል ለእኔ ዝግ ናቸው። (T) R				
20	አካል ጉዳቴ የምፈልጋቸውን ነገሮች ሁሉ እንዳላደርግ እና መሆን የምፈልገው አይነት ሰው እንዳልሆን ይከለክለኛል። (C) R				
21	አካል ጉዳቴ ውስንነት ቢኖርብኝም፣ እንደማንኛውም ሰው ይሰማኛል። (E)				
22	አካል ጉዳቴ በሕይወቴ ውስጥ በጣም በምፈልጋቸው ጉዳዮች ላይ ተጽዕኖ				

	ያሳድራል። (C) R				
23	የኔ አካል ጉዳት በአንድ ሰው ላይ ሊደርስ ከሚችለው እጅግ የከፋ ነገር ነው። (T) R				
24	ጤናማ አዕምሮ እንዲኖር ጉዳት አልባ መሆን ያስፈልጋል። (S) R				
25	አካል ጉዳተኛ መሆኔን ሙሉ በሙሉ የምረሳባቸው ጊዜያት አሉ። (E)				
26	አካል ጉዳቴ ባይኖር ኖሮ፣ እጅግ የተሻለ ሰው እሆን ነበር ብዬ አስባለሁ። (T) R				
27	ስለ አካል ጉዳቴ ሳስብ ሌላ ምንም ማድረግ ባለመቻሌ በጣም ያሳዝነኛል እና ያበሳጫል። (C)R				
28	አካል ጉዳተኞች በብዙ መንገዶች ሊሳካላቸው ይችላሉ። (T)				
29	በችሎታዬ ላይ እምነት ስላለኝ አካል ጉዳቴ ብዙም አያስጨንቀኝም። (E)				
30	በሁሉም ነገር የአካል ጉዳቴ በጣም ስለሚያናድደኝ በምንም ነገር መደሰት አልችልም። (C)R				
31	ጉዳት አልባነት እና አካለዊ ገጽታ አንድ ሰው ማንነቱን ይወስናሉ።(S)				
32	በአካል ጉዳቴ ምክንያት ምን ማድረግ እንደማልችል አውቃለሁ፣ ነገር ግን የተሟላ ህይወት መኖር እንደምችል ይሰማኛል። (E)				

ክፍል 4፡ የስነ-ልቦና ደህንነት (18 ጥያቄዎች)

ምን ያህል እንደተስማሙ ወይም እንዳልተስማሙ ለማሳየት ከእያንዳንዱ ጥያቄ በታች አንድ ምላሽ ላይ ምልክት ያድርጉ።

1. አብዛኛዎቹን የስብዕናዬን ክፍሎች እወዳለቸዋለሁ

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

2. የሕይወቴን ታሪክ ስመለከት ነገሮች ያሉበት ሁኔታ ደስተኛ ነኝ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

3. አንዳንድ ሰዎች ያለዓላማ ይቅበዘበዛሉ፣ እኔ ግን እንደነሱ አይደለሁም።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

4. የዕለት ተዕለት የኑሮ ፍላጎቶች ብዙውን ጊዜ ወደኃላ ይጎትቱኛል።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

5. በተለያየ ሁኔታ በሕይወቴ ባገኘኋቸው ብዙ ስኬቶች ቅር ተሰኝቻለሁ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

6. ከሰው ጋር ያለኝን ቅርብ ግንኙነቶችን ማስቀጠል ለእኔ ከባድ እና ተስፋ አስቆራጭ ሆኖብኛል።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

7. ዛሬን ህይወትን እኖራለሁ እና ስለወደፊቱ ጊዜ አላስብም።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

8. በአጠቃላይ የምኖርበትን ሁኔታ እንደምቆጣጠር ይሰማኛል።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

9. የዕለት ተዕለት ኃላፊነቶች በመወጣት ረገድ ጥሩ ነኝ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

10. አንዳንድ ጊዜ በሕይወቴ ውስጥ ማድረግ ያለብኝን ሁሉ እንዳደረግኩ ይሰማኛል ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

11. ሕይወት ለእኔ ቀጣይነት ያለው የመማር፣ የመለወጥ እና የማደግ ሂደት ነው።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

12. ስለራሴ እና ስለዓለም ያለኝን አስተሳሰብ የሚሞግተኝ አዲስ ተሞክሮዎች መኖራቸው አስፈላጊ እንደሆነ እስባለሁ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

13. ሰዎች ጊዜዬን ሌሎችን በመርዳት ለማሳለፍ ፈቃደኛ የሆነ ለጋስ ሰው አድርገው ይገልጹኛል።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

14. ከረጅም ጊዜ በፊት በህይወቴ ላይ ጉልህ ማሻሻያዎችን ወይም ለውጦችን ለማድረግ መሞከሬን ትቻለሁ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

15. ጠንካራ አስተያየት ባላቸው ሰዎች ተጽዕኖ እደርሳለሁ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

16. ከሌሎች ጋር የጠበቀ እና እምነት የሚጣልበት ግንኙነት አልነበረኝም።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

17. አብዛኛው ሰዎች ከኔ የተለየ ቢያስቡም እኔ ግን በራሴ እይታዎች ላይ በራስ መተማመን አለኝ።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም

18. ራሴን የምፈርጀው አስፈላጊ ነው ብዬ በማስበው ላይ እንጂ ሌሎች አስፈላጊ ብለው በሚስቀምጡት ላይ በመመስረት አይደለም።

1. በጣም እስማማለሁ	2. በተወሰነ ደረጃ እስማማለሁ	3. ትንሽ እስማማለሁ	4. አልስማማም	5. ትንሽ አልስማማም	6. በመጠኑ አልስማማም	7. በጣም አልስማማም