BLACKSEA JOURNAL OF PSYCHOLOGY
eISSN: 2068-4649; Print ISSN: 2068-1186

The "Black Sea" Journal of Psychology
Vol. 14, Special Issue, 1-15, Fall, 2023
ISSN: 2068-4649
www.bspsychology.ro

Aspects of quality of life of employees with disabilities

Author: Totolan Mircea Damian[1], Memet Memiș Feiza[2]
[1]Ovidius University of Constanta, Romania; [2]Independent researcher, Romania
damiantotolan@yahoo.com[1], feizamemet@gmail.com [2]

Abstract. The general purpose of this research is to measure the quality of life of employees with disabilities. It is believed that a professionally integrated person with disabilities has a higher overall satisfaction level. However, there are other variables that influence the well-being of any individual, not only those with disabilities. Additionally, job satisfaction or dissatisfaction can significantly impact a person's overall quality of life. Furthermore, impairments, limitations in activities, and participation restrictions can affect the quality of life, considering their awareness. Thus, young individuals with intellectual disabilities who are employed may have a different perception of their well-being depending on their awareness of social relationships at the workplace as well as relationships outside the employing institution. In this regard, with the support of the management of the „Albatros" Inclusive Education Center in Constanta, we aimed to identify the quality of life of graduates employed in the workforce and to identify the variables that influence their well-being. The tools used included the Quality of Life Inventory, which is a questionnaire measuring the importance and satisfaction level regarding key aspects of life. Additionally, we used a brief screening tool to identify employed graduates, interview methods, and discussions.

Cuvinte cheie. Quality of life, happiness, well-being, disability, intelectual disability.

1. Theoretical presentation of the constructs.

1.1. Quality of life

The concept of „quality of life" being a relatively modern notion, has attracted attention from various sciences, including economics, political science, philosophy, religion, sociology, psychology, medicine, and others. For over 2,500 years, the issue of human existence and survival has been the subject of philosophical research. Human needs or requirements for a good, quality life, which must be fulfilled, were first systematized in 1954 by A. Maslow in his famous „Hierarchy of Needs" laying the foundation for subsequent research on quality of life.

In Romania, the foundation of sociological research was laid in the 1970s and 1980s by C. Zamfir, N. Lotreanu, and I. Rebedeu, whose studies were later complemented by I. Marginean, G. Socol, and A. Bălaşa. They discovered the three major functions of the sociological research theme on the quality of life:

- A more detailed definition of social and economic development objectives;
- Evaluating the efficiency of human development and its impact on quality of life;
- Assessing quality of life as a tool for evaluating social progress.

„This concept crystallized around the 1960s, although it is entirely justified to consider that reflections on one's life have accompanied humans in the process of forming self-consciousness—writings on this subject have been recorded since antiquity, and we find them even more in modern approaches in philosophy and social sciences. Moreover, references to the concept of quality of life (quality of life, life quality, qualite de vie, lebensqualitat) are becoming increasingly frequent in scientific works, national programs, and international organizations, in the media, and in public discourse, concurrently addressing the issue of social indicators used to measure the quality of life of the population" (Mărginean, Vasile, 2015).

1.2. Happiness

The concept of „quality of life" being a relatively modern notion, has attracted attention from various sciences, including economics, political science, philosophy, religion, sociology, psychology, medicine, and others. For over 2,500 years, the issue of human existence and survival has been the subject of philosophical research. Human needs or requirements for a good, quality life, which must be fulfilled, were first systematized in 1954 by A. Maslow in his famous „Hierarchy of Needs" laying the foundation for subsequent research on quality of life.

