PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION

Thesis Submitted in partial fulfillment of
the requirements
for the Degree of Doctor of Philosophy in
Psychology

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DEPARTMENT OF PSYCHOLOGY
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CERTIFICATE

Certified that this dissertation entitled " **PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION"** submitted to the University of Calicut for the award of the Degree of Doctor of Philosophy in Psychology is a bonafide record of the research work carried out by **GREESHMA K**, under my supervision and guidance. No part of this has been submitted earlier for any other purpose.

Prof. (Dr.) K. Manikandan
(Supervising Teacher)

DECLARATION

I, GREESHMA K., do hereby declare that this thesis entitled**,** **"PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION "** is a bonafide record of the research work done by me under the guidance of Prof. (Dr.) K. Manikandan, Professor in Psychology, Department of Psychology, University of Calicut. I further declare that this dissertation has not previously formed the basis for the award of any degree, diploma, associateship, fellowship, orother similar title of recognition.

C.U. Campus, **Greeshma K**
... / ..... / 2023

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABSTRACT

Research work in the area of disability, especially in developmental disability is very limited in Kerala. Among the published studies, most of them focus on persons with disabilities. There are very few studies that address the issues faced by their caretakers. The constant and time-consuming caretaking, additional resources for raising the child, etc., may contribute many psychological problems among caretakers. In most families, mothers are the primary caregivers who experience many issues concerning their wards. This may create negative influence on many aspects of their life, including personal, social, and economic spheres. The stress may be varied based on the type or severity of the disability. By realizing this, the researcher has scientifically studied the personal and social problems experienced by mothers of children with disabilities.

The study followed a mixed-method design for understanding the psychological distress of mothers of children with disabilities. The present research is composed of two sections-a qualitative phase and a quantitative phase. To study the experiences of mothers, 21 mothers of differently-abled children were met directly and information was collected scientifically. The data were coded using the thematic analysis method. Then, based on this information and based on previously published studies in this field, research instruments were prepared and collected. Information from 289 mothers was collected through the survey method. Data were analyzed using various statistical methods including ANOVA and correlation and conclusions were reached.

The findings of the study have revealed that mothers experience psychological distress in a variety of means. Societal, personal, and child-related factors play a role in stress levels. It was found that being labeled as the mother of a differently-abled child has an impact on their psychological distress. They also face problems economically, physically, cognitively, and emotionally. It has also been found that family support, confidence as an effective parent, positive thoughts, spirituality, and religious practices help to some extent in overcoming such problems. Likewise, the lack of clear knowledge about the disability of these children and the lack of understanding of how to deal with it can add fuel to the mothers' mental distress. Financial difficulties and health problems in the family also often lead to distress.

To study more on the relevant topics found in the qualitative analysis, a

further quantitative study was conducted. Since there were no appropriate instruments for Affiliate Stigma and Parental Self-efficacy, the researcher developed instruments for these two variables in Malayalam. Then the data were collected using the Perceived Social Support Scale, the Affiliate Stigma Scale, the Parental Self-Efficacy Scale, and the Psychological Distress Scale. All the collected data were entered into a spreadsheet for statistical analysis. Descriptive statistics, Pearson product-moment correlation, regression (enter method), and ANOVA were used for analysis. The results revealed a significant relationship between perceived social support, affiliate stigma, parental self-efficacy, and psychological distress. The regression analysis showed that most of the dimensions of selected variables significantly predicted the psychological distress of mothers of children with disabilities. The 3-way Analysis of Variance revealed a significant interaction of perceived social support, affiliate stigma, and parental self-efficacy on the psychological distress of participants. Mothers who have high perceived social support, high parental self-efficacy, and low affiliate stigma scored low mean scores in psychological distress.

While going through the results, it is clear that most of the participants in the study experience distress at varying levels. For the identification and interventions on this issue, the caregivers are also to be included in the rehabilitation programs for children with disability. While including the caregivers in the rehabilitation process, their problems should also be addressed. Most of the study participants perceived professional support as great support. In this way, if professional support can be arranged at the government level for everyone, the difficulties may be eased.

Most of them adapt to the stress by having a hopeful approach to life, learning about the disability and how to deal with it, trying to get to know it, ensuring family or partner support, and spirituality. Meanwhile, stress has been reported to be higher in those who get involved without trying to figure out the problem. Furthermore, Psychological distress is reduced when it includes better family support, a social environment, and belief in one's abilities. Based on these observations, stress management programs/training programs can be developed.

Keywords: Affiliate Stigma, Exploration, Mothers of children with disabilities, Parental Self-Efficacy, Perceived Social Support, Psychological distress

CHAPTER 1
INTRODUCTION

Regardless of cultural boundaries, motherhood is considered as a great experience. From an Indian perspective, it can be seen that the 'child-mother dependency', goes beyond the level of childhood years and continues for years up to adulthood where the 'child' becomes a comparatively independent individual in many senses! It is not an underestimation of paternal importance; but mostly mothers are viewed as the primary caretakers of their children.

Everyone seeks or dreams of healthy babies. Due to a variety of reasons, some children may be unhealthy, either mentally or physically. Genetic, biological or psychosocial factors individually or in combination with the other may contribute to these kinds of deformities. Some of the deformities (cleft foot etc.) can be cured by medical treatments. However, it is not much possible to completely cure conditions like mental retardation, Down's syndrome, autism etc. through medicinal application. Psychosocial management through appropriate therapies and interventions can be helpful in managing and reducing the risk of severity of these conditions.

Disability

In accordance with unique historical, social, legal and philosophical interpretations, the concept of disability has been defined in different ways in different countries. World Health Organization (WHO) describes disability as an umbrella term, covering impairments, activity limitations, and participation restrictions. Disability is neither purely biological nor social but instead an interaction between health conditions and environmental and personal factors (WHO, 2007).

Disability can occur at three levels:

1. An impairment in body function or structure, such as a cataract which prevents the passage of light and sensing of form, shape, and size of visual stimuli;
2. A limitation in activity, such as the inability to read or move around;
3. A restriction in participation, such as exclusion from school.

Common people use the terms disability, impairment, handicap, and disorder with same meaning hence they use the terms interchangeably. WHO (1980)

differentiates the terms impairment, disability and handicap from one another. Impairment is any visible structural or anatomical loss of physical or sense organs in an individual. The loss of little finger is impairment. The consequence of impairment is termed as disability. It may affect ability of the person to live within the considered "normal" manner or to perform functional activities. There is a restriction in activities as a result of impairment. Disability interferes in the performance of daily activities of an individual. Temporary or permanent disability can be caused by diseases, accidents or genetic causes, and may vary from case to case. Handicap is a disadvantage resulting from or the consequence of impairment as well as disability. The expected role of an individual based on age, sex and cultural background gets changed or becomes limited because of the disadvantage. In the case of a person with a limb lost but not facing any impairment in his job, he is physically impaired not handicapped. These classifications are truly different from the concept of laymen, and thus they use the terms interchangeably.

WHO (2011) explained disability as a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Childhood disabilities or developmental disabilities are considered as the functional impairment of a child with respect to his or her developmental stage. Hence, a child at risk of a disability can be illustrated as showing variation or delay in basic skills including day to day activities.

For many years, disability was studied under various medical conditions, referring to the medical model. Recently, medical model has been replaced by the psychosocial model of disability, which conceptualizes disability as originating from the interaction of a person's functional status with the physical, cultural, and policy environments.

Developmental Disabilities

The term Developmental disabilities are explained as the health-related limitation of a child to perform age-appropriate activities, self-help skills and participate in social activities. Rubin and Crocker (1989) explained developmental disabilities as a group of conditions due to an impairment in physical, learning, language, or behaviour areas. These conditions begin during the developmental

period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

WHO (2013) also describes developmental disabilities as a group of conditions with onset in infancy or childhood and characterized by impairment or delay in functions related to the central nervous system maturation. They may affect a single area of development (e.g. specific developmental disorders of speech and language, of scholastic skills, and/or motor function) or several (e.g. pervasive developmental disorders and intellectual disability). They can hinder children from achieving their developmental potential, through adverse effects on learning, participation and access to information and services. WHO recognizes the significance of early interventions and is focusing efforts on building capacities for timely detection and interventions, at primary health care and community level.

World Statistics of Disabilities

While trying to get an idea about the epidemiology of disabilities worldwide, the research says that, the numbers of children with disabilities are underestimated in most of the developing countries. Severity of developmental disabilities and the basic criteria of identification of a condition as disability vary with respect to the social and cultural factors. Children with severe and moderate disability are noticed but children with mild disability might be ignored. Since they are not included in the statistics, they will not get proper care and treatment even though they are more vulnerable to treatment and show results easily.

In 2011 the World Report on Disability revealed that more than a billion people (or 15%) in the world today experience disability. Estimates for the number of children (between 0-14 years) living with disabilities range between 93 million and 150 million. This is the only number, although an estimate, that provides any kind of real global insight on the situation of children with disabilities (WHO/World Bank, 2011).

Disability Statistics in India

As per the government records, in India according to the Census 2011, 2.2% of population had some form of disability. The prevalence of disability was found to be more in rural areas (2.24%) as compared to urban areas (2.17%) and more among

males (2.4%) than among females (2%). The proportion of different types of disability among people with disability reported as: (i) vision 18.8%, (ii) hearing 18.9% (iii) speech 7.5% (iv) movement 20.3% (v) intellectual disability7.6% (vi) mental illness 2.7%, (vii) multiple disabilities 7.9% (viii) Any other 18.4%.

UNICEF (2014) conducted a survey in Indian context, which demonstrated that 38% rate of children with disabilities aged 6-13 to be out of school, compared to a general 6% rate, which means that children with disabilities are more than 5 times likely to be out of school than the average. This implies there are a number of children with disability in India who are out of treatment and need proper care and guidance.

Disability Statistics in Kerala

According to the state-wide Anganwadi-based systematic sample survey in partnership with IAP Kerala, 2.5-3.4% of children had various forms of developmental problems diagnosed using screening tools (Nair, et al., 2013). The most common forms were: developmental delay (69.3%), speech delay (14.3%), global delay (5.7%), gross motor delay (5.3%) and hearing impairment (3.6%). The prevalence rate of autism spectrum disorder (ASD) is estimated to be 1 in 500 and the incidence rate is approximately 1 in 91000 people in India (Nair et al., 2014.)

Disability Management

Disability management interventions are intended to address the needs of people with disabilities. The key elements are early identification, proper education and interventions, effective case management and work place accommodation.

According to WHO (2009), Community Based Rehabilitation (CBR) focuses on enhancing the quality of people with disability and their families, meeting basic needs, ensuring inclusion and participation in society. It is a multi-sector strategy that empowers person with disabilities to assess and benefit from education, employment, health and social services. In CBR working closely with the person with disability and their families help them to overcome physical, social and psychological barriers and improve his own skills to get independent life. In rehabilitation, mutual development of different areas of life is important because they are interconnected. Proper parental and social support, acquiring self-help

skills, good environment and health conditions, appropriate education, effective social interaction are more important for empowerment of a child with disability. So, a multi-disciplinary approach is needed.

Early intervention involves strategies which aim to identify problems or chance of problems and provide appropriate individually tailored solutions as early as possible. It typically focuses on populations at higher risk of developmental delays, and early intervention should be on the correct time of development that helps to get easy result. Disabled children may show difficulty in different areas of development. Delay or difficulties are different for different disability conditions and its severity may vary with person to person. Delay or difficulties can be seen in the areas such as speech, movement, fine motor skills, gross motor skills, cognitive process, self-help skills, social skills and educational skills. Through a multi-disciplinary approach, physiotherapy, speech therapy, occupational therapy, psychotherapy and special education and social skills training can be combined to make good and effective results and eventually, the total empowerment of the child.

Parents, especially mothers, spend more time with their children than others. So, they can observe and identify if their children have any delay or difficulty in their functioning. A basic knowledge of disabilities enables them to identify difficulties of their children. Hence, for the effective management of the conditions through interventions and therapies, the parent has a major role as the primary caregiver.

However as aforementioned, it wouldn't be an easy task to perform the day to day needs of a child with disability. Additional physical and mental efforts of parents may be required to manage the needs of the children. The discussion on importance of mental health of parents having children with disabilities arises here. The challenges they face may be of personal or of social ones. For instance, they may get tired of doing additional activities for their children apart from normal daily activities; they may not receive considerable support from family or society; they may be stigmatized of being a "parent of child with disability"; or they may not be that much of competent enough to do all those challenging task. It is also important to note that some parents may not have resources which enable them to face all

those challenges in a positive manner. Nevertheless, mental health of parents matters in many dimensions- for themselves; for their children; for the society as a whole.

Mental Health

Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act as we cope with life. It also helps determine how we handle stress, relate to others, and make choices, and is important in every stage of life, from childhood to adulthood.

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, overcome the stresses of everyday life and work productively and successfully, and able to make a contribution to his or her community. According to the World Health Organization (WHO), mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others."

Mental health can be weakened by unbalanced activities or unexpected daily events/stressors. In that manner stress would be an unavoidable concomitant of daily living. A person's response towards stress depends on whether an event is appraised as a challenge or a threat (Lazarus & Folkman, 1984).

The term stress has typically been used to refer both to adjustive demands placed on an organism and to the organism's internal biological response to such demands. The adjustive demands can be referred as stressors, to the effect they create with an organism as stress, and the efforts to deal with stress as coping strategies. Stress is a by-product of poor or inadequate coping (Carson et al., 2007).

All situations, positive or negative, that require adjustment can be stressful. Thus, according to Canadian Physiologist Selye (1956), the notion of stress can be broken down further into eustress (positive stress) and distress (negative stress). Both types of stress tax a person's resources and coping skills, although to do more damage.

The Nature of Stressors

The nature of stressors differs; it can be minor or major according to its magnitude. The longer a stress operates, the more severe its effects according to the

casting of stress, it can be termed as acute or chronic. The most common stress we experience acute that is sudden and intense.

Our psychosocial environment can play a significant role in causing stress in individuals. The experience of stress differs from person to person; one person's stress may be another person's thrill. These differences in people's reaction to the changes rely upon various factors.

Impact of Stress

Severe stress may pay high cost in terms of lesser efficiency, depletion of adaptive resources, wear and tear on the biological system, and, in extreme cases, severe personality and physical deterioration or even death.

Stress has biological and psychological impacts on human beings. Selye's(1956) general adaption syndrome (GAD) model helps in explaining the course of biological decompensation under excessive stress. According to Selye, body's reaction to sustained and excessive stress typically occurs in these major phases:

(1) An alarm reaction, in which the body's defensive forces are "called to alarm" by activation of the autonomic nervous system,

(2) A stage of resistance, in which biological adaption is the maximal level in terms of resources used, and

(3) Exhaustion, in which bodily resources are depleted and the organism loses its ability to resist and at this point, further exposure to stress can lead to illness and death.

As already noted, stress itself divides into two types based on their impact on individuals: eustress and distress. Eustress effects positively whereas distress impacts negatively. Due to its variety means of attacking an individual's resources, distress can be considered as one among the mostly used term in studying the parents of children with disabilities.

Psychological Distress

Psychological distress is widely used indicator of mental health of the population in public health, in population surveys and in epidemiological studies and, as an outcome, in clinical trials and intervention studies. Psychological distress

is a type of stress that is a general term that is used to describe negative or unpleasant feelings or emotions that impact a person's level of functioning and it is the inability to cope with stressful conditions, or a condition that is painful physically or mentally, that is observable in behavior. An acute or chronic stress condition can also be regarded as distress, because it also brings pain and a sense of not being able to control the stressor.

Psychological distress can be defined as a state of emotional suffering characterized by symptoms of depression (e.g. sadness; lost interest; hopelessness) and anxiety (e.g., restlessness; feeling tense). These symptoms may be tied with different somatic symptoms (e.g., insomnia; headaches; lack of energy) that are likely to vary in accordance with cultures (Kleinman, 1991). The demands of caring for children with chronic conditions like intellectual disability may precipitate symptoms of depression and general psychological distress (Breslau & Davis, 1986). Moreover, both the general psychological literature and specific studies pertaining to disabled children showed that parental distress and family functioning affects children in numerous ways, impacting their cognitive, behavioural and social development. Parental psychological distress has significant effect upon behavioural and emotional problems among chronically ill children (Thompson et al., 1993).

The way by which psychiatric nosology views psychological distress is ambiguous and it has been a debate for the field till date. Psychological distress is viewed as an emotional disturbance that may impact on the social functioning and day-to-day living of individuals at one point of view (Wheaton, 2007). Thus, it has been the object of various studies seeking to identify the risk and protective factors related to it. Instead, others view distress as a diagnostic criterion for some psychiatric disorders (e.g., obsessive-compulsive disorders; post- traumatic stress disorder) and, together with impairment in day to day living and functioning, a marker of the severity of symptoms in other disorders (e.g., major depression; generalized anxiety disorder). Thus, psychological distress would be a medical concern mostly when it is accompanied by other symptoms that, when added up, satisfy the diagnostic criteria for a psychiatric disorder. Otherwise, when it complies with the stress-distress model, it is viewed as a transient phenomenon consistent

with a "normal" emotional reaction to a stressor. Horwitz (2007) argued about this by pointing out a series of studies conducted among adolescents and showing the high fluctuation of depressive symptoms over intervals as short as one month. He explained that this fluctuation reflects the relatively brief sorrow that follows from failing a test, losing a sporting match or breaking up with a boyfriend or girlfriend. Wheaton (2007) disputed the transient nature of psychological distress, as they investigated the stability of psychological distress among adults based on seven longitudinal studies lasting from 1 to 10 years. In their study it is proven that psychological distress was moderately stable and argued that this finding runs counter to the assertion that distress is a transient phenomenon. Nevertheless, they could not identify the role of personality in this relative stability of psychological distress over time. In addition, neuroticism has been shown to be related to psychological distress and some argue that it may partly account for chronic distress (Jorm & Duncan-Jones, 1990).

Definition of Psychological distress

According to the conceptualization of Decker (1997) and Burnette and Mui (1997), psychological distress is the lack of enthusiasm, problems with sleep (trouble falling asleep or staying asleep), feeling downhearted or blue, feeling hopeless about the future, feeling emotionally bored.

Mirowsky and Ross (1989) defined psychological distress as the unpleasant subjective state of depression and anxiety (being tense, restless, worried irritable and afraid), which has both emotional and psychological manifestations. They further added that there is a wide range of psychological distress, ranging from mild to extreme, with extreme levels being considered as mental illness such as schizoaffective disorder.

Lerutla (2000) defined psychological distress as the emotional condition that one feels when it is necessary to cope with upsetting, frustrating or harmful situations.

Selye (1956) explained psychological distress as the negative feelings and reactions that compete with threatening and challenging situation. When this unpleasant and harmful stress becomes too great and lasts too long, people may

experience distress. Psychological distress is a state in which our coping abilities begin to breakdown.

A three-dimensional model of psychological distress was presented by Hariharan and Rath (2008) to show the cyclic nature of stress. This model signifies that the three different angles or dimensions of stress. In that model, one angle represents the initial experience of stress as presented by external factors and translated into primary appraisal. Those are the situations of conflict, criticism, change, ambiguity, imbalance, timeliness, and discomfort.

The second angle or dimension in this model represents the "distress factor of stress". Each one of the expressions under distress such as tension, frustration, strain, trauma, fear, pressure and hatred connotes something unpleasant. The third dimension is eustress which includes expressions such as challenge, opportunity, progress, success, achievement and excitement that are the pleasant. If a person experiences "stress", whether he or she would move to "distress" or "eustress" from that point is depending on different factors such as the general personality disposition and past experience. Whether a stressful situation is considered positive or negative depends upon the interpretations attached to the situation, and this happen through cognitive mediation of appraisal.

A stressful situation becomes distress when it is unwanted, unexpected, ongoing, due to serious life changing events which includes domestic violence, bereavement, divorce, trauma, death of loved one, unemployment etc. When individuals experience distress, or imbalance in life, their bodies and minds cry out for some kind of help. This call for help may take many forms such as moodiness, frustration, anxiety, irritability, depression, insomnia, including physical symptoms such as stomach upset, headache etc.

Proper caring and support from the family, friends, and coworkers helps to reduce and recover stress both in men and women. Researchers consistently showed that social support can protect against physical and mental consequences of stress. This can occur through a variety of mechanisms.

As social beings, human beings seek support and consideration from the society. In contrast, societal neglect can be quite disturbing in nature. It may be

more defective while considering parents of children with certain disabilities. The disgrace and negative attitude of society may affect their mental health. Stigma is such a condition in which people negatively label the targeted people; directly or indirectly they will show their negative attitude towards the target people.

Stigma

The term 'stigma' was popularized by the pioneering works of famous sociologist Goffman (1963). In his famous publication entitled 'Stigma: Notes on the Management of Spoiled Identity', he portrayed the basic features of stigma and it was influential to many other fields like criminology, medicine, and psychology. Goffman(1963), demonstrated the term stigma by reminding the practices of ancient Greek, who cut or burned marks into the skin of criminals, slaves in order to identify them as tainted or immoral people who should be avoided. Nowadays, rather than a physical mark, stigma extended as an attribute and impacts in widespread social disapproval.

Stigma can be defined as an adverse reaction to the perception of a negatively evaluated difference (Susman, 1994). These perceptions and reactions can profoundly affect the quality of the individual's life experience. In a society in which health, beauty and independence are highly valued, individuals with disabilities can be viewed as the bearers of negatively valued traits (Barnes, 1996). These traits can overshadow other characteristics that clearly place the individual within familiar social categories. Faced with these traits, others often feel awkward, anxious or sad when interacting with those who bear them and may react in a variety of ways to compensate for their discomfort (Susman, 1994). These public reactions can, in turn, have an impact on the stigmatized individual's sense of self and full participation in the work and social life of the community (Link et al., 1989).

Stigma has been defined as an identifying mark of shame or discredits (Goffman, 1963). Stigma involves perceiving some people and groups under negatively defined characteristics, which is apart from normalized social order (Khakha, 2003) and is also associated with discrimination (Sartorius, 2002). Stigma not only related to labelling, but also leads to stereotyping, separation, status loss and discrimination within a power situation (Link & Phalen, 2001)

The prejudice and stereotypic thought about disability arise in school age itself. Because many of the pupils consider mentally or physically disabled people as "dangerous, dirty, unpredictable, and worthless", this may be rooted in the society and patients are attributed with inferiority and inability in the mental health facility (Dube & Sachdev, 1983). Majority of adult people also show the same attitude towards disability.

Disability and related stigma make noticeable consequences that go beyond the stigmatized individual, but it also affects those closely associated with them like parents, family, relatives and neighbours. This is known as 'courtesy stigma' or 'stigma by association' (Sarkar, 2010). The type of relation plays a role in the current study. Stigma increases the perceived burden of care giving tasks in parents (Green, 2003) and parents sometimes blame themselves for their child's condition (Mak & Kwok, 2010).

As it is visible, definitions of stigma indicate two basic components namely, recognition of difference and devaluation (Dovidio et al., 2000). Furthermore, as it occurs in social interactions, it is not just limited to an individual but rather extended to the social context (Hebl & Dovidio, 2005). The process of stigmatisation may vary across different social contexts (Crocker et al., 1998).

Family Stigma

While the individuals with mental illness or intellectual disabilities were the direct targets of the stigmatization, Wahl (1989) found that their care giving relatives were also impacted by the stigmatization of their loved ones. The most commonly cited effects on the caregiver and family unit were lowered self-esteem and damaged family relationships. Many studies support the idea that the effects of stigma are not limited to the stigmatized individuals but also often affect those who are closely associated with them, such as members of the family, friends, and even professionals who work with them. Courtesy stigma may result in family members being teased, abused, blamed or considered responsible for their relative's disability (Larson & Corrigan, 2008). Family members may develop negative self-perceptions and emotions that may cause them to withdraw from social activities or conceal their perceived negative status from others. Previous research has shown that caregivers

of people with intellectual disabilities, including parents and other older relatives, face courtesy stigma (Ali et al., 2012).

Affiliate stigma refers to the 'general affect (feelings of shame, embarrassment and despair), cognitions (perceived lack of worth and competence) and behavioural reactions (withdrawal)' that result from closely associating with people with a stigmatized condition (Mak & Cheung, 2008). Individuals who experience affiliate stigma could be family members, friends and service providers of the person with a disability. Although there is much knowledge about the impact of public, family and self-stigma (Bambauer & Prigerson, 2006; Werner et al., 2012), not much is known on how affiliate stigma impacts caregivers' well-being, specifically those who care for individuals with Intellectual developmental disorders(IDD) (Werner et al., 2012; Werner & Shulman, 2013). In Asia, where stigma towards a person with a disability and their family is socially and culturally sanctioned, affiliate stigma is of greater significance to caregivers, compared with public, family and self-stigma, warranting further research.

According to Mak and Cheung (2008) affiliate stigma could distort a caregiver's relationship and views towards the care recipient and negatively impact the caregiver's subjective appraisal of the care giving situation, which in turn could then negatively impact their psychological well-being. The stigma if internalized could exacerbate parents' negative appraisal of the care giving situation or subjective burden (Zarit et al., 1980), which could then impact parents' psychological well-being.

From the above descriptions it is clear that society has an important role in person's life. Whether it is positive or negative it influences the individual's wellbeing. Apart from stigmatization, the support they receive for rearing the child is another important social aspect to be considered.

Social Support

Social support can be defined in terms of comfort, caring, esteem, or help available to a person from other people or groups (Uchino, 2004). Support can gain from many sources-the person's spouse or lover, family, friends, physician, or community organizations. People having social support believe as they are loved,

valued, and part of a social network, such as a family or community organization, that can help in times of need. When parents tend to perceive lack of support while talking to doctors or other professionals, or when they have trouble in dealing with relatives, parents report higher levels of stress (Thompson et al., 2006). Many studies indicate social support as a coping mechanism that may act as a buffer against stress (Bailey et al., 1994) and also it could be useful to improve parents' competence in order to foster an adequate development of social skills (Cuzzocrea et al., 2014).

Social support can be of two types: received and perceived support. Received refers to the actual receiving of assistance from others. Perceived refers to one's perceptions of the availability of support and/or satisfaction with the support provided (Pottie et al., 2009). It can also be stated as getting unconditional acceptance from society, being positive and satisfied about one's life and living a meaningful life (Walen & Lachman, 2000; Sarason et al., 1994). In other words, it can be described as follows:

1. Perceived support: refers to a recipient's subjective judgment that providers will offer (or have offered) effective help during times of need.
2. Received support (also called enacted support): refers to specific supportive actions (e.g., advice or reassurance) offered by providers during times of need.

Perceived social support is an important means of coping because the extent to which individuals regard themselves as being cared for and supported by others is positive (Smith et al., 2010). Research indicates mothers of children with Autism spent more time providing child care, less time in leisure activities, had more stressful events, arguments, and fatigue than mothers from a nationally representative sample of children without disabilities (Smith et al., 2010). Parents' beliefs about receiving adequate social support for themselves and their child have been shown to be very important for successful family adaptation (Siklos & Kerns, 2006).

The researchers have highlighted the importance of social support as a vital resource for individuals who are dealing and coping with stressful situations

(Sarason et al., 1990), such as mothers raising a child with a disability (Dunst et al., 1994). Numerous studies indicate that people with spouses, friends, and family members who provide psychological and material resources have better health than those with fewer supportive social contacts (Broadhead et al., 1983).

Buffering hypothesis

According to the buffering hypothesis, social support affects health by saving the person against the negative effects of high stress.

The buffering model suggests that social support mediates or 'buffers' the adverse effects of chronic adverse life stressors (Cohen & Willis, 1985). Buffering works in two ways: First, when people face a strong stressor, such as a major financial crisis, those who have high levels of social support may be less likely to appraise the situation as stressful as those with low levels of support. Individuals with high social support may expect that someone they know will help them, such as by lending money or giving advice on how to get it. Second, social support may modify people's response to a stressor after the initial appraisal. For instance, people with high social support might have someone provide a solution to the problem, convince them that the problem is not very important, or cheer them on to ''look on the bright side.'' People with little social support are much less likely to have any of these advantages-so the negative impact of the stress is greater for them.

Many researches show that social support is associated with increased psychological well-being in the workplace and in response to important life events. In stressful times, social support helps people reduce psychological distress such as anxiety or depression. Social support can simultaneously function as a problem-focused (e.g. receiving tangible information that helps resolve an issue) and emotion-focused coping strategy (e.g. used to regulate emotional responses that arise from the stressful event). Social support has been found to promote psychological adjustment in conditions with chronic high stress like Cancers, HIV etc.

From this, it is evident that social support acts as an adaptive mechanism for facing different kinds of stressors in a person's life. As already seen a variety of ways of support system can be effective with respect to the problem facing. Apart from a social view point, an individual may have different kinds of adaptive

mechanism inside him for tackling the stressors. Altogether it can be termed as coping strategies. A detailed description of coping strategies and how it is connected with parents having children with disability are given below.

Coping

Coping refers to a variety of cognitive and behavioral strategies a individuals use to manage their stress (Folkman & Moskowitz, 2004). It is the tendency to be stable in some or all stressful situations. In order to manage the stress pertaining to raising a child with disability, certain types of coping strategies should be adopted by parents of children with disabilities. The coping styles of the parents may affect the development of the child, harmony of the family and physical and psychological health of the parents themselves.

Cohen and Lazarus (1979) pointed out the goals of coping as the following:

- To reduce stressful environmental conditions and maximize the chance of recovery.
- To adjust or tolerate negative events.
- To maintain a positive self-image.
- To maintain emotional equilibrium.
- To continue satisfying relationships with others.

Styles, processes and strategies

When discussing coping, some research focuses on ‘styles’, some on ‘processes’ and some on ‘strategies’. At times this may just reflect different use of terminology. However, it also reflects an on-going debate within the coping literature concerning whether coping should be considered a ‘trait’ similar to personality, or whether it should be considered a ‘state’ which is responsive to time and situation. The notion of a ‘style’ tends to reflect the ‘trait’ perspective and suggests that people are quite consistent in the way that they cope. The notions of ‘process’ or ‘strategy’ tends to reflect a ‘state’ perspective suggesting that people cope in different ways depending upon the time of their life and the demands of the situation.

Researchers have described different types of coping. Some differentiate between approach and avoidance coping, while others describe emotion-focused and problem-focused coping.

Approach versus avoidance coping

Roth and Cohen (1986) defined two basic modes of coping: approach and avoidance. Approach coping involves confronting the problem, gathering information and taking direct action. In contrast, avoidant coping involves minimizing the importance of the event. People tend to show one form of coping or the other, although it is possible for someone to manage one type of problem by denying it and another by making specific plans. Some researchers have argued that approach coping is consistently more adaptive than avoidant coping. However, research indicates that the effectiveness of the coping style depends upon the nature of the stressor. For example, avoidant coping might be more effective for short-term stressors (Wong & Kaloupek, 1986), but less effective for long-term stressors (Holahan & Moos, 1986).

Problem Focused versus Emotion Focused coping

Problem focused approach, deals with the source of stress. In this strategy effective and logical methods are taken as solutions. This involves attempts to take action to either reduce the demands of the stressor or to increase the resources available to manage it. Examples of problem-focused coping include devising a revision plan and sticking to it, setting an agenda for a busy day, studying for an extra qualification to enable a career change and organizing counselling for a failing relationship.

'Emotion Focused' approach reflects attempts to handle the thoughts and feelings associated with the stressor. It explains that people reach a state of relaxation or adjustment through emotional expressions of feelings (Folkman & Lazarus, 1985).This involves attempts to manage the emotions evoked by the stressful event. People use both behavioural and cognitive strategies to regulate their emotions. Examples of behavioural strategies include talking to friends about a problem, turning to drink or smoking more or getting distracted by shopping or watching a film. Examples of cognitive strategies include denying the importance of the problem and trying to think about the problem in a positive way.

Researchers showed that there are several factors that can influence and which coping strategy is to be adopted:

- Type of problem: Work problems seem to evoke more problem-focused coping whereas health and relationship problems tend to evoke emotion-focused coping (Vitaliano et al. 1990).
- Age: Children tend to use more problem-focused coping strategies whereas emotion focused strategies seem to develop in adolescence (Compas et al., 1991,). Folkman et al. (1987) reported that middle-aged men and women tended to use problem-focused coping whereas the elderly used emotion-focused coping.
- Gender: It is generally believed that women use more emotion-focused coping and that men are more problem focused. Stone and Neale (1984) considered coping with daily events and reported that men were more likely to use direct action than women. However, Folkman and Lazarus (1980) and Hamilton and Fagot (1988) found no gender differences.
- Controllability: People tend to use problem-focused coping if they believe that the problem itself can be changed. In contrast they use more emotion-focused coping if the problem is perceived as being out of their control (Lazarus & Folkman, 1987).
- Available resources: Coping is influenced by external resources such as time, money, children, family and education (Terry, 1994). Poor resources may make people feel that the stressor is less controllable by them, resulting in a tendency not to use problem-focused coping.

Social and emotional support from family and friends help people to cope with stressful conditions. Two types of social support are there - providing resource is material support while listening to the person and encouraging him/her is emotional support (Pestonjee,1992).

The above description portrayed different styles or tactics a person may utilize during a stressful situation. It may be influenced by past experiences, religious beliefs etc. Whatever the style a person may adopt, he/she is attempting to adjust with the stressors. Beyond the level of adopting a particular style of coping strategy, it is also very important to have a control over events in a person's life. In that way, self-efficacy is found to be a fundamental psychological resource for

exercising control over stressful events in an individual's life. In other words, self-efficacy can be considered as a powerful motivational, cognitive, and affective determinant of a person's life.

Self-efficacy

The term self-efficacy is introduced by Albert Bandura and it is a set of ideas embedded within his more general social-cognitive theory of personality (Bandura, 1997). According to him, it can be defined as a person's belief in his or her capacity to execute actions necessary to produce specific performance attainments. It points that key personal resources and efficacy beliefs which not only help to understand people's behavior but also the antecedents and consequences of these behaviors. Efficacy belief may influence peoples thinking, goals, opinions, aspirations, outcome expectation, emotional state, the course of action people choose to purse, how much effort they put in their activities etc (Bandura, 2008).In other words, Self-efficacy can be defined as the self-perception of a person's capability which becomes instrumental when he or she pursue to the goals and the control which he or she can exercise over his or her environments. Perceived self-efficacy can be referred as beliefs which we hold about our capability of organizing and performing tasks within a specific domain to effectively lead to specific goals. Much of our lives are guided by efficacy beliefs, since we generally pursue courses of action which we believe will lead to desired outcomes and have little incentive to act in ways which we believe will involve failure.

Judgements on self-efficacy can be measured using three basic scales named as magnitude, strength and generality.

- ***Self-efficacy magnitude*** measures the difficulty level (e.g. easy, moderate, and hard) an individual feels is required to perform a certain task (Van der Bijl & Shortridge-Baggett, 2002). How difficult is my class work? Are the exams easy or hard?
- ***Self-efficacy strength*** refers to the amount of conviction an individual has about performing successfully at diverse levels of difficulty (Van der Bijl & Shortridge-Baggett, 2002). How confident am I that I can excel at my work tasks?

- ***Generality of self-efficacy*** refers to the "degree to which the expectation is generalized across situations (Lunenburg, 2011). How sure am I that what I have learned will apply to my new works?