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Mărginean I. in his work titled „Quality of Life in Romania" from the year 2002 makes the following statement: „a evaluative concept defining the set of elements referring to the conditions in which people live (physical, economic, social, cultural, political, health-related, etc.), the content and nature of their activities, the characteristics of the relationships and social processes they engage in, the goods and services they have access to, the consumption patterns adopted, lifestyle, the assessment of their circumstances and the outcomes of their activities, their expectations, as well as their subjective states of satisfaction/dissatisfaction, happiness, frustration, etc". (after Mărginean, 2002). Thus, the effective measure of quality of life includes both objective indicators of state and perception, personal evaluation and experience, as well as evaluation by researchers and the studied population as self-assessment. The purpose of this is to determine the impact of various quantitative values on people's lives. In this way, in the paradigm of quality of life, the characteristics of the state are subject to perceptions and evaluations by the population aimed at determining its satisfaction state and, more generally, the degree of happiness/unhappiness (Mărginean, 2002).

Enache R. & Matei R. (2019) state in their work „Optimizing the Quality of Life for Young People and Adults with Special Needs" that: "In a broad sense, quality of life resides

achieving a pleasant life based on personal and social well-being, general social protection, and social progress". They continue by saying that there is no complete agreement regarding the definition of the concept of quality of life, but it is known that specialists in this field agree that there is a combination of the subjective and objective dimensions of life. Perceptions and representations of a person regarding their personal quality of life, the estimation of their satisfaction level with their own life, and the degree of well-being are indicators of the subjective dimension. The subjective perspective refers to the so-called states of „happiness" and satisfaction, being a concept difficult to define due to its many philosophical connotations.

1.3 Well-being

The experts of the World Health Organization, along with numerous researchers (Campbell, Converse, and Rogers, 1976; Abrams, 1973), base their guidelines on five health recommendations that are remarkably important in evaluating the quality of life.

Physical Well-being: This refers to the physical health of a person capable of engaging in a variety of dynamic activities by safely activating the motor potential and specific abilities of each body component.

Material Well-being: This concerns the relationship between a person's income and their needs; vital, physical, cultural, educational, and other aspects can be fulfilled through payment. This relationship involves individuals as individuals and people as a population.

Social Well-being and Interpersonal Relationships: These two concepts are closely related (friends, colleagues, close family members) both at the community level (public associations, creative or cultural circles, interests, sports).

Emotional Health: This includes a variety of related issues such as mental health, emotional disorders, stress, affiliation with certain religious groups, the person's place and role in their communication environment, self-esteem, and respect for others (workplace, studies, participation in various activities).

"The subjective state of well-being (subjective/psychological well-being) is operationally defined from a hedonistic perspective as expressing a high level of positive feelings and emotions, a low level of negative affects, and an increased level of satisfaction with one's life. To the extent that the individual meets these three components, it can be assessed whether they possess an optimum level of subjective well-being. The concept of subjective well-being is interchangeable with that of happiness. However, increasing subjective well-being enhances the feeling of happiness." (Turchină T., Platon C., Boltea Z., 2012)

"Well-being is the state in which the individual feels good about themselves, their own feelings, and moods, but can also relax; the state in which the individual can empathetically relate to others. According to the WHO (World Health Organization), well-being has the following components:

- Self-acceptance: Positive attitude towards oneself, accepting personal qualities and flaws, positive perception of past experiences and the future.
- Positive Relationships with Others: Trust in people, sociability, intimacy, the need to give and receive affection, empathetic and open attitude.
- Autonomy: Independence, decision-making, the subject resists pressures exerted by the group, evaluates themselves by personal standards, is not excessively concerned with others' expectations and evaluations.

- Control: Feeling of competence and personal control over tasks, creates opportunities to fulfill personal needs, makes choices in line with personal values.
- Meaning and Purpose in Life: The subject is directed by medium and long-term goals, positive past experiences, the joy of the present, and the relevance of the future, believing that it is worth getting involved." (Potâng A., Șișianu A., 2013).

1.4 Intelectual disability

Disability is the result of complex relationships between multiple factors (both internal and external) and refers to the individual as a consequence of impairment, hindering them from reaching the desired or environment-imposed level of performance due to limitations in activity and participation restrictions (Radu Gh., 1999).

Intellectual disability is conceptualized as a global impairment resulting from an organic or functional lesion of the central nervous system (CNS) with direct consequences concerning socio-professional adaptation, skills, and autonomy. It typically emerges during the developmental period, often in the early years of life, and is influenced by genetic factors, the environment, and educational influences (Patlog D., Stanciu R., 2016).

Neuromotor disability is a consequence of injury or abnormal development of the central nervous system (brain). It is defined as a long-term health imbalance, conditioned by dysfunctions and losses of bodily integrity and the influence of harmful environmental factors. This condition reduces an individual's activity and personal autonomy, limiting their participation in social life (Radu Gh., 1999).

Intellectual Developmental Disorder (IDD) has its onset during the developmental period and includes both intellectual functioning and adaptive functioning deficits across conceptual, social, and practical domains (cf. DSM-V, 2013):

The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed through clinical evaluation and standardized intelligence testing.

Social domain involves awareness of thoughts, feelings, and experiences; empathy; motivation for social interaction; interpersonal relationships, etc.

Practical domain involves, among other things, developing the ability to manage life, including personal care, taking responsibilities, managing money, recreation, self-control, organizing school and work life.

B. Deficits in adaptive functioning, resulting in the inability to meet the standards expected for the individual's age and sociocultural group in terms of personal independence and social responsibility. Without ongoing support, adaptive deficits limit functioning in at least one or more daily activities, such as communication, social participation, and independent living, across multiple environments—home, school, work, and community.

C. Onset of intellectual and adaptive deficits occurs during the developmental period, specifically in childhood or adolescence (cf. DSM-V, 2013).

Diagnostic criteria according to 315.39 (ICD-11) and F80.9 (DSM-V) are:

A. Persistent difficulties in acquiring and using language across multiple modes (spoken, written, sign language, or other) due to comprehension or production difficulties, including the following aspects:

Limited vocabulary (knowledge and use of words).

Limited phrase structure (ability to respect grammar and morphology rules to form sentences).

The "Black Sea" Journal of Psychology
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Speech difficulties (ability to use vocabulary and coherent expression to describe a subject, an event, or sustain a conversation).

B. Language developmental level is substantially below the expected level for a given age, resulting in functional limitations regarding efficient communication, social participation, individual academic and professional performance, or any combination thereof.

C. Onset of symptoms is early in the developmental period.

D. Difficulties are not attributable to hearing impairment or other sensory impairments, motor dysfunctions, or other neurological or medical conditions and are not explained by intellectual disability (Intellectual Developmental Disorder) or global developmental delay.

Intellectual disability has multiple causes. Some of these causes can be prevented, while others cannot. These causes can be grouped into four categories:

a. Medical conditions
b. Brain injuries/central nervous system disorders
c. Genetic conditions
d. Psychiatric conditions

2. Research aim, objectives and hypotheses.

The aim of the work is to measure the level of quality of life of employees with disabilities.

2.1. Research objectives.

Objective 1: To determine the level of overall quality of life of people with disabilities employed/

Objective 2: To establish the hierarchy of life areas in the overall quality of life concerns of people with disabilities.

Objective 3: Identify the relationship between overall quality of life and areas of life.

2.2. Research hypotheses

Hypothesis 1: Assume that the level of quality of life of employed disabled people is low.

Hypothesis 2: We assume that money, work, health and self-esteem are the areas of life to which employed disabled people attach the greatest importance.

Hypothesis 3: We assume that overall well-being varies in proportion to the areas of life: self-esteem, work, money and health..

3. Participants and research instruments.

3.1. Research participants

The research sample consisted of 30 employed graduates (experimental group) and 30 non-employed graduates (control group) identified by us with the consistent support of the two psycho-pedagogical teachers, the social worker, the former headmasters and the school management.