For Bandura, for any domain of functioning our efficacy beliefs (or judgements about our capabilities) determine our expectations about the effects or consequences of our actions. If we expect to be successful and achieve desired outcomes, then this acts as an incentive to perform the action. If we expect to be unsuccessful, this acts as a disincentive. These efficacy beliefs and expectations of certain consequences determine our behavioural performance, and this in turn leads to certain outcomes. Our efficacy beliefs will vary in their level, strength and generality with respect to the domain of functioning. These beliefs will lead to expectations about the effects or consequences of our behavioural performance. People may hold expectations about the physical and social effects or consequences of their behavioural performance and their effects on how they will evaluate themselves if they perform well or poorly.

According to Bandura (1997), for better understanding of domain of functioning, it has to be studied specifically. For instance, if it is needed to know a student's self-efficacy belief it has to be studied specifically as student efficacy-likewise of teacher efficacy, parent efficacy etc. For the current research the most appropriate domain would be parent self-efficacy. Through which it can be studied the level of expectancy on effectiveness as a parent to rear a child with disability.

Parenting self-efficacy

Parental self-efficacy refers to the expectations about the degree to which he or she is able to perform competently and effectively as a parent (Teti & Gelfand, 1991). It is also related to parents' perceptions that they can have a positive influence on their child's development and outcome. Given self-efficacy can influence whether an individual persists or gives up when faced with stress or difficult situations. Parenting self-efficacy has important consequences for parenting and child development.

Sources of self-efficacy

Bandura (1977) outlined four sources of information that individuals employ to judge their efficacy: performance outcomes (performance accomplishments), vicarious experiences, verbal persuasion, and physiological feedback (emotional arousal). These components help individuals determine if they believe they have the capability to accomplish specific tasks. Williams and Williams (2010) note that "individuals with high levels of self-efficacy approach difficult tasks as challenges to master rather than as threats to be avoided".

- *Performance Outcomes:* According to Bandura, performance outcomes or past experiences are the most important source of self-efficacy. Positive and negative experiences can influence the ability of an individual to perform a given task. If one has performed well at a task previously, he or she is more likely to feel competent and perform well at a similarly associated task (Bandura, 1977).
- *Vicarious Experiences*: People can develop high or low self-efficacy vicariously through other people's performances. A person can watch someone in a similar position perform, and then compare his own competence with the other individual's competence (Bandura, 1977). If a person sees someone similar to them succeed, it can increase their self-efficacy. However, the opposite is also true; seeing someone similar fail can lower self-efficacy.
- *Verbal Persuasion***:** According to Redmond (2010), self-efficacy is also influenced by encouragement and discouragement pertaining to an individual's performance or ability to perform. The level of credibility directly influences the effectiveness of verbal persuasion; where there is more credibility, there will be a greater influence. Although verbal persuasion is also likely to be a weaker source of self-efficacy beliefs than performance outcomes, it is widely used because of its ease and ready availability (Redmond, 2010).
- *Physiological Feedback (emotional arousal):* People experience sensations from their body and how they perceive this emotional arousal influences their beliefs of efficacy (Bandura, 1977). Some examples of physiological feedback are: giving a speech in front of a large group of people, making a presentation to

an important client, taking an exam, etc. All of these tasks can cause agitation, anxiety, sweaty palms, and/or a racing heart (Redmond, 2010). Although this source is the least influential of the four, it is important to note that if one is more at ease with the task at hand they will feel more capable and have higher beliefs of self-efficacy.

Outcomes of self-efficacy

Self-efficacy beliefs are thought to be regulated by cognitive, motivational, emotional and choice processes (Bandura, 1997). People with high perceived self-efficacy show greater cognitive resourcefulness, strategic flexibility and effectiveness in managing environmental challenges from a cognitive level. They use a future-time perspective to structure their lives. They look upon potentially beneficial opportunities rather than risks. They will probably visualise successful outcomes and use these to guide their problem-solving efforts. While it is considered from motivational level, people with strong self-efficacy beliefs set challenging goals, expect their efforts to produce good results, ascribe failure to controllable factors such as inadequate strategies, insufficient effort or unfavourable circumstances rather than uncontrollable factors such as lack of ability, view obstacles as surmountable and so are motivated to persist in striving to achieve their goals. Efficacy beliefs play on emotional states by permitting people to interpret potentially threatening demands as manageable challenges and by reducing worrying and negative thinking about potential threats. Efficacy beliefs are also help to regulate emotional states by facilitating problem-focused coping to alter potentially threatening environmental circumstances; by facilitating people to solicit social support to act as a buffer against stress; and by enabling the use of self-soothing techniques such as humour, exercise and relaxation to reduce arousal associated with potentially threatening situations.

The Interaction of Self-Efficacy with the Environment

According to Bandura (1997), two levels of efficacy (low and high) interact with two types of environment (responsive and unresponsive) to produce the following four predictive variables:

1. **Success (H, R)** - A person with a high level of self-efficacy in a responsive environment will be successful. Their positive attitude toward their abilities coupled with environmental change promotes success and improves long-term motivation.
2. **Depression (L, R)** - A person with a low level of self-efficacy in a responsive environment may fall into a depressed state. They know the environment will change but their lack of belief in their own abilities stops them from trying and succeeding.
3. **Apathy and helplessness (L, UR)** - A person with low self-efficacy and an unresponsive environment will feel helpless and decide that all efforts are pointless thus causing them to be completely inactive.
4. **Effort intensification or change of course (H, UR)** - A person with high self-efficacy in an unresponsive environment will either increase their efforts toward change or decide they need to change their goals.

Need and significance

Despite the terminologies referring people with disabilities are changing, most of the time society views disability as a "less" in many manners with which people having disability always tend to kept away from mainstream via "bonus" of sympathy. In fact, it is a way by which society tends to veil the problems of differently abled people indirectly. Usually the problems of children, parents and families are not properly identified or addressed. Multiple challenges as already noted require additional mental and physical effort from the side of parents. Parents of children with disability face emotional problems and stress like difficulty in managing the child's physical and emotional problems, managing time and finance for caring and treatments, and adjusting other familial and social responsibilities. As they are the primary caretakers, they need to be bolder and stronger before the stressors. It is crucial for the proper caring and systematic treatment for the needy.

While considering parents, usually the primary care taker would be mothers. Indeed, the peculiar familial system in India foist upon all those responsibilities on the shoulders of mothers. It may be true that the presence of disabled children will affect the whole family functioning. But studies have shown that when compared to

fathers, mothers experience more stress (Hastings et al., 2005). The need for knowing more about mother's status becomes relevant in this sense. Thus, the mothers may be the appropriate sample for a better understanding of problems of rearing differently abled children in a society like India. For ensuring better mental health of mothers, their problems and feelings should be identified and understood. The present study is an attempt to understand the extent and nature of stress, and related aspects of mothers of differently abled children.

Disability studies are at its budding age in India especially in psychological field. For promoting and developing more evidence-based practices in rehabilitation programmes for disabled people, it is necessary to have more studies within this cultural realm. Even now, many people are unaware about their child condition and treatments available for them. As the child gets older caregivers become more and more stressed because of lack of knowledge regarding how to handle the situation. Some people may be efficient to handle it but they may not have enough support from family or friends. Various studies have suggested that mother's perceived support is linked with stress level they are experiencing (Hauser-Cram et al., 1999). Some people stick on believing this condition as a punishment from God or as a faith. Such a way, managing stress would be of different kinds. Here comes the relevance of studying about social and personal perspectives of stress among mothers of differently abled children.

For a better understanding of a person, it is needed to be studied within the social realm. As already noted society views these "differences" in different manner. Layman usually sees the disabled as unfit for normal living. They may shower additional sympathy towards the children and parents to withdraw from social gatherings and activities etc. Moreover, the support system available for them is also to be studied thoroughly to address the stress level they experience.

From an individualistic perspective, people may adapt with the stressful situation based on their past experiences, belief system they hold and the like.Likewise, mothers may choose different coping methods to adjust with the difficult times. The present study is attempting to address the variety of methods adopted by mothers to adapt with the stressful life events. It is also very important to

understand the extent of confidence in their ability to manage the stressful experiences-whether they perceive themselves as capable of managing their child's problems or not would also be analyzed in the present study.

Following both qualitative and quantitative method, the current study will enable a framework for knowing more about these kinds of tendencies. It will be useful for future researchers who are interested to study about wellbeing and related aspects of mothers of differently abled children.

Statement of the Problem

The study is entitled as "PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION"

Definitions of Key terms:

PSYCHOLOGICAL DISTRESS: A state of emotional sufferings characterized by symptoms of depression (e.g. sadness; lost interest; hopelessness) and anxiety (e.g., restlessness; feeling tense). These symptoms may be tied with different somatic symptoms (e.g., insomnia; headaches; lack of energy) that are likely to vary in accordance with cultures (Kleinman, 1991).

MOTHERS OF DISABLED CHILDREN: Mothers of children with certain kinds of disability such as intellectual disability, Autism, ADHD etc.

EXPLORATION: A thorough investigation/examination of a particular topic.

CHAPTER 2
REVIEW OF RELATED LITERATURE

Considerably, in the arena of studies on developmental disabilities, psychological distress of parents is a widely explained area and showed variety of results in relation to the varying types and degree of disabilities. Most of the studies conducted in this area focused on certain groups such as parents of child with mental retardation, autism spectrum disorder, ADHD, cerebral palsy, sensory impairments, learning disabilities etc. Indeed, most of them emphasized the distress of mothers.

Gallagher and Whiteley (2012) attempted to explain the important factors that are determining levels of stress in parents of children with disabilities. Primarily, the characteristics of the child with disability which include type and/or severe of disability, child's independency, age, and visibility of disability can affect parents in many ways. Secondly parents and family characteristics such as social-economical level, personality traits, past experiences, age, education, career, income level, perceptions about disability, and beliefs about ability to affect the development of child. Next, family structure (demographic characteristics such as rank of the child with disability, siblings, and the presence of other disabilities in family). Last but not least, the social factors such as attitudes in society toward disability, and availability of services to individuals with disability.

Most of the studies were focused especially on general stress rather than distress and it is revealed that parents of disabled children experience more stress than those of normal children (Ranta & Sharma, 2015; Hidangmayum & Khadi, 2012). While considering the types of disabilities, mental disabilities induce more stress than physical disabilities (Shyam et al., 2014). Another important observation was that mothers experienced more stress as they take more responsibilities on taking care of their children's daily life (Tehee et al., 2009; Hastings et al., 2005). Tanaka et al., (1996) revealed that Japanese mothers of children with disabilities showed higher stress than did mothers whose children had no disabilities, consistent with research from other countries (Emerson, 2003; Glidden & Schoolcraft, 2003; Olsson & Hwang, 2001).

Psychological distress is widely used as an indicator of the mental health of the population in public health and in population surveys. Psychological distress is viewed as an emotional condition that involves negative views of the self, others and

the environment and is characterised by unpleasant subjective states such as feeling tense, worried, worthless and irritable (Barlow & Durand, 2005). The demands of caring for children with chronic conditions may precipitate symptoms of depression and general psychological distress (Breslau & Davis, 1986; Jessop et al., 1988). In addition, both the general psychological literature and specific studies of disabled children show that parental distress and family functioning impacts children in numerous ways, affecting their cognitive, behavioural and social development. Parental psychological distress contributes significantly to behavioural and emotional problems among chronically ill children (Thompson et al., 1993).

Ren et al., (2020) commented that during the outbreak of COVID-19, parents of special needs children suffered mental and behavioral problems, together with parenting stress and social support, which influenced their state anxiety. According to them during the pandemic, social support negatively predicted parents' state anxiety whereas parenting stress and parental mental and behavioral problems positively predicted parents' state anxiety. Conversely in a study conducted by Asbury and Toseeb (2022), parental psychological distress remains stable during Covid-19 pandemic in parents of children with autistic features.

Comparison of stress, depression, and anxiety between mothers and fathers

As aforementioned, most of the researchers selected mothers as their participants as they are supposed to be the primary caregivers of the children. According to Upadhyaya and Havalappanavar (2008), when compared to fathers, mothers faced more stress in the areas of care, emotional and social support. They also noted that the severity of stress is associated with the number of disabled child in the family, high status moral behavior, childish behavior, mental retardation as well as socioeconomic status of the family and familial support. According to Millaku and Kraja-Bardhi (2023), mothers were more depressed than fathers of disabled children. In addition fathers were more concerned about the financial state. Families of lower income expressed more depressive than higher ones. Furthermore, Parents of autism and mental delays had more depression than that of other disabilities.

According to Hastings (2003) mothers and fathers having autistic children, mothers did not differ in levels of stress and depression, but mothers reported more

anxiety than fathers. Correlation analysis showed that children's behavior problems and father's mental health are related to mother's stress. However, neither the child's behavior problems nor the mother's mental health were associated with the father's stress. Authors pointed out the importance of psychological health of other family members on stress in mothers of children with disabilities.

Type of disability and stress

Niimi and Uemura (1987) suggested that stress patterns differed across different types of disabilities. In particular, the mothers of autistic children showed distinctive stress patterns compared with the parents of children with different disabilities, such as an ID and Down syndrome. Similar observation was found in USA as well (Olsson & Hwang, 2001). While considering the influence of child perspectives into parental stress, child's lack of communication skills, abnormal behaviors, social isolation, and difficulties in self-care were found to cause high level of stress and feel extremely high level of psychological distress (Estes et al., 2009) among parents of children with autism.

An Indian study conducted by Guptha (2007) demonstrated the similar pattern that type of disability is associated with parental stress. Researchers also revealed that parents of children with autism were more distressed compared with parents of children with other developmental disabilities, such as Down syndrome (Sanders & Morgan, 1997), fragile X syndrome, severe intellectual disability (White & Hastings, 2004) than parents of children with special health care needs without developmental problems (Schieve et al., 2007) or typically developing children (Yamada et al., 2007). Elevated level of stress was found in a study of parents of autistic children by Tomanik et al. (2004).

High levels of risk for mental health problems exist in parents of children with ASDs, particularly in mothers, perhaps because they often assume primary care giving responsibilities (Hastings & Brown, 2002). One psychological outcome that is especially relevant for parents of children with ASDs is depression. Parents of children with ASDs often report heightened levels of depression. According to Miranda et al., (2019), parental stress has been shown to affect ASD symptoms and behavior problems in children. In comparison to a national sample of adults, Benson

and Karlof (2009) found that parents of children with ASDs report heightened levels of anger and depressed mood. Mothers of adolescents and young adults with ASDs report greater levels of depressive symptoms than mothers of children with Down syndrome (Abbeduto et al., 2004) and other intellectual disabilities (Olsson & Hwang, 2001). In a study by Benson (2006), almost half of the mothers of children with ASD scored at or above the cut-off for depressive symptomatology. The heightened prevalence of these symptoms in caregivers of children with ASDs again underscores the need to address the entire family system rather than focus exclusively on child functioning. Interestingly, Mello et al., (2022) found that parental distress is mostly predicted by children's emotional problems and aggressive behaviour. Moreover, autism symptoms along with emotional problems and aggressive behavior, respectively, were linked to stress pertaining to interactions and to the child.

Al-Towairqi et al., (2015) demonstrated that mothers of autistic children had more depression. While considering socio-demographic factors, female sex had a significant impact on maternal depression. Number of siblings, family income, level of mother education, showed no significant impact on maternal depression. Considering factors related to autism, the only significant factor was the mean age of autism child. In relation to the support factors, while mother knowledge about autism, mother joining a support group had no significant impact on maternal depression. The social and financial supports for autistic families had significant impact on maternal depression. Autism was associated with burden and stress for mothers of the affected child. The increased demands contribute to increased incidence of depression among mothers. They also suggested the importance of social support to mothers of ASD children as it had a significant impact on maternal depression.

While analysing the results of studies on parents of children with mental retardation and Down's syndrome, it is evident that mothers experienced more stress than fathers (Roach et al., 1999; Shin et al., 2006; Aldosari, & Pufpaff, 2014). Further, severity of the disability also matters. Majumdar et al., (2005) reported that parents of profoundly retarded children were more vulnerable to stress and anxiety

than parents of mildly retarded or normal children. According to them, parental education and family income had an impact on perceived stress and anxiety among the parents. While considering the mothers of children with intellectually disability, Lloyed and Hastings (2008) demonstrated that acceptance was negatively associated with maternal anxiety, depression and stress, such that mothers who were generally more accepting reported fewer psychological adjustment problems. Kermanshahi et al., (2008) found themes concerning the lives of Iranian mothers of mentally retarded children as challenging the process of acceptance, painful emotional reactions, the inter-relatedness of the mother's health and the child's well-being, struggles to deal with oneself or the child, inadequate support from the family and community, and anxiety related to the child's uncertain future. In their study, Chandravanshi et al. (2017) found that prevalence of depression in mothers of intellectually disabled children was 79% which was a higher score when comparing the previous research findings. Indeed it was more in mothers of female intellectually disabled (ID) child, ID child with significant co morbidities, severer forms of retardation, and with higher levels of anxiety in the mother.

Several studies have shown that considerable stress is associated with raising children with Specific Learning disability (SLD). One study found that mothers of children with LD experience more stress than mothers without LD (Fuller & Arankin, 1994). This finding is similar to findings of Margalit and Heiman (1986) who found that mothers of boys with LD are more anxious than those of boys without LD. Higher levels of stress are associated with less social competence and behavioral problems (Dyson, 2003). A study on adolescents with LD and family members suggests that families with LD adolescents experience less family cohesiveness and less communication about family problems than families without LD adolescents. However, this same study also reported no differences in functioning or adjustment within the family (Morrison & Zetlin, 1992). But from comparison studies of different disabilities, parents of children with learning disabilities face less stress than parents of children with other disabilities.

Studies have shown an association between parental distress and caretaking of children with developmental cognitive delays (Cramm & Nieboer, 2011; Khamis,

2007; Saloviita et al., 2003). The skills acquired through parental intervention may be limited dependent upon the level of cognitive delay. Therefore, various demands persist throughout childhood and later into adult years, leading to ongoing parental stress. Additionally, a large number of these children have behavioural issues, which can lead to higher levels of parental stress (Floyd & Gallagher, 1997; Greenberg et al., 1997).

Severe stress in parents may leads to psychopathological conditions. It is a high risk factor in parents of disabled children. Many of the parents are at risk of anxiety, depression or both. Mothers showed more psychopathological symptoms than fathers (Azeem et.al, 2013; Johnston et.al, 2003). Further, single mothers are more vulnerable to these pathological conditions (Olsson & Hwang, 2001). Researchers identified variables that were likely to predict heightened levels of depression including challenging child behavior (Bromley et al., 2004), lower family income (Mackintosh et al., 2006), a higher number of children in the family with disabilities (Ekas et al., 2010), greater autism symptomatology, and fewer maternal coping strategies (Abbeduto et al., 2004). Hastings et al., (2006) proved that families of children who have intellectual disability, maternal distress and children's behavior problems formed a bidirectional relationship over time. This relationship was found to be specific to externalizing problems. Maternal distress and depression had a bidirectional longitudinal relationship. In terms of maternal expressed emotion, criticism and no emotional over-involvement was cross-sectional; but not longitudinally related to children's externalizing behavior problems and to maternal distress.

It was evident from the study of Gowen et al., (1989) that care giving difficulty predicted maternal depression of mothers of handicapped infants. Mothers of handicapped infants differ in terms of level of functioning and difficulty of care giving, when compared to mother of non-handicapped. However, the mother's two groups had no difference in the level of mother's depression and their parents. The positive family relationship with the group with disabilities predicted the child's perception. In the disability group, depression and parenting skills were predicted by childhood aggression and quality of family relationships. In the non-handicapped

group, both feelings of depression and of parenting competence were predicted by child irritability and the quality of family relations.

Severity of disability and stress

While considering the severity of the condition, the study conducted by Morya et al., (2015) found that in various dimensions of perceived stress, families with mentally retarded children having IQ less than 50 experienced significantly higher daily care stress, emotional stress, social stress and total perceived stress than the families with mentally retarded children having IQ greater than or equal to 50. On the other hand families in both groups used similar coping strategies (i.e., awareness about mental retardation, attitude and expectation, rearing practices and social support) except global support strategy which was used significantly higher by the families of children with IQ less than 50. Presence of female mentally retarded child and nuclear family were the factors associated with higher stress in families. Jaiswal et al., (2018) found that mothers had higher score for depression and interpersonal sensitivity. Parental psychopathology did not differ significantly with severity of intellectual disability of child. Global severity index correlated negatively with age of parents and positively with fatalism, expressive-action and passivity coping mechanisms. Depression was the most common psychopathology especially among mothers of child with intellectual disability. Psychopathology was independent of severity of ID and worsened with coping mechanisms like fatalism, expressive-action, and escape-avoidance. According to the authors, a child with intellectual disability should be seen and treated as a family unit giving enough attention to parent's psychological needs as well. According to Benson (2018) parental depression was predicted by both child symptom severity and by stress proliferation and that stress proliferation partially mediated the effect of child symptom severity on parent depression. Moreover, informal social support was found to reduce levels of parent stress proliferation and parent depression. Interestingly, in contrast to the stress buffering hypothesis, the ameliorative effect of support on stress proliferation was shown to be greatest when reported child symptomatology was less (rather than more) severe.

Apart from severity and type of disability stress also can originate from child's peculiar behavioural problems, socio-economic characteristics of the family and various personal factors. Hassall et al., (2005) found that parental stress variables were explained by parental control, parental satisfaction and child behavior problems. Family support was strongly correlated with parenting stress, and this was mediated by parental locus of control. Ritzema and Sladeczek (2010) in a study to assess whether changes in child behaviour problems or adaptive functioning affect parent stress. Very beginning of the study, child behaviour problems significantly predicted parent stress. Over the time, child behaviour problems decreased significantly, as did parent stress. At the last phase, child behaviour problems were significantly related with parent stress, and so was child adaptive functioning. Daulay et al., (2018) demonstrated that parenting stress was directly influenced by hardiness, social support, child's maladaptive behavior, and parenting sense of competence of mothers having children with special needs. In addition there was a mediating effect of parenting sense of competence between hardiness and parenting stress.

Anuar et al., (2021) demonstrated parents of children having learning disability as well as higher educational background and socioeconomic status tend to feel more stressful than those with lower educational background and socioeconomic status.

Mothers having children with autism spectrum disorder went through parenting stress higher than those raising children with other types of special need. The determinants of parenting stress are directly affected by child abuse and have a positive effect on parenting stress. Parental trust and understanding as an internal force is associated with parental stress and social support as an external force. Eo et al., (2018) found that parental distress/parent-child dysfunctional interaction of parenting stress was a predictor of both mothers' recognition and family support. Further, spouse cooperation in family support was a predictor of parenting stress. Oh and Lee (2009) found out that a high level of overall burden, especially in financial domains among mothers raising children with developmental disabilities in South Korea. Higher level of subjective caregiver burden was associated with increased

disability-related costs, maternal factors such as being younger and having higher educational attainment, and less social support. Indeed, extra cost related to disabilities was the strongest predictor of increased caregiver burden. Social support was found to be a factor to reduce this burden. Parents reported more psychiatric symptomatology when the child showed a high level of dysfunction (Khamis, 2007).

While analysing the studies it is evident that parents of children with disabilities face varying levels of stress, anxiety and depression than parents of normally developing children. Furthermore mothers were more prone to the psychopathological conditions compared to fathers and other family members. Type of disability, severity of disability, familial and social factors had impact on the stress levels of the parents. Autism, ADHD, severe and profound Intellectual disability are the major stress causing developmental disabilities.

Coping

According to Wallander and Varni (1998) it is very important to understand the ways of family coping as these are central to cognitive models of stress and coping often applied to families of children with disabilities. Seymour et al., (2013) demonstrated the outcomes of using certain strategies that might be in behavioral appearance such as neglecting responsibilities at home and work, or cognitive appearance such as weakness in problem-solving or emotional appearance which includes negative feelings toward the child with disability. According to Woodman and Hauser (2013) coping strategies can be defined as continuous change in cognitive and behavioral efforts by individual to handle the increasing external and/or internal demands of caring the child with disability. In general, parents of children with disabilities tend to use various strategies to cope with stress such as, looking for support, avoidance strategies, self-blame, drug abuse, making jokes, reconstruction of stressful situation in positive manner, or denial (Taanila et al., 2012).

Conversely, an Indian study conducted by Selvakumar and Panicker (2020) demonstrated that despite the having positive coping styles, mothers of autistic children presented depressive and anxiety symptoms.

People adopt different styles of coping patterns which may or may not result in successful management of stressful situation. Specifically parents having children with disabilities use variety of coping patterns which are relying upon factors such as certain demographic variables and child's condition. Studies on variety of populations demonstrated that avoidance or passive coping is related to a few number of mental health elements (Chang et al., 2006). In contrast, adopting avoidance coping and emotion-oriented strategies is linked with lower mental health and higher psychological distress (Qazanfari & Qadampoor, 2008).

A cross-sectional study conducted by Bilgin et al., (2022) determined that caregivers with children having special needs mostly tend to turning to religion, planning, positive reinterpretation, and instrumental social support as coping styles. Furthermore, significant correlation has been found between this variable with depression. The term "religious coping" refers to a technique through which people exploit religious beliefs and rituals to deal with the problems and pressures of life (Koening et al., 1997). According to Pargament (1990), religion is a coping process that can affect one's evaluation of the threatening factors and their severity. Religion redefines the problem as a solvable issue, and affects the interpretation of the results and consequences of stressors. Reviewing 130 studies on religious coping and their correlation with mental health, Pargament (1997) concluded that 34% of the investigations indicate positive and significant effects of religious coping in easing depression and anxiety. A number of them (4%) suggested negative effects of religious coping and adaptation on mental health and 62% of them reported no correlation between religious variables and mental health. At the same time a Turkey based study by Alemdar et al., (2022) demonstrated a positive relationship between effective coping with stress and religious coping as well as a negative relationship between ineffective coping with stress and general self-efficacy.

Based on a study in Spain (Paez et al., 1995) reported that people having access to the resources of social support, especially friends, perform more logical analyses and propose a greater number of new cognitive definitions of a problem compared to others. According to Bujnowska et al., (2021) there was a significant difference between parents of children with and without developmental disabilities

in one of three coping styles and one of eight coping strategies. Parents of children having developmental disabilities less often used the avoidance-oriented style and emotional support strategy. The task-oriented style and strategies were the dominant approach in both groups of parents. In stressful situations connected with rearing a child, parents of children with developmental disabilities do not use as dominant strategies connected with seeking emotional support and religion, which occur in the parents of typical development children. Hastings et al., (2005) found out four reliable coping dimensions of parents of autistic children such as Dysfunctional coping, problem-focused coping, active coping, and religious/negative coping. Another analysis of the data showed gender differences in the first two domains, but there was no reliable evidence that changes in parenting depend on the age of children with autism. A correlation was found between coping strategies, parenting stress and mental health.

Usage of coping strategies is linked to a variety of factors. Woodman and Hauser (2013) found that parents tend to use emotional-focused and avoidance strategies in early stages of diagnosing disability, and as the child grows, parents tend to use problem-focused strategies. This difference in coping patterns was found also between fathers and mothers, the results of research studies (Seymour et al., 2013; Hartley et al., 2012; Glidden & Natcher, 2009) suggested that mothers of children with disabilities were looking for social support and concerned more about emotions, while fathers, in return, tend to use avoidance and problem-focused strategies. It is very important to understand the strategies used by parents to cope with stress of caring child with disability as it is a major component of psycho-social support programs.

In a study conducted by Auriemma et al., (2022), parents' perceptions of the severity of their child's learning disability, as well as their use of emotion-focused coping strategies, were significant predictors of parenting stress levels. Interestingly problem focused coping did not predict parental stress. Anuar et al., (2021) determined that parents of children with learning disability used emotion-based coping strategies most frequently.

Miranda et al., (2019) suggested that parenting stress was negatively correlated with the engagement. Mothers reported overcoming difficulties and benefiting from functional social support. Multiple mediator analyzes indicated that commitment variables and behavioral adjustment issues were important mediators of the relationship between ASD symptoms and parenting stress, with commitment variables having a greater impact.

Adams et al., (2018) found that coping strategies of mothers of children with intellectual disabilities were not associated with child age or ability. This is not related to the age and abilities of the child, but to the mental health of the mother. A large number of positive coping mechanisms are associated with positive development. Underreporting that active avoidance coping was associated with higher levels of negative affect and increased anxiety and depression. Active avoidance moderated the association between levels of problem behavior and poorer maternal mental health, but only among non-problem-focused mothers. Active conflict is associated with the deterioration of the mental health of mothers of children with moderate or mild cognitive impairment based on concurrent pathology.

Based on Organismic Appraisal theory, Loepp (2015) examined the association and predictive power of internal coping strategies and external support with stress-related development for mothers and fathers of children with autism spectrum disorder (ASD). Coping by positive reframing was associated with active coping, perceived social support, and lower levels of stress. The construct of perceived stress related growth was also found to be different from internal coping strategies. In addition, mothers reported more stress and perceived stress related growth and also used active, instrumental support, planning, and self-blame coping strategies more than fathers. When compared to mothers, fathers reported higher perceived support from their significant others. Altogether, the majority of mothers and fathers reported that they had been achieved growth in parenting children with ASD and this process was organic and occurred over a period of time. To understand the differences in perceived disability impact and related coping in mothers having children with intellectual disabilities, Kishore (2011) compared

differences in the impact of perceived disability and related coping strategies between mothers of children with intellectual disabilities, children with intellectual disabilities, and children with additional disabilities. Based on this, 30 mothers of children with intellectual disabilities and 30 mothers of children with mental and additional disabilities were evaluated in terms of impact and treatment of disability. There were group differences in the incidence of disability in some areas, but not overall. Although there was a difference in coping style, positive and negative coping strategies. The results indicate that the impact of intellectual disability is high, as mothers do not perceive a greater impact of additional disabilities, except in certain areas. Positive coping does not preclude negative coping strategies. These conclusions have a special relation to the provision of services in the field of culture.

Stress levels and coping strategies are linked in variety of ways. Parental coping styles and presence of social support in relationship with developmental disabilities can impact the level of parental distress (Dabrowska & Pistula, 2010). This risk can be considered within four broad domains: physical health, psychological health, social relationships, and environment, while appreciating that parents function both independently and as a unit throughout the course of a day and across the lifetime of a child with ID. Kumar (2008) showed that psychological stress and coping strategies of the parents of mentally retarded children was negatively and significantly correlated. Azar and Badr (2006) confirmed that the father's education, informal social support, and stress were the best predictors of coping among parents of children with intellectual disability. The age of the child, the severity of the illness and the health status of the parents did not play a significant role in predicting coping behavior. Both fathers and mothers reported similar levels of stress, informal social support and coping. Overall, research shows that the use of problem-oriented strategies is associated with lower levels of stress in parents of people with intellectual disabilities. Interestingly, despite differences in reported stress, parents of children with delays were using similar amounts and styles of coping as parents of children without delays (Lopez et al., 2008). Morya et al., (2015) also found that the usage of similar coping patterns without regard to the severity of mental retardation. In a study of coping effectiveness among aging

mothers and fathers of adults with intellectual disabilities, Essex et al. (1999) found that greater use of problem-focused coping strategies buffered the negative impact of caregiver stress on mothers' psychological wellbeing. Also, Miller et al. (1992) in a study of stress appraisal and coping style found that the use of problem-focused coping was tied to decreased distress for mothers of individuals with intellectual disabilities.

Smith et al., (2008) investigated the impact of autism and coping style on maternal well-being. For mothers of toddlers with autism, increased use of problem-focused strategies was generally correlated with greater maternal well-being, regardless of the severity of the autistic disorder. The use of positive coping strategies has been shown to lower stress in parents of children with disabilities (Jones & Passey, 2004). In the absence of positive coping, parental stress is likely to have an effect on the child (Hadadian & Merbler, 1996). Interestingly interventions focused on parents' coping skills have reported positive results. These interventions use ideas from stress and coping theories to inform parent training in problem solving and decision-making, communication skills, skills in accessing and utilising social networks, and coping strategies such as positive self-statements, self-praise and relaxation. Some successful strategies include gaining perspective, finding meaning in an event, acceptance, positive reinterpretation, and humour (Terry & Haynes, 1998).

Stigma

Apart from personal level, society influences the disability community in many ways. As it can be seen in the current review of studies, social support became a coping strategy, and it influences the distress level of the parents directly and indirectly. When a person lacks such support from intimate relatives or society in general they may have some negative impacts. Stigma is such an impact with which a person will be labelled negatively for certain discreditable conditions, deformities, abnormalities etc. Studies on stigma are being prominent in the field of mental disorders but minimal in disability field. Most of the studies in this area adopted qualitative analysis. It is an attempt to review the causes and consequences of stigma on parents of children with disabilities.

According to Tilahun et al., (2016), most caregivers having children with developmental disability reported experience of stigma. Some of them worried about being treated differently, others felt ashamed about their child's condition and some of them made an effort to keep their child's condition secret. Stigma did not depend on the type of developmental disorder, the child's age or gender, or on the age or level of education of the caregiver. Reported stigma was significantly higher in caregivers who sought traditional help, provided supernatural explanations for their child's condition, and in caregivers of Orthodox Christian faith. Caregivers gave a mixture of biomedical explanations (e.g. head injury or birth complications) and supernatural explanations (e.g. spirit possession or sinful act) for their child's condition. The important unmet need was educational provision for their child, followed by treatment by a health professional, financial support and expert help to support their child's development. Most caregivers reported that talking to health professionals and family helped them to cope. Many caregivers also used support from friends and prayer as coping mechanisms. The nature of stigma (labelling and stereotyping; separation; emotional reactions, discrimination and power), and coping and resistance (the power of language; faith as a resource; learning, peer support and community relationships) were the key themes identified by Selman et al., (2018) in a search of stigma experienced by parents of disabled children. Children with autism were labelled and stereotyped (e.g. as 'sick', 'naughty', 'different') and parents blamed for not controlling them, this in turn resulted in social rejection and isolation. Stigma was associated with a poor understanding of autism, a lack of vocabulary related to autism in the Somali community, and prejudice against mental illness and disability. There was evidence of enacted and felt stigma and examples of discrimination. Finding their own language to describe their child's condition and drawing on faith, learning and peer support were important resources in resisting stigma. Minichilet al., (2021) portrayed that the prevalence of perceived stigma among primary caregivers of children and adolescents with mental illness was high. Factors like being mother, absence of other caregiver, poor social support, and symptoms of depression were significantly associated with perceived stigma.

Most of the studies revealed lack of knowledge, the nature of the illness itself, and behavioral symptoms as the main reasons for stigma and discrimination. Shrivastava et.al, (2011) explained that the effects of stigma were low self-esteem, and discrimination in family, work place, and society. Main areas of a person that get affected by stigma are self-esteem, social contacts, personal goals, family relationship and physical health. Stigma against people with disabilities often includes stereotyping based on misperceptions. In many cultures, physically or mentally challenged persons are considered as "dangerous, dirty, unpredictable and worthless."

According to Aldersey et al., (2018), stigma was commonly felt when people directed negative looks, used negative language and names, or refused to touch their family member with intellectual disability. Further, stigma was also directed at the family members as being the 'cause' of the intellectual disability. Family members noted engaging a range of coping mechanisms or strategies to minimise the stigma.

Dehnavi et al., (2018) revealed that internalized stigma was a predictor of mental health and autism quotient had no significant relationship with mental health of mothers of autistic children in Iran.

Heng et al., (2023) demonstrated that difficulties including hardships related to safety and supervision, challenging emotions and financial difficulties, were impacted by a lack of social support and community stigma towards disabled children. Nevertheless, parents still felt deep love for their children, perceived desired acceptance from the community and found sources of strength from faith and religious institutions.

Type and severity of disability and stigmatization

Broomhead (2019) examined the influence of the nature of children's disabilities on stigmatisation experienced by their parents. According to the findings, regardless of the nature of their children's disabilities, differential treatment was experienced by all parents. Visibility of the child's disability, evidence of behaviour deemed to be socially inappropriate and perceived controllability of the disability were the key factors determining the type of reaction from others. Parents of children with behavioural, emotional and social difficulties experienced intensely

negative reactions from others; whereas other parents experienced much pity.

Contrary to the aforementioned study, reviews revealed that there are some differential treatments in terms of different types of disabilities. About 77% of the parents of a child who received an initial diagnosis of attention-deficit hyperactivity disorder (ADHD) reported stigmatization experiences (DoasReis et al., 2010). Nearly half were concerned about how society would label their child, some of them felt social isolation and rejection, and rest perceived health care professionals and school personnel as being dismissive of their concerns. Parents' own attitudes about ADHD treatment were shaped by their exposure to negative media, their mistrust of medical assessments, and the influence of general public views. Wnoroski (2008) demonstrated that, as an often-invisible disability, autism was certainly susceptible to stigmatization against both children and parents. Conversely a Malaysian study reported that parents of child with Cerebral Palsy did not feel stigmatized (Chu et al., 2022). An Indian study conducted by Patra and Patro (2019) revealed that affiliate stigma perception is high in parents of children with autism. They also highlighted that perception of stigma is higher in mothers than fathers. From their study, it was also evident that severe autistic symptoms and female children correlate with higher stigma. Farrugia (2009) reported that a child's diagnosis with an autism spectrum disorder (ASD) is critical for parents to resist stigmatisation. Parents experienced considerable enacted stigma, but successfully resisted felt stigma by deploying medical knowledge to articulate unspoiled subject positions. The institutionalisation of medical knowledge within the autism community was critical to this process. Resistance to enacted stigma was successful to the degree that medical constructions of deviance deployed by parents were accepted by others, notably those in power within institutions. It is concluded that post structural accounts of subjectivity and social control provide a useful way of conceptualising stigmatisation.

Mourya et al., (2016) revealed that the intellectually disabled child's activity limitation was significantly and positively related with stigma and restriction in social life of parents. Stigma was also positively related to restricted social life. The study sheds light on growing need for interventions that include both behavioral and

psychosocial components to better address needs of families of children with intellectual disability. It also highlights the need for future research on culturally sensitive parenting and effective group parenting programs for families of children with mild and severe intellectual disabilities. Werner and Shulman (2013) revealed that affiliate stigma was found to be higher among caregivers of individuals with autism spectrum disorder when compared with caregivers of individuals with intellectual or physical disabilities. In a study on siblings of Down's syndrome people, Fulk (2014) found that 76% of respondents reported courtesy stigma as adolescents and 62% reported courtesy stigma as adults. The levels of courtesy stigma reported were higher in adolescence than adulthood. There was also a positive correlation between aberrant behaviors on the part of the individual with Down syndrome and higher levels of courtesy stigma reported by their siblings and an increase in courtesy stigma when the sibling with Down syndrome also had a co-morbid condition, such as autism or a lack of verbal communication skills.

Kinnear et al., (2016) demonstrated that autism behaviors contributed both to the difficulty families experienced for raising a child with autism and to the stigma processes associated with those behaviors. Stigma also played an important role in predicting how difficult life is overall for parents. Gray (1993) indicated that autism had uniquely stigmatising aspects because of the extremely disruptive nature of autistic symptoms, the normal physical appearance of autistic children, and the lack of public knowledge and understanding regarding the nature of autism. Most parents perceived themselves to be stigmatised by their child's disorder. There was a strong tendency for mothers to feel more stigmatised than fathers. Parents with more severely disabled children and children who were under the age of twelve were also somewhat more likely to perceive themselves to be stigmatised.

Rani and Thomas (2019) revealed that most of the parents of children with chronic seizures perceived reactions of others to be negative and would limit family social interaction which resulted into emotional reaction in the form of anger, guilt, fear, anxiety, and depression.

Demographic variables and stigmatization

Demographic variables influence stigma in variety of ways. Gobrial (2018)

reported that inadequate education, hygiene and stigmatization are the main problems of mothers of children with ASD in Egypt. Moreover, ASD had a negative impact on social life, emotional well-being and attachment of mothers of children with ASD. These findings provide valuable insight into the lives of mothers and show what life is really for mothers caring for a child with ASD in a lower-middle income country.

Girma et al., (2014) found a statistically significant difference in mean self-stigma between urban and rural respondents. Self-stigma of caregivers showed significant positive correlation with perceived signs of mental illness, perceived supernatural explanations of mental illness, and perceived psychosocial and biological explanations of mental illness. The only independent predictor of caregivers' self-stigma was perceived supernatural explanation of mental illness. Caregivers tried to avoid being identified with the patients. Exposure to mental health information was less. Caregivers' self-stigma was also related to perceived supernatural explanation of mental illness. Corson (2017) stated that caregivers' partnership status, exposure to problematic behaviors, and perceptions of courtesy stigma predicted desire to relinquish care.

After statistical control of children's severity of inattentive and hyperactive impulsive symptoms (as reported by parents and teachers), Mikami et al., (2015) found that parents' self-reports of greater affiliate stigma were associated with more observed negative parenting. The associations between high parental affiliate stigma and children's poorer adult informant-rated social skills and greater observed aggression were partially mediated by increased parental negativity. Further, the positive association between children's adult informant-rated aggressive behavior and parental negativity was partially mediated by parents' increased affiliate stigma.

Ryan and Runswick-Cole (2008) set out to review the ways in which mothers of disabled children have been portrayed within disability studies and the broader academic literature. They argued that within disability studies mothers of disabled children occupy a liminal position because they are often not disabled and yet they can experience forms of disablism. Their experiences can differ markedly from the experiences of mothers of non-disabled children and yet the consequences

and outcomes of these experiences, such as developing a 'special competence' are largely overlooked. Mothers can work to effect change on behalf of their children and, in some cases, for disabled people more generally; however, this role of activist mother is largely undervalued.

Shin et al., (2006) reported that mothers experienced more stress than fathers who have children with cognitive delays in Vietnam. Parent's poor economic conditions and a small social support network added additional pressure than other parents. At that time, both mother and father were under great stress when they experienced stronger stigma, although the effects were not significant when other variables were considered together in path analyses. As in traditional gender roles, mothers were more affected by the child's characteristics and the spouse's functioning. Further they worried about future problems related to the work of children rather than fathers. Concerns about family ties to the rest of the world, such as economic problems and social networks affect fathers more.

Koro-Ljungberg and Bussing (2009) investigated how parents of adolescents with attention deficit hyperactivity disorder (ADHD) manage courtesy stigma in their lives. Focus group studies were conducted with mothers and fathers of adolescents with ADHD who were part of a cohort study on ADHD detection and service use. Using grounded theory analysis, researchers found that parents reacted to external expectations put forward by various community networks, but they responded to an internalized sense of responsibility in the context of immediate family. In addition, parents' stigma management extended beyond coping with their child's disability, adding an extra layer of stressful demands that could be lessened through societal stigma reduction. They concluded that advice offered to family's needs to be individualized, carefully matched with their current support networks and priorities, and there is need to consider certain stigma management approaches that can perpetuate existing negative identity markers.

Self-Efficacy

Evaluation of one's capabilities on performing various tasks in the day-to-day life has a significant role in our life. It enables us to deal effectively with the situations and predict whether we will succeed or fail in the forthcoming tasks.

Motherhood and of course parenthood involve various responsibilities in the process of child rearing. Then what about the mothers of children with difficulties? The evaluation of competence may facilitate or inhibit further actions in the face of these challenges. These may lead to further distress in life. Hence here the researcher is attempting to review various patterns and perspectives on maternal self-efficacy relating to mothers of differently abled children.

In a recent study conducted by Zulkarnaen et al., (2022), parenting self-efficacy has been found to be a significant contributor to psychological wellbeing of mothers of children with special needs. Interestingly, Struass et al., (2022) found that parenting self-efficacy mediated the relationship between parenting stress and children's behavioural and emotional problems in fathers only.

Nurlatifah and Fikrie (2022) demonstrated a negative relationship between parental self -efficacy and stress among parents of children with special needs.

Gohari et al., (2012) did not find any significant difference between self-efficiency in mothers of children with ADHD and mothers of normal children in preschool and first grade of primary school. There were significant group differences in mothers of children in second grade of primary school. The most associated factors with parenting self-efficacy were children's age, and education level. There was no difference between self-efficacy of parents of ADHD children and parents of normal children in pre-school and first grade of primary school. However, parenting self-efficacy was significantly lower in parents of the second grade ADHD children compared to the normal group. Increase in age and education level of children with ADHD might be associated with lower level of parenting self-efficacy.

Considering and contrasting the self-efficacy beliefs of fathers and mothers, Sevigny and Loutzenhiser (2010) found that parental self-efficacy (PSE) was significantly and positively associated with, and predicted by general self-efficacy for both mothers and fathers, suggesting one's general sense of competence is important for both maternal and paternal PSE beliefs. Findings also indicated that maternal PSE was predicted by hostile or coercive parenting behaviors and child behavior problems, whereas supportive or engaged parenting behaviors emerged as

the only other variable to predict paternal PSE. Results also suggested that previously used measurement strategies of paternal self-efficacy may have identified tasks more applicable to mothers than fathers.

Interestingly Salas et al., (2017) demonstrated that self-efficacy was the variable that best explained the level of satisfaction in mothers having children with autism, whereas the use of problem solving explained a higher level of satisfaction in fathers. Men and women reported similar levels of life satisfaction. Interestingly, significant differences were found in coping strategies where women showed higher in expressing emotions and social support strategies than men. Authors pointed out that the development of functional coping strategies and of a high level of self-efficacy are peculiar key tool for adapting to caring for children with autism.

Type of disability and self-efficacy

Types of disability and self-efficacy beliefs are linked in variety of ways. Rosenblum-Fishman (2013) demonstrated that mothers having children with ASD and ADHD reported higher levels of parenting-related perceived stigma than mothers from the typical group. Although mothers of ASD and ADHD children reported lower levels of maternal self-efficacy compared to mothers from the typical group, this difference was no longer significant when child problem behaviours was controlled, indicating that maternal self-efficacy might be more related to children's disruptiveness level than a diagnostic category. Perceived stigma, child problem behaviors, and social support were all associated with maternal self-efficacy. Maternal stress mediated the relationship between child problem behaviors and maternal self-efficacy, and between social support and maternal self-efficacy.

Al-Kandari and Al-Qashan (2010) found that mothers of children with developmental disabilities did not differ in their beliefs about aspects of maternal self-efficacy according to the child's age, child's gender, and the mother's age. Mothers of children with intellectual disability, when compared to other mothers, had negative beliefs of all aspects of maternal self-efficacy. All mothers' groups had negative beliefs about their ability to control their child's behavior and their own emotions.

Auriemma et al., (2022) found that parents' beliefs regarding their self-

efficacy in the parenting role and their satisfaction with the parenting role were not significant predictors of parenting stress.

Weiss et al., (2016) found that parental self-efficacy is related to child's age, parent immigrant status, barriers to service access, and caregiver burden among parents of adolescent children with ASD.

Thorsteinsson et al., (2017) demonstrated that mothers who had a child with diabetes had lower quality of life measured by general health, vitality, social functioning, and mental health than mothers that did not have a child with diabetes. Self-efficacy, relationship satisfaction, and social support were significant predictors of quality of life (mental health domain). They pointed out the importance of adequate psychosocial support for enhancing the psychological wellbeing.

Rezendes and Scarpa (2011) found that parenting stress of parents having children with ASD mediated the relationship between child behavior problems and decreased parenting self-efficacy, and decreased parenting self-efficacy in turn partially mediated the relationship between parenting stress and increased depression/anxiety. Desjardin (2005) found that mothers of children with cochlear implants rated their child's early intervention program lower in quality, they perceived themselves as more efficacious in the care and maintenance of their child's sensory device and their involvement in developing their child's speech-language skills. Mothers of children with hearing aids had lower self-ratings of self-efficacy related to their child's sensory device and involvement in their child's early intervention program. Benzies (2013) found that maternal general self-efficacy was a significant predictor of family adjustment. In other words, maternal general self-efficacy acted as a cognitive coping resource in families having children with serious disabilities. Harty (2007) attempted to describe maternal self-efficacy beliefs within the parenting domain and maternal rating of pre-school child's language abilities, where the child has a communication disability. The results revealed that mothers generally had high self-efficacy beliefs within certain parenting roles, in spite of the fact that their child has a communication disability. The lowest competence was reported in discipline and teaching roles.

Self-efficacy, stress and related variables

Self-efficacy can be demonstrated via its relationship with depression and related variables. While studying parents of autistic children, Hastings and Brown (2002) proved that self-efficacy mediated the effect of child behavior problems on mothers' anxiety and depression, but there was no evidence that it functioned as a mediator for fathers. However, it was evident that self-efficacy moderated the effect of child behavior problems on fathers' anxiety. No evidence for the moderating effect of self-efficacy was apparent for mothers. Kuhn et al., (2006) revealed that depression, parenting stress, agency, and guilt each accounted for unique variance in maternal self-efficacy when controlling for time since diagnosis and the presence of a second child with a disability. Knowledge regarding the condition, autism, was not associated with parenting self-efficacy. Self-efficacy found to be associated with well-being, agency, and feelings of guilt among mothers of children with autism. In a study conducted by Bitsika and Sharpley (2004), over 90% of parents reported that they were sometimes unable to deal effectively with their child's behaviour. Nearly half of the participants were severely anxious and nearly two thirds were clinically depressed. Factors that emerged as significant in differentiating between parents with high versus low levels of anxiety and depression included access to family support, parents' estimation of family caregivers' expertise in dealing with the behavioural difficulties of a child with ASD, and parental health.

Self-efficacy and stigma

As part of a multidisciplinary approach to identity, Bruffel (2017) had taken a psychological perspective to the role of self-efficacy in stigma theory. Maintaining a positive sense of self is a central feature of research into stigmatised identities. Breakwell (1993) suggests that there are four motivational principles which are essential to this; self-esteem, continuity, distinctiveness and self-efficacy, yet within the stigma literature only self-esteem seems to be mentioned and it appears to be used as a general term to cover all the other principles. This is important to the work on stigma because as Bandura (1986) suggested, self-efficacy allows the individual to ‘produce their own future, rather than simply foretell it’. This study extended the work of Bruffell (2015) and examined the role of self-efficacy in stigma theory with

young mothers living in hostels in the south-east of England. Interviews were analysed with Interpretative Phenomenological Analysis and semantic content and language use were explored to identify common themes arising within the interviewees'/women's accounts. Findings indicated that having a baby provides young mothers with the opportunity to create and maintain a positive sense of self-efficacy, which might play a role in ameliorating the negative effects of living with a stigmatised label. Moreover, it would appear that whilst traditional views of stigma might have conflated the concepts of self-esteem and self-efficacy, these findings suggest that these two concepts may operate independently.

Social Support

As a social being, support is an inevitable part for human being. For every stage of lives, one seeks support from others in many ways. Researchers in the field of disability enquired and documented about the significance of social support system and its impacts on stress (Johnston et al., 2003; Kersh et al., 2006; Sarimski 1997; Smith et al., 2001; White & Hastings, 2004). These studies demonstrated a strong correlation between social support, and coping. Furthermore, it also revealed the potential of social support to act as a stress buffer (Koeske & Koeske, 1990).

Major themes emerged from a qualitative study aimed to examine the experiences of having a child with disability, were objective challenges such as, financial challenges, employment issues and demands of care; subjective challenges in the form of stigma, isolation and pity; positive experiences such as the child's progress, respect and happiness; material and financial needs; and coping mechanisms which included beliefs, support and attitudes (McNally & Mannan, 2013). Objective challenges were common and more significant than subjective challenges. According to the study, carers did not experience their roles as entirely negative as they simply need the resources to deal with objective challenges which in a developing context were not easily reachable.

Meta analytic study conducted by Boyd (2002) demonstrated an association between challenging child characteristics and a mother's tendency to seek social support, with mothers under greater stress being more prone to pursue social support. For mothers of children with autism, informal support appeared to be a

more effective stress-buffer than formal support. In addition, low social support was the most important factor in maternal depression and anxiety. Moreover Ha et al., (2011) revealed that having a child with a disability is associated with more somatic symptoms. However, the negative consequences of the child's disability on parents' mental health were reduced when parents receive greater positive support from family.

Types of disability and Social support

Different types of disability significantly differ with their impact upon caregivers. Tsai and Wang (2009) demonstrated that mothers with intellectually disabled children had a high level of strain and received inadequate social support. Major predictors of caregiver's strain were found to be mothers' health status, social support and amount of time spent as a caregiver, as well as the intellectually disabled children's dependent degree of daily living activity. According to Pearson and Chan (1993) mothers of children with learning disability showed more stress and significantly less support than those have non handicapped children.

According to Cooke (2010) social support and hope were the predictors of positive parenting behaviors in caregivers of children with intellectual deficits. Stress was found to predict positive but not negative parenting behaviors when controlling for social support.

Peer and Hillman (2012) revealed that coping style partially mediated the relationship between social support and the feeling of stress in parents of mentally retarded people. A descriptive cross-sectional study titled as perceived social support and quality of life of parents of children with autism conducted by Kuru and Piyal (2018) suggested that providing support and understanding families of children with autism and their experiences, nurses, doctors and health professionals can positively affect their health outcomes.

According to Jeong et al., (2013), level of disability, mother's health status and social support were significant predictors of the parenting stress of mothers who have children with cerebral palsy (CP). Interestingly Polita et al., (2014) found that although family received emotional, instrumental, informational and cognitive support, which were not sufficient and generated negative feelings in parents of

children with cerebral palsy. According to Kerenhappachu and Sridevi (2014) mothers of children with mental retardation showed significant difference on care givers burden than the mothers of normal children in the areas of general strain, disappointment, and emotional involvement. And there was also a significant difference in social support for mothers of children with mental retardation and mothers of normal children in the areas of support seeking and actually received support. Mothers of children with mental retardation were experiencing more caregiver's burden and seeking more social support than the mothers of normal children.

Plumb (2011) found that most families having children with ASD experienced clinically high levels of stress. Greater family resilience was associated with lower levels of stress. Interestingly, higher levels of perceived social support were associated with increased parental stress. The author explained that families who were experiencing clinically significant levels of stress seek out community supports at higher rates than other families. He also pointed out that some social connections such as attending religious services and parenting groups may potentially increase stress in parents of children with ASD.

Stylianou (2017) revealed the different stages of grief associated with mothers' journeys with their children having Cyprus. Shock, disappointment and lack of trust in doctors and other professionals were the main feelings that characterised the different stages of their journeys. In terms of support, the results highlighted differences between the formal and informal support that they received. Mothers were much less satisfied with formal than informal support. All the mothers experienced courtesy stigma of having a child with a disability. The study concluded with the assumption that in Cyprus there is still a huge gap between policy and practice.

Yaghoubnezhad et al., (2016) indicated that among mothers of children with intellectual disability, depression had a positive and significant correlation with co-dependency. According to Kenny and McGilloway (2007) parents having children with learning disability showed high levels of objective and subjective caregiver strain and most were receiving inadequate support. However, parents employed a

range of strategies to help them cope more effectively. The qualitative data shed light on the difficulties and rewards of care giving and the inadequacies of current service provision. Sipal and Sayin (2013) studied the impact of having a child who is deaf on maternal depression and how social support facilitate coping with the depression caused by deafness as well as the parenting behaviors of those mothers. Results showed that 24.4% of the mothers showed depression and perceived social support from family and friends were found to be predicting depression. According to them, depression was found to be affecting authoritarian and hostile parenting styles. Perceived social support from friends and significant other did not have significant effect on parental attitudes. The findings showed that having a child who is deaf caused high levels of depression in mothers which leads to insufficient and/or inappropriate parenting attitudes. Furthermore, social support acts as a protective source lowering depression levels of mothers as well as indirectly facilitating the maintenance of positive parenting.

While investigating the challenges experienced by mothers having children with cerebral palsy in Zambia, Singogo et al., (2015) found that mothers had experienced social isolation and marital problems, as well as negative attitudes from family, friends, community members and health care professionals. The physical environment created access challenges because of a lack of sidewalks, ramps, functioning lifts and small indoor space.

Barakat and Linney (1992) reported that social support was found to be related to higher maternal psychological adjustment and to higher child adjustment, and maternal psychological adjustment was related positively to child adjustment among mothers of children with Spina bifida. Kronenberger and Thompson Jr. (1992) revealed that mothers (having children with Spina bifida) with more supportive families and marriages and less conflicted and controlling families reported lower levels of psychological symptoms. Coping strategies directed at friends were related to more symptoms.

Suzuki et al., (2018) found that maternal psychological distress was increased by higher severity of children's developmental disability and decreased by higher family resiliency. Moreover, there was a significant interaction between the

severity of children's disability and family resiliency, where family resiliency moderated the relationship between maternal psychological distress and the severity of children's disability.

Different levels or severity of disability yields different results. Carlson and Miller (2017) reported that mothers' perceptions of the severity of their child's disability (epilepsy) were associated with decreased perceived social support, which in turn related to higher reported levels of depression and anxiety. Furthermore, low levels of perceived social support partially mediated the relation between family burden and depression, anxiety, and stress. However, mothers' perceptions of the severity of their children's disability and family burden were not related to their reports of emotion-focused or social support seeking coping. Though, their use of emotion-focused and social support seeking behaviors was related to lower levels of depression.

Impact of social support

A recent study conducted by Park and Lee (2022), demonstrated a moderating effect of social support is between parental stress and depression among mothers of children with disabilities. They suggested social support as a critical resource preventing negative effect of parental stress on depression.

Different types of support system provide different results. Meral and Cavkaytar (2012) demonstrated that emotional support sub field was being the highest perceived one and the lowest perception is in care support sub field. Family social support sub field is on the average. Important predictors of the social support perception were the social support resources formed by family, friends or significant others. According to them densest support resources amongst all is family. Moreover, it was also found that household income per month is the secondary predictor of social support perceptions of parents.

Wang (2016) examined the association between perceived, received, informal, and formal social support and parental stress level among American and Chinese parents of young children (ages 0-6) suspected or diagnosed with ASD. Results showed that a high percentage of parents in both samples experienced high levels of parental stress. American parents' stress levels decreased as their perceived

support increased. However, none of the four types of social support, individually or combined, were significantly associated with parental stress among Chinese parents.

According to Wang et al., (2017) family support and friend support had mediating effects on the relationship between parenting stress and life satisfaction among Chinese mothers having children with cerebral palsy. In addition, the mediating effect of friend support was equal to family support. Study suggested the importance of increasing support from family and friends to lessen the parenting stress and help improve life satisfaction in mothers of children with cerebral palsy.

Macdonald (2011) revealed a decrease in reported feelings of anxiety and depression with greater use of social support among parents of children with ASD. They also suggested that informal sources of support might be particularly important. Furthermore, increased use of emotional-based coping was reported to be increased the feelings of depression and anxiety.

An ethnographic study by Ellison (2006) pointed out that social support from both informal and formal networks was significant in the lives of families of children with disabilities. Parents generally viewed their formal and informal networks as supportive and vital to the daily care of their child with disabilities. Ethnicity was not found to be a marked source of variation in families' perceptions of social support. An interpretation of this finding was that families who have a child with a disability come to share common experiences with other parents of children with disabilities. Medical views of disability, religious beliefs, views of normalcy, labelling, stigma and discrimination were found to be factors influencing how families viewed their child with a disability. These factors influenced parental beliefs regarding the diagnosis, treatment, and prognosis of their child's condition.

Duvdevany and Abboud (2003) found a relationship between informal support resources, and the marital and economic stress of the Arab mothers having children with special needs; the higher the amount of the informal support resources, the lower the level of stress that was experienced by the mothers. Amount of support resources was positively related to personal well-being of the mothers. However, education and place of living were not related to level of stress or personal well-being.

According to Davis and Payne (2009) parental perceptions and experiences of family-centred professional support was one of the strongest predictors of family quality of life. The perceived intensity of child behavioural problems as well as support from extended family members also accounted for a significant proportion of unique variance in predicting quality of family life. The study also shed light on importance of a family-focused approach to intervention that acknowledges and provides support that is tailored to the unique needs of each individual family.

Comparison of Support system available for fathers and mothers

While considering the difference in support received by fathers and mothers, Fonseca et al., (2014) revealed that fathers directly benefited from the support they received from friends in reducing their burden, while mothers only indirectly benefited from it through the father's adjustment. Interestingly, mothers directly benefited from the support they received from their family in reducing their stress levels, while fathers benefited both directly from the support they received from friends and indirectly from the support that their partners received from family. The study pointed out the different support needs of mothers and fathers (due to their different roles during transition to parenthood) and the diffusion of benefits of social support within the couple should be taken into account when developing strategies to promote support to families.

Deris (2005) conducted a study to identify the forms of social support that mothers and fathers of children recently diagnosed with autism perceive as being most important. Results indicated that both fathers and mothers ranked "information on how I can help my child" as the most important support and "help with transportation" as the least important support. Overall, fathers' preferred instrumental (goods, services, financial assistance, and information) types of supports, such as, "financial help for expenses." Mothers' preferred emotional (someone to talk to about problems, feelings, and attitudes) types of supports, such as, "contact with other parent(s) who experienced the same situation." "involvement with a church or strong religious beliefs", "special equipment to help meet my child's needs", "financial help for expenses", "participation in an organized parent support group", and "information on how I can help my child" were significant.

Large number of studies demonstrates the relationship and impact of social support on stress, anxiety and depression levels and related variables relevant to the concerned area of interest. Gill and Harris (1992) have investigated the hardiness and social support as predictors of psychological discomfort in mothers of children with autism. Interpersonal support and commitment were found to be the predictors of depression. The hardiness in total became the predictor of somatic complaints. There was a significant correlation between hardiness and perceived social support.

Weiss et al., (2013) demonstrated that perceived self-efficacy and social support mediated the link between the pile-up of stressors and family hardiness, and that hardiness was a partial mediator in explaining how stressors were associated with family distress.

Findler et al., (2016) examined the role of stress, attachment, guilt and social support on subjective happiness among mothers of children with disabilities. General anxiety is associated with negative happiness, and mediates the relationship between anxiety, support, and specific anxiety. Guilt and happiness are negatively linked and balanced between attachment anxiety and support and happiness. The study highlighted the importance of engaging in social support for happiness and shed light on the unique role of guilt in promoting or inhibiting happiness.

Felizardoa et al., (2016) revealed significant differences between groups of parents in the partial results of parental stress, specifically in the Hyperactivity/Distract (DI), Acceptability (AC) and Adaptability (AD), dimensions of the Child Domain subscale (CD stress) and the Role Restriction (RO), dimension of Parent Domain subscale (PD stress). With regard to social support dimensions, they found significant differences between parents in the extent and availability of the social support network.

A longitudinal study, conducted by Pozo and Sarria (2011) revealed sense of coherence (SOC) as a predictor of stress of mothers of children having ASD. It also indicated the permanence of stress levels and behavior problems and the effects of reduced social support and increased SOC levels.

Jones et al. (2014) found out that psychological acceptance act as a mediator variable for maternal anxiety, depression, and stress, and for paternal depression.

General mindfulness and mindful parenting had significant mediation effects for maternal anxiety, depression, and stress. These results contribute to evidence that mindfulness and acceptance may be important parental psychological processes, with implications for parent support.

Jeong et al., (2013) revealed that level of disability, mother's health status and social support were significant predictors of the parenting stress of mothers having children with cerebral palsy. A negative relation has been found between social support, depression, anxiety and anger among parents in the study of Gray and Holden (1992). The age of manifestation of symptoms was positively linked with depression. Cuzzocrea et al., (2016) compared parental stress, coping strategies and social support perceived in families of children with low functioning autism, high functioning autism, Down syndrome and parents of typically developing children and found significant differences among groups in all of the variables considered. They suggested the advisability of fostering functional coping strategies and social support received in families of children with disabilities, and especially in those with children with low functioning autism.

According to Ozyazicioglu and Buran (2014), as the degree of disability of the children increased and the income levels decreased, the trait anxiety scores of the parents increased. It was also found a significant negative correlation between parental age and social support. Among the parents, 37.3% experienced problems with their spouses after having a child with a disability.

While going through the studies pertaining to psychological distress of mothers of differently abled children, researcher found little published studies in India especially of Kerala. There is lack of scales in native language also. As the studies portrayed ethnicity/cultural aspects also played role in dealing with disabled child, it is very important to understand what is happening in this culture. Indeed mixed results on variables were also seen. Thus researcher decided to conduct the study based on the following objectives and of hypothesis.

Objectives

1. To explore the psychological distress of mothers of children with disability.
2. To find out the relationship between social support, parental self-efficacy, affiliate stigma and psychological distress of mothers of children with disability.
3. To find out the predictors of psychological distress of mothers of children with disability.
4. To find out the influence of social support, parental self-efficacy, affiliate stigma on psychological distress of mothers of children with disability.
5. To find out the influence of certain demographic variables on psychological distress of mothers of children with disability.

Hypotheses

1. There is a significant correlation between social support, parental self-efficacy, affiliate stigma and psychological distress of mothers of children with disability.
2. Social support, parental self-efficacy, affiliate stigma are the significant predictors of psychological distress of mothers of children with disability.
3. There is significant influence of social support, parental self-efficacy and affiliate stigma on psychological distress of mothers of children with disability.
4. There is a significant influence of certain demographic variables on psychological distress of mothers of children with disability.

CHAPTER 3
METHOD

For the systematic execution of any research, method plays a significant role. Research method constitutes all those methods or techniques used by the investigator during the course of studying his/her research problem. As the blueprint of the entire research, method covers a master plan specifying the techniques and procedures for collecting and analysing the relevant data or information. Here the chapter on method gives the details of this study (with whom to how it is conducted). In the beginning, there was only a limited published works available in the area of interest in Indian perspective especially of Keralites. With the current study, the researcher tried to explore the psychological distress of mothers of differently abled children.The investigation also intended to find out how all those factors associated with psychological distress influence and linked with each other. To explore the same, researcher adopted particular methods and techniques. The study plan is comprised of the selection of the participants, mode of data collection, identifying the definite area of further investigation, and analysis.

The present study followed the mixed method design, which is characterized by the combination of at least one qualitative and one quantitative research component. In this, researcher collect both narrative and numerical data, employ both structured and emergent designs, analyse their data via statistical and content analysis. It also integrates the inferences drawn from both set of data. Since the researcher needed clearer framework of psychological distress, an initial exploration of psychological distress has been carried out for the current study. Based on this exploration, the quantitative study was executed. Thus the whole study has two sections.

- **Section 1**: Exploration of Psychological distress among mothers of children with disability.
- **Section 2**: Quantitative data collection and analysis

Section 1: Exploration of Psychological distress among mothers of differently abled children

In this stage the investigator planned to explore the factors associated with psychological distress among mothers of differently abled children. For this, it was decided to conduct a qualitative study.

A preliminary small-scale investigation can serve as a guide for the larger study. In the current study, the investigator planned to get clear cut idea of experiences of psychological distress of mothers of differently abled children. Indeed, through this study, the researcher can get a general framework of the factors associated with the psychological distress.

Participants

Participants of the study consisted of 21 mothers of differently abled children including intellectual disability, cerebral palsy, autism, learning disability, ADHD, speech and language problems and the like; selected from Community Disability Management and Rehabilitation Programme (CDMRP) advanced clinic at Calicut University campus. Participants were aged between 23 to 46 years. Out of which 17 mothers were qualified matriculation and the remaining 4 were educated at degree level. Out of 21, fourteen mothers had male children and seven had female children with certain kind of disability. Children were aged between four to 14 years.

Inclusion Criteria

1. Mothers of children with developmental disabilities.
2. Mothers who were visiting CDMRP clinics for therapies to their children.

Instrument

1. A semi structured interview schedule was used to elicit information on psychological distress of mothers of disabled children. The interview comprised of questions that focused on different areas such as demographic information, experiences of having a disabled child, and how they adapt with the situation. Probing questions were also asked where necessary to obtain information, clarify a point, or expand on ideas. A copy of semi-structured interview schedule is appended as Appendix-A

Procedure

Investigator first contacted the Director and other professionals of community disability management and rehabilitation programme (CDMRP) at the Department of Psychology, University of Calicut to get permission to collect data from different community clinics of the same. After getting approval from the authorities, a comfortable place in the clinic was selected and arranged for the data

collection. The investigator selected the mothers who were visiting with their child for therapies randomly from the clinic. All the participants were approached personally, a self-introduction was given. They were first informed about the details of current study. They are also requested to sign in the consent form. After establishing a good rapport, face to face semi structured interview was carried out to collect the research data. Each interview took approximately 20 to 40 minutes.

With the permission of the participants, the researcher also used a voice recorder to record the interviews. Thus, use of audio recorder ensured that a detailed account of the interview was captured.

Data Analysis

Thematic content analysis was employed to analyze data. Thematic content analysis involves identifying, analyzing and reporting patterns (themes) within data and minimally organizes it and frequently it goes further than this, and interprets various aspects of the research topic (Braun & Clarke, 2006). The researcher made recordings and notes of the interviews conducted. The recorded tapes were encoded and interpreted using the tones and contrast in the voices of the participants. This data was then transcribed. The researcher repeatedly read the transcribed data as well as listening to recording to pin point key words, trends, and themes. The key themes were identified and transformed into codes.

Section 2: Quantitative Data collection and analysis

Based on the qualitative data analysis, researcher carried out the quantitative data collection and the analysis. Details are given below.

Participants

In the present study, participants consisted of 289 mothers of disabled children including Intellectual disability, cerebral palsy, autism, learning disability, ADHD, speech and language problems and the like; selected from Community Disability Management and Rehabilitation Programme (CDMRP) advanced clinic at Calicut university campus and different community clinics of CDMRP at Calicut, Kannur Districts.Participants are aged between 26 to 65 years. Further details of participants and of their children and family are presented in the following tables.

Table 1

Details of Age of the participants

Age of the mother	Frequency	Percent	Cumulative Percent
26-35	101	35	35
36-45	140	48.4	83.4
46-65	48	16.6	100
Total	289	100	

Table 1 shows the age category of the mothers. For the current study age has been classified as 26 to 35, 36 to 45 as well as 46 to 65 years. There are 101 mothers in the 26 to 35 category (35%). About 48.4% mothers were aged between 36 to 45 years (N=140). Furthermore there are 48 (16.6%) mothers with an age range of 46 to 65 years.

Table 2

Details of Education of the participants

Education of the mother	Frequency	Percent	Cumulative Percent
Up to 9Std	65	22.5	22.5
10 to 12Std	160	55.3	77.8
Degree	50	17.4	95.2
PG and above	14	4.8	100
Total	289	100.0	

Table 2 gives the education level of mothers in this study. There are 65 mothers studied up to 9^{th} standard (22.5%). Majority of the participants (N=160) were educated between 10^{th} to 12^{th}level (55.3%). There are 50 mothers with degree qualification (17.4%). Only 14 mothers have qualification PG and above (4.8%).

Table 3

Details of working Sector of mothers

Sector of Job of mothers	Frequency	Percent	Cumulative Percent
House wife	256	88.6	88.6
Government sector	17	5.9	94.5
Private Sector	2	.7	95.2
Own Initiatives	7	2.4	97.6
Coolie	7	2.4	100.0
Total	289	100.0	

Table 3 shows the details of working sector of mothers and its frequencies. There are 256 mothers who reported no job/house wife category. It is the majority category (88.6%). There are 17 mothers having government job (5.9%). Two of the mothers were working under private sector (.7%). There are seven mothers (2.4%) who were designated as business personalities (own initiative). Another seven mothers (2.4%) reported their job as coolie.