Our research took place from March 2023 to May 2023. Instruments were administered individually by telephone and face-to-face. The teachers of the mentioned school identified the target group, asked for consent to participate in the research, provided contact details and together we administered the samples

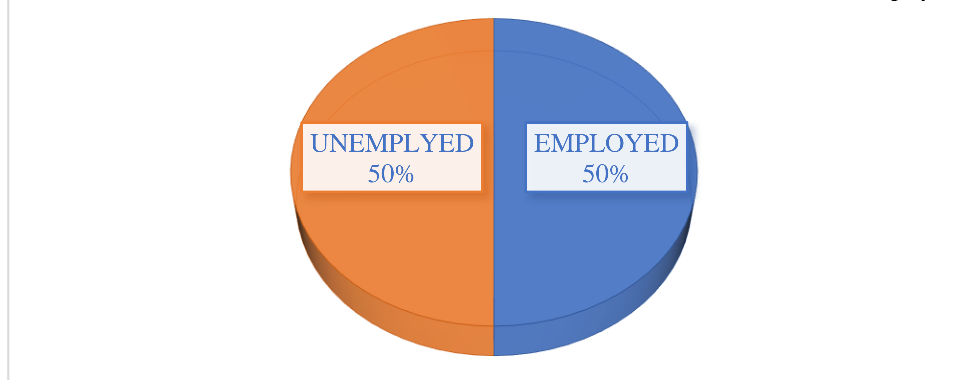

Figure 1. Percentage by social status of graduates.

Table 1. Distribution of subjects in the experimental group according to disability category

Type of disability	**No subjects**	**percentage(%)**
intellectual disability associated with other disorders	22	73,3%
disability other than intellectual disability	8	26,7%

3.2. Research tools

The QOLI questionnaire (Quality of life inventory) was conducted in order to assess the immortance and the level of satisfaction regarding the main aspects that contribute to increasing the quality of life. This questionnaire is a short and comprehensive method for measuring life satisfaction (quality of life).

Each aspect of life also contains an explanation that is offered customized (as forms) depending on each respondent's level of understanding. We may not have answers to some items. Exp. „Children" – if he does not have children, proceed to the next item.

The questionnaire analyzes the total quality of life score in 16 areas:

1. Health
2. Goals and values
3. Self-esteem
4. Game
5. Money
6. Work
7. Help
8. Learning creativity
9. Children
10. Love
11. Friends
12. Community
13. District
14. House

Respondents rate each area in terms of satisfaction and importance. Thus, the questionnaire consists of 32 items, the wording is simple, can be filled in quickly and without problems by participants.

The questionnaire scoring is done as follows: the weighted satisfaction scores between -6 and +6 (from the shocks from -6 to -1 it follows that people are dissatisfied, and the scores from 1-6 result that people are satisfied) are the results between the product of the scores obtained in the satisfaction section and the importance of the same area.

Stifaction comprises values between -3 and 3:

15. -3 very dissatisfied
16. -2 somewhat dissatisfied
17. -1 a little dissatisfied
18. 1 little satisfied
19. 2 somewhat satisfied
20. 3 very satisfied

Importance ranges from 0 to 2:

21. 0 unimportant
22. 1 important
23. 2 Very important

The raw score is averaged between the sum of the weighted satisfaction scores and the number of areas each participant responded to. After finding the score, we consult the table where the corresponding ranges of T-scores and centile scores are presented to determine the overall level of quality of life.

Quality of life level according to values of QOLI scores - raw, standardized T and expressed in percentiles.

Analysis of school and archival documents.

The study of school materials is necessary to establish the evolution of subjects from year to year. Through this method, certain results, data on their social origin, health status (physical and mental) and level of schooling can be accurately established using medical certificates, admission tickets, results of clinical investigations, observation sheets, psycho-pedagogical sheets, speech therapy sheets, etc. This involves the analysis of data from school documents reflecting the educational and recovery-therapeutic situation of the investigated participants.

Secondly, the study of school materials is a concrete method that does not require special attention as observation or biographical method, in this case the materials are used directly and the data necessary to carry out the proposed research or study will be noted.

We obtained valuable information from the school archive regarding the evolution of the school institution and from the transcripts and other documents (school and professional orientation sheets, etc.) information on the type and depth of disability, the level of school training, the social situation of the family, the environment of origin and last but not least the contact details of the investigated subjects.

4. Presentation, analysis and interpretation of results.

4.1. Hypothesis 1

Following the frequency analysis of the responses it was observed that 63.3% of the respondents consider that they have a high level of overall quality of life - level 3. Level 2 (medium level of quality of life), we find 36.6% of responses. It is worth noting that none of

respondents rate their quality of life as low (level 1) or very low (level 2). In figure 4, the SPSS program unfortunately does not represent these two values as shown in figure 2.

First of all, we note that employees with disabilities rate their overall quality of life as high (63.3%) and medium (36.6%). This would be due, on the one hand, to having a good and very good life, on the other hand we can explain as overcompensation (most respondents have intellectual disability).

In this way objective 1: Establishing the level of overall quality of life of people with disabilities in employment was achieved. At the same time, hypothesis 1 was invalidated: We assume that the level of quality of life of employed disabled people is low..

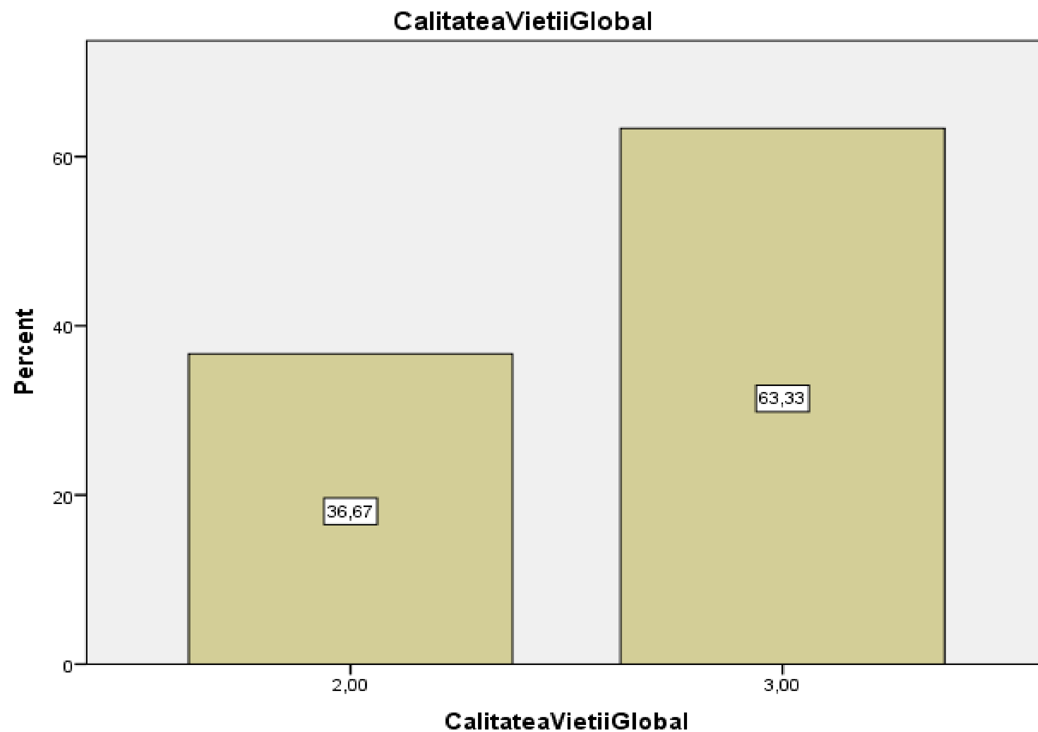

Figure 2. The overall quality of life level of employees with disabilities

4.2. Hypothesis 2

Following the analysis of the responses and the interpretation of the results, the following hierarchy of life areas is outlined according to the maximum level of importance given (level 11):