Table 4

Details of Type of Disability of the child and frequencies

Type of disability	Frequency	Percent	Cumulative Percent
Intellectual disability	102	35.3	35.3
Intellectual disability+Autism	1	.3	35.6
Down's Syndrome	39	13.5	49.1
ADHD	13	4.5	53.6
Autism	44	15.2	68.9
Learning Disability	32	11.1	79.9
Multiple Disability	24	8.3	88.2
Cerebral Palsy	34	11.8	100.0
Total	289	100.0	

Table 4 shows the type of disability and its frequencies. According to table 4, there are 102 mothers (35.3%) of children with intellectual disabilities participated in the current study. Majority participants fall under this category. One child was reported with both autism and intellectual disability. There are 39 children with Down's syndrome (13.5%). There are 13(4.5%) mothers who reported Attention

deficit Hyper Active disorder in their children. In addition there are 44 (15.2%) mothers with children having autism. Learning Disability is reported among 32(11.1%) children; Multiple disability among 24(8.3%) and cerebral palsy among 34(11.8%).

Table 5

Details of number of children of the mother

Number of children	Frequency	Percent	Cumulative Percent
1	28	9.6	9.6
2	213	73.7	83.3
3	34	11.8	95.1
4	8	2.8	97.9
5	4	1.4	99.3
6	2	.7	100
Total	289	100.0	

Table 5 portrays the details of total number of children of the mother and its frequencies. There are 28 mothers (9.6%) who have only one child, ie., the child with disability. The majority (73.7%) of the mother have two children (N=213). There are 34 mothers with three children. Among the participants, eight mothers (2.8%) have four children. Four mothers have five children. There are two mothers with six children.

Table 6

Details of Age at delivery of the mother

Age at delivery	Frequency	Percent	Cumulative Percent
19 to 34	268	92.7	92.7
35 and above	21	7.3	100
Total	289	100	

Table 6gives the details of delivery age of the mother (of the child with disability). Age has been classified as 19 to 34 and 35 and above. There are 268 mothers who delivered their child at the age range of 19 to 34 years. Only 21 mothers were classified under 35 and above category (7.3%). That is, the majority of the mothers delivered their disabled child during the 19 to 34 years of their age.

Table 7

Details of socioeconomic status of the participants

Socio Economic Status	Frequency	Percent	Cumulative Percent
Above Average	14	4.8	4.8
Average	178	61.6	66.4
Below Average	97	33.6	100.0
Total	289	100.0	

Table 7 shows the socioeconomic status (SES) of the participants. The SES has been classified as above average, average and below average. Here it can be seen that about 14 mothers were classified under above average category (4.8%). Further, the majority of the participants (61.6%) fall under the category of average level. The frequency of this category is found as 178. In the below average level, there are 97 participants with a percentage of 33.6.

Table 8

Details of Age of the child with disability

Age of the child	Frequency	Percent	Cumulative Percent
3-10	128	44.2	44.2
11-18	161	55.8	100
Total	289	100	

Table 8gives the age category of child with disability and its frequencies. For the current study, the age has been grouped into 3 to 10 years and 11 to 18 years. There are 128 children who are aged between 3 to 10 years (44.2%). The remaining 161 children fall under the category of 11 to 18 years age group (55.8%).

Table 9

Sex of the child and its frequencies

Sex	Frequency	Percent	Cumulative Percent
Male	169	58.5	58.5
Female	120	41.5	100.0
Total	289	100.0	

Table 9 shows the sex of the child and its frequencies. While collecting data,

the researcher collected some information of their disabled child for better understanding. There are 169 male children (58.5%) and 120 female children (41.5%). That is majority of the mothers of this study have male children.

Table 10

Details of birth order of the child and its frequencies

Birth order	Frequency	Percent	Cumulative Percent
1st born	155	53.6	53.6
2nd born	99	34.3	87.9
3rd born & Later	35	12.1	100
Total	289	100.0	

Table 10 shows the details of birth order of the child and its frequencies. There are 155 children who were first born (53.6%). About 34.3 % of children were second born (N=99). About 12.1% of children (N=35) were third born or later.

Table 11

Details of number of children having disability in the family

Number of other children having disabilities	Frequency	Percent	Cumulative Percent
0	265	91.7	91.7
1	24	8.3	100.0
Total	289	100	

Table 11 shows the details of number of children having disability in the participants' family. As per the table 265 mothers (91.7%) have no other children with disabilities. At the same time about 8.3% participants,(N=24) mothers have children with certain disabilities.

Table 12

Details of Sector of Job of fathers

Working Sector of fathers	Frequency	Percent	Cumulative Percent
No job	10	3.5	3.5
Government sector	29	10.0	13.5
Private Sector	61	21.1	34.6
Farmers	4	1.4	36.0
Coolie	185	64.0	100.0
Total	289	100.0	

Table 12 shows the working sector of fathers of child with disability. There are 10 fathers having no jobs (3.5%). About 10% of fathers works under government sector (N=29). Under private sector, there are 61 fathers (21.1%). Among the total sample participants, there are 4 farmers (1.4%) and 185 (64%) fathers are reported as coolie workers.

Instruments

To measure the variables which are derived from the qualitative phase, different research instruments were selected from authorized publishers. It was assured that the instruments were suitable for the culture, where the study was conducting.

At the same time researcher did not get relevant instruments on variables such as, parental self-efficacy and affiliate stigma of the special population concerned in Malayalam language. Thus, researcher decided to develop research instruments on these two variables. The details of the test construction have been given as separate chapter. To collect personal details of the participant a personal data sheet was used.

The instruments selected were as following:

Psychological Distress Scale

Psychological Distress Scale developed by Saheera and Manikandan (2015) was used to measure Psychological distress of the participants. The scale consists of 18 items: of these, 4 items measures stress (1 to 4), 7 items (5 to 11) belong to anxiety and the last 7 items (12 to 18) correspond to depression.

Scoring

The response categories involve ‘Never’, ‘Rarely’, ‘Sometimes’, ‘Most of the times’ and ‘Always’, the corresponding scores are 0, 1, 2, 3, and 4 respectively. The items in the scale were constructed in a positive direction, and higher the score, higher is the degree of stress, anxiety and depression experienced. The sum total of all the items constitutes Psychological Distress.

Reliability and Validity

The authors calculated Cronbach Alpha for establishing the reliability of Psychological distress scale and it was found to be .87 for the whole scale. The reliability of the subscales was reported as .58 for stress, .78 for anxiety and .84 for depression. Face validity was also established by the authors for the scale. A copy of Psychological Distress Scale is appended as Appendix-B.

Perceived Social Support Scale

This scale was developed by Zimet, et al., (1988) for measuring perceived social support of individuals. It is a 12 item scale based on 5 point Likert type scale. The scale consists of three subscales namely-perceived support from family, friends and of significant others.

Scoring

The response categories are as 'Strongly agree', 'Agree', 'Undecided', 'Disagree', 'Strongly Disagree'; the corresponding scores are 5, 4, 3, 2 and 1 respectively. Items 1, 2, 5, and 10 are belonging to support from Significant others, items 3, 4, 8, and 11 corresponding to family support and the remaining items 6, 7, 9, and 12 are belonging to support from friends. Sum of these three dimensions constitutes Perceived Social Support of an individual. All the items in the scale were worded in positive direction and higher the score higher the perceived social support and viz versa.

Reliability and Validity

The reliability of the scale was estimated through Cronbach's Alpha and it was found to be .83. Reliability of the subscales was found to be .91 for significant others; .87 for family, and .85 for friends. Since the scale is based on theoretical assumption, it has construct validity. A copy of Perceived Social Support Scale is appended as Appendix-C

Affiliate Stigma Scale

The Affiliate stigma scale is used to measure the stigmatization experiences of mothers having children with disability. With the three dimensions (cognitive, affective and behavioural) the extent of stigmatization can be measured. Currently there were no published scales on the same. Hence the researcher developed the scale for the study. The details of the test development procedure are given in

chapter "Test Development" titled as Development of Affiliate Stigma Scale.

Parental Self-Efficacy Scale

Parental Self-Efficacy Scale is used to measure the caregivers' or parents' confidence about their ability to successfully raise the children. Since there are no published Parental Self-Efficacy scales in Malayalam, the researcher developed Parental Self-Efficacy Scale. The details of the test development procedure are given in chapter "Test Development" titled as development of Parental Self-efficacy Scale.

Personal Information Schedule

The basic personal details of the participants were collected by using Personal information schedule. It is like an interview schedule. Socio demographic details such as child's age, sex, class, type of disability, mothers' age, father's age, and their job, number of children, educational qualification, family type, total members in the family and the like are included in this sheet. Numerical codes were assigned to each question in the schedule. A copy of Personal Information Schedule is appended as Appendix-D.

Data collection and analysis

Here, the researcher collected data using the research instruments and newly developed scales.

Procedure

Initially, for the permission to collect data from Community Disability Management and Rehabilitation programme (CDMRP) at the Department of Psychology, University of Calicut, as well as from different community clinics of CDMRP, investigator contacted the Director and other professionals (therapists) working at CDMRP . After getting approval from the concerned authorities, a comfortable place in the clinic was selected and arranged for the data collection. The investigator randomly selected the mothers who were visiting with their child for therapies randomly from the clinic. All the participants were approached personally and a self-introduction was given. They were first informed about the details of current study. They are also requested to sign in the consent form. After getting the signed consent form and establishing a good rapport, the four research instruments and personal data sheet were given to the mothers of disabled children from

different places of Malappuram, Kozhikode, Palakkad, Kannur and Thrissur districts who have been consulting for therapies in CDMRP clinics. They were asked to read instruction carefully and were briefly told about the purpose of the study and assured about the confidentiality of the responses. It is also assured that, they had responded to all the items in the research instruments. After completion, the instruments were collected back and scored as per the scoring scheme; then the collected data were entered into spread sheet for further statistical analysis.

Statistical Analysis

Based on the objectives and hypotheses set forth earlier for the study, appropriate statistical techniques were selected. The statistical techniques used by the investigator were descriptive statistics, 't' test, correlation, regression, and ANOVA. A brief description of the statistical techniques is described.

Descriptive statistics

This involves measures such as Mean, Median, Mode, Standard Deviation, Skewness, and Kurtosis of the scores.

't' test

A t-test is an analysis of two populations' means through the use of statistical examination**.** In other words, it can be used to determine whether two groups of data are significantly different from each other. It will be most commonly used when test statistic would follow a normal distribution if the value of a scaling term in the test statistic were known. The t-statistic was introduced in 1908 by William Sealy Gosset.

Correlation

Correlation is the measurement of the extent to which pairs of related values on two variables tend to change together. It also gives a measure of the extent to which values on one variable can be predicted from values on the other variable. If one variable increases with the other, the correlation is positive (near to + 1). If the relationship is inverse, it will be a negative correlation (near to - 1). A lack of any correlation is signified by a value close to zero.

Regression

In statistics, regression analysis is a statistical process for estimating the

relationships among variables. It includes many techniques for modelling and analysing several variables, when the focus is on the relationship between a dependent variable and one or more independent variables (or 'predictors'). Regression analysis helps one understand how the typical value of the dependent variable (or 'criterion variable') changes when any one of the independent variables is varied, while the other independent variables are held fixed.

ANOVA

The set of procedures generally known as ANOVA (analysis of variance) are powerful parametric methods for testing significance where more than two conditions are used, or even when several independent variables are involved. In other words it is the statistical method used to compare the variance across the Means (average) of different groups. There are different set of ANOVA procedure based on the number of independent groups. One way ANOVA is the most common used model to determine whether there are any statistically significant differences between among the means of three or more independent groups of one dependent variable/factor. Models like two-way ANOVA, three-way ANOVA, etc., are the extension of one way ANOVA. The difference is in the number of independent variables in the analysis. In addition to the main effect of each independent variable on a single dependent variable, these models also help the researcher to find out the interaction between them.

TEST DEVELOPMENT

The exploratory phase yielded information on various social and personal facets associated with psychological distress of mothers of children with disability. The societal support they may get or perceive; the stigmatization they experience as a mother etc. has to be studied extensively to understand the phenomenon clearly. In addition various personal factors such as confidence as a competent parent may also play role on psychological distress of mothers. From these assumptions, for the present study, the investigator decided to collect further data on social support, parental self-efficacy and affiliate stigma of mothers having children with disabilities using research instruments.

Considering Parental Self Efficacy, according to Bandura (1997) task-level parental self-efficacy may be more predictive of actual performance of parental behaviours as 'specific self-efficacy beliefs guide a person's behaviour and dictate how well activities are performed'. Despite scales such as Parenting Sense of Competence Scale (PSOC) (Johnston & Mash, 1989), parenting scales (Arnold et al., 1993) are available in literature, there were no published research instruments in Malayalam to measure Parental Self-Efficacy.

People associated with children having disability/mental illness etc. may experience affiliate stigma. There are various scales available in the literature related to measure affiliate stigma. Among them, The *Affiliate Stigma Scale* (ASS) (Mak & Cheung, 2008) is the widely used instrument to measure *affiliate* stigma in the caregivers of individuals with various types of mental illnesses. It has been widely adapted in many countries for measuring the variable. Nevertheless, as in the case of Parental Self-Efficacy, there were no published Malayalam scales on Affiliate Stigma specifically for parents of children with disabilities. Hence, it is need of the hour to develop research instruments for measuring parental self-efficacy and affiliate stigma of mothers of disabled children suitable for Malayalam speaking population. For this, researcher forced to develop instruments for Affiliate Stigma and Parental Self-Efficacy.

This chapter deals with the development and standardization of Affiliate Stigma Scale and Parental Self Efficacy Scale. The various steps of the development of each scale are described under separate headings.

Development of Affiliate Stigma Scale

Introduction

According to Susman (1994) stigma is the adverse reaction to the perception of negatively evaluated difference. Public stigma is a type of stigma in which a group of people may be stigmatized or devalued on the basis of some kind of negatively attributed difference such as colour, incompetency etc. When these negative public notions are internalized by the individuals involved it is termed as self-stigma. When the stigma is internalized by the people associated with the stigmatized person it is called as courtesy stigma otherwise known as affiliate stigma.

In this society disability is mostly associated with stigmatization experiences. Beyond the level of person's with disability, it is extended to the people associated with the person having disability; mostly the family members. Raising and rearing children with disability entail challenges in many ways. Beyond the personal level, the societal attitude also matters in this case. Mostly primary caregivers are the victims of affiliate stigma; especially the mothers. By internalizing the stigma they tend to feel more stress, guilt, embarrassment, shame, helplessness, inferiority, etc (Zhang, et al., 2018).

Mak and Cheung (2008) opined that affiliate stigma is comprised of cognitive, affective and behavioural component. For instance, the manifestation of affiliation starts from the negative thoughts related to the association with disabled one to the social withdrawal. The negative feelings and distress associated with stigmatization yields negative impact on caregiving tasks; thereby affect rehabilitating the people. For a better understanding on the issue is necessary for identifying and implementing interventions for both parties.

The nature and peculiarities of culture, ethnicity, education etc. are connected with stigmatization in many dimensions. Despite instruments are available for measuring affiliate stigma in connection with mental illness, HIV etc across the world, most studies are conducted qualitatively to understand the nature of stigma in India. Considering educational and cultural realm of Kerala, there is scarcity of studies on the issue. For the better understanding on the topic, there is a need of developing an instrument in native language.

Preparation of items

The investigator reviewed previous literature on affiliate stigma and conceptualizing the idea about theoretical framework of the same. Based on the theory and previous studies, researcher decided to develop a multi-dimensional scale consisting of 25-30 items with 5 point Likert type (Strongly agree to Strongly disagree) anchors. Initially 35 items were prepared in native language (Malayalam) and it was distributed among the experts in the field of psychology (Professors, and senior most research scholars who are well versed in psychometrics and affiliate stigma) and experts from other fields like counselling and Malayalam Language in order to rectify any correction and to ensure the quality of statements. After obtaining the comments and suggestions, some items were deleted; some were added and some of them were edited. After this editing process the draft scale consisted of 17 items.

Try out

In order to understand how the respondents receive, perceive and respond to the statements, it was administered among 20 mothers who were visiting CDMRP for therapies to their children in the various clinics. According to their comments and suggestions some of the items were modified. And also the participants reported that they have no difficulty in understanding and marking the response as well.

Method

Participants

For the development of this instrument data were collected from 271 mothers of disabled children including mental retardation, cerebral palsy, autism, learning disability, ADHD, speech and language problems and the like; selected from various disability management and rehabilitation programme clinics from Calicut, Malappuram, and Kannur districts. The age of the participants ranges from 23 to 50 years.

Instruments

1. Affiliate stigma scale (Draft): It consists of 17 items in Malayalam language with 5 point Likert type response category. The scale was designed in such a way that it could be answered by anyone who can read and write in Malayalam.

The responses can be marked on the right side of each statement. Instructions were clearly printed on the top of the scale and subject would take approximately 10 minutes for responding to the items. A copy of the Affiliate Stigma Scale (Draft) is appended as Appendix-E.

2. Personal Data sheet: Personal data was indeed to collect details such as age, education, occupation, age, sex and type of disability of the child.

Procedure

Participants of this study were selected from a community disability management centre.After obtaining the consent from the concerned authorities of rehabilitation centre, researcher approached the mothers personally, and provided a brief introduction about the study. A good rapport was established with the parents, and purpose of the study was explained. Informed consent was taken and the participants were firmly convinced that their identity and information gathered will be treated confidential and used for research purpose only. The personal details were collected in personal data sheet. After giving the general information, proper instructions were given to fill the affiliate stigma scale. It was ensured that they had responded to all the items in the scale. Instruments were scored as per the scoring scheme and the collected data were entered into spread sheet for further statistical analysis.

Results and Discussion

This part discusses the various steps in the construction and standardization of valid scale for measuring affiliate stigma of mothers of children with disability. There are so many arguments regarding the selection of items from a pool of items, here the researcher adopted a combination of the traditional as well as new methods for selecting an item, establishing its psychometric properties etc.

Item Analysis

The responses of all participants in each item were entered into a spread sheet and loaded into a statistical software. There are many methods available for items selection. Here the investigator decided to calculate the corrected item-total correlation (Point Biserial Correlation), discriminating power (t-value) and factor loading of each items in the instrument. The criterion for selecting an item for the scale was as follows. If an item achieve a corrected item-total correlation of 0.25 or above (Seema, n.d), discriminating power greater than 2.58 (t value) as proposed by Edwards (1957) and item loading 0.45 or above will be included in the final scale. The details of the computations are given in the following tables.

Table 13

Item statistics (Item total Correlation and Discriminating Index)

Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted	Discriminating Index (t-value)
Item1	31.79	224.602	.599	.924	12.613
Item2	31.68	221.046	.695	.922	21.435
Item3	32.29	225.458	.708	.922	11.615
Item4	32.29	222.983	.770	.920	14.967
Item5	32.07	223.142	.686	.922	14.514
Item6	32.32	225.219	.704	.922	11.446
Item7	32.22	220.112	.802	.919	15.480
Item8	32.27	230.651	.578	.925	8.774
Item9	32.22	228.254	.588	.924	9.905
Item10	32.06	225.153	.537	.926	11.294
Item11	31.68	224.520	.559	.926	14.251
Item12	31.48	223.877	.584	.925	14.504
Item13	31.91	224.159	.612	.924	14.498
Item14	32.07	230.066	.492	.927	7.112
Item15	32.39	226.674	.667	.923	9.949
Item16	32.50	228.322	.674	.923	8.996
Item17	32.69	233.660	.596	.925	6.568

From table 13, it can be seen that all the 17 items in the affiliate stigma for mothers of differently abled children significantly discriminate the low and high scorers in the Affiliate Stigma Scale. All the calculated‘t’ values were above 2.58

($p < .01$). When the corrected item-total correlations were scrutinized, all the items were found to have a correlation above 0.25. Then all these 17 items were analysed for factor structure by principal component method with varimax rotation. The details of factor analysis are presented in table 14.

Table 14

Exploratory Factor Analysis of Affiliate Stigma Scale

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.154	47.964	47.964	8.154	47.964	47.964	4.336	25.504	25.504
2	1.489	8.759	56.722	1.489	8.759	56.722	3.437	20.220	45.724
3	1.311	7.711	64.433	1.311	7.711	64.433	3.181	18.709	64.433
4	.868	5.106	69.539						
5	.769	4.525	74.064						
6	.714	4.201	78.265						
7	.630	3.704	81.969						
8	.528	3.107	85.077						
9	.504	2.965	88.042						
10	.428	2.518	90.560						
11	.351	2.064	92.624						
12	.288	1.694	94.318						
13	.262	1.539	95.857						
14	.218	1.285	97.142						
15	.208	1.221	98.362						
16	.177	1.039	99.401						
17	.102	.599	100.000						

From table 14, it can be seen that there are three factors with Eigen value above one. These factors constitute a total variance of 64.433 (Factor 1 =25.504, Factor 2 =20.220, Factor 3 =18.709). The table 15 gives the results of varimax rotation and the resultant component matrix with three factors. Items are clustered in components (factors) either in one, two or in three. The preset criteria for

selecting an item was those items which have a factor loading 0.45 or above. As per the table all the items under the three factors have a factor loading of 0.5 or above. Thus all the items in the scale satisfied the criteria of factor loading and hence decided to keep all the 17 items in the scale (Field, 2005).

Table 15

Rotated component matrix of Affiliate Stigma Scale

Items	Component		
	1	**2**	**3**
Item3	**.831**	.123	.307
Item4	**.812**	.263	.285
Item1	**.788**	.158	.108
Item2	**.752**	.264	.203
Item5	**.700**	.297	.229
Item6	**.633**	.284	.374
Item7	**.550**	.512	.376
Item11	.155	**.787**	.118
Item12	.098	**.704**	.321
Item10	.363	**.653**	-.028
Item9	.312	**.641**	.143
Item13	.130	**.631**	.424
Item8	.261	**.533**	.301
Item17	.262	.145	**.772**
Item15	.271	.273	**.754**
Item16	.295	.287	**.735**
Item14	.174	.121	**.711**

After the careful examination of the meaning and nature of the items loaded under component one, two and three, it was clear that these items are measuring three dimensions of affiliate stigma and are named as cognitive, affective, and behavioural components. In this first seven items were related to cognitive aspect (component 1); next six items with affective component (Component 2); the last four items with behavioural aspect (Component 3). Cognitive dimension of affiliate stigma involves the thinking patterns of mothers who have child with certain

disability. Specifically of negative thoughts related to the close relationship with the disabled child. The Affective factor is comprised of the emotional aspect of internalised stigma associated with the situation. Behavioural component involves the responses to the outer environment with these particular experiences of internalised stigma. Affiliate stigma of mothers of differently abled children in general involves the perception of stigmatization associated with rearing a child with disability.

The importance of affiliate stigma scale arises where the primary caregivers could not identify their problems related to the mental health. Most often they are facing distress in many dimensions one which is related to the stigmatization. For instances the "less" feeling outside the world because of the child with disability, tendency to withdraw from the society etc. Further they could not tackle the situation. Indeed, they could not seek professional help for them and of their child's condition due to this. For developing better interventions for rehabilitating the disabled community, the professionals can eliminate such negative tendencies from the primary care giver. Thus identification of the same is needed. The affiliate stigma scale developed here can be used in this regard for the Kerala community who can read and comprehend Malayalam language.

Reordering of the items

There were 17 items in the draft scale. Researcher utilized all those items throughout the analysis process like, item analysis, factor analysis etc. The serial numbers of the items in the same factors were not continuous and also difficult to organise the score in each component. Hence the items were re-numbered and re-arranged from item one (1) to seventeen (17). The initial item number and newly assigned serial number (final item number) Mean, Standard deviation, and N in each item is presented in table 16.

Table 16

Items and descriptive statistics of each item in the Affiliate Stigma Scale

Initial Number	Final number	Group	N	Mean	SD
Item 3	Item1	Low	54	1.24	.799
		High	54	3.67	1.166
Item 4	Item2	Low	54	1.11	.317
		High	54	3.87	.891
Item 1	Item3	Low	54	1.04	.191
		High	54	3.11	1.298
Item 2	Item4	Low	54	1.09	.293
		High	54	3.39	1.089
Item 5	Item5	Low	54	1.07	.428
		High	54	3.57	1.191
Item 6	Item6	Low	54	1.00	.000
		High	54	3.15	1.379
Item 7	Item7	Low	54	1.00	.000
		High	54	3.63	1.248
Item 11	Item8	Low	54	1.07	.428
		High	54	2.76	1.345
Item 12	Item9	Low	54	1.07	.428
		High	54	3.11	1.449
Item 10	Item10	Low	54	1.09	.486
		High	54	3.50	1.489
Item 9	Item11	Low	53	1.04	.192
		High	54	3.65	1.320
Item 13	Item12	Low	54	1.20	.711
		High	54	3.89	1.160
Item 8	Item13	Low	54	1.06	.231
		High	54	3.67	1.303
Item 17	Item14	Low	54	1.41	1.091
		High	54	3.22	1.525
Item 15	Item15	Low	54	1.06	.408
		High	54	3.06	1.420
Item 16	Item16	Low	54	1.02	.136
		High	54	2.83	1.476
Item 14	Item17	Low	54	1.00	.000
		High	54	2.37	1.533

Reliability & Validity

Reliability of the three dimensions were calculated by the method of Cronbach Alpha and found to be .91 for the cognitive component and .82 for the affective component and .82 for behavioural component. The reliability for the whole scale was found to be .92. Face validity of the scale was also assured by experts' opinion. A copy of the final scale is appended as Appendix-F

Scoring

Affiliate Stigma scale is a three dimensional scale which provides an extent of person's affiliate stigma experiences. It is a five point Likert scale with response category as Strongly Agree (5), Agree (4), Undecided (3), Disagree (2) and Strongly disagree (1). All the items in the scale are worded positively and scored 1 to 5. The sum total of items from one to seven constitutes the cognitive component. The next six item's total constitutes affective; and the last four with behavioural component. Sum total of the total items constitutes Affiliate Stigma score.

Conclusion

For the better understanding of human behaviour, psychologists always tend to quantify and measure behaviour with scientifically developed instruments. Due to its social relevance affiliate stigma is a very important variable to study in the field of rehabilitation psychology. The current study tried to develop a reliable and valid instrument to measure the variable affiliate stigma for the Malayalam speaking population exclusively for the parents of disabled children. Following the procedures in test construction yielded a three dimensional 17 item scale which can measure affiliate stigma of a person associated with disabled child.

Development of Parental Self-Efficacy Scale

Introduction

The concept of self-efficacy was coined by Bandura (1997), preceding the development of social cognitive theory in which he put forward an explanation for performance in certain tasks based on the reciprocities of personal factors (e.g.,cognitive , biological and affective events) as well as environmental events. Self-efficacy provides an insight into how a person may behave, how much effort he or she will put into the task, and how long the person will remain stand before the obstacles or aversive situation (Bandura, 1997).

Based on individuals' interpretation of their own performance, their own abilities by watching others perform a task, their response to social persuasion as well as their physiological and emotional states people gauge their self-efficacy (Bandura & Adam, 1977). Furthermore, Gist and Mitchell (1992) contributed three more core processes which determine self-efficacy. According to them, in the first phase, there is an assessment on various requirements of tasks to be completed. Secondly there is an analysis on past performance. Thirdly an analysis of various personal and situational factors may take place to understand the resources and obstacles required in order to complete a task.

The Bandurian framework itself demonstrated that the beliefs about the self-efficacy are associated with requirements and dimensions of referent tasks occurring in a specific context (Coleman & Karakker, 1998). Thus self-efficacy can be conceptualized in terms of dynamic, emergent system rather than a global, fixed personality trait. Altogether, measurements of the competencies may also be changed across population and of specific situations.

According to Jone and Prinze (2005) parenting self-efficacy (PSE) can be defined as the caregivers' or parents' confidence about their ability to successfully raise the children. Though the term parental self-efficacy is related to parental confidence, competence and esteem they are different terminologies. As Bandura (1997) argued parental confidence refers to the strength of a belief about a task, but it does not specify what it is meant by the strength of the belief is about. But parental self-efficacy covers both strength of belief and an interpretation of capability based

on that belief. While considering parental self-esteem, it is one's judgement of worth as a parent; whereas parental self-efficacy is one's judgement of personal capability to fulfil the role of a parent (Bandura, 1997). Furthermore parental competence is the ability to complete a task successfully and efficiently (Pearsall & Hanks, 1998), in terms of others' perspectives of how well the task will be completed rather than a parents' own judgement as in parental self-efficacy.

Coleman and Karakker (1998) described the meaning of the parental self-efficacy construct and explored the relevant empirical findings and explained its effects on parenting. They identified eight measures of parental self-efficacy and provided the psychometric properties on their reliability and validity. Jones and Prinze (2005) found that parental self-efficacy is strongly correlated with positive parenting and child functioning, child adjustment, parenting competence and satisfaction. Parenting skills such as responsive, stimulating and non-punitive caretaking (Unger & Waudersman, 1985) as well as positive maternal health (Kwok & Wong, 2000) have found to be associated with higher maternal self-efficacy. In contrast, maternal perception of child difficulty is related to lower level of maternal self-efficacy (Coleman & Karakker,1998).

Though the literature provides various measures on parental self-efficacy these English versions are not suitable to Malayalam speaking people. More over the study is focused on mothers of disabled children. Parenting a child with disability is a challenging task in many ways. Persistent caring, time allocation, financial requirement and other household tasks and the like make it more challenging. Indeed the 'psychological investment' on child condition is also a concern. Hence the tasks in this particular condition may not be as in general condition. Tasks may be much more difficult and situational factors may also be changed. In this regard, a general self-efficacy scale may not be appropriately measure the specific task oriented efficacy beliefs of the particular population. Keeping this in mind, researcher decided to develop an instrument which can be useful in understanding the parental self-efficacy of parents of disabled children.

Planning and item writing

Literature reviews provided a framework for developing an instrument which

can measure parental self-efficacy especially of parents of differently abled children in Malayalam language with minimum number of items. Primarily it was decided to construct a one-dimensional scale consisting of around 10 to 15 items with 5point Likert type (Agreement format- Strongly agree to Strongly disagree) anchors. Initially 23 items were prepared in native language (Malayalam) and it was distributed among the experts in the field of psychology (Professors, research scholars, counsellors, and teachers in developmental disability etc.) and experts from the field like counselling and Malayalam literature in order to rectify any correction and to ensure the quality of statements. After obtaining the comments and suggestions, some items were deleted; some were added and some of them were rewritten. At the end there were 18 items in the draft scale. A copy of the draft scale is appended as Appendix-G

Try out

This scale has been developed to measure parental self-efficacy of the parents with disabled children (especially mothers). In the context of Kerala while interacting with the mothers of disabled children, it was found that their mother tongue is best way to elicit responses. The parental self-efficacy scale is utilised Malayalam language for developing the instrument. Hence to know how the respondents welcome and respond to the newly developed parental self-efficacy scale, it was given to 20 mothers who were consulting the CDMRP clinics, University of Calicut along with their children for therapies. After getting comments from them some corrections were incorporated in the scale. They were also requested to comment the nature and styles of items and responds options; they reported no difficulty in understanding the statements and marking the response as well.

Method

Participants

Participants of the study consists of 175 mothers of disabled children including Intellectual disabilities, cerebral palsy, autism, learning disability, ADHD, speech and language problems and the like; selected from various disability management and rehabilitation programme clinics from Calicut, Malappuram,

Calicut University campus, and Kannur districts of the state of Kerala. The age of the participants ranges from 23 to 50 years.

Instruments

1. Parental self-efficacy scale: Parental self-efficacy (draft) scale consists of 18 items in Malayalam language with 5 point Likert type response category was used to measure parental self-efficacy. The scale was designed in such a way that it could be answered by any person who can read and write in Malayalam. The responses were marked on the right side of each statement. Instructions to mark their response were clearly printed on the top of the scale and respondents would take approximately 10 minutes to complete the items.
2. Personal Data sheet: Personal information such as age, education, occupation, sex and type of disability of the child etc., were collected using personal data sheet

Procedure

Participants of the study were selected from the Community Disability Management and Rehabilitation Programme (CDMRP) clinics. After obtaining permission from the Director CDMRP, the researcher approached the mothers personally, and given a brief introduction about the study. A good rapport was established with the parents, and purpose of the study was explained. Informed consent was taken and the participants were firmly convinced that their identity and information gathered will be treated confidential and used for research purpose only. The personal details were collected in personal data sheet. After giving the general information, proper instructions were given to fill the parental self-efficacy scale. It was ensured that they had responded to all the items in the scale. After completion, the instruments were collected back, checked, scored as per the scoring scheme and the collected data were entered into a spread sheet for further statistical treatments.

Results and Discussion

This part discusses the various steps in the construction and standardization of valid scale for measuring Parental Self-Efficacy of mothers of children with disability. There are so many arguments regarding the selection of items from a pool

of items, here the researcher adopted a combination of the traditional as well as new methods for selecting an item, establishing its psychometric properties etc.

Item Analysis

The responses of all subjects in each item were entered into a spread sheet and loaded into statistical software. There are many methods available for items selection. Here the investigator decided to calculate the corrected item-total correlation (Point Biserial Correlation), discriminating power and factor loading of each items in the scale. The criterion for including an item in the parental self-efficacy scale was as follows. If an item gets corrected item-total correlation of 0.25 or above (Seema, n.d), discriminating power greater than 2.58 (t-value) as suggested by Edwards (1957) and item loading 0.45 or above will be selected for the final scale. The details of the analysis and the results are given in the following tables.

Table 17

Item statistics (Item total Correlation and Discriminating Index)

Item	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted	Discriminating power(t- value)
Item 1	68.56	146.398	.396	.906	6.14
Item 2	68.64	140.023	.674	.898	12.42
Item 3	68.70	140.719	.577	.900	8.93
Item 4	68.36	149.666	.287	.909	4.69
Item 5	68.67	143.934	.438	.905	7.76
Item 6	68.53	137.337	.737	.895	13.73
Item 7	68.74	140.251	.658	.898	11.63
Item 8	68.18	144.706	.560	.901	7.83
Item 9	68.65	140.541	.637	.899	11.22
Item 10	68.56	142.386	.559	.901	8.40
Item 11	68.40	144.993	.492	.903	6.75
Item 12	68.65	139.871	.693	.897	11.61
Item 13	68.60	143.040	.564	.901	9.05
Item 14	68.75	141.586	.586	.900	9.88
Item 15	68.87	138.867	.629	.899	12.94
Item 16	68.72	140.620	.583	.900	10.02
Item 17	68.44	142.872	.541	.901	7.57
Item 18	68.13	145.699	.518	.902	6.31

From table 17, it can be seen that all the 18 items in the parental self-efficacy (draft) scale significantly discriminate the low and high scorers in the scale. All the calculated 't' values were above 2.58 ($p<.01$). Similarly the corrected item-total correlations were examined and all items satisfied the set criteria of 0.25 or above. Then the 18 items were undergone factor analysis to know the factor loading of each item to the factor "Parental Self-Efficacy". The details of the factor analysis are presented in table 18.

Table 18

Factor Analysis of parental self-efficacy Scale

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.143	39.682	39.682	7.143	39.682	39.682
2	1.239	6.884	46.565			
3	1.208	6.714	53.279			
4	1.033	5.740	59.019			
5	.960	5.335	64.354			
6	.868	4.820	69.175			
7	.776	4.309	73.483			
8	.687	3.816	77.299			
9	.599	3.326	80.626			
10	.552	3.067	83.693			
11	.491	2.729	86.422			
12	.489	2.715	89.137			
13	.408	2.269	91.406			
14	.400	2.225	93.631			
15	.336	1.864	95.495			
16	.320	1.780	97.275			
17	.307	1.708	98.983			
18	.183	1.017	100.000			

From table 18, it can be seen that there is only one factor was extracted with Eigen value more than one. This factor constitutes a total variance of 39.682. Table 19 gives the component matrix of the factor analysis. The criteria for selecting an item for the final scale was those items which have a factor loading of 0.45 or above.

All the items except item number 4 have a factor loading above 0.45. Thus all the items in the scale except item number 4 satisfied the criteria of factor loading and hence decided to keep all other 17 items in the draft scale (Field, 2005).

Table 19

Component matrix of parental Self-Efficacy Scale

Item	Component
Item 6	.784
Item 12	.749
Item 2	.728
Item 7	.726
Item 9	.702
Item 15	.698
Item 14	.649
Item 3	.640
Item 16	.638
Item 13	.626
Item 10	.625
Item 8	.614
Item 17	.595
Item 18	.565
Item 11	.557
Item 5	.491
Item 1	.450
Item 4	.326*

***Item removed from the draft scale*

Reordering of the items

There were 18 items in the draft scale. Researcher utilized all those items throughout the analysis process like, item analysis, factor analysis etc. When the factor loading of items in the scale were examined, item number 4 was found to have factor loading below 0.45. Since the item not satisfied the preset condition (factor loading 0.45 or above), item 4 has been deleted from the final scale. There by the serial number of the items has been changed hence the items were re-numbered and arranged from item one '1' to '17'. The initial item number and newly assigned serial number (final item number), Mean, Standard deviation, and N of each item are presented in table 20.

Table 20

Initial item number, Final item number, Mean and SD of each item in the Parental self-efficacy scale

Initial item number	Final item number	Group	N	Mean	S D
Item 1	Item 1	Low	47	4.62	0.945
		High	47	3.21	1.250
Item 2	Item 2	Low	47	4.89	0.375
		High	47	2.85	1.063
Item 3	Item 3	Low	47	4.64	0.870
		High	47	2.79	1.122
Item 5	Item 4	Low	47	4.70	0.883
		High	47	3.00	1.216
Item 6	Item 5	Low	47	5.00	0.000
		High	47	2.72	1.136
Item 7	Item 6	Low	47	4.79	0.549
		High	47	2.85	1.000
Item 8	Item 7	Low	47	4.96	0.292
		High	47	3.55	1.194
Item 9	Item 8	Low	47	4.85	0.465
		High	47	2.87	1.115
Item 10	Item 9	Low	47	4.81	0.680
		High	47	3.13	1.191
Item 11	Item 10	Low	47	4.85	.659
		High	47	3.45	1.265
Item 12	Item 11	Low	47	4.85	0.465
		High	47	2.94	1.030
Item 13	Item 12	Low	47	4.85	0.416
		High	47	3.28	1.117
Item 14	Item 13	Low	47	4.68	0.695
		High	47	2.89	1.026
Item 15	Item 14	Low	47	4.79	0.508
		High	47	2.66	1.006
Item 16	Item 15	Low	47	4.72	0.579
		High	47	2.85	1.142
Item 17	Item 16	Low	47	4.79	0.690
		High	47	3.17	1.291
Item 18	Item 17	Low	47	4.91	0.282
		High	47	3.72	1.263

Reliability and Validity

Reliability of the scale was established by calculating the internal consistency of items (Cronbach Alpha) and it was found to be .90. The scale was distributed among experts for comments regarding the items and its content, and they commended its suitability to measure parental self-efficacy. A copy of the parental self-efficacy scale is appended as Appendix-H.

Scoring

Parental self-efficacy is a five point Likert type scale with response category as Strongly Agree (5), Agree (4), and Undecided (3), Disagree (2) and Strongly disagree (1). All the items in the scale are worded positively and scored 5 to 1. Sum of the scores of all items in the scale constitute an index of the individuals' parental self-efficacy.

Conclusion

For better specifications and prediction of human behaviour, testing and quantification of the variables is important. The scientific nature of psychological research can be strengthened by this process. Initial search for such scales resulted in various general self-efficacy scales. No published work on the special population was available. Based on the theoretical assumptions and interviews conducted with the sample, the researcher planned and executed the scale development. Following the principles of test construction yielded a 17 item scale with satisfactory psychometric properties; which can measure parental self-efficacy of parents of children with disabilities.

CHAPTER 4
RESULTS AND DISCUSSION

This chapter describes the results obtained through the analysis of collected data. Since the current study is conducted in two phases as mixed method design, the investigator adopted the contiguous approach to integrate the results. In contiguous approach, the integration of results involves the presentation of findings within a single report, but the qualitative and quantitative findings are reported in different sections. Hence here the results are presented in two sections. In the first section, the investigator describes the results of qualitative study. This section demonstrates all those stages relating to the analysis of qualitative data and obtained results of the present study. In the next section, based on the quantitative measures, the statistical analysis carried out and results and discussions are presented.

Section 1- Qualitative Analysis

The aim of the present study was to explore the psychological distress of mothers of disabled children. In the first phase investigator collected data with the help of semi structured interviews with mothers of children with disability. On the basis of experiences they shared, the researcher identified themes which are relevant to the question under study through thematic analysis.

Thematic analysis is the process of identifying patterns or themes within qualitative data in other words, the patterns in the data which are relevant to the research question or interest. As suggested by Braun and Clarke (2006) researcher first attempted to familiarize with the data collected by interviews. Secondly, initial codes were generated. In this, the data were organized in a meaningful and systematic way. This process reduces data into small chunks of meaning. As the research questions were specific to the exploration of psychological distress, the analysis was done on the basis of theoretical thematic analysis rather than inductive one. In other words the investigator coded only the segments of data which are relevant to the research question. In inductive analysis it has to be line-by-line coding. Despite there are variety of ways in coding the data, here the researcher used open coding. In open coding, pre-set codes are absent. In accordance with the coding process, the codes may be developed or modified.

After the initial coding process completed, the themes have identified. As aforementioned, a theme is a pattern that is significant or relevant to the research question. After thorough examination of codes, the codes which are clearly fitted together were transformed into distinct themes.

The details of coding are tabulated in the table 21

Table 21

Open code, Selective code, and subthemes of thematic analysis done

Open Code	Selective Code	Subthemes
"I don't know what will happen after my death"(35)	Concerned about future	Concern of future
"I am nothing ..i don't know.."(15)	Low self esteem	Self doubt
"ente kuttam kondaayikkum ithokke…"	Self criticism/blaming	Self doubt
"It is too much to manage whole things in a house"(32)	Increased responsibilities	Roles and responsibilities
"Adutha oru kutti undayal enthakum nnareela…"(2)	Fear of being pregnant	Concern of future
"Eppalum vishamaanu…"(21)	Sadness	Emotion
No one can be trusted in this world(11)	Lack of trust	Self doubt
"Enthokkeyo oru pediyaanu…arumillathond…"	Feeling of insecurity	Emotion
In many ways I am a failure(17)	Feeling of being a failure in life	Self Doubt
She is not supporting me(33)	In-law problem/conflicts(doubt etc)	Multiple roles+ stereotyped gender roles
Always I needed to be there behind him/her(of the child)(26)	Constant child rearing	Roles and responsibilities
"I don't know who will look after my child after my death"(36)	Concerned about child's future	Concern of future
I needed to depend on husband..in laws..(24)	Financial dependency	Economic
Unlimited works are there in home(15)	Increased household works	Roles and responsibilities
May be my unknown sins are came in this way(12)	Blaming as the cause of child condition	Guilt/Self blame
Husband is not supporting(18)	Lack of support(emotional, financial)	Social support
I tend to feel sorrow when I see other children(24)	Comparison with other children without disabilities	Social/child Characteristics
Family itself made me alone(25)	Humiliating nature of family members	Social support
People try to taunt us..(21)	Negative comments from others	Social support

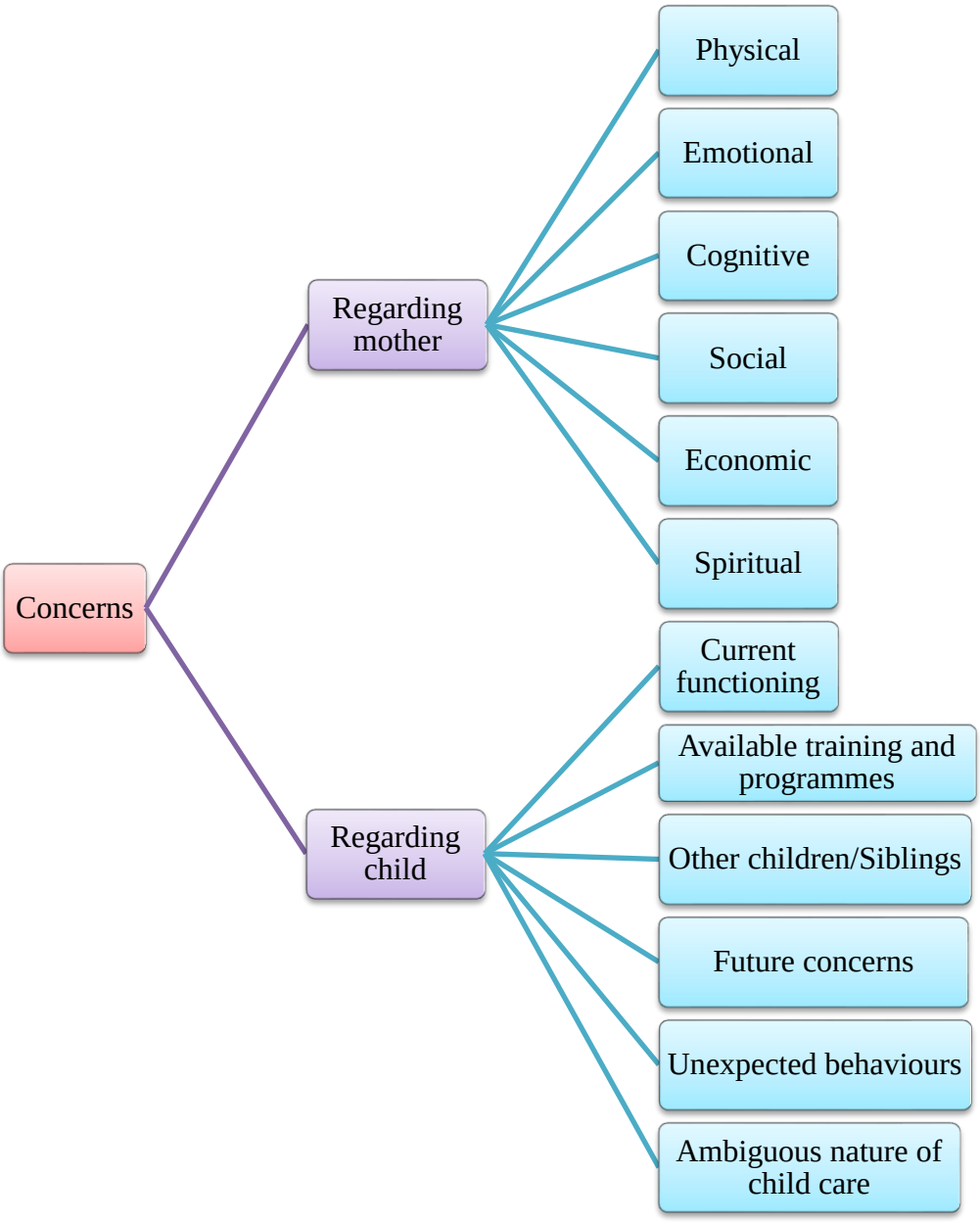
Open Code	Selective Code	Subthemes
She tends to irritate me with negative words while going for therapy(5)	Negative attitudes of mother in law while going for therapies	Social support
I don't have close friend(14)	Lack of close relationship	Social support
I don't know how to interact with others(29)	Inhibition for interaction	Social support
They comment negatively(19)	Irritating nature of neighbours	Social support
I don't get support(26)	Lack of support	Social support
At times I feel facing people makes problems(15)	Difficulty in facing people	Social support+ Self doubt
People stare at my son(5)	Staring	Social support
"Aalkkark ennem kuttiinem kaanumbo bahyankara sympathiyaa.."(4)	Sympathy of others	Social support
Often felt excluded from family functions(25)	Exclusion from get together	Social support
I myself tend to withdraw from functions(24)	Withdrawal from get together	Social support+ self Doubt
He is not supporting me when I feel sad(15)	Lack of emotional support from partner	Social support+Emotion
Kettyon purathaanu…anganeyonnum varuthilla(11)	Absence of partner in home	Social support+ lack of physical/ proximal support
He is not concerned about child(28)	Indifferent nature of partner towards child condition	Social support
He tends to show unexpected behaviour mostly(29)	Behavioural difficulties	Child characteristic
My second child is not getting enough care from my side(6)	Unmet needs of siblings	Family+ Roles and responsibilities
Mostly I couldn't help my child for his needs(21)	Unmet needs of disabled child	Roles and responsibilities+ Guilt
He is not like this every time(21)	Unexpected nature of child	Child characteristic
I needed to attend him all the time (39)	Time management difficulties	Roles and responsibilities
I don't know much about it. He is only having difficulty in studying(12)	Lack of knowledge regarding child condition	Child characteristic
I don't know what will happen for him after sometime(41)	Future of child	Future
I am unemployed(21)	Unemployment	Economic
Not studied much(26)	Illiteracy	Self Doubt
We have only coolie for	Low income	Economic

Open Code	Selective Code	Subthemes
nadanpani(25)		
Loan is there(11)	Debt/loan	Economic
Child and family members are suffering from different disorders…they need costly medicines(29)	Expensive medicines etc.	Economic
We need much money for living today"(24)	Increased expenditure	Economic
Travelling and medicines are costly(25)	Travelling, therapy	Economic
"nalloruveetilla"(14)	Lack of infrastructure	Economic
I don't know what to do sometimes.(29).	Inability to tackle situations	Ambiguous nature of parenting
Sometimes I think being died(15)	Negative thoughts	Emotion/congition
I can't manage such situations(16)	Feeling of incompetency	Cognition
I surrender myself to God(12)	Prayer	Spirituality
I used to visit temple(4)	Religious activities	Spiritual+ Rituals
I have sleep related problems(19)	Sleep disturbances	Physical difficulties
In addition to caring child, aged parents are also there(19)	Aged parents	Roles and responsibilities
I have blood pressure.sugar etc..(10)	Life style diseases- own and family members	Physical difficulties+ Roles and responsibilities
I tend to be more tensed without no reason(28)	Tension	Emotion
I don't know what to do next(26)	Anxiety	Emotion
Often I feel extreme sadness (16)	Distress	Emotion

Table 21 displays the open codes (their frequencies in brackets), selective codes and subthemes identified by the thematic analysis done for exploring the psychological distress of mothers of children with disability.

From the themes emerged by the analysis, it is evident that the mothers feel distress in a variety of ways which cannot be limited to a particular aspect. Various social and personal factors play a major role in developing the distress in these mothers. Mothers described their psychological distress mainly from following themes- cognitive, emotional, behavioural, physical, economic, social, and spiritual as well as child characteristics. Figure 1 and Figure 2 portray the overall picture of the analysis.

Figure 1
Summary of thematic analysis of exploration of psychological distress of mothers of children with disability- Major themes



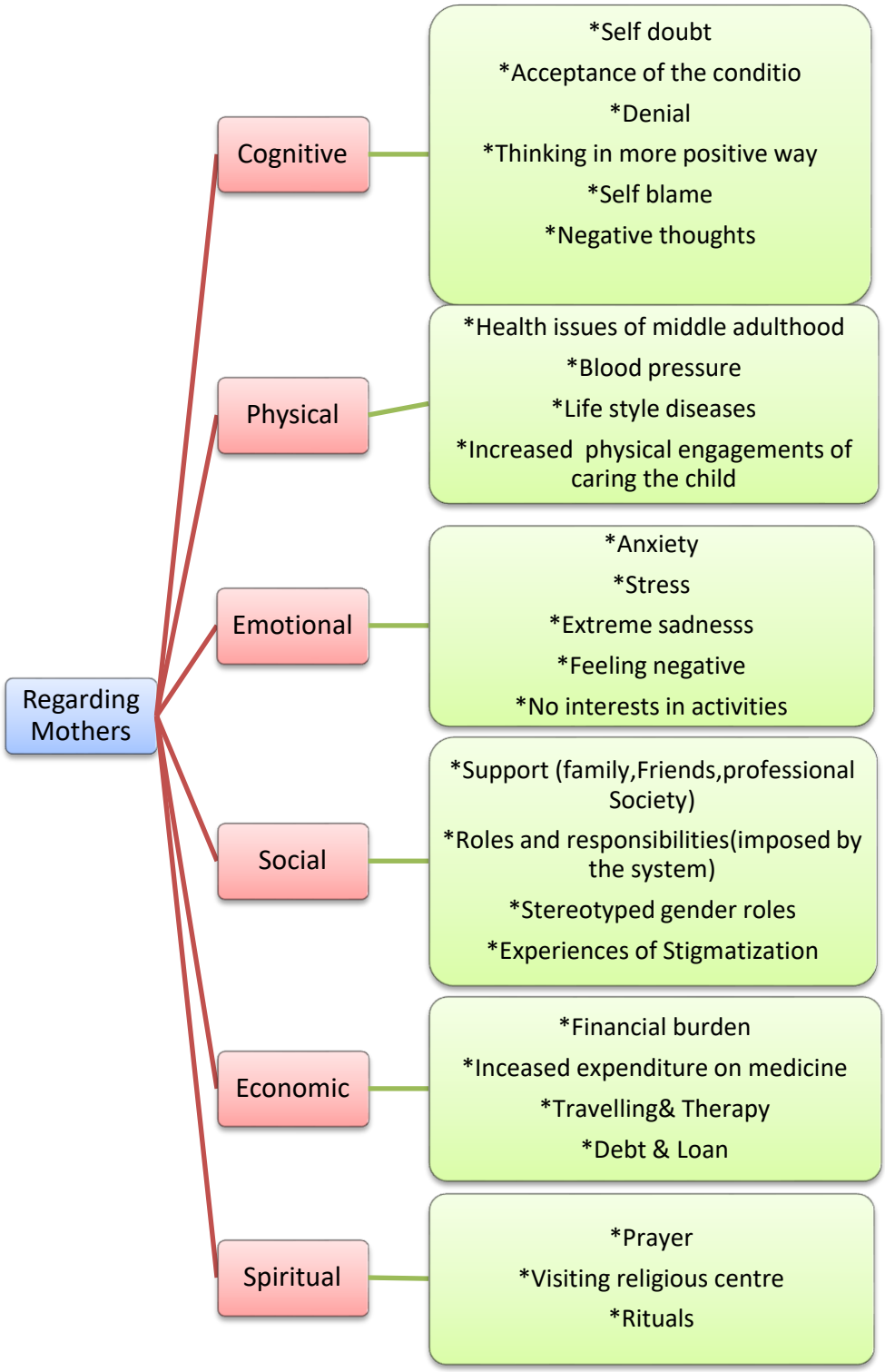
In Figure 1, the concerns are classified as concerns regarding mothers and of children with disabilities. On the basis of this, the themes are arranged. Concerns of mothers include themes such as cognitive, emotional, physical, economic, social, and spiritual aspects. Child related themes are current functioning, available training and programmes, other children and siblings, concerns of future, unexpected behaviour, and ambiguous nature of child care.

Figure 2, describes the subthemes of concerns regarding the mother. In cognitive level the subthemes are self-doubt, helplessness etc. The emotional level is comprised of the themes- anxiety, stress, extreme sadness etc. Concerns on physical aspects are composed of health related issues and ailments of the participants. Economic concerns are pertaining to the financial burdens associated with the participants. Social perspective includes the support availing from family, friends, society, stigmatization etc. Spiritual level includes the activities related to manage the distress levels-visiting religious centres, following rituals etc.

After the careful examination of the themes identified (with two more experts in the field to ensure the reliability), it is decided to define each major themes. For the current study the major themes concerning mothers are cognitive, emotional, physical, economic, social, and spiritual. In the following section a detailed description on each theme is given.

Figure 2

Summary of thematic analysis of exploration of psychological distress of mothers of children with disability- Sub themes



Firstly, while considering the cognitive concerns, these are various thinking/thought processes associated with having a child with disability. It may be in terms of self doubt, self blame, accepting or denying the condition, the belief in oneself as an effective parent or not, view things in more positive way etc.

Mothers reported various issues ranging from negative thoughts to inability to tackle the situation.

A common pattern can be seen while talking with the mothers about the child condition and life in general. Mothers tend to think in a way that is more inclined to negativity. They described themselves as 'unlucky lady' in the world. As they have less hope about their child and success of their lives as well as they always feel helplessness from inside and outside they are mostly showing negative thoughts. More often they have a tendency to think in way that the condition is the result of their 'sins, and they are 'being punished by the almighty'.

Most of the mothers expressed their self-doubt on the ability to manage the stressful life situations. They feel embarrassed in adapting to the situation especially in the case of child condition. Often they try to manage or overcome the stressful events by praying, attending religious talks, think about the positive qualities they have, talking or clearing the doubts with more knowledgeable individuals in the field of disability and the like, thinking the disability as a 'gift from God'.

One among the important ways which they manage their stress was of support seeking from various resources. Starting from family, friends, and of professionals like doctors, psychologists, physiotherapists, special educators, speech pathologists and occupational therapists etc. By assuring involvement of family members especially husband and siblings of the child in helping the household and related tasks they tried to manage the difficulties. They also seek support from professionals in clarifying their doubts and concerns of their child condition. As per their reports, to some extend these clarifications made them to feel relaxed. In addition they also report that their interactions with other parents having children with disabilities made them to alleviate some stress. Some of the statements are given below:

"...I tend to feel relaxed when some responsibilities are shared with family…my husband is supportive…my elder son is also helping me in doing household tasks…."

"...I had so many doubts about the condition…this made me to feel so stressed…but when I came to know the facts from this doctor(in clinic) my tension has been decreased ...I thought I can do nothing for my child in my life….but now…I have some hope…"

"…This place (clinic) itself is a blessing for me…I can talk with other parents having similar issues…by sharing our concerns I feel relaxed for some extend…they also feel the same…"

Majority of the participants emphasized the role of their spiritual/religious beliefs in alleviating stressful situations. Through which they tried to interpret the condition in terms of 'why the almighty gave the child to them' and surrendered everything to God through prayers. Some of them termed it as God's experiment. Some others described it as *"the almighty knows the child is safe at my hand….that is why he chosen me as the mother of him/her".*

"...I used to go temple…it is a tension free place where I can open my mind…"

"... Niskaaram (prayer) made me to feel free ...I surrender myself to The Almighty…"

Furthermore, they also tend to reframe the situations in a more positive way. Although everybody knew their children's limitations, they were all tend to feel happy even when a mild improvement seen while therapeutic session attended. Some of them look forward in a more optimistic way. They tend to think like 'this will all change….he can at least do his/her day today tasks'.

"...As I found he is able to pick the pen himself I feel so proud…now I have hope…"

"...the class he has been receiving from clinic is very good…he improved a lot…he will change…I am damn sure…"

"...Now I know when and why she will misbehave…so I can manage it…"

A cross-sectional study conducted by Ozdemir et al., (2022) determined that caregivers with children having special needs mostly tend to turning to religion,

planning, positive reinterpretation, and instrumental social support as coping styles. Furthermore, it is also related with depression. The term "religious coping" refers to a technique through which people exploit religious beliefs and rituals to deal with the problems and pressures of life (Koening et al., 1997). According to Pargament (1990), religion is a coping process that can affect one's evaluation of the threatening factors and their severity. Religion redefines the problem as a solvable issue, and affects the interpretation of the results and consequences of stressors. Reviewing 130 studies on religious coping and their correlation with mental health, Pargament (1997) concluded that 34% of the investigations indicate positive and significant effects of religious coping in easing depression and anxiety.

Coping through positive reinterpretation/reframing also effects psychological distress. Here an individual focuses on the positive aspects of the situation, thereby deal with stress. Cheshire et al., (2010) suggested that that positive reinterpretation as an adaptive mechanism to deal with the stressful situations of parents having children with cerebral palsy. Seltzer et al. (1995) demonstrated that planning and positive reinterpretation as coping strategies to buffer the impact of caregiving demands on depressive symptoms of mothers of adults with intellectual disabilities.

Feeling of competency

Mothers expressed their doubt on how they can overcome the difficulties with their limited capacities. Without having much support from the family, especially from partner, limited knowledge regarding child condition, limited financial resources, etc.

In accordance with their report often they were embarrassed because of unexpected behavioural pattern showed by the child. Many of them confused about how to handle the tantrums. This tendency is mostly reported by mothers of autistic children. At the same time some of them emphasized that they were tackled the situation and know how to deal the situation. Educated mothers reported that they were successful in completing the home tasks given by the therapist/special educator in home. At the same time some of them did not know/manage these tasks at home due to multiple responsibilities. For them, “raising a child with disability needs a powerful mind”. It may be an expression of the multiple roles and responsibilities,

the social system attributing to a woman. Some of them felt guilty on not giving enough support from their side. They described about themselves as *"nothing"*. Some of the verbatim are given below:

"...I got embarrassed when he is showing temper tantrums…I don't know what to do at that time…"

"...I can handle her in almost every situations…"

"... I can help him in doing home works assigned by therapist…"

Katkic et al., (2018) demonstrated significant differences between mothers of children with and without disabilities in stress, as well as self-perceived sense of maternal efficacy. In addition, while studying parents of children with autism, Hastings and Brown (2002) proved that self-efficacy mediated the effect of child behavior problems on mothers' anxiety and depression. Moreover, Nurlatifah and Fikrie (2022) demonstrated a negative relationship between parental self-efficacy and stress among parents of children with special needs. Weiss et al., (2016) found that parental self-efficacy is related to child's age, parent immigrant status, barriers to service access, and caregiver burden among parents of adolescent children with Autism.

Emotional concerns

While considering the emotional level, it can be seen that they expressed a pattern of extreme sadness. Some of them were crying while talking to the interviewer. Many of them were stressed and anxious in their appearance. A wide range of negative emotions ranging from tiredness to frustration could be seen. Some of them expressed their emotion in terms of *"I feel that it would have been better if I had died, hence the problems would end. My son is not like every other `child outside, which makes me unhappy and stressed, and increases my blood pressure, and leads to other health issues."*

Intense sadness could be seen in many of them either through the words they expressed or the body language. Long term commitment of issues of children with disabilities and the need for continuous treatment, mothers would experience high levels of stress and frequently became disappointed. Researcher also found that mothers of autistic children reported comparatively higher stress, anxiety and

depressive attitudes than that of mothers of child having other disabilities. A mother of child with ADHD also reported high level of anxiety due to the irritable nature of her child. She is anxious on who will be patient enough to manage him even if she is ill. Feelings of despair, guilt, helplessness, anger etc are expressed by most of them. Care and education requirements, social attitudes and judgments regarding disability, and ambiguity about the child's current and future status were crucial sources of anxiety and stress for parents.

Most of them were very anxious about the lives of their children and of them. Few reported no such feelings. Specifically they all tend to anxious about the future of the child, worsening of the condition, lacking care for the child after their death, and how to deal with all these physical and emotional needs as they grow up.

"…what will happen to my child after my death is my most concern…"

"…I am so distressed on what is happening around me…"

"…I feel I am an unlucky woman …"

"…sometimes I feel it is better to die …"

"…I get tensed even without reason now a day…"

"… No one is there to help…that makes me to cry…"

Biological concerns

While sharing the experiences, they pretended to talk about their physical issues as well. Most of them were at the stage of middle adulthood and some of them feel exhausted by the increased responsibilities, household tasks, and consistent care for the child as well as the aged parents in the home. Some of them suffered from life style diseases such as blood pressure, diabetics, cholesterol, arthritis etc. Due to the difficulties their child may have in the night, they also suffer from sleep disturbances. Some of them experience insomnia due to the extreme stress they experience. Even they feel some sort of head ache and the like, it may become a burden for them to manage every issues in single hand. Nevertheless they do!

"…as I get only short duration of sleeping I feel tired almost all the time…"

"…I have physical issues as I am aged now…blood pressure, blood sugar…"

"…throughout the day, I feel headache…"

Social concerns

As a social being the person will have influence on the society and vice versa. Following session will provide a clear picture on various societal influences on mothers having child with certain disabilities as reported by the mothers of disabled children.

The word 'support' was the one among the familiar words the researcher heard throughout the whole interview sessions. As they talk about their emotional difficulties, physical issues, thought processes, social issues, they seemed to have given much importance to talk about the support network available for them- some of them lack it; some tried to get it; rest of them were satisfied with it!

One of the common issues expressed by almost every participants was that their withdrawal tendency to participate in social gatherings such as marriages and other ceremonies where people gathered. Interactions with relatives were limited to their own homes as they could not visit relatives' houses. If the guests came to their home, attention to them was limited as priority was required to be given to child's routines such as feeding and going to sleep. One of them reported that some family members suggested her to sit inside a closed room with her autistic child during a marriage function.

Familial concerns

Some of the mothers reported that that they were getting harassed at their home rather than the support they expected. As the mothers reported, some mother in laws even humiliates the woman for attending treatments. The questions like *"where are you going…what is the purpose of going… and do you have any other connections there"…*were irritating and questioning the personality in essence as reported by them. Some of the mother in laws discourage the in laws for attending the therapies by providing information such as *"this condition cannot be treated…it is not curable… as the fate just live with it…no need of going outside for treatment and all…if you needed you can go for some religious practices".* As they reported it is only because of the financial dependency, some of them were living with their mother in laws. Incidence of verbal torturing is high among participants.

While considering the partners, most of them were living apart from their

husbands. Partners are working abroad so that the intimacy and direct emotional support were less for them. Despite availing the financial support, many of them expressed their need of being consoled by their partners, their presence in day today lives etc. It is very important here to consider the case of presence of partner in home. A woman living with her husband in their home told, despite the conditions were worse the presence of him made her much relaxed.

At the same time, one of the mothers reported that if the child's father was involved in care of the child, then his family members did not approve of him especially mother in law. She tended to shower negative comments on him and her. She also tried to attribute the cause of child's condition as mother of the child. Thus mother of the child with disability is blamed for the condition.

They also faced questioning from friends and peers, with the questions being related to duration of treatment and improvement of the child. Many mothers disclosed that care of the child was overly time consuming and often clashed with other household duties. At the same time marital relationship was intact as per their reports. One of the participants reported complaints from sibling of the disabled child about the increased attention given to the affected child *"You care more about my sister than me."* Those types of comments from siblings made them to feel guilty, and stressed.

All of the participants were consulting professionals for therapies and advices for their children. They emphasized the relevance of professional support in their lives. According to their comments professional support seemed to change some lifestyles of them. Some pressures have been reduced for some of them. Apart from consulting a professional in a clinic, they are also seeing many parents suffering from similar issues. They can share their difficulties; give and take suggestion and experiences of each etc.

"…When I came to this clinic and consulted the teachers (therapists), I feel much relaxed…they gave me a hope…"

"… There will be some improvement for the child and of parents when we visit a clinic than sitting inside the home…"

"…actually beyond the level of consultation...the parents coming here are all

friends now…sharing our sorrows with each other…interactions with teachers…these all made some changes in lives…"

A study on social support of parents of children with autism conducted by Deris (2006) indicated that both fathers and mothers ranked "information on how I can help my child" as the most important support and "help with transportation" as the least important support. Overall, fathers' preferred instrumental (goods, services, financial assistance, and information) types of supports, such as, "financial help for expenses." Mothers' preferred emotional (someone to talk to about problems, feelings, and attitudes) types of supports, such as, "contact with other parent(s) who experienced the same situation." "Involvement with a church or strong religious beliefs", "special equipment to help meet my child's needs", "financial help for expenses", "participation in an organized parent support group", and "information on how I can help my child" were significant.

Macdonald (2011) revealed a decrease in reported feelings of anxiety and depression with greater use of social support among parents of children with autism. They also suggested that informal sources of support might be particularly important. Furthermore, increased use of emotional-based coping was reported to be increased the feelings of depression and anxiety. According to Wang et al., (2017) family support and friend support had mediating effects on the relationship between parenting stress and life satisfaction among Chinese mothers having children with cerebral palsy.

According to Green (2003), mothers of children with disabilities experience high levels of stigma from society. According their study, most of them were considered as the outcasts in family because of this special condition. It made them to feel emotionally burdened by the necessity of raising their children (McKeever & Miller, 2004).

Majority of mothers in the study internalized the stigma of being the mother of a child with disability. Some of them were trying to withdraw from social gathering due to the behavioural problems of child. Some of them even stay away from family members also. The attitude of family members especially of mother in laws was emphasized by many. The comments made by them impact the mothers

negatively. Cursing words and humiliating tendency of family members were common as per their reports. In addition to the lack of support, this kind of tendency made them more distressed as per their report.

As per their reports they feel being embarrassed in so many situations such as family get together due to the unexpected nature of child. This is frequently reported by mothers of children having autism. As part of this they tend to avoid keep contact with people. This kind of attitude made them to feel more distressed.

At the same time some mothers of children having intellectual disability stated that despite taunting is there, they go outside with their children. They tried to explore the world for their children. They also received negative comments.

"... The society looks at with a sympathetic way..."

"... Family indeed tried to isolate us..."

"...they tend to comment like...I am an unlucky woman..."

"...I feel less in front of others..."

"...they are all cursing me for this ..."

"...often I feel my child is becoming a showpiece in front of others..."

Wnoroski (2008) demonstrated that, as an often-invisible disability, autism was certainly susceptible to stigmatization against both children and parents. An Indian study conducted by Patra and Patro (2019) revealed that affiliate stigma perception is high in parents of children with autism. They also highlighted that perception of stigma is higher in mothers than fathers. From their study, it was also evident that severe autistic symptoms and female children correlate with higher stigma. Farrugia (2009) reported that a child's diagnosis with an autism spectrum disorder (ASD) is critical for parents to resist stigmatisation. Parents experienced considerable enacted stigma, but successfully resisted felt stigma by deploying medical knowledge to articulate unspoiled subject positions.

Child's condition

During the interview and rapport building session the investigator had identified that some of them were not well informed about their child condition even though IQ assessments were done. Some mothers of children having intellectual disability mentioned their child condition as:

"he/she only has problem in studying…otherwise she is okay…if she improved her reading and writing capacity I will happy…" .

They view the condition in terms of academic backwardness. Many of the mothers reported that the pronounced issue of dealing with children was on the unexpected tantrums and emotional reactions. This is most frequently emphasized by mothers of autistic children. Mothers of ADHD also reported the same kind. As per mothers report, children with autism might exhibit frustration and anxiety due to several reasons such as communication issues, unable to go outside etc. Since they could not interact effectively with their parents, the condition gets worsened. These kinds of child conditions affect mothers negatively in terms additional effort they should exert when they interact with their child. They have to provide more time and resources for the same. As the communication is not effective and child becomes more problematic, parents prone to be more decisive and control by verbal or physical chastising. Mothers disclosed that their fear on reduction of bonding by this kind of behaviour. Otherwise they were helpless.

"…I become stuck when he screams at public place…:"

"… I scolded him many times… I don't know what to do at that time…I am afraid of being disliked by him…"

"…I need to pay full attention at her…she may run away if I take a rest…"

Children's ubiquitous behavioural problems and /or mental disorders were found to the primary contributors to distress in families having children with Autism (Van Steijn et al., 2014). In addition the study conducted by Firth and Dryer (2013) demonstrated that behavioural and emotional impairments of the child with ASD predicted overall parental distress. At the same time parental stress was predicted by the severity of the child's social impairment.