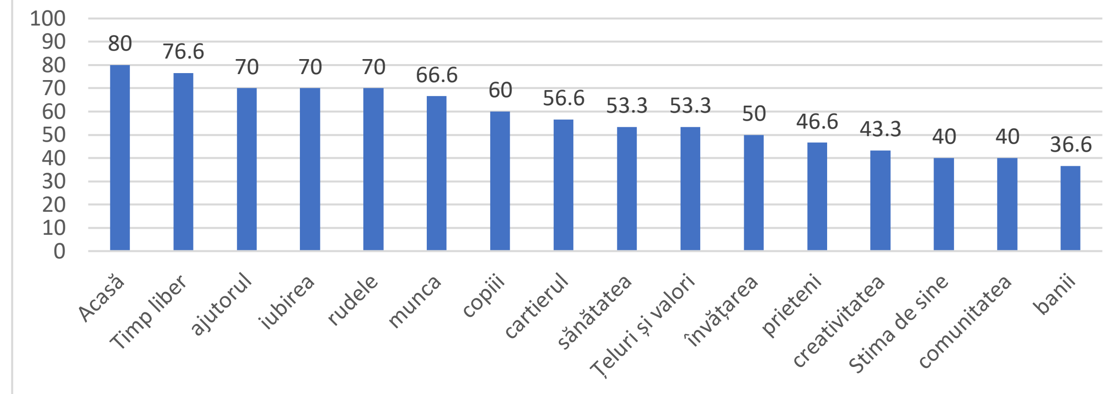

Figure 3. Hierarchy of life areas according to the maximum level of importance

Table 2. The level of satisfaction in each area of life.

Aria vieții	Nivel preocupare / satisfacție (pondere %)
Acasă	80%
Timp liber	76,6%
ajutorul	70%
iubirea	70%
rudele	70%
munca	66,6%
copiii	60%
cartierul	56,6%
sănătatea	53,3%
Țeluri și valori	53,3%
învățarea	50%
prieteni	46,6%
creativitatea	43,3%
Stima de sine	40%
comunitatea	40%
banii	36,6%

We see in Table 2 and Figure 3 that work (66.6%) is only in 6th place, health (53.3%) is in 9th place, self-esteem (40%) is in second last place (14-15) and in last place (16) is money (36.6%).

Thus we have achieved our objective 2: Establishing the hierarchy of life areas in the overall quality of life concerns of people with disabilities. At the same time, Hypothesis 2 was invalidated (We assume that money, work, health and self-esteem are the areas of life to which employed people with disabilities attach the greatest importance).

Assumptions: a good life is given by the money the person has; with disability, health concerns should be of paramount importance; declaratively, self-esteem should be the "main pillar" on which a good life rests and work is assumed to bring fulfilment, security and satisfaction.

Equally surprisingly, none of the four areas of life (work, health, self-esteem, money), which we agree with experts measuring quality of life (e.g. gross domestic product based on money), are of prime importance to employees with disabilities..

4.3. Hypothesis 3

Table 3. Correlations between global quality of life and areas of life

			CalitateaVietiiGlobal
Spearman's rho	Health	Correlation Coefficient	.429
		Sig. (2-tailed)	**.018**
		N	30
	Self-esteem	Correlation Coefficient	.640
		Sig. (2-tailed)	**.000**
		N	30
	Goals and values	Correlation Coefficient	.580
		Sig. (2-tailed)	**.001**
		N	30
	Money	Correlation Coefficient	.475
		Sig. (2-tailed)	**.008**
		N	30
	Work	Correlation Coefficient	.615
		Sig. (2-tailed)	**.000**
		N	30
	Free time	Correlation Coefficient	.404
		Sig. (2-tailed)	**.027**
		N	30
	Learning	Correlation Coefficient	.429
		Sig. (2-tailed)	**.018**
		N	30
	Creativity	Correlation Coefficient	.481
		Sig. (2-tailed)	**.007**
		N	30
	Help	Correlation Coefficient	.420
		Sig. (2-tailed)	**.021**
		N	30
	Love	Correlation Coefficient	.380
		Sig. (2-tailed)	**.038**
		N	30
	Friends	Correlation Coefficient	.647
		Sig. (2-tailed)	**.000**
		N	30
	Children	Correlation Coefficient	.710

	Sig. (2-tailed)	**.000**
	N	30
	Correlation Coefficient	.587
Family	Sig. (2-tailed)	**.001**
	N	30
	Correlation Coefficient	.304
Home	Sig. (2-tailed)	.103
	N	30
	Correlation Coefficient	.444
Neighbourhood	Sig. (2-tailed)	**.014**
	N	30
	Correlation Coefficient	.351
Community	Sig. (2-tailed)	.057
	N	30

We observe (shaded in bold and red) in Table 6., highly significant correlations with significance threshold p = 0.01 between overall quality of life and self-esteem (p < 0.001), goals and values (p = 0.001), money (p = 0.008), work (p < 0. 001), creativity (p = 0.007), friends (p < 0.001), children (p < 0.001), relatives (p = 0.001). All correlations being positive, it means: as the value of a variable increases, the value of the variable with which it is correlated will increase proportionally.