Economic concerns

Bahry et al., (2019) demonstrated that raising children having disabilities is a costly and arduous for parents. According to him, food, special equipment and medical costs were expensive over time. According to Kim et al., (2020) financial burden was evident as the parents wanted to seek medical and additional treatment for their children. Another important observation made by Vonneilich et al. (2016) was that, over time, one of the parents needed to be the primary care taker for full time, which might decrease the income to the family thereby increasing the financial burden. Parents' anxiety might be increased as the family income decreased (Ren et al., 2020).

In the present study, financial problems have also been identified as an important factor affecting both stress and anxiety levels of parents of children with disabilities. From the clinician's consultation and medicines to transport of the child, money plays an important role. The requirements vary with severity of the disability. Many of them have to travel almost daily for obtaining special education/physiotherapy treatment for the child. In addition to this, most of them had bank loans/debts.

"…we have house loan…in addition we need money for consultation, medicine etc…"

"…for coming here we need to have a special vehicle…for medicines also we need money…we are financially backward…"

"…for living today we need more money…everything is costly…food...medicine…but in our pocket no money is there…"

The analysis provided a clear picture of the experiences of mothers of children with disabilities. It sheds light on the wide range of social, psychological, physical, and financial problems experienced by the mothers of children with disabilities. The social support can be considered as a major concern of this community. The lack of support from family and of significant people made them to feel more distress. Thus researchers in this field can further explore the nature and impact of social support on distress of this community. Social support is also found to be used as a coping strategy here. While seeking help from society (in terms of

finance, knowledge, emotional) they tend to feel lesser negative emotions. They could handle the situations. The lack of confidence as an effective parent to deal the problems of "disabled" children is also found to be a major concern for this community. They could not address the problems of the children in effective manner. This in turn makes them to feel guiltier. The attitude of society also found to be a factor in determining the distress. The negative labelling of society made them to internalize the stigma. This also contributes to negative emotions. Physical problems of the participants/other family members are also found to be a factor in determining distress levels. The financial status also found to contribute to the negative emotions. The severity of disability, lack of knowledge regarding the child condition etc. made more distress among mothers.

Beyond the level of designing interventions/therapies for the children with disability, the mothers are also to be addressed. In order to enhance the effectiveness of therapies as well as to boost the mental health of mothers, training programmes can be developed. Assuring the support system is a major point to be included in the programmes. Training programmes can be developed to get more knowledge on disabilities and of management of the same can ensure the competency level of mothers. The policy makers can ensure financial support for the family of children with disability. It may be done through assuring job opportunities for family members. Policy makers can assure the quality of life of children with disability, thereby lessen the worries of mothers. For this residential set up can be developed in government settings. Providing job opportunities for mothers in the residential programmes designed for children with disability may be beneficial for some. By this set up, based on the education and abilities, mothers can also avail other job opportunities. Thus the current study points out the relevance of conducting tremendous studies in the field.

Section 2- Quantitative analysis

This section gives the results reached by the investigator by doing statistical analysis of the collected data. Analysis is a very crucial step of any research work and it is the scientific path to test the hypothesis put forward by the investigator. It helps the investigator to make sense of the variety of information collected through

data collection.

Descriptive and inferential statistics are the two types of statistics used in psychology. As the name indicates, descriptive statistics describes and summarizes a set of data whereas inferential statistics enables scientist to draw conclusions from the data drawn from descriptive statistics.

There are three types of descriptive statistics named as distribution, central tendency and variability. The distribution concerns the frequency of each value. The central tendency concerns the averages of the value (Mean, Median, and Mode). The variability or dispersion (Range, Standard deviation, Variance etc.) concerns how spread out the values are.

Mode is the most commonly occurring value in a distribution. Median is the middle value in distribution when the values are arranged in ascending or descending order. Mean is the sum of the value of each observation in a data set divided by the number of observations. When a distribution is symmetrical, the Modes, Median and Mean are in the middle of the distribution. When it is skewed, the Mode remains the most commonly occurring value, the Median is the middle value in the distribution, but the Mean is generally 'pulled' in the direction of the tails. A distribution is said to be positively skewed when the tails on the right side of the distribution is longer than the left side. Negatively skewed distribution displays a longer tail on the left side of the distribution.

Another important aspect to be considered in describing data set is the Kurtosis. It describes how much of probability distribution falls in the tails instead of its centre. In normal distribution, the kurtosis is equal to three (or zero in some models). It is named as mesokurtic. Positive or negative Kurtosis changes the shape of the distribution accordingly. Distribution having low Kurtosis (thin tails) is platykurtic. At the same time distribution with high Kurtosis (fat tails) are leptokurtic.

To draw conclusions from the data set, the researcher utilized various inferential statistics such as correlation analysis, regression analysis, Analysis of Variance (ANOVA) etc. Correlation analysis enables to find out the relationship between the variables. Regression analysis provides details of predictors and

linearity of variables under study. Analysis of Variance is a statistical formula used to compare the variances across the Means (averages) of different groups.

For the detailed understanding of psychological distress of mothers of children with disability, researcher has selected perceived social support, affiliate stigma and parental self efficacy as the main variables to the present study (based on the qualitative study).The following session describes the results of the study based on different statistical analysis.

Primarily, to understand the nature and quality of the data collected, the fundamental descriptive statistics like Mean, Median, Mode, Standard Deviation, Kurtosis and Skewness of the parental self-efficacy, perceived social support, affiliate stigma and psychological distress were calculated and results are presented in table 22.

Table 22

Descriptive statistics of variables under study

Statistic	Significant others	Family	Friends	Social support	Parental self-efficacy	Cognitive	Affective	Behavioural	Affiliate stigma	stress	anxiety	Depression	Psychological distress
Mean	13.07	12.14	12.26	37.47	56.93	13.99	13.23	9.12	36.35	8.25	12.34	11.67	32.26
Median	13.00	12.00	12.00	37.00	59.00	12.00	13.00	9.00	34.00	9.00	12.00	12.00	33.00
Mode	11	12	11	37	42	14	12	11	34	9	13	11	32
S.D	4.223	4.334	3.962	7.219	13.690	6.622	4.439	4.256	14.286	3.924	5.727	5.399	13.795
Skewness	-.229	-.035	.112	.345	-.103	.729	.403	-.125	.379	-.231	.052	.082	.063
Kurtosis	-.561	-.713	-.251	.161	-.847	-.356	-.392	-.859	-.575	-.467	-.026	.051	-.322

Table 22 shows the descriptive statistics of variables under the current study. While considering the variable perceived social support, the Mean (37.47), Median (37.00), Mode (37) were found to be more or less equal. The Skewness (.345) and Kurtosis (.161) are also within range. In addition while considering the sub-variables of social support, it can be seen that the Mean (13.07), Median (13.00) and Mode (11) of the variable perceived support from significant others were almost equal. Furthermore, the Kurtosis (-.561) and Skewness (-.229) are within limit. The similar

results can be seen in the case of perceived familial support (Mean=12.14; Median=12.00; Mode=12; Skewness=-.035; Kurtiosis=-.713) as well as support from friends (Mean=12.26; Median=12.00; Mode=11; Skewness=.112; Kurtosis=-.251). The minimal positive and negative skewness and platykurtic and leptokurtic tendencies can be ignored as per the statistical rules. Thus the variable can be considered as normally distributed among the sample.

Further, the Mean (56.93), and Median (59) of the variable parental self-efficacy were found to be more or less equal. Skewness (-.103) and Kurtosis (-.847) were also within the limit. At the same time Mode (42) is somewhat lesser. Nevertheless it is ignorable. Thus the variable parental self-efficacy can be considered as normally distributed among the sample.

Affiliate stigma is found to have the scores as Mean (36.35), Median (34), and Mode (34). In addition, the Skewness (.379) and Kurtosis (-.575) were within range. The sub-variable cognitive component got the scores as Mean (13.99), Median (12), Mode (14), Kurtosis(-.356) as well as Skewness (.729) which can be considered as normally distributed among the sample. Similar tendency can be seen in the case of sub variable affective component with the scores of Mean (13.323), Median (13),Mode (12), Kurtosis (-.392), Skewness (.403) as well as behavioural component (Mean=9.12; Median=9; Mode=11; Skewness=-.125; Kurtosis=-.859). The minimal negative and positive skewed plots can be ignored. Altogether, the variable can be considered as normally distributed among the sample.

Considering the descriptive statistics of psychological distress, the Mean (32.26), Median (33), and Mode (32) were found to be more or less equal. Skewness (.063) and Kurtosis (-.322) were within limit. The sub variable stress has the scores as Mean (8.25), Median (9), Mode (9), Skewness (-.231) and Kurtosis (-.467) which were within limit. Similar results were found in the case of anxiety (Mean=12.34, Median=12, Mode=13, Skewness=.052, Kurtosis-.026) as well as depression (Mean=11.67, Median=12, mode=11, Skewness=.082, Kurtosis-.051).The minimal negative and positive skewed plots can be ignored. Altogether, the variables under study can be considered as normally distributed among the sample. Hence the investigator has decided to proceed with parametric statistics.

Relationship of Perceived Social Support, Parental Self-Efficacy, Affiliate Stigma and Psychological Distress

The social relations are inevitable in people's lives. People may explore different kinds of social networks as per their day to day needs. Perceiving and receiving support from the social networks enable individuals to look forward more positively. A belief of 'someone is there to help me in need' is beneficial in many ways. For parents of children with disabilities, the scope of this belief may be widened. As already noted in previous chapters, the challenging lives of these parents may be simplified for an extent by this belief itself. Obviously perceiving the support will essentially change the outlook of lives. The support may be from family, friends and even from a significant one. The support may be in terms of instrumental assistance (helping in child rearing responsibilities, financial aid etc.), emotional support (caring, empathetic, encouragement), practical child-rearing advice, and informational support, and role models of positive parenting practices and the like. At the same time the perception of negative labelling of society as a parent of differently abled children would eventually impact the person in negative way. In addition to the increased responsibilities, the societal attitude may further worsen the condition. At the same time the belief in oneself as an 'effective parent" would foster the quality of child rearing practices and of the confidence of the parent itself. Psychological distress indeed plays a negative role among mothers for rearing a child with disability. The challenging nature of the condition, the more time and resource consuming situation etc. may precipitate increased stress, anxiety, and even depression in mothers. Based on these assumptions and of intriguing responses of mothers during interview sessions, the researcher was interested to study the relationship between these variables. For this researcher carried out Pearson's Product moment correlation analysis and the results are presented in table 23.

Table 23

Correlation of perceived social support and its dimensions (significant others, family, friends), parental self-efficacy, ,affiliate stigma and its dimensions(cognitive, affective and emotional components) and psychological distress and its dimensions(stress, anxiety and depression)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
Significant others(1)	-												
Family (2)	.434**	-											
Friends (3)	-.348**	-.130*	-										
Social support (4)	.655**	.783**	.267**	-									
Parental Self-efficacy(5)	.440**	.598**	.049	.643**	-								
Cognitive(6)	-.426**	-.658**	-.125*	-.712**	-.693**	-							
Affective(7)	-.378**	-.605**	-.125*	-.653**	-.549**	.767**	-						
Behavioural(8)	-.442**	-.682**	-.100	-.723**	-.597**	.810**	.838**	-					
Affiliate Stigma(9)	-.446**	-.696**	-.127*	-.749**	-.670**	.943**	.916**	.934**	-				
Stress(10)	-.508**	-.665**	-.172**	-.791**	-.617**	.716**	.595**	.687**	.721**	-			
Anxiety(11)	-.505**	-.690**	-.154**	-.794**	-.663**	.758**	.608**	.701**	.749**	.799**	-		
Depression(12)	-.443**	-.623**	-.195**	-.741**	-.607**	.684**	.587**	.635**	.689**	.755**	.729**	-	.
Psychological Distress(13)	-.528**	-.719**	-.189**	-.844**	-.688**	.786**	.652**	.735**	.786**	.912**	.928**	.909**	-

*p<.05; **p<.01

Table 23 gives the results of correlation analysis of variables under study. While considering the result of correlation analysis of perceived social support and psychological distress of mothers of differently abled children, it is evident that there is a significant negative relationship between these variables(r=-.844, p<.01). Going through the sub-dimensions of perceived social support resonate the same trend of having strong negative relationships- perceived family support and psychological distress (r=-.719, p<.01) perceived friends' support and psychological distress (r=-.189, p<.01); as well as perceived support from significant others and psychological distress (r=-.528, p<.01). While considering the relationship of dimensions of social support with dimensions of psychological distress, the results are as follows: family support and stress (r=-.665, p<.01); family support and anxiety (r=-.690, p<.01);

family support and depression (r=-.623, p<.01); perceived support from friends with stress (r=-.172, p<.01); anxiety (r=-.154, p<.01): depression (r=-.195, p<.01); perceived support from significant others with stress (r=-.508, p<.01); anxiety (r=-.505, p<.01): depression (r=-.443, p<.01). Put simply, the more the support they perceive either through family, friends or significant others, the less they feel psychological distress and its sub dimensions and vice versa. The feeling that 'someone will be there to support' eventually makes a positive vibe thereby lessen the negative feelings such as stress associated with rearing a disabled child, anxiety of future of both child and mother and the like. This result indeed suggests the importance of providing support for the mothers to enhance their mental health. Family, friends and of significant people of their lives can do many things for their better life. Thus during developing rehabilitation programs for the disabled child, mothers and family members are to be included. So that it would be beneficial not only for the child but also for the mother and thereby family.

The results add to the existing studies on social support and psychological distress as well as related variables. According to Greeshma and Manikandan (2017) perceived social support is negatively related to psychological distress and its sub dimensions of parents of disabled children. In addition, Perceived and received support has been found to be associated with different dimensions of psychological health and functioning (Haber et al., 2007; Rueger et al., 2016). Smith et al., (2015) found that family support is essential for parents and other primary caregivers rearing children with identified disabilities, chronic medical conditions, and other child related risk conditions. Cantwel et al.,(2015) also suggested the negative association of social support and depression. Thus social support is an important resource that can help individuals cope with stress, enhance self confidence and improve self-efficacy.

Parental self-efficacy is also found to be related to psychological distress negatively (-.688, p<.01). That is, the more the person feels effective as a parent, the less she may experience psychological distress and its sub dimensions. In other words, evaluating ones capacities as effective and efficient is related with lesser feelings of stressful, anxious, and depressive. Hence, in order to lessen the impact of

psychological distress, the result suggests the importance of fostering the belief of 'being an effective parent' in mothers. This result is in line with previous research conducted in this area. Negative relationship has been found between parental self - efficacy and stress among parents of children with special needs (Nurlatifah & Fikrie, 2022; Greeshma & Manikandan, 2017). In addition, De Hann et al., (2009) found that mothers who perceive themselves as ineffective in their parental role tend to be more punitive, and more depressed. Mothers with low self-efficacy tend to experience more distress and reporting higher levels of parenting stress (Sevigny & Loutzenhiser, 2010) and depression (Kuhn & Carter, 2006).Parents having low parenting self-efficacy tend to make more internal attributions of failure and manifest higher degrees of anxiety and depressive symptoms (Miller et al., 1992). Lower parenting self-efficacy has been shown to be related to giving up more quickly, feeling anxious, depressed, frustrated, as well as reporting less perceived social support, less spousal support, perceptions of futility, and higher levels of stress (Shumow & Lomax, 2002). Thus the result can be useful for those who are interested in developing interventions for parents of differently abled children for their better mental health and related aspects.

The affiliate stigma and its sub dimensions are positively related to psychological distress and its sub dimensions. The correlation coefficient of affiliate stigma (AS) and psychological distress (PD) is .786 ($p<.01$). The cognitive dimension is related to PD with a score of $r=.786$ ($p<.01$). The affective dimension is related with a score of $r=.652$ ($p<.01$) and behavioural with $r=.735$ ($p<.01$). The cognitive dimension of AS is linked with stress ($r=.716$, $p<.01$), anxiety ($r=.758$, $p<.01$) and depression ($r=.684$, $p<.01$) significantly. The affective dimension of AS is also related to stress ($r=.595$, $p<.01$) anxiety ($r=.608$, $p<.01$) and depression ($r=.587$, $p<.01$) significantly. Furthermore, behavioral dimension of AS is also related to stress ($r=.687$, $p<.01$) anxiety ($r=.701$, $p<.01$) and depression ($r=.635$, $p<.01$) significantly. The results are consistent with the previous studies in this field. Recio et al., (2021) showed that caregivers' perceived discrimination is positively related to their affiliate stigma that in turn is harmful to their anxiety and depression. Nevertheless, caregivers' self-efficacy plays a mediating role in the

relation between affiliate stigma and caregivers' anxiety and depression. Lovell and Wetherel (2019) found positive relationship between affiliate stigma and perceived stress. This relationship is occurred indirectly via lower perceived support from family, but not from friends or significant others. Chen et al.,(2021) reported that affiliate stigma was positively related to the depression level in caregivers of children with ADHD. The level of the association between affiliate stigma and depression symptoms was negatively linked with the levels of family support and self-esteem. According to Cantwel, et al., (2015), perceived stigma is associated with depressive symptomatology. Simply, more the person internalise the stigma of "being a mother of differently abled children', more will be the psychological distress and its sub variables. Whether it is through thinking (cognitive dimension), feeling (affective), or behaving it may all related to increased distress. Thus the negative attitude of society in general makes them to feel more distressed as a parent of 'disabled' child. The result suggests the importance of developing a positive attitude in society towards disability. The adequate knowledge regarding the disability conditions may be beneficial in this case.

Predictors of psychological distress and its sub dimensions

Often raising a child with disability is found to be challenging in many ways. It may be social, personal or otherwise child related. Mostly, as primary caregivers, mothers tend to be more stressed than that of any other individuals in the family. Challenges like increased responsibilities, financial burden, and negative attitude by the family and of society in general may impact the mothers negatively. However some of them overcome this stressful situation effectively by certain personal and social factors. The positive thinking pattern or competency may enhance their capacity to deal with stressful situation. Adequate support given by a peculiar person may even enhance their self-efficacy or well -being. Usage of appropriate adaptive mechanism also helps in this way. At the same time they may withdraw from society due to the 'deficiency' of aforementioned factors. In addition, they may think more negatively, and feel more distress. Moreover, they may be more anxious towards rearing them; altogether about their future. Indeed, the attribution given by the society for 'being a mother of disabled child' has a tremendous impact on the well-being of caregivers.

Since the researcher was interested in studying the psychological distress based on social support, affiliate stigma, and of self-efficacy, she had a question in mind about the explanatory power of these variables on psychological distress and of the predictive values. For the purpose of answering these questions regression analysis is done and the results are presented in the following tables.

Table 24

Statistical characteristics of regression

Index	R	R Square
Regression	.890	.787

The R square in table 24 is the indication of explanatory power of regression model on psychological distress. R square is the percentage of variance in the psychological distress explained by the collection of independent variable (perceived social support, self-efficacy, and affiliate stigma). Here the value is 78.7%. It means about 78.7 % (R^2=.787) variation in psychological distress is accounted by perceived social support, parental self-efficacy, and affiliate stigma.

Furthermore, to test the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and psychological distress, regression ANOVA has been done. The results are tabulated as table 25.

Table 25

Summary of the ANOVA

Source of variance	Sum of Squares	Df	Mean Square	F
Regression	43407.682	7	6201.097	152.827**
Residual	11401.854	281	40.576	
Total	54809.536	288		

**p<.01

Table 25, shows the regression ANOVA carried for testing the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and psychological distress. From the table, it can be seen that calculated F value is 152.827 (p< .01).This indicates there is a linear relationship between perceived social support, parental self-efficacy, affiliate stigma and psychological distress.

Finally, to find the predictors of psychological distress, regression analysis (method-enter) has been carried out. The results are displayed in table 26.

Table 26

Predictors of psychological distress (regression analysis via enter method)

Variable	Unstandardized Coefficients		Standardized Coefficients	t
	B	Std. Error	Beta	
(Constant)	68.715	4.604		14.926
Significant others	-.933	.115	-.286	-8.136**
Family	-1.105	.132	-.347	-8.354**
Friends	-1.013	.112	-.291	-9.074**
Self- Efficacy	-.119	.040	-.119	-2.966**
Affective	-.864	.218	-.278	-3.955**
Behavioural	-.335	.254	-.103	-1.317
Affiliate stigma	.629	.113	.651	5.559**

**p<.01

Table 26 shows the predictive capacity of each variable on psychological distress. From table 26, it can be seen that perceived support from significant others (t=8.136), family (t=8.354), friends (t=9.074), parental self-efficacy (t=2.966), affective (t=3.955) component of affiliate stigma and of affiliate stigma (t=5.559) were significantly predict psychological distress of mothers of differently abled children. Family is one of the basic social system with which a person develops his/her sense of self. If an individual cannot perceive the support from family, it may eventually deteriorate his/her mental health. Indeed in the case of a mother having child with disability, the impact may be worsened. Family members' support, spousal support and the like are very essential for maintaining the mental health. In addition, the finding is supported by various studies. Among them, Weiss (2002) found that social support and hardiness as the significant predictors of stress in mothers of typical, autistic and mentally retarded children. Furthermore, lack of perceived support was a predictor for level of stress experienced by parents of disabled children (Jones & Passey, 2004)). During the Covid -19 pandemic outbreak

also social support negatively predicted parent state anxiety (Ren et al., 2020). The belief in oneself as an 'effective parent or not' also found to be a predictor in this study. By this result it can be state that, the confidence of having competence to manage all those challenging situation as a mother of disabled child will substantially predict the level of distress they may experience. The self-recognition as a parent of child with disability in negative terms may also increase the distress levels. Masulani-Mwale et al., (2018) showed, that low confidence in managing the disabled child, and having no sources for psychological support significantly predicted psychological distress among the parents for children with disabilities. Banga and Ghosh (2017) reported that Affiliate stigma experienced by mothers of children with specific learning disability (SLD) in India significantly predicted low levels of psychological well-being. Results resonate with other recent research involving caregivers of children with autism, in which affiliate stigma positively, and perceived social support negatively, predicted psychological distress (Dalky et al., 2017; Hinshaw & Stier, 2008). Dehnavi et al., (2018) also revealed that internalized stigma was a predictor of mental health.

Based on the results of regression analysis the relationship between Psychological distress, perceived social support, parental self-efficacy and affiliate stigma can be expressed as following equation.

PD= 68.715+ (-0.933 x SIO) + (-1.105 x F) + (-1.013 x FR) + (-0.119 x SE) + (-0.864 x A)+ (0.629 x AS)

Where

PD = Psychological distress

SIO = Perceived support from Significant others

F = Perceived support from family

FR = Perceived support from friends

SE = Parental self-efficacy

A = Affective component of Affiliate stigma

AS = Affiliate stigma

So it can say that, for a unit of change in psychological distress score, 68.715 can be added to the score of -0.933 multiplied with Perceived support from

Significant others, -1.105 multiplied with Perceived support from family, -1.013 multiplied with Perceived support from friends, -0.119 multiplied with parental self-efficacy, -0.864 multiplied with Affective component of Affiliate stigma and 0.629 multiplied with Affiliate stigma.

The strong explanatory power, linear relationship, as well as predictive capacity of perceived social support, parental self-efficacy and affiliate stigma and of their sub-dimensions on psychological distress demand furthermore exploration on its sub variables also. Psychological distress is composed of three factors such as stress, anxiety and depression. There may be difference in experiencing these dimensions even when a person has increased distress level. Thus exploring the explanatory power, linear relationship, as well as predictive capacity of perceived social support, parental self-efficacy and affiliate stigma and of their sub-dimensions on sub variables of psychological distress may be fruitful for the research realm.

For identifying the predictors of each sub-variables of Psychological distress (stress, anxiety, depression), regression analysis was done with each dimension. Firstly the predictors of stress have been calculated and results are presented in the following tables.

Table 27

Statistical characteristics of regression

Index	R	R Square
Regression	.825	.672

The R square in table 27 is the indication of explanatory power of regression model on stress. R square is the percentage of variance in the stress explained by the collection of independent variable(social support, self-efficacy, and affiliate stigma). Here the value is 67.2%. It means about 67.2 %(R^2=.672)variation in stress is accounted by perceived social support, parental self-efficacy, and affiliate stigma.

Moreover, to test the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and stress, regression ANOVA has been done. The results are presented in table 28.

Table 28

Summary of the ANOVA

Source of Variance	Sum of Squares	Df	Mean Square	F
Regression	3016.356	7	430.908	85.440**
Residual	1417.201	281	5.043	
Total	4433.557	288		

**p<.01

Table 28 shows the regression ANOVA carried for testing the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and stress. From the table the F value is found to be 85.440. That means, at 1% error level, there is a linear relationship between perceived social support, parental self-efficacy, affiliate stigma and stress.

To find out the predictors of stress, regression analysis (enter method) has been carried out. The results are tabulated in table 29.

Table 29

Predictors of stress (regression analysis via enter method)

Predictors	Unstandardized Coefficients		Standardized Coefficients	t
	B	Std. Error	Beta	
(Constant)	18.126	1.623		11.168
Significant others	-.281	.040	-.302	-6.942**
Family	-.298	.047	-.330	-6.396**
Friends	-.281	.039	-.284	-7.148**
Self- Efficacy	-.021	.014	-.072	-1.461
Affective	-.241	.077	-.272	-3.124**
Behavioural	-.016	.090	-.018	-.183
Affiliate stigma	.148	.040	.538	3.706**

**p<.01

Table 29 shows the results of the 't' values obtained via regression analysis (enter method). It also shows the significant level which in turn indicates the

predictive capacity of each variable on stress. From the table 29, it can be seen that perceived support from significant others (t=6.942), family (t=6.396), friends (t=7.148), affective (t=3.124) component of affiliate stigma and of affiliate stigma (t=3.706) were significantly predict stress of mothers of differently abled children. From the results it is evident that the perceived social support is a powerful factor in determining the stress levels of mothers of children with disabilities. All of the sub-variables of social support significantly predicted the stress levels of participants. It indicates the importance of the 'feeling of having someone to help'. According Hsiao et al., (2017) one of the strongest predictors of parental stress is family support. In addition, Jones and Passey (2004) reported that lack of perceived help from social support was a predictor for levels of stress experienced by parents. In addition, emotional aspect of affiliate stigma also found to be significant at predicting the stress levels. The negative 'feelings of having a child with disability within a normal society' may increase the stress levels. Dehnavi et al., (2018) also revealed that internalized stigma was a predictor of mental health.

Based on the results of regression analysis the relationship between stress, perceived social support, parental self-efficacy and affiliate stigma can be expressed as following equation.

S= 18.126+ (-0.281x SIO) + (-0.298x F) + (-0.281 x FR) + (-0.241 x A) + (0.538 x AS)

Where

S	=	Stress
SIO	=	Perceived support from Significant others
F	=	Perceived support from family
FR	=	Perceived support from friends
A	=	Affective component of Affiliate stigma
AS	=	Affiliate stigma

So it can say that, for a unit of change in stress score, 18.126 can be added to the score of -0.281 multiplied with Perceived support from Significant others, -0.298 multiplied with Perceived support from family, -0.281 multiplied with Perceived support from friends, -0.241 multiplied with Affective component of Affiliate stigma and 0.538 multiplied with Affiliate stigma.

To find out the predictors of anxiety, regression analysis (enter method) has

been carried out. The results are tabulated in table 30.

Table 30

Statistical characteristics of regression

Index	R	R Square
Regression	.848	.712

The R square in the table 30 is the indication of explanatory power of regression model on anxiety. R square is the percentage of variance in the anxiety explained by the collection of independent variable (social support, self-efficacy, and affiliate stigma). Here the value is 71.2%. It means about 71.2 %(R^2=.712) variation in anxiety is accounted by perceived social support, parental self-efficacy, and affiliate stigma.

To understand the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and anxiety, regression ANOVA has been done. The results are tabulated as table 31.

Table 31

Summary of ANOVA

Source of variance	Sum of Squares	Df	Mean Square	F
Regression	6794.919	7	970.703	102.859**
Residual	2651.849	281	9.437	
Total	9446.768	288		

**p<.01

Table 31 shows the regression ANOVA carried for testing the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and anxiety. From the table the F value is found to be 102.859. That means, at 1% error level, there is a linear relationship between perceived social support, parental self-efficacy, affiliate stigma and anxiety.

Table 32

Predictors of anxiety (regression analysis via enter method)

Predictors	Unstandardized Coefficients		Standardized Coefficients	t
	B	Std. Error	Beta	
(Constant)	25.867	2.220		11.651
Significant others	-.344	.055	-.254	-6.220**
Family	-.424	.064	-.321	-6.641**
Friends	-.349	.054	-.241	-6.484**
Self- Efficacy	-.050	.019	-.120	-2.578**
Affective	-.450	.105	-.349	-4.268**
Behavioural	-.140	.123	-.104	-1.139
Affiliate stigma	.288	.055	.718	5.277**

**p<.01

Table 32 shows the 't' values obtained via regression analysis(enter method) and its significant level which in turn indicates the predictive capacity of each variable on anxiety. From the table 32, it can be seen that perceived support from significant others (t=6.220), family (t=6.641), friends (t=6.484), parental self-efficacy (t=2.578) affective (t=4.268) component of affiliate stigma and of affiliate stigma (t=5.277) were significantly predict anxiety of mothers of differently abled children. This result is in line with previous studies. For instance Boyd (2002) demonstrated that social support is a strong predictor on anxiety levels of mothers of children with autism. Indeed the powerful nature of social support has been established in predicting the anxiety levels of mothers. Whether it is a significant one/friend/family member, the perception of having someone to support predicts the anxiety levels of participants. The significant t score of parental self-efficacy indicates significance of having a competency feel as an effective parent in predicting anxiety level of participants. In the literature on youth with ASD, increased levels of parent self-efficacy have been linked with decreased parental anxiety, depression, and child behavioral problems (Hastings & Brown, 2002; Kuhn & Carter, 2006).As in the case of stress levels, the affective component of affiliate stigma also predicts the anxiety levels of participants. Affiliate stigma in general also found to be a predictor. That is negative labelling as a parent of child with disability can predict the anxiety levels of participants. Dehnavi et al., (2018) also

revealed that internalized stigma was a predictor of mental health.

Based on the results of regression analysis the relationship between anxiety, perceived social support, parental self-efficacy and affiliate stigma can be expressed as following equation.

A= 25.867+ (-0.344 x SIO)+(-0.424 x F)+(-0.349 x FR)+ (-0.050 x SE)+(-0.450 x A)+ (0.288 x AS)

Where

A	=	Anxiety
SIO	=	Perceived support from Significant others
F	=	Perceived support from family
FR	=	Perceived support from friends
SE	=	Parental self-efficacy
A	=	Affective component of Affiliate stigma
AS	=	Affiliate stigma

So it can say that, for a unit of change in anxiety score, 68.715 can be added to the score of -0.344 multiplied with Perceived support from Significant others, -0.424 multiplied with Perceived support from family, -0.349 multiplied with Perceived support from friends, -0.050 multiplied with parental self-efficacy, -0.450 multiplied with Affective component of Affiliate stigma and 0.288 multiplied with Affiliate stigma.

To find out the predictors of depression, regression analysis (enter method) has been carried out. The results are tabulated in table 33.

Table 33

Statistical characteristics of regression

Index	R	R Square
Regression	.779	.597

The R square in the table 33 is the indication of explanatory power of regression model on depression. R square is the percentage of variance in the depression explained by the collection of independent variable (social support, self-efficacy, and affiliate stigma). Here the value is 59.7%. It means about 59.7 %(

R^2=.597) variation in depression is accounted by perceived social support, parental self-efficacy, and affiliate stigma.

To understand the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and depression, regression ANOVA has been done. The results are tabulated as table 34.

Table 34

Summary of ANOVA

Source of variance	Sum of Squares	Df	Mean Square	F
Regression	5096.397	7	728.057	62.013**
Residual	3299.029	281	11.740	
Total	8395.426	288		

**p<.01

Table 34 displays the regression ANOVA carried for testing the linear relationship between perceived social support, parental self-efficacy, affiliate stigma and depression. From the table the F value is found to be 62.013. That means, at 1% error level, there is a linear relationship between perceived social support, parental self-efficacy, affiliate stigma and depression.

Finally, to identify the predictors of depression, regression analysis (enter method) has been utilized. The results are presented in table 35.

Table 35

Predictors of depression (regression analysis via enter method)

Predictors	Unstandardized Coefficients		Standardized Coefficients	t
	B	Std. Error	Beta	
(Constant)	24.723	2.476		9.984
Significant others	-.308	.062	-.241	-4.998**
Family	-.383	.071	-.308	-5.384**
Friends	-.382	.060	-.281	-6.370**
Self- Efficacy	-.049	.022	-.123	-2.245*
Affective	-.174	.118	-.143	-1.479
Behavioural	-.179	.137	-.141	-1.307
Affiliate stigma	.193	.061	.511	3.174**

*p<.05 **p<.01

Table 35 shows the 't' values obtained via regression analysis(enter method) and its significant level which in turn indicates the predictive capacity of each variable on depression. From the table 35, it can be seen that perceived support from significant others (t=4.998), family (t=5.384), friends (t=6.370), parental self-efficacy (t=-2.245) and affiliate stigma (t=3.174) were significantly predict depression of mothers of differently abled children. The perception of having someone to support may enhance the positive feeling and alter the levels of depression levels. This is line with previous research in this field. Social support is a strong predictor of depression levels of mothers of children with autism (Boyd, 2002). Depression is also predicted by parental self efficacy. Recendes and Scarpa (2011) reported that decreased parental self efficacy is related to increased anxiety and depression. Being a more efficient parent in providing the needs of a child with disability may decrease the negative feelings. Affiliate stigma is also found to be a predictor in determining depression levels of participants. Dehnavi et al., (2018) also revealed that internalized stigma was a predictor of mental health. According to Sipal and Sayin (2013), that perceived social support from family and friends were also found to be the predictors of depression.

Based on the results of regression analysis the relationship between depression, perceived social support, parental self-efficacy and affiliate stigma can be expressed as following equation.

D= 24.723+ (-0.308 x SIO)+(-0.383 x F)+(-0.382 x FR)+ (-0.049 x SE)+ (0.193 x AS)

Where

D	=	Depression
SIO	=	Perceived support from Significant others
F	=	Perceived support from family
FR	=	Perceived support from friends
SE	=	Parental self-efficacy
AS	=	Affiliate stigma

So it can say that, for a unit of change in depression score, 24.723 can be added to the score of -0.308 multiplied with Perceived support from Significant others, -0.383 multiplied with Perceived support from family, -0.382 multiplied with Perceived support from friends, -0.049 multiplied with parental self-efficacy, and 0.193 multiplied with Affiliate stigma.

Influence of Social Support, Parental Self Efficacy and Affiliate Stigma on Psychological Distress of Mothers of Differently abled Children

Care giving a child with disability may be highly challenging due to the increased responsibilities, lifelong constant care taking etc. They may experience more stress and anxiety in dealing with the child's condition. Both external and internal factors may play role inducing the negative feelings such as psychological distress. For the thorough understanding of the feelings of stress, anxiety, and depression among mothers of differently abled children, psychological distress has to be studied in detail. Here the variables social support and affiliate stigma were selected as the socially relevant variables and parental self-efficacy as the personally relevant variable. The following section discusses the influences of these variables on psychological distress and its dimensions. Various demographic details were also collected for understanding more about its effects on psychological distress. All those results are tabulated and discussed in detail.

To know the main and interaction effects of perceived social support, parental self-efficacy, and affiliate stigma on psychological distress of mothers of differently abled children, Univariate Analysis of Variance (ANOVA) has been carried out. Since the variables were measured in interval scale, they were classified into high and low based on their respective median as cut off point. The classification of the variables is presented in the table 36.

Table 36

Cross tabulation of Perceived Social Support, Parental Self-Efficacy, and Affiliate Stigma

Affiliate Stigma	Social Support	Statistic	Parental Self-Efficacy		Total
			Low Parental Self-efficacy	High Parental Self-efficacy	
Low affiliate stigma	Low Support	Count	20	19	39
		% within Social Support	51.3%	48.7%	100.0%
		% within Parental Self-Efficacy	44.4%	17.9%	25.8%
		% of Total	13.2%	12.6%	25.8%
	High support	Count	25	87	112
		% within Social Support	22.3%	77.7%	100.0%
		% within Parental Self-Efficacy	55.6%	82.1%	74.2%
		% of Total	16.6%	57.6%	74.2%
	Total	Count	45	106	151
		% within Social Support	29.8%	70.2%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	29.8%	70.2%	100.0%
High affiliate stigma	Low Support	Count	89	25	114
		% within Social Support	78.1%	21.9%	100.0%
		% within Parental Self-Efficacy	86.4%	71.4%	82.6%
		% of Total	64.5%	18.1%	82.6%
	High support	Count	14	10	24
		% within Social Support	58.3%	41.7%	100.0%
		% within Parental Self-Efficacy	13.6%	28.6%	17.4%
		% of Total	10.1%	7.2%	17.4%
	Total	Count	103	35	138
		% within Social Support	74.6%	25.4%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	74.6%	25.4%	100.0%

Table 36 displays the cross tabulation of Perceived Social Support, Parental Self-Efficacy, and Affiliate Stigma. From table 37, it can be seen that about 20 participants were categorised under low affiliate stigma, low social support and low parental self-efficacy combination. At the same time 19 participants fall under the category of low affiliate stigma, low social support and high parental self-efficacy. From the table it can be seen that about 87(30% of total participants) participants scored under the category of high parental self-efficacy, high social support, and low affiliate stigma. Only 25 fall under the combination of low affiliate stigma, high social support and low parental self- efficacy. Another intriguing result has been found in the category of combination of high affiliate stigma, low social support and low parental self-efficacy. About 89 participants were classified under this category. That means about 89 (31% of total participants) people experience a combination of high affiliate stigma, low social support and low parental self-efficacy in this study. Only 25 participants were categorised under the combination of high affiliate stigma, low social support with high parental self-efficacy. While considering the combination of high affiliate stigma with high social support and low parental self-efficacy, only 14 participants were classified under this category. Where as in high affiliate stigma with high social support and high parental self-efficacy, there were 10 participants.

Next, to know the influence of perceived social support, affiliate stigma and parental self-efficacy on psychological distress and its dimensions (stress, anxiety, and depression) three-way ANOVA carried out and the results are presented in the following tables.

The main and interaction effect of social support, affiliate stigma and parental self-efficacy on psychological distress and its sub-dimensions such as stress, anxiety and depression were calculated and the results are presented and discussed separately.

Influence of perceived social support, affiliate stigma and parental self-efficacy on psychological distress

Psychological distress is a state of emotional suffering related to stressors and demands that are difficult to handle or cope up with daily life. Mothers of

differently abled children may face difficult experiences while raising their children. Thus, understanding the nature of psychological distress in association with various social and personal aspects enable the community to deal effectively with the stressors linked to raising a child with disability. For the current research, the investigator has interested to know whether there exists any significant influence of social support, affiliate stigma and parental self-efficacy on psychological distress. For this three-way ANOVA was carried out and results are presented in table 37.

Table 37

Summary of 3-way ANOVA of Psychological distress by Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Social support	5075.114	1	5075.114	66.163*
Affiliate stigma	789.007	1	789.007	10.286**
Parental self-efficacy	2544.259	1	2544.259	33.169*
Social support*Parental self-efficacy	55.782	1	55.782	0.727
Social support*Affiliate stigma	76.688	1	76.688	1.000
Affiliate stigma*Parental self-efficacy	243.012	1	243.012	3.168
Social support*Parental self-efficacy*Affiliate stigma	700.763	1	700.763	9.136**
Error	21554.569	281	76.707	
Total	355565.000	289		

*p< .05; **p< .01

Table 37 portrays the results of 3-way ANOVA of psychological distress by perceived social support, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way significant interaction of perceived social support, affiliate stigma and parental self-efficacy on psychological distress ($F=9.136$, $p<.01$). This implies that when the different levels of perceived social support, affiliate stigma and parental self-efficacy are taken into consideration, there is significant interaction of these variables on psychological distress. Put simply, the varying levels of social support, affiliate stigma and parental self-efficacy can influence the experience of psychological distress of mothers of differently abled children. The significant interaction of these variables suggests the importance of combination of these variables in dealing with the psychological distress in mothers of differently abled children. The support system they perceive; the affiliate stigma they internalize; and

the belief in them as an effective parent in combination might influence the level of distress they experience. The synergistic relationship between affiliate stigma, social support and parental self-efficacy and their connection with psychological distress provides a basis for designing interventions to enhance the quality of effective parenthood to manage the child with disability and to reduce and prevent the negative impact of stigmatization experiences that impedes accessing or perceiving support networks available.

While considering the 2-way interactions, there is no significant interaction of social support and affiliate stigma; social support and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of social support and affiliate stigma, social support and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no interaction effects on psychological distress. At the same time social support, affiliate stigma and parental self -efficacy have independent main effects on psychological distress. Again, the importance of these variables on psychological distress has been established by these results.

Although the three-way interaction could not find out in related literature, independent effects have been seen. Thus, the results are consistent with the previous studies in this field. Greeshma and Manikandan (2017) found significant effects of social support and self-efficacy on psychological distress of mothers of disabled children. Recio et al., (2021) demonstrates the negative association of affiliate stigma with anxiety and depression. They also found the mediating role of self-efficacy between affiliate stigma and anxiety and depression. Ma and Mak (2016) reported the significant and positive indirect effect of affiliate stigma on psychological distress through increasing worry. They also pointed out the effect of perceived social support in reducing psychological distress. Ali et al., (2012) demonstrated that perceived stigma may prompt negative self-evaluation, negative social comparison and psychiatric symptomatology. In addition Leitch et al., (2019) reported that lack of support from the surrounding had an impact on the worsening of distress of parents in terms of feeling isolated, frustrated and stigmatized. Meirsschaut et al., (2010) found mothers' symptoms of depression and stress

strongly influenced by their parenting experiences and beliefs about parenting.

To know more about the interactions, the cell means of psychological distress by social support, affiliate stigma and parental self–efficacy was calculated and the results are presented in table 38.

Table 38

Mean, S.D and N of psychological distress by social support, affiliate stigma and parental self -efficacy

Social Support	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low Support	Low Parental Self-efficacy	Low affiliate stigma	34.10	20	4.529
		High affiliate stigma	46.01	89	10.349
		Total	43.83	109	10.599
	High Parental Self-efficacy	Low affiliate stigma	34.16	19	2.986
		High affiliate stigma	33.16	25	2.035
		Total	33.59	44	2.509
	Total	Low affiliate stigma	34.13	39	3.806
		High affiliate stigma	43.19	114	10.621
		Total	40.88	153	10.159
High support	Low Parental Self-efficacy	Low affiliate stigma	29.72	25	6.315
		High affiliate stigma	31.21	14	8.460
		Total	30.26	39	7.085
	High Parental Self-efficacy	Low affiliate stigma	18.97	87	9.675
		High affiliate stigma	23.80	10	13.088
		Total	19.46	97	10.105
	Total	Low affiliate stigma	21.37	112	10.069
		High affiliate stigma	28.13	24	11.019
		Total	22.56	136	10.523
Total	Low Parental Self-efficacy	Low affiliate stigma	31.67	45	5.954
		High affiliate stigma	44.00	103	11.291
		Total	40.25	148	11.467
	High Parental Self-efficacy	Low affiliate stigma	21.69	106	10.606
		High affiliate stigma	30.49	35	8.165
		Total	23.87	141	10.728
	Total	Low affiliate stigma	24.66	151	10.493
		High affiliate stigma	40.57	138	12.095
		Total	32.26	289	13.795

Table 38 shows the cell means of psychological distress by social support, affiliate stigma and parental self-efficacy. The cell means indicate the different levels of social support, affiliate stigma and parental self-efficacy in experiencing psychological distress among mothers of differently abled children. From the mean scores it can be seen that the participants who were having high social support, high parental self-efficacy, and low affiliate stigma scored low mean scores in psychological distress (Mean=18.97). Moreover, participants with low social support, low parental self-efficacy and high affiliate stigma scored high mean scores in psychological distress (Mean=46.01). The result yielded more clarity on the interaction of variables on psychological distress. From one side it can be assumed that, mothers who perceive themselves as competent parents feel less stigma because they do not see themselves as 'bad parents', having a higher level of psychological health and a more positive self-evaluation making them less vulnerable to others' judgements. The importance of perceiving more support, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the effects of psychological distress is clearly portrayed in this result. It also enables to get the idea of risk of being more stigmatised as a caregiver of disabled child, perceiving low support from society, and decreased level of confidence as an effective parent.

Influence of Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy on Stress

Stress is a normal reaction to everyday pressures. If it is upsetting the day to day life, it is a matter of concern. It may have negative impact on both physical and psychological level. Dealing a child with disability might be stressful in many ways. The increased demands of raising a differently abled child may affect every systems of body-both physically and mentally. This may influence how people think, behave etc. To know more about the stress experienced by the mothers of differently abled children by linking social support, affiliate stigma and parental self-efficacy together the investigator has carried out 3-way ANOVA of stress by social support, affiliate stigma and parental self-efficacy. The results are presented in table 39.

Table 39

Summary of 3-way ANOVA of Stress by Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Social support	369.246	1	369.246	45.970*
Affiliate stigma	37.370	1	37.370	4.652**
Parental self-efficacy	165.318	1	165.318	20.582*
Social support*Parental self-efficacy	5.685	1	5.685	0.708
Social support*Affiliate stigma	18.448	1	18.448	2.297
Affiliate stigma*Parental self-efficacy	7.858	1	7.858	0.978
Social support*Parental self-efficacy*Affiliate stigma	45.385	1	45.385	5.650**
Error	2257.089	281	8.032	
Total	24083.000	289		

*p< .05, **p< .01

Table 39 presents the results of 3-way ANOVA of Stress by Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy. Similar to the result on psychological distress, there exists a significant crossover effect of social support, affiliate stigma and parental self-efficacy on stress ($F=5.65$, $p<.01$). Which means when the different levels of social support, affiliate stigma and parental self-efficacy are taken together; they significantly interacts each other on stress-the dimension of psychological distress. In other words, the combined effects of different levels of social support, affiliate stigma and parental self-efficacy on stress experienced by the mothers should address together instead of addressing individually.

Although the three-way interaction could not find out in related literature, independent effects have been seen. This finding is congruent with previous studies among parents of children with disabilities (Bayat, 2007; Ruiz-Robledillo et al., 2014) implying that the support one perceives from his/her networks have the potential to foster the ability to overcome distress and sustain well-being. Meirsschaut et al., (2010) demonstrated that mothers' symptoms of stress are strongly influenced by their parenting experiences and belief about parenting. Mothers who reported lower parenting self-efficacy reported psychological symptoms of maternal depression (Teti & Gelfand, 1991). Parent depression and anxiety may increase attributions of parenting failure. In turn, failure at parenting may increase depression, anxiety, withdrawal, and helplessness. Parents who feel

distress are likely to feel less capable and parents who feel less capable are more likely to feel distress**.** Daulay et al., (2018) demonstrated that parenting stress was directly influenced by hardiness, social support, child's maladaptive behavior, and parenting sense of competence of mothers having children with special needs. In addition there was a mediating effect of parenting sense of competence between hardiness and parenting stress.

To know more about the interactions, the cell means of stress was calculated and the results are presented in table 40.

Table 40

Mean, Standard deviation and Number of participants of stress by Social Support, Affiliate Stigma and Parental Self -Efficacy

Social Support	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S D
Low Support	Low Parental Self-efficacy	Low affiliate stigma	8.85	20	2.059
		High affiliate stigma	11.62	89	2.975
		Total	11.11	109	3.020
	High Parental Self-efficacy	Low affiliate stigma	9.00	19	1.491
		High affiliate stigma	8.84	25	1.405
		Total	8.91	44	1.428
	Total	Low affiliate stigma	8.92	39	1.783
		High affiliate stigma	11.01	114	2.940
		Total	10.48	153	2.838
High support	Low Parental Self-efficacy	Low affiliate stigma	7.96	25	2.590
		High affiliate stigma	7.93	14	2.556
		Total	7.95	39	2.544
	High Parental Self-efficacy	Low affiliate stigma	4.72	87	3.248
		High affiliate stigma	5.90	10	4.175
		Total	4.85	97	3.349
	Total	Low affiliate stigma	5.45	112	3.385
		High affiliate stigma	7.08	24	3.400
		Total	5.74	136	3.432
Total	Low Parental Self-efficacy	Low affiliate stigma	8.36	45	2.385
		High affiliate stigma	11.12	103	3.176
		Total	10.28	148	3.213
	High Parental Self-efficacy	Low affiliate stigma	5.49	106	3.426
		High affiliate stigma	8.00	35	2.797
		Total	6.11	141	3.448
	Total	Low affiliate stigma	6.34	151	3.408
		High affiliate stigma	10.33	138	3.362
		Total	8.25	289	3.924

Table 40 shows the cell means of stress by perceived social support, affiliate stigma and parental self-efficacy. The cell means indicate the interaction of different levels of social support, affiliate stigma and parental self-efficacy do produce difference in experience of stress in mothers of differently abled children. From the mean scores it can be seen that the participants who were having high social support, high parental self-efficacy, and low affiliate stigma scored lower mean scores on stress (Mean=4.72). In addition, participants with low social support, low parental self-efficacy and high affiliate stigma scored high mean scores in stress (Mean=11.62). The importance of perceiving more support, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatization experiences for reducing the effects of stress is clearly portrayed in this result. The result implicates the relevance of having high support and self-efficacy as well as reduced levels of affiliate stigma.

Influence of Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy on Anxiety

Anxiety, as an emotion mostly considered to be future oriented, plays a significant role in mothers of differently abled children. It is characterized by feelings of tension, worried thoughts and physical changes such as increased blood pressure. The uncertainty of the future of the child and the condition is the key element of anxiety in many of them. Apart from this, various other factors may also play role in increasing the worries. In the current study, for the better understanding of the effects of social support, affiliate stigma and parental self-efficacy on anxiety, the investigator has carried out a 3- way ANOVA of anxiety by social support, affiliate stigma and parental self-efficacy. The results are presented in table 41.

Table 41
Summary of 3-way ANOVA of Anxiety by Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Social support	628.775	1	628.775	41.985**
Affiliate stigma	189.096	1	189.096	12.626**
Parental self efficacy	561.159	1	561.159	37.470**
Social support*Parental self-efficacy	9.633	1	9.633	0.643
Social support*Affiliate stigma	24.445	1	24.445	1.632
Affiliate stigma*Parental self-efficacy	68.697	1	68.697	4.587*
Social support*Parental self-efficacy*Affiliate stigma	53.554	1	53.554	3.576
Error	4208.328	281	14.976	
Total	53448.000	289		

*p< .05 **p< .01

Table 41 shows the results of 3- way ANOVA of anxiety by perceived social support, affiliate stigma and parental self-efficacy. There is no three-way interaction of perceived social support, affiliate stigma and parental self-efficacy on anxiety. However, while considering the 2-way interactions, there is a significant interaction of affiliate stigma and parental self-efficacy ($F=4.587$, $p<.05$) on anxiety. The result points out the importance of the connection of affiliate stigma and parental self-efficacy in dealing anxiety of mothers of differently abled children. Varying levels of internalization of stigma as a mother of disabled children together with belief of being a 'failure/successful parent' influences their anxiety levels. For an extent, the social withdrawing tendency of mothers can be explained by this result. There were no significant interactions for the combination of social support and parental self-efficacy as well as social support and affiliate stigma. This result indicates that the combinations of social support and affiliate stigma, as well as social support and parental self-efficacy have no effects on anxiety. At the same time social support, affiliate stigma and parental self -efficacy have independent main effects on anxiety. Miller et al., (1992) reported that parents who possess less parenting self-efficacy tend to make more internal attribution of failure and display higher levels of

depressive and anxiety symptoms. Again, the importance of these variables on anxiety has been established by these results. Lower parental self- efficacy found to be associated with giving up more quickly, feeling anxious, depressed, frustrated as well as reporting less perceived social support (Shumow, et. al., 2002). Macdonald (2011) revealed a decrease in reported feelings of anxiety and depression with greater use of social support among parents of children with ASD. They also suggested that informal sources of support might be particularly important.

Influence of Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy on Depression

Depression is an emotional state characterised by low self-worth, feelings of guilt, lower self-esteem, sadness, reduced ability to enjoy life etc. The challenging natures of nurturing a child with disability sometimes owe the parent to the state of depression/low mood. Thorough understanding of the social and personal aspects on depression of mothers of differently abled children is needed for overcoming such situation. Thus, for the current study, researcher carried out a 3-way ANOVA of depression by social support, affiliate stigma and parental self-efficacy. Results are presented in table 42.

Table 42

Summary of ANOVA of depression by Perceived Social Support, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Social support	726.231	1	726.231	47.394**
Affiliate stigma	67.650	1	67.650	4.415*
Parental self-efficacy	193.050	1	193.050	12.598**
Social support*Parental self-efficacy	3.924	1	3.924	0.256
Social support*Affiliate stigma	.232	1	.232	0.015
Affiliate stigma*Parental self-efficacy	20.225	1	20.225	1.320
Social support*Parental self-efficacy*Affiliate stigma	154.183	1	154.183	10.062**
Error	4305.851	281	15.323	
Total	47786.000	289		

*p< .05 **p< .01

From table 42, it can be seen that the variables perceived social support, affiliate stigma and parental self-efficacy significantly interacts on depression ($F=10.062$, $p<.01$). That is, the varying levels of social support, affiliate stigma and parental self-efficacy may in combination influence the experience of depression of mothers of differently abled children. The significant interaction of these variables suggests the importance of combination of these variables in dealing the depression in mothers of differently abled children. Professionals in this field can design programmes in connection with this result for decreasing the feelings of depression.

While considering the 2-way interactions, there is no significant interaction of social support and affiliate stigma; social support and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of social support and affiliate stigma, social support and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on depression. At the same time social support, affiliate stigma and parental self -efficacy have independent main effects on depression. Meirsschaut et al., (2010) demonstrated that mothers' symptoms of stress are strongly influenced by their parenting experiences and belief about parenting. Mothers who reported lower parenting self-efficacy reported psychological symptoms of maternal depression (Teti & Gelfand, 1991). Parent depression and anxiety may increase attributions of parenting failure. In turn, failure at parenting may increase depression, anxiety, withdrawal, and helplessness. Parents who feel distress are likely to feel less capable and parents who feel less capable are more likely to feel distress.

To know more about the interactions, the cell means of depression was calculated and the results are presented in table 43

Table 43

Mean, Standard deviation and Number of participants of Depression by Perceived Social Support, Affiliate Stigma And Parental Self -Efficacy

Social Support	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low Support	Low Parental Self-efficacy	Low affiliate stigma	12.40	20	1.635
		High affiliate stigma	16.56	89	4.393
		Total	15.80	109	4.337
	High Parental Self-efficacy	Low affiliate stigma	12.79	19	1.584
		High affiliate stigma	11.76	25	1.052
		Total	12.20	44	1.391
	Total	Low affiliate stigma	12.59	39	1.601
		High affiliate stigma	15.51	114	4.387
		Total	14.76	153	4.071
High support	Low Parental Self-efficacy	Low affiliate stigma	10.40	25	5.074
		High affiliate stigma	10.14	14	4.753
		Total	10.31	39	4.900
	High Parental Self-efficacy	Low affiliate stigma	7.13	87	4.023
		High affiliate stigma	9.30	10	4.498
		Total	7.35	97	4.103
	Total	Low affiliate stigma	7.86	112	4.470
		High affiliate stigma	9.79	24	4.568
		Total	8.20	136	4.531
Total	Low Parental Self-efficacy	Low affiliate stigma	11.29	45	4.026
		High affiliate stigma	15.69	103	4.941
		Total	14.35	148	5.091
	High Parental Self-efficacy	Low affiliate stigma	8.14	106	4.295
		High affiliate stigma	11.06	35	2.722
		Total	8.87	141	4.151
	Total	Low affiliate stigma	9.08	151	4.445
		High affiliate stigma	14.51	138	4.910
		Total	11.67	289	5.399

Table 43 shows the cell means of depression by perceived social support, affiliate stigma and parental self -efficacy. As per the table report, varying levels of social support, affiliate stigma and parental self-efficacy together make difference in experience of depression in mothers of differently abled children. From the mean scores it can be seen that the participants who were having high social support, high parental self-efficacy, and low affiliate stigma scored low mean scores depression (Mean=7.13). Moreover, participants with low social support, low parental self-efficacy and high affiliate stigma scored high mean scores in depression (Mean=16.56). The result is an indication of importance of perceiving support from the society, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for alleviating the depression.

These results are consistent with the previous studies in this area. According to Miller et al., (1992) parents who possess less parenting self-efficacy tend to make more internal attribution of failure and display higher levels of depressive and anxiety symptoms. Meirsschaut et al., (2010) demonstrated that mothers' stress related symptoms are strongly influenced by their parenting experiences and belief about parenting.

To know the main and interaction effects of dimensions of perceived social support(significant others, family, and friends), parental self-efficacy, and affiliate stigma on psychological distress of mothers of differently abled children, Univariate Analysis of Variance (ANOVA) has been carried out. Since the variables were measured in interval scale, they were classified into high and low based on their respective median as cut off point. The classification of the variables is presented in the table 44.

Table 44

Cross tabulation of Perceived support from Significant others, Parental Self-Efficacy and Affiliate stigma

Affiliate Stigma	Significant others	Statistic	Parental Self-Efficacy		Total
			Low Parental Self-efficacy	High Parental Self-efficacy	
Low Affiliate Stigma	Low Significant others	Count	25	32	57
		% within Significant Others	43.9%	56.1%	100.0%
		% within Parental Self-Efficacy	55.6%	30.2%	37.7%
		% of Total	16.6%	21.2%	37.7%
	High Significant others	Count	20	74	94
		% within Significant Others	21.3%	78.7%	100.0%
		% within Parental Self-Efficacy	44.4%	69.8%	62.3%
		% of Total	13.2%	49.0%	62.3%
	Total Significant others	Count	45	106	151
		% within Significant Others	29.8%	70.2%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	29.8%	70.2%	100.0%
High Affiliate Stigma	Low Significant others	Count	81	19	100
		% within Significant Others	81.0%	19.0%	100.0%
		% within Parental Self-Efficacy	78.6%	54.3%	72.5%
		% of Total	58.7%	13.8%	72.5%
	High Significant others	Count	22	16	38
		% within Significant Others	57.9%	42.1%	100.0%
		% within Parental Self-Efficacy	21.4%	45.7%	27.5%
		% of Total	15.9%	11.6%	27.5%
	Total Significant others	Count	103	35	138
		% within Significant Others	74.6%	25.4%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	74.6%	25.4%	100.0%

Table 44 shows the cross tabulation of Perceived support from Significant others, Parental Self-Efficacy and Affiliate stigma. The classification of high and low perceived support from significant others, parental self-efficacy and affiliate stigma portray a comprehensive view of these variables. From the table 44, it can be seen that about 25 participants were categorised under low affiliate stigma, low perceived support from significant others and low parental self-efficacy combination. At the same time 32 participants fall under the category of low affiliate stigma, low perceived support from significant others and high parental self-efficacy. Interestingly, about 74 (26% of total participants) participants scored under the category of high parental self-efficacy, high perceived support from significant others, and low affiliate stigma. Only 20 falls under the combination of low affiliate stigma, high perceived support from significant others and low parental self-efficacy. Another intriguing result has been found in the category of combination of high affiliate stigma, low perceived support from significant others and low parental self-efficacy. About 81 participants were classified under this category. That means about 81 (28% of total participants) people experience a combination of high affiliate stigma, low perceived support from significant others and low parental self-efficacy in this study. Only 19 participants were categorised under the combination of high affiliate stigma, low perceived support from significant others with high parental self-efficacy. While considering the combination of high affiliate stigma with high perceived support from significant others and low parental self-efficacy, only 22 participants were classified under this category. Where as in high affiliate stigma with high perceived support from significant others and high parental self-efficacy, there were 16 participants.

To know the influence of perceived support from significant others, affiliate stigma and parental self-efficacy on psychological distress and its dimensions (stress, anxiety, and depression) three-way ANOVA with different combinations was carried out and the results are presented in separate tables.

Table 45

Summary of 3- way ANOVA of Psychological Distress by Perceived Support from Significant Others, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Significant others	2873.613	1	2873.613	33.936**
Self-efficacy	4702.099	1	4702.099	55.530**
Affiliate stigma	3624.942	1	3624.942	42.809**
Significant others* Self efficacy	139.815	1	139.815	1.651
Significant others* Affiliate stigma	73.288	1	73.288	0.866
Self-efficacy* Affiliate stigma	269.297	1	269.297	3.180
Significant others* Self-efficacy* Affiliate stigma	268.255	1	268.255	3.168
Error	23794.099	281	84.677	
Total	355565.000	289		

*p< .05 **p< .01

Table 45 displays the results of 3-way ANOVA of psychological distress by perceived support from significant others, affiliate stigma and parental self-efficacy. As per the table reports, there is no significant three-way interaction of these variables on psychological distress of mothers of differently abled children. That means when the different levels of perceived support from significant others, affiliate stigma and parental self-efficacy are taken into consideration, there is no interaction effects on psychological distress. For caring children, the need of having a constant support may be beneficial. The significant person may not be fit in this regard. Moreover, there is no significant two-way interaction between these variables on psychological distress of mothers.

Table 46

Summary of 3- way ANOVA of Stress by Perceived Support from Significant Others, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Significant others	230.273	1	230.273	27.782**
Self-efficacy	271.602	1	271.602	32.768**
Affiliate stigma	199.969	1	199.969	24.126**
Significant others* Self efficacy	7.030	1	7.030	0.848
Significant others* Affiliate stigma	14.585	1	14.585	1.760
Self-efficacy* Affiliate stigma	3.797	1	3.797	0.458
Significant others* Self efficacy* Affiliate stigma	42.709	1	42.709	5.153*
Error	2329.086	281	8.289	
Total	24083.000	289		

*p< .05 **p< .01

Table 46 presents the results of 3-way ANOVA of stress by perceived support from significant others, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way interaction of perceived support from significant others, affiliate stigma and parental self-efficacy on stress ($F=5.153$, $p<.05$). The significant interaction of these variables suggests the importance of combination of these variables in dealing stress in mothers of differently abled children. Having someone there to share the sorrows may be a relief for mothers. If they cannot perceive such a support from anywhere it may affect negatively. According to Thoits (2020), compared to family and friends, significant others in a person's life play important and virtually guaranteed emotional, informational and instrumental roles situated in the provision of empathy, a sense of relationship stability, financial support and non-judgmental counsel, among others Once available, these forms of support are noted to improve wellbeing, reduce stress and foster resilience (Bergstorm et al., 2020). As per the study result of Peer and Hillman (2014), parents raising children with special needs have reported that support from their networks is effective in tackling care giving stress and promoting positive outcomes through the non-judgmental discussion of their concerns, receiving empathy from others, venting out negative emotions and seeking counsel. While considering the 2-way interactions, there is no significant interaction of perceived support from family and affiliate stigma; perceived support from family and parental self-efficacy; affiliate stigma and parental self-efficacy. At the same time, there is significant independent effects of perceived support from significant others ($F=27.782$, $p<.05$), parental self-

efficacy (F= 32.768, p<.05) and affiliate stigma (F= 24.126, p<.05) on stress.

To know more about the interactions, the cell means of stress by perceived support from significant others, affiliate stigma and parental self -efficacy was calculated and the results are presented in table 47.

Table 47

Cell mean of stress by perceived support from significant others, affiliate stigma and parental self -efficacy

Perceived support from Significant Others	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from significant others	Low Parental Self-efficacy	Low affiliate stigma	8.96	25	1.814
		High affiliate stigma	11.57	81	2.941
		Total	10.95	106	2.929
	High Parental Self-efficacy	Low affiliate stigma	8.22	32	2.685
		High affiliate stigma	8.47	19	2.010
		Total	8.31	51	2.437
	Total	Low affiliate stigma	8.54	57	2.353
		High affiliate stigma	10.98	100	3.035
		Total	10.10	157	3.036
High perceived support from significant others	Low Parental Self-efficacy	Low affiliate stigma	7.60	20	2.817
		High affiliate stigma	9.45	22	3.515
		Total	8.57	42	3.299
	High Parental Self-efficacy	Low affiliate stigma	4.31	74	3.025
		High affiliate stigma	7.44	16	3.502
		Total	4.87	90	3.319
	Total	Low affiliate stigma	5.01	94	3.261
		High affiliate stigma	8.61	38	3.606
		Total	6.05	132	3.727
Perceived support from significant others	Low Parental Self-efficacy	Low affiliate stigma	8.36	45	2.385
		High affiliate stigma	11.12	103	3.176
		Total	10.28	148	3.213
	High Parental Self-efficacy	Low affiliate stigma	5.49	106	3.426
		High affiliate stigma	8.00	35	2.797
		Total	6.11	141	3.448
	Total	Low affiliate stigma	6.34	151	3.408
		High affiliate stigma	10.33	138	3.362
		Total	8.25	289	3.924

Table 47 shows the cell means of stress by perceived support from significant others, affiliate stigma and parental self-efficacy. The cell means point out the interaction of different levels of perceived support from significant others, affiliate stigma and parental self-efficacy do produce difference in experiences of stress in mothers of differently abled children. From the mean scores it can be seen that the participants who were having high perceived support from significant others, high parental self-efficacy, and low affiliate stigma scored low mean scores in stress (Mean=4.31). Moreover, participants with low perceived support from significant others, low parental self-efficacy and high affiliate stigma scored high mean scores in stress (Mean=11.57). The result indicates the importance of perceiving more support from significant others, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the effects of stress. It also demonstrates the risk of being more stigmatised as a caregiver of disabled child, perceiving low support, and decreased level of confidence as an effective parent.

To find out the influence of perceived support from significant others, affiliate stigma and parental self-efficacy on anxiety of participants, 3-way ANOVA has been carried out and the results are presented in table 48.

Table 48

Summary of 3- way ANOVA of Anxiety by Perceived Support from Significant Others, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Significant others	455.087	1	455.087	29.884**
Self-efficacy	852.460	1	852.460	55.979**
Affiliate stigma	613.468	1	613.468	40.285**
Significant others* Self efficacy	46.769	1	46.769	3.071
Significant others* Affiliate stigma	10.531	1	10.531	0.692
Self-efficacy* Affiliate stigma	72.932	1	72.932	4.789
Significant others* Self efficacy* Affiliate stigma	26.212	1	26.212	1.721
Error	4279.130	281	15.228	
Total	53448.000	289		

**p< .01

Table 48 portrays the results of 3- way ANOVA of anxiety by perceived support from significant others, affiliate stigma and parental self-efficacy. As per the

table reports, there is no significant three-way interaction of these variables on anxiety levels of mothers of differently abled children. At the same time there is significant independent effect of these variables on anxiety. This implies that significant others, affiliate stigma and parental self-efficacy acts independently on anxiety of the participants.

To know the influence of perceived support from significant others, affiliate stigma and parental self-efficacy on depression, 3-way ANOVA has been carried out and the results are presented in table 49.

Table 49

Summary of 3- way ANOVA of Depression by Perceived Support from Significant Others, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Significant others	292.361	1	292.361	16.617**
Self efficacy	524.162	1	524.162	29.791**
Affiliate stigma	453.613	1	453.613	25.782**
Significant others* Self efficacy	5.448	1	5.448	0.310
Significant others* Affiliate stigma	2.240	1	2.240	0.127
Self efficacy* Affiliate stigma	35.067	1	35.067	1.993
Significant others* Self efficacy* Affiliate stigma	22.312	1	22.312	1.268
Error	4944.053	281	17.594	
Total	47786.000	289		

**p< .01

Table 49 gives the results of 3- way ANOVA of depression by perceived support from significant others, affiliate stigma and parental self-efficacy. As per the table reports, there is no significant three-way interaction of these variables on depression levels of mothers of differently abled children. That is, when the different levels of perceived support from significant others, affiliate stigma and parental self-efficacy is taken into consideration; there is no interaction between these variables on depression. Moreover, there is no significant two-way interaction between these variables on depression levels of mothers.

To know the main and interaction effects of perceived family support, parental self-efficacy, and affiliate stigma on psychological distress of mothers of differently abled children, Univariate Analysis of Variance (ANOVA) has been

carried out. Since the variables were measured in interval scale, they were classified into high and low based on their respective median as cut off point. The classification of the variables is presented in the table 50.

Table 50

Cross tabulation of classification of high and low Perceived Support from Family, Parental Self-Efficacy and Affiliate Stigma

Affiliate Stigma	Family support	Statistic	Parental Self-Efficacy		Total
			Low Parental Self-efficacy	High Parental Self-efficacy	
Low affiliate stigma	Low Family support	Count	24	22	46
		% within Family	52.2%	47.8%	100.0%
		% within Parental Self-Efficacy	53.3%	20.8%	30.5%
		% of Total	15.9%	14.6%	30.5%
	High Family support	Count	21	84	105
		% within Family	20.0%	80.0%	100.0%
		% within Parental Self-Efficacy	46.7%	79.2%	69.5%
		% of Total	13.9%	55.6%	69.5%
	Total Family support	Count	45	106	151
		% within Family	29.8%	70.2%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	29.8%	70.2%	100.0%
High affiliate stigma	Low Family support	Count	88	20	108
		% within Family	81.5%	18.5%	100.0%
		% within Parental Self-Efficacy	85.4%	57.1%	78.3%
		% of Total	63.8%	14.5%	78.3%
	High Family support	Count	15	15	30
		% within Family	50.0%	50.0%	100.0%
		% within Parental Self-Efficacy	14.6%	42.9%	21.7%
		% of Total	10.9%	10.9%	21.7%
	Total Family support	Count	103	35	138
		% within Family	74.6%	25.4%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	74.6%	25.4%	100.0%

Table 50 presents the cross tabulation of classification of high and low Perceived Support from Family, Parental Self-Efficacy and Affiliate Stigma. From table 50, it can be seen that about 24 participants were categorised under low affiliate stigma, low perceived support from family and low parental self-efficacy grouping. At the same time 22 participants fall under the category of low affiliate stigma, low perceived support from family and high parental self-efficacy. Interestingly, about 84 (29%) of total participants grouped under the category of high parental self-efficacy, high perceived support from family, and low affiliate stigma respectively. Only 21 falls under the combination of low affiliate stigma, high perceived support from family and low parental self- efficacy. Another intriguing result has been found in the category of combination of high affiliate stigma, low perceived support from family and low parental self-efficacy. About 88 (30%) participants were classified under this category. That is 30% of total participants comes under this grouping of high affiliate stigma, low perceived support from family and low parental self-efficacy in this study. Only 20 participants were categorised under the combination of high affiliate stigma, low perceived support from family with high parental self-efficacy. While considering the group of high affiliate stigma with high perceived support from family and low parental self-efficacy, only 15 participants were classified under this category. Where as in high affiliate stigma with high perceived support from family and high parental self-efficacy, there were 15 participants.