Also here, we observe (shaded with bold) significant correlations with significance threshold p = 0.05 between overall quality of life and health (p = 0.018), leisure (p = 0.027), learning (p = 0.018), help (p = 0.021), love (p = 0.038), neighbourhood (p = 0.014). All correlations being positive, they mean: as the value of a variable increases, the value of the variable with which it is correlated will increase proportionally.

Only the correlation between overall quality of life and home and community living areas are not statistically significant.

elul 4. Corelatii între sănătate, stima de sine, bani, muncă și celelalte arii ale vieții.

			Sanatatea	StimaDeSine	Bani	Munca
Spearman's rho	Health	Correlation Coefficient	.444	1.000	.258	.375
		Sig. (2-tailed)	**.014**	.	.169	**.041**
		N	30	30	30	30
	Self-esteem	Correlation Coefficient	.569	.390	.308	.396
		Sig. (2-tailed)	**.001**	**.033**	.098	**.030**
		N	30	30	30	30
	Goals and values	Correlation Coefficient	.164	.258	1.000	.484
		Sig. (2-tailed)	.387	.169	.	**.007**
		N	30	30	30	30
	Money	Correlation Coefficient	.054	.375	.484	1.000
		Sig. (2-tailed)	.776	**.041**	**.007**	.
		N	30	30	30	30
	Work	Correlation Coefficient	.360	.193	.395	.386
		Sig. (2-tailed)	.051	.307	**.031**	**.035**
		N	30	30	30	30
	Free time	Correlation Coefficient	.178	.380	.486	.491
		Sig. (2-tailed)	.347	**.038**	**.006**	**.006**
		N	30	30	30	30
	Learning	Correlation Coefficient	.460	.477	.342	.105
		Sig. (2-tailed)	.011	**.008**	.065	.582
		N	30	30	30	30
	Creativity	Correlation Coefficient	.160	.188	.453	.183
		Sig. (2-tailed)	.398	.320	**.012**	.334
		N	30	30	30	30
	Help	Correlation Coefficient	.114	.538	-.059	.071
		Sig. (2-tailed)	.550	**.002**	.758	.707
		N	30	30	30	30
	Love	Correlation Coefficient	.389	.431	.666	.209
		Sig. (2-tailed)	**.034**	**.017**	**.000**	.267
		N	30	30	30	30

Friends	Correlation Coefficient	.515	.560	.255	.254
	Sig. (2-tailed)	.004	**.001**	.174	.175
	N	30	30	30	30
Children	Correlation Coefficient	.164	.433	.141	.259
	Sig. (2-tailed)	.385	**.017**	.457	.168
	N	30	30	30	30
Family	Correlation Coefficient	.012	.059	.279	.506
	Sig. (2-tailed)	.949	.755	.136	**.004**
	N	30	30	30	30
Home	Correlation Coefficient	.033	.275	.425	.405
	Sig. (2-tailed)	.863	.141	**.019**	**.027**
	N	30	30	30	30
Neighbourhood	Correlation Coefficient	.344	.392	.542	.275
	Sig. (2-tailed)	.063	**.032**	**.002**	.142
	N	30	30	30	30
Community	Correlation Coefficient	1.000	.444	.164	.054
	Sig. (2-tailed)	.	**.014**	.387	.776
	N	30	30	30	30

All correlations being positive, it means: as the value of a variable increases, the value of the variable with which it is correlated will increase proportionally. And reciprocally, as the value of a variable decreases, the value of the variable with which it is correlated will decrease proportionally.