To know the influence of variables such as perceived support from family, affiliate stigma and parental self-efficacy on psychological distress and its dimensions (stress, anxiety, and depression) three-way ANOVA with different combinations was carried out and the results are presented in the following tables.

Table 51

Summary of 3-way ANOVA of psychological distress by perceived support from family, affiliate stigma and parental self-efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Self-efficacy	3363.603	1	3363.603	37.476**
Affiliate stigma	2310.651	1	2310.651	25.744**
Family	2058.161	1	2058.161	22.931**
Self- efficacy * Affiliate stigma	81.281	1	81.281	0.906
Self-efficacy * Family	4.364	1	4.364	0.049
Affiliate stigma * Family	72.639	1	72.639	0.809
Self-efficacy * Affiliate stigma* Family	686.278	1	686.278	7.646**
Error	25220.763	281	89.754	
Total	355565.000	289		

**p< .01

Table 51shows the results of 3-way ANOVA of psychological distress by perceived support from family, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on psychological distress ($F=7.646$, $p<.01$). The significant interaction of these variables suggests the importance of combination of these variables in understanding psychological distress in mothers of differently abled children. It is not surprising that mothers often rely on the family members for sharing caretaking responsibilities. If they cannot perceive such a support from family, it may affect negatively. While considering the 2-way interactions, there is no significant interaction between perceived support from family and affiliate stigma; between perceived support from family and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of perceived support from family and affiliate stigma, perceived support from family and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on psychological distress. At the same time perceived support from family, affiliate stigma and parental self -efficacy have independent main effects on psychological distress. Again, the importance of these variables on psychological distress has been established by these results. Lovell and

Wetherel (2019) found positive relationship between affiliate stigma and perceived stress. This relationship is occurred indirectly via lower perceived support from family, but not from friends or significant others. According to A-Park and Lee(2022) social support from extended family members, friends, and informal social networks in the community moderates the influence of parental stress on depression among mothers of children with disabilities. This points out that a high level of informal social support lessens the negative effect of parental stress on depression. If mothers are assured with adequate informal social support from extended family members, friends, and informal social networks in the community, their depressive symptoms may be decreased. At the same time, those mothers with a low level of informal social support can suffer from depressive symptoms due to parental stress.

To get more clarity on the interaction of variables cell means of psychological distress by perceived support from family, affiliate stigma and parental self –efficacy have been calculated and tabulated in table 52

Table 52

Cell means of psychological distress by perceived support from family, affiliate stigma and parental self -efficacy

Perceived support from Family	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	32.25	24	5.825
		High affiliate stigma	45.66	88	10.408
		Total	42.79	112	11.067
	High Parental Self-efficacy	Low affiliate stigma	29.23	22	7.017
		High affiliate stigma	32.35	20	5.797
		Total	30.71	42	6.579
	Total	Low affiliate stigma	30.80	46	6.531
		High affiliate stigma	43.19	108	11.001
		Total	39.49	154	11.382
High perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	31.00	21	6.173
		High affiliate stigma	34.27	15	11.701
		Total	32.36	36	8.900
	High Parental Self-efficacy	Low affiliate stigma	19.71	84	10.528
		High affiliate stigma	28.00	15	10.233
		Total	20.97	99	10.851
	Total	Low affiliate stigma	21.97	105	10.787
		High affiliate stigma	31.13	30	11.261
		Total	24.01	135	11.505
Total perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	31.67	45	5.954
		High affiliate stigma	44.00	103	11.291
		Total	40.25	148	11.467
	High Parental Self-efficacy	Low affiliate stigma	21.69	106	10.606
		High affiliate stigma	30.49	35	8.165
		Total	23.87	141	10.728
	Total	Low affiliate stigma	24.66	151	10.493
		High affiliate stigma	40.57	138	12.095
		Total	32.26	289	13.795

Table 52 shows the cell means of psychological distress by perceived support from family, affiliate stigma and parental self -efficacy. From the mean scores it can be seen that the participants who were having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in psychological distress (Mean=19.71). Moreover, participants with low perceived support from family, low parental self-efficacy and high affiliate stigma scored high mean scores in psychological distress (Mean=45.66). The result provides more clarity on the interaction of variables on psychological distress. The relevance of perceiving more support family, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the effects of psychological distress is clearly presented in this result. It also enables to get the idea of risk of being more stigmatised as a caregiver of disabled child, perceiving low support from families, and decreased level of confidence as an effective parent.

Three-way ANOVA has been carried out to find out the influence of perceived support from family, affiliate stigma and parental self-efficacy on stress and results are presented in table 53..

Table 53

Summary of 3- way ANOVA of Stress by Perceived Support from Family, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Self efficacy	184.570	1	184.570	21.232**
Affiliate stigma	111.207	1	111.207	12.793**
Family	231.609	1	231.609	26.643**
Self efficacy * Affiliate stigma	.090	1	.090	0.010
Self efficacy * Family	.026	1	.026	0.003
Affiliate stigma * Family	8.177	1	8.177	0.941
Self efficacy * Affiliate stigma* Family	45.347	1	45.347	5.217*
Error	2442.712	281	8.693	
Total	24083.000	289		

*p<.05 **p<.01

Table 53 gives the results of 3-way ANOVA of stress by perceived support from family, affiliate stigma and parental self-efficacy. As per the table report, there exists a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on stress ($F=5.217$, $p<.05$). The significant interaction of these variables suggests the importance of combination of these variables in treating stress in mothers of differently abled children. Mothers often depend upon the family members for sharing caretaking responsibilities. If they cannot perceive such a support from family it may affect negatively. It may result in high stress in mothers. While considering the 2-way interactions, there is no significant interaction of perceived support from family and affiliate stigma; perceived support from family and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of perceived support from family and affiliate stigma, perceived support from family and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on stress. At the same time perceived support from family, affiliate stigma and parental self -efficacy have independent main effects on stress. Again, the importance of these variables on stress has been established by these results. Lovell and Wetherel (2019) found positive relationship between affiliate stigma and perceived stress. This relationship is occurred indirectly via lower perceived support from family, but not from friends or significant others.

To have a more clarity on interaction of these variables, cell means of Stress by Perceived Support from Family, Affiliate Stigma and Parental Self-Efficacy have been calculated and presented in table 54

Table 54
Cell means of Stress by Perceived Support from Family, Affiliate Stigma and Parental Self -Efficacy

Perceived support from family	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	8.75	24	2.308
		High affiliate stigma	11.65	88	2.909
		Total	11.03	112	3.027
	High Parental Self-efficacy	Low affiliate stigma	7.68	22	3.014
		High affiliate stigma	8.70	20	2.203
		Total	8.17	42	2.677
	Total	Low affiliate stigma	8.24	46	2.693
		High affiliate stigma	11.10	108	3.011
		Total	10.25	154	3.194
High perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	7.90	21	2.448
		High affiliate stigma	8.00	15	2.952
		Total	7.94	36	2.629
	High Parental Self-efficacy	Low affiliate stigma	4.92	84	3.308
		High affiliate stigma	7.07	15	3.283
		Total	5.24	99	3.378
	Total	Low affiliate stigma	5.51	105	3.366
		High affiliate stigma	7.53	30	3.104
		Total	5.96	135	3.404
Total	Low Parental Self-efficacy	Low affiliate stigma	8.36	45	2.385
		High affiliate stigma	11.12	103	3.176
		Total	10.28	148	3.213
	High Parental Self-efficacy	Low affiliate stigma	5.49	106	3.426
		High affiliate stigma	8.00	35	2.797
		Total	6.11	141	3.448
	Total	Low affiliate stigma	6.34	151	3.408
		High affiliate stigma	10.33	138	3.362
		Total	8.25	289	3.924

Table 54 shows the cell means of stress by perceived support from family, affiliate stigma and parental self-efficacy. The cell means indicate that the interaction of different levels of perceived support from family, affiliate stigma and parental self-efficacy do produce difference in experience of stress in mothers of differently abled children. From the mean scores it can be seen that the participants

who were having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in stress (Mean=4.92). Moreover, participants with low perceived support from family, low parental self-efficacy and high affiliate stigma scored high mean scores in stress (Mean=11.65). The result implies the importance of perceiving more support family, increasing the confidence level as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the impact of stress. It also points out the negative effect of being more stigmatised as a caregiver of disabled child, perceiving low support from families, and decreased level of confidence as an effective parent.

To know the influence of perceived support from family, affiliate stigma and parental self-efficacy on anxiety, 3-way ANOVA has been calculated and the results are presented in table 55.

Table 55

Summary of 3- way ANOVA of anxiety by perceived support from family, affiliate stigma and parental self-efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Self efficacy	632.948	1	632.948	39.035**
Affiliate stigma	428.158	1	428.158	26.405**
Family	275.549	1	275.549	16.993**
Self efficacy * Affiliate stigma	46.056	1	46.056	2.840
Self efficacy * Family	5.034	1	5.034	0.310
Affiliate stigma * Family	.945	1	0.945	0.058
Self efficacy * Affiliate stigma* Family	91.037	1	91.037	5.614*
Error	4556.405	281	16.215	
Total	53448.000	289		

*p< .05 **p< .01

Table 55 shows the results of 3-way ANOVA of anxiety by perceived support from family, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on anxiety ($F=5.614$, $p<.05$). That is, when the different levels of perceived support from family, affiliate stigma and parental self-efficacy are

taken into consideration, there is an interaction of these variables on anxiety. The significant interaction of these variables suggests the importance of combination of these variables in dealing anxiety in mothers of differently-abled children. Mostly, mothers depend upon family members for caretaking responsibilities. If they cannot perceive such a support from family it may affect negatively. Perceiving 'no one is there to protect their children' may increase the risk of anxiety. While considering the 2-way interactions, there is no significant interaction of perceived support from family and affiliate stigma; perceived support from family and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of perceived support from family and affiliate stigma, perceived support from family and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on anxiety. At the same time perceived support from family, affiliate stigma and parental self -efficacy have independent main effects on anxiety. Recio et al., (2021) showed that caregivers' perceived discrimination is positively related to their affiliate stigma that in turn is harmful to their anxiety and depression. Nevertheless, caregivers' self-efficacy plays a mediating role in the relation between affiliate stigma and caregivers' anxiety and depression. According Zhou et al., (2013) people can get the beneficial effects of reducing anxiety levels or solving problems from the support of family, friends, or neighbours.

To know more about the interaction of these variables, cell means anxiety by perceived support from family, affiliate stigma and parental self-efficacy have been calculated and the results are presented in table 56.

Table 56
Cell means of anxiety by perceived support from family, affiliate stigma and parental self-efficacy

Perceived support from family	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	12.42	24	2.165
		High affiliate stigma	17.68	88	4.600
		Total	16.55	112	4.719
	High Parental Self-efficacy	Low affiliate stigma	11.45	22	2.405
		High affiliate stigma	11.95	20	3.252
		Total	11.69	42	2.815
	Total	Low affiliate stigma	11.96	46	2.309
		High affiliate stigma	16.62	108	4.908
		Total	15.23	154	4.796
High perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	11.57	21	2.619
		High affiliate stigma	14.33	15	4.499
		Total	12.72	36	3.731
	High Parental Self-efficacy	Low affiliate stigma	7.17	84	4.374
		High affiliate stigma	10.73	15	4.448
		Total	7.71	99	4.547
	Total	Low affiliate stigma	8.05	105	4.441
		High affiliate stigma	12.53	30	4.761
		Total	9.04	135	4.870
Total	Low Parental Self-efficacy	Low affiliate stigma	12.02	45	2.398
		High affiliate stigma	17.19	103	4.716
		Total	15.62	148	4.780
	High Parental Self-efficacy	Low affiliate stigma	8.06	106	4.397
		High affiliate stigma	11.43	35	3.798
		Total	8.89	141	4.488
	Total	Low affiliate stigma	9.24	151	4.305
		High affiliate stigma	15.73	138	5.145
		Total	12.34	289	5.727

Table 56 shows the cell means of anxiety by perceived support from family, affiliate stigma and parental self –efficacy. From the cell mean it can be seen that the participants who were having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in anxiety (Mean=7.17). Moreover, participants with low perceived support from family, low parental self-efficacy and high affiliate stigma scored high mean scores in anxiety (Mean=17.68). The importance of perceiving more support family, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the effects of anxiety is clearly portrayed in this result. In addition, it points out the risk of being more stigmatised as a caregiver of disabled child, perceiving low support from families, and decreased level of confidence as an effective parent.

To find out the influence of perceived support from family, affiliate stigma and parental self-efficacy on depression3-way ANOVA has been calculated and the results are presented in table 57.

Table 57

Summary of 3- way ANOVA of depression by perceived support from family, affiliate stigma and parental self-efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Self efficacy	370.658	1	370.658	20.759**
Affiliate stigma	283.308	1	283.308	15.867**
Family	183.564	1	183.564	10.280**
Self efficacy * Affiliate stigma	6.396	1	6.396	0.358
Self efficacy * Family	5.219	1	5.219	0.000
Affiliate stigma * Family	44.029	1	44.029	2.466
Self efficacy * Affiliate stigma* Family	98.438	1	98.438	5.513*
Error	5017.426	281	17.856	
Total	47786.000	289		

*p< .05 **p< .01

Table 57 gives the results of 3- way ANOVA of depression by perceived support from family, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on depression ($F=5.513$, $p<.05$). Since the mothers often rely on family members for sharing caretaking responsibilities, the lack of support will affect negatively. Perceiving 'no one is there to protect their children' may increase the risk of depression. The result can be utilized as a basis for treating such negative tendencies by enhancing the support from family etc. While considering the 2-way interactions, there is no significant interaction of perceived support from family and affiliate stigma; perceived support from family and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of perceived support from family and affiliate stigma, perceived support from family and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on depression. At the same time perceived support from family, affiliate stigma and parental self -efficacy have independent main effects on depression. Lovell and Wetherel (2019) found positive relationship between affiliate stigma and perceived stress. This relationship is occurred indirectly via lower perceived support from family, but not from friends or significant others.

To get more clarity on interaction of these variables, cell means of Depression by Perceived Support from Family, Affiliate Stigma and Parental Self-Efficacy have been calculated and tabulated as follows.

Table 58

Cell means of Depression by Perceived Support from Family, Affiliate Stigma and Parental Self -Efficacy

Perceived support from family	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	11.08	24	3.955
		High affiliate stigma	16.33	88	4.606
		Total	15.21	112	4.954
	High Parental Self-efficacy	Low affiliate stigma	10.09	22	3.939
		High affiliate stigma	11.70	20	1.658
		Total	10.86	42	3.143
	Total	Low affiliate stigma	10.61	46	3.935
		High affiliate stigma	15.47	108	4.582
		Total	14.02	154	4.922
High perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	11.52	21	4.191
		High affiliate stigma	11.93	15	5.325
		Total	11.69	36	4.628
	High Parental Self-efficacy	Low affiliate stigma	7.63	84	4.259
		High affiliate stigma	10.20	15	3.590
		Total	8.02	99	4.250
	Total	Low affiliate stigma	8.41	105	4.506
		High affiliate stigma	11.07	30	4.548
		Total	9.00	135	4.633
Total perceived support from family	Low Parental Self-efficacy	Low affiliate stigma	11.29	45	4.026
		High affiliate stigma	15.69	103	4.941
		Total	14.35	148	5.091
	High Parental Self-efficacy	Low affiliate stigma	8.14	106	4.295
		High affiliate stigma	11.06	35	2.722
		Total	8.87	141	4.151
	Total	Low affiliate stigma	9.08	151	4.445
		High affiliate stigma	14.51	138	4.910
		Total	11.67	289	5.399

Table 58 shows the cell means of depression by perceived support from family, affiliate stigma and parental self-efficacy. From the cell mean it can be seen that the participants who were having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in depression (Mean=7.63). Moreover, participants with low perceived support from family, low parental self-efficacy and high affiliate stigma scored high mean scores in depression (Mean=16.33). The importance of perceiving more support family, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the effects of depression is clearly portrayed in this result. It also shows the risk of being more stigmatised as a caregiver of disabled child, perceiving low support from families, and decreased level of confidence as an effective parent.

To know the main and interaction effects of dimensions of perceived friends' support, parental self-efficacy, and affiliate stigma on psychological distress of mothers of differently abled children, Univariate Analysis of Variance (ANOVA) has been carried out. Since the variables were measured in interval scale, they were classified into high and low based on their respective median as cut off point. The classification of the variables is presented in the table 59.

Table 59
Cross tabulation of Perceived Support from friends, Parental Self-Efficacy and Affiliate stigma

Affiliate Stigma	Friends	Statistics	Parental Self-Efficacy		Total
			Low Parental Self-efficacy	High Parental Self-efficacy	
Low affiliate stigma	Low support from Friends	Count	21	60	81
		% within Friends	25.9%	74.1%	100.0%
		% within Parental Self-Efficacy	46.7%	56.6%	53.6%
		% of Total	13.9%	39.7%	53.6%
	High support from Friends	Count	24	46	70
		% within Friends	34.3%	65.7%	100.0%
		% within Parental Self-Efficacy	53.3%	43.4%	46.4%
		% of Total	15.9%	30.5%	46.4%
	Total	Count	45	106	151
		% within Friends	29.8%	70.2%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	29.8%	70.2%	100.0%
High affiliate stigma	Low support from Friends	Count	72	20	92
		% within Friends	78.3%	21.7%	100.0%
		% within Parental Self-Efficacy	69.9%	57.1%	66.7%
		% of Total	52.2%	14.5%	66.7%
	High support from Friends	Count	31	15	46
		% within Friends	67.4%	32.6%	100.0%
		% within Parental Self-Efficacy	30.1%	42.9%	33.3%
		% of Total	22.5%	10.9%	33.3%
	Total	Count	103	35	138
		% within Friends	74.6%	25.4%	100.0%
		% within Parental Self-Efficacy	100.0%	100.0%	100.0%
		% of Total	74.6%	25.4%	100.0%

Table 59 displays the cross tabulation of perceived support from friends, parental self-efficacy and affiliate stigma. From the table 59, it can be seen that

about 21 participants were categorised under low affiliate stigma, low perceived support from friends and low parental self-efficacy combination. At the same time 60 participants fall under the category of low affiliate stigma, low perceived support from friends and high parental self-efficacy. A total of 46 participants scored under the category of high parental self-efficacy, high perceived support from friends, and low affiliate stigma. Only 24 falls under the combination of low affiliate stigma, high perceived support from friends and low parental self- efficacy. About 72 participants were classified under the category high affiliate stigma, low perceived support from friends and low parental self-efficacy. Only 20 participants were categorised under the combination of high affiliate stigma, low perceived support from friends with high parental self-efficacy. While considering the combination of high affiliate stigma with high perceived support from friends and low parental self-efficacy, only 31 participants were classified under this category. Where as in high affiliate stigma with high perceived support from friends and high parental self-efficacy, there were 15 participants.

To find out the influence of perceived support from friends, affiliate stigma and parental self-efficacy on stress 3-way ANOVA has been calculated and the results are presented in table 60.

Table 60

Summary of 3- way ANOVA of Stress by Perceived Support from Friends, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Self efficacy	457.661	1	457.661	47.821**
Affiliate stigma	323.537	1	323.537	33.806**
Friends	34.727	1	34.727	3.629
Self efficacy * Affiliate stigma	0.011	1	0.011	0.001
Self efficacy * Friends	1.218	1	1.218	0.127
Affiliate stigma * Friends	41.436	1	41.436	4.330*
Self efficacy * Affiliate stigma* Friends	1.721	1	1.721	0.180
Error	2689.244	281	9.570	
Total	24083.000	289		

*p< .05 **p< .01

Table 60 shows the results of 3-way ANOVA of stress by perceived support from friends, affiliate stigma and parental self-efficacy. Results revealed no significant 3-way interaction of these variables on stress levels of mothers of differently abled children. That means when the different levels of perceived support from friends, affiliate stigma and parental self-efficacy are taken into consideration, there is no interaction of these variables on stress. At the same time there is a two way interaction between affiliate stigma and perceived support from friends on stress ($F=4.33$, $p<.05$). That is, internalization of stigma together with perceiving support from friends influences the stress levels of mothers having children with disability.

To find out the influence of perceived support from friends, affiliate stigma and parental self-efficacy on anxiety 3-way ANOVA has been calculated and the results are presented in table 61.

Table 61

Summary of 3- way ANOVA of anxiety by perceived support from friends, affiliate stigma and parental self-efficacy (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Self efficacy	1226.016	1	1226.016	69.707**
Affiliate stigma	892.371	1	892.371	50.737**
Friends	16.746	1	16.746	0.952
Self efficacy * Affiliate stigma	36.233	1	36.233	2.060
Self efficacy * Friends	3.101	1	3.101	0.176
Affiliate stigma * Friends	58.176	1	58.176	3.308
Self efficacy * Affiliate stigma* Friends	0.644	1	0.644	0.037
Error	4942.289	281	17.588	
Total	53448.000	289		

**p< .01

Table 61 shows the results of 3-way ANOVA of anxiety by perceived support from friends, affiliate stigma and parental self-efficacy. As per the table

reports, there is no significant three-way interaction of these variables on anxiety of mothers of differently abled children. In other words, when the different levels of perceived support from friends, affiliate stigma and parental self-efficacy are taken together there is no interaction of these variables on anxiety. The importance they are giving to the family for alleviating the anxiety rather than depending on friends for the same may be the reason of no interaction in this case.

To find out the influence of perceived support from friends, affiliate stigma and parental self-efficacy on depression 3-way ANOVA has been calculated and the results are presented in table 62.

Table 62

Summary of 3- way ANOVA of depression by Perceived Support from Friends, Affiliate Stigma and Parental Self-Efficacy (2x2x2)

Source of variance	Sum of Squares	df	Mean Square	F
Self efficacy	734.436	1	734.436	39.781**
Affiliate stigma	650.770	1	650.770	35.250**
Friends	32.949	1	32.949	1.785
Self efficacy * Affiliate stigma	11.648	1	11.648	0.631
Self efficacy * Friends	0.346	1	0.346	0.019
Affiliate stigma * Friends	25.591	1	25.591	1.386
Self efficacy * Affiliate stigma* Friends	74.006	1	74.006	4.009*
Error	5187.760	281	18.462	
Total	47786.000	289		

*p< .05 **p< .01

Table 62 displays the results of 3- way ANOVA of depression by perceived support from friends, affiliate stigma and parental self-efficacy. Interestingly, there exists a 3-way interaction of perceived support from friends, affiliate stigma and parental self-efficacy on depression ($F=4.009$, $p<.05$). The significant interaction of these variables implies the importance of combination of these variables in dealing depression in mothers of differently abled children. Apart from family support, they may seek help from friends. It is a usual tendency to contact friends when they not getting enough support from family. The feeling of no help from their friends during needy time may produce feeling of worthlessness in them. The result can be utilized as a basis for treating such negative tendencies by enhancing the support from friends. Therapeutic interventions with similar people having similar problems may

be effective. While considering the 2-way interactions, there is no significant interaction of perceived support from friends and affiliate stigma; perceived support from friends and parental self-efficacy; affiliate stigma and parental self-efficacy. This result indicates that the combinations of perceived support from friends and affiliate stigma, perceived support from friends and parental self-efficacy as well as affiliate stigma and parental self-efficacy have no effects on depression. This is in line with previous studies in the field. Wang et al., (2022) found that stigma partially mediated depressive symptoms, while self-efficacy moderated this relationship. In addition, less social support increased depression symptoms by bringing about higher stigma. Moreover, subjects with higher self-efficacy are less susceptible to stigma and therefore have mild depressive symptoms. In a recent study conducted by Zulkarnaen et al., (2022), parenting self-efficacy has been found to be a significant contributor to psychological wellbeing of mothers of children with special needs.

In order to get more clarity on interaction of these variables, cell means of depression by Perceived Support from Friends, Affiliate Stigma and Parental Self – Efficacy have been calculated and the results are presented in table 63.

Table 63

Cell means of depression by Perceived Support from Friends, Affiliate Stigma and Parental Self -Efficacy

Perceived support from Friends	Parental Self-Efficacy	Affiliate Stigma	Mean	N	S. D
Low perceived support from friends	Low Parental Self-efficacy	Low affiliate stigma	10.76	21	2.862
		High affiliate stigma	16.50	72	4.905
		Total	15.20	93	5.115
	High Parental Self-efficacy	Low affiliate stigma	8.65	60	3.999
		High affiliate stigma	11.15	20	2.323
		Total	9.27	80	3.799
	Total	Low affiliate stigma	9.20	81	3.835
		High affiliate stigma	15.34	92	4.982
		Total	12.46	173	5.423
High perceived support from friends	Low Parental Self-efficacy	Low affiliate stigma	11.75	24	4.839
		High affiliate stigma	13.81	31	4.564
		Total	12.91	55	4.754
	High Parental Self-efficacy	Low affiliate stigma	7.48	46	4.613
		High affiliate stigma	10.93	15	3.262
		Total	8.33	61	4.549
	Total	Low affiliate stigma	8.94	70	5.084
		High affiliate stigma	12.87	46	4.365
		Total	10.50	116	5.166
Total perceived support from friends	Low Parental Self-efficacy	Low affiliate stigma	11.29	45	4.026
		High affiliate stigma	15.69	103	4.941
		Total	14.35	148	5.091
	High Parental Self-efficacy	Low affiliate stigma	8.14	106	4.295
		High affiliate stigma	11.06	35	2.722
		Total	8.87	141	4.151
	Total	Low affiliate stigma	9.08	151	4.445
		High affiliate stigma	14.51	138	4.910
		Total	11.67	289	5.399

Table 63 shows the cell means of depression by perceived support from friends, affiliate stigma and parental self -efficacy. From the table, it can be seen that the participants who were having high perceived support from friends, high parental self-efficacy, and low affiliate stigma scored low mean scores in depression (Mean=7.48). But participants with low perceived support from friends, low parental

self-efficacy and high affiliate stigma scored high mean scores in depression (Mean=16.50). This implies that perceiving more support from friends, enhancing the confidence as an effective parent as well as reducing the internalization of stigmatising experiences for reducing the level of depression is clearly depicted in this result. It also indicates the impact of being more stigmatised as a caregiver of disabled child, perceiving low support from families, and decreased level of confidence as an effective parent in developing depression.

For some families, sex of the child is important in many ways. Baby girls are not accepted in some families. Female infanticide is an example for this. In one study conducted by Rivard (2014), paternal stress (fathers of autistic children) is predicted by child's gender. Sharma et al., (2021) in their study reported that parents were having more anxiety and depression in case of female child, although it was significant only with respect to anxiety in mother. The possible reason for the same can be the gender bias and vulnerability of female gender in countries of the Indian subcontinent. The incidences of child trafficking and sexual harassment against these differently able children may be considered as additional factors which might have added to the worries of the parents. With this thought in mind, researcher has decided to carry out ANOVA to find out whether sex of the child has any influence on psychological distress and its sub variables. In order to find out interaction of sex with affiliate stigma and social support on psychological distress, investigator carried out 3-way ANOVA and the results are tabulated in table 64.

Table 64

Summary of 3-way ANOVA of Psychological distress by sex of the child, Affiliate Stigma and Perceived Social Support (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Sex	238.708	1	238.708	2.502
Affiliate Stigma	2341.218	1	2341.218	24.541**
Perceived Social Support	8185.868	1	8185.868	85.804**
Sex* Affiliate Stigma	0.161	1	0.161	0.002
Sex * Perceived Social Support	158.817	1	158.817	1.665
Affiliate Stigma * Perceived Social Support	119.351	1	119.351	1.251
Sex*Affiliate Stigma*Perceived Social Support	14.366	1	14.366	0.151
Error	26807.842	281	95.402	
Total	355565.000	289		

**p< .01

From table 64, it can be seen that there exist no interaction among affiliate stigma, perceived social support, and sex of the child; or independent effect of sex of the child on psychological distress of mothers of differently abled children.

To find out the interaction of sex of the child with affiliate stigma and social support on stress of mothers, investigator carried out 3-way ANOVA for these variables. Results are presented in table 65.

Table 65

Summary of 3-way ANOVA of stress by Sex of the child, Affiliate Stigma and Perceived Social Support (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Sex	0.764	1	0.764	0.082
Affiliate Stigma	168.885	1	168.885	18.193**
Perceived Social Support	508.530	1	508.530	54.781**
Sex* Affiliate Stigma	17.927	1	17.927	1.931
Sex * Perceived Social Support	1.044	1	1.044	0.112
Affiliate Stigma * Perceived Social Support	3.066	1	3.066	0.330
Sex*Affiliate Stigma*Perceived Social Support	0.629	1	0.629	0.068
Error	2608.497	281	9.283	

**p< .01

From table 65, it can be seen that there exists no 3-way interaction among affiliate stigma, perceived social support, and sex of the child or independent effect of sex of the child on stress of mothers of differently abled children. From the table 65, it can be seen that there is no interaction (affiliate stigma, perceived social support, and sex of the child) or independent effect of sex of the child on stress of mothers of differently abled children. This is line with the findings of Weiss et al., (2013). According to their study, there were no difference between mothers of male or female children in terms of self efficacy, social support and family hardiness.

Similarly, to find out the main and interaction effect of sex of child with affiliate stigma and social support on anxiety of mothers, investigator has carried out 3-way ANOVA for these variables and the results are presented in table 66.

Table 66

Summary of 3-way ANOVA of anxiety by sex of the child, affiliate stigma and social support (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Sex	21.322	1	21.322	1.156
Affiliate Stigma	503.002	1	503.002	27.261**
Perceived Social Support	1041.152	1	1041.152	56.428**
Sex* Affiliate Stigma	0.453	1	0.453	0.025
Sex * Perceived Social Support	10.121	1	10.121	0.549
Affiliate Stigma * Perceived Social Support	14.231	1	14.231	0.771
Sex*Affiliate Stigma*Perceived Social Support	1.170	1	1.170	0.063
Error	5184.745	281	18.451	
Total	53448.000	289		

**p< .01

From table 66, it can be seen that, there exists no 3-way interaction of affiliate stigma, perceived social support, and sex of the child or independent effect of sex of the child on anxiety of mothers of differently abled children.

Finally, to find out the interaction effect of sex of the child with affiliate stigma and social support on depression of mothers, investigator carried out 3-way ANOVA on depression and the results are presented in table 67.

Table 67

Summary of 3-way ANOVA of depression by Sex of the child, Affiliate Stigma and Perceived Social Support (2x2x2)

Source of variance	Sum of Squares	Df	Mean Square	F
Sex	99.168	1	99.168	5.864*
Affiliate Stigma	168.035	1	168.035	9.937
Perceived Social Support	1271.513	1	1271.513	75.191
Sex* Affiliate Stigma	15.696	1	15.696	0.928
Sex * Perceived Social Support	109.052	1	109.052	6.449*
Affiliate Stigma * Perceived Social Support	29.174	1	29.174	1.725
Sex*Affiliate Stigma*Perceived Social Support	12.264	1	12.264	0.725
Error	4751.861	281	16.911	
Total	47786.000	289		

*p< .05

The table 67 demonstrated the results of 3-way ANOVA on depression by sex of the child, perceived social support and affiliate stigma. There is no 3 way interaction of these variables. At the same time it can be seen a Two-way interaction of sex of the child with social support (F=6.449, p>.05) on depression. Moreover sex itself independently effect (F=5.864, p>.05) depression among mothers. That means the sex of the child with varying levels of perceived social support impact the mothers' depression. According to Sharma et al., (2021) parents were having more anxiety and depression in case of female child, although it was significant only with respect to anxiety in mother. The incidences of child trafficking and sexual harassment against these differently able children may be considered as additional factors which might have added to the worries of the parents. Al-Towairqi et al., (2015) demonstrated that socio-demographic factors such as, female sex had a significant impact on maternal depression. An Indian study conducted by Patra and

Patro (2019) that severe autistic symptoms and female children correlate with higher stigma. As already noted society has a discrimination tendency between male and female child. Beyond the level of sex, the disability may further increase the negative stereotype. It may affect mothers negatively. The result shows the importance of providing education on gender for the community to see the world in a more broadened way.

For the current research, data has been collected from mothers of children with different disabilities. The knowledge of influence of type of disability of children on mothers will be beneficial to professionals working in this field. However, for the current research, there were no enough data to be analyzed in detail due to the fact that no enough number of participants in certain disabilities (For example in ADHD category, there are only 13 participants). For this reason investigator could not carry out higher level analysis. Nevertheless, for identifying the trend the investigator calculated the cell means of Psychological distress by type of disability. With the mean scores a minor comparison can be done on each disability.

Table 68

Mean, number of participants and Standard deviation of Psychological distress by Type of disability

Type of disability	Statistic	Psychological distress
Intellectual disability	Mean	32.02
	N	102
	S.D	13.863
Intellectual disability + Autism	Mean	34.00
	N	1
	S.D	0.00
Down's Syndrome	Mean	30.15
	N	39
	S. D	13.088
ADHD	Mean	29.77
	N	13
	S.D	16.639
Autism	Mean	35.27
	N	44
	S. D	16.194
Learning Disability	Mean	32.41
	N	32
	S. D	14.681
Physical disability	Mean	29.79
	N	14
	S. D	9.736
Multiple Disability	Mean	32.10
	N	10
	S. D	5.109
Cerebral Palsy	Mean	33.32
	N	34
	S. D	12.739
Total	Mean	32.26
	N	289
	S. D	13.795

Table 68 shows the cell means, number of participants and standard deviation of Psychological distress on Type of disability. The highest Mean scores (35.27; N=44) of psychological distress is for the mothers of children with autism. That is, mothers of children with autism experience more distress than other categories. It may be due to the normal like appearance of the child with bizarre

behavior. The inappropriate communication and unexpected behavior may also a reason. According to Millaku and Kraja-Bardhi (2023), parents of autism and mental delays had more depression than that of other disabilities. Rezendes and Scarpa, (2011) found that parents of children with autism reported more depression than the parents of children with a pervasive developmental disorder. According to Vasilopoulou and Nisbet (2016), parents reported to have an extent of degrees of stress, anxiety, and depression compared to parents of typically developing children and children with other developmental problems. Bristol and Schopler (1984) reported that mothers of children with autism were less involved with people and activities outside the home; the reasons cited are significantly high stress levels and more negative child characteristics. Niimi and Uemura (1987) suggested that, the mothers of autistic children showed distinctive stress patterns compared with the parents of children with different disabilities, such as an ID and Down syndrome. Similar observation was found in USA as well (Olsson & Hwang, 2001). While considering the influence of child perspectives into parental stress, child's lack of communication skills, abnormal behaviors, social isolation, and difficulties in self-care were found to cause high level of stress and feel extremely high level of psychological distress (Estes et al., 2009) among parents of children with autism. An Indian study conducted by Guptha (2007) demonstrated the similar pattern that type of disability is associated with parental stress. Researchers also revealed that parents of children with autism were more distressed compared with parents of children with other developmental disabilities, such as Down syndrome (Sanders & Morgan, 1997), fragile X syndrome, severe intellectual disability (White & Hastings, 2004) than parents of children with special health care needs without developmental problems (Schieve et al., 2007) or typically developing children (Yamada et al., 2007).

The lowest Mean scores (29.77; N=13) of psychological distress is for the category ADHD. That means mothers of children having ADHD experience less distress compared to other categories. Comparatively ADHD is more manageable than other disabilities. It may be a reason for less distress of mothers. The limited sample size (N=13) may also be a reason. Similar trend can be seen in affiliate

stigma also. The highest score is in the autism category (38.48). Lowest score (32) can be seen in both ADHD and Learning Disability categories (32).

For the present study, data has been collected from mothers of children with different disabilities