That is, when the value of the variables goals and values, children, self-esteem, creativity and friends are modified, the value of the variable health will change proportionally. When the value of the variables creativity, love, children, goals and values, work, learning, friends, relatives, community are moderated, then the variable self-esteem will also change proportionally.

When the value of the variables work, learning, friends, community, free time, help, neighborhood is changed, then proportionally the variable money will also change, and when the variables learning, home, leisure and neighborhood are changed, then proportionally the variable work will also change.

Conluzii

The motivation for choosing this topic was driven by the ultimate goal of special psychopedagogy, which has two aspects. Some specialists formulate this goal considering the quality of life (representing the improvement of the quality of life for people with disabilities), while others view the goal as achieving social and professional integration to the fullest extent possible.

It is assumed that the quality of life for people with disabilities is low due to impairments, limitations in activities, and restrictions on social participation. In other words, they have compromised health, limited behaviors, limited professional training, restricted employment opportunities, lower incomes, and may face bullying and discrimination.

Taking the above into account, Objective 1 was formulated: Establishing the overall quality of life for employed people with disabilities, and Hypothesis 1: We assume that the overall quality of life for employed people with disabilities is low.

Objective 1 was achieved, and Hypothesis 1 was invalidated. 63.3% of the respondents consider that they have a high overall quality of life - level 3. Level 2 (medium level of quality of life) was reported in 36.6% of the responses. It is noteworthy that none of the respondents evaluated their quality of life as low (level 1) or very low (level 2).

Here, we observe that the subjective evaluation of quality of life, given the limitations imposed by cognitive functioning and the ego's defense mechanisms acting as compensation, does not align with external and objective evaluations. Due to these factors, we believe that the formulated hypothesis has been invalidated.

Next, we wanted to establish a relationship between overall quality of life and the life domains that shape the individual's well-being, focusing on four essential areas: work, money, self-esteem, and health. We aimed to construct a hierarchy of all these areas and see where these four areas stand in this context.

In this regard, Objective 2 was formulated and achieved: Establishing the hierarchy of life domains within the concerns about the quality of life for people with disabilities. Regarding this, we formulated Hypothesis 2 (We assume that money, work, health, and self-esteem are the life domains to which employed people with disabilities attach the greatest importance), which was invalidated.

In formulating Hypothesis 2, we started from the following premises: a good life is determined by one's financial resources; in the context of disability, concerns for health should be of major importance; self-esteem should be the "main pillar" supporting a good life, and work is assumed to bring fulfillment, security, and satisfaction.

Should we conclude then that money and self-esteem do not bring happiness? Is the Nepalese government right to abandon GDP as an indicator of happiness and consider other aspects such as the top-ranking relational aspects (home, assistance, love, relatives)?

To add nuance to the analyses and interpretations, we wanted to establish the relationships between the four aspects (considered significant by us in accordance with specialists): work, health, self-esteem, and money. Thus, we formulated and achieved Objective 3: Identifying the relationship between overall well-being and life domains, and Hypothesis 3 was verified: We assume that overall well-being varies proportionally with the life domains: self-esteem, work, money, and health.

Among the limitations and difficulties of the research, we mention the following. First and foremost, identifying employees with disabilities, contacting them, and convincing them to participate in the study are very challenging. The researcher is entirely dependent on information held by third parties (special school staff), their goodwill, effort, and professionalism. Secondly, due to intellectual disabilities, the items of the instruments must be few, brief, and most importantly, their formulation must be individualized. They cannot be administered face-to-face, nor through self-administration.

We express our gratitude for participating in the study to Director Nicoleta Luminița Ristea, teacher-psychopedagogue Dima Mădălina, and Mihalcea Luminița, as well as social worker Soroiu Georgeta.

The "Black Sea" Journal of Psychology
Vol. 14, Special Issue, 1-15, Fall, 2023
ISSN: 2068-4649
www.bspsychology.ro

All objectives were achieved, and only the third hypothesis was validated; the first two were invalidated.

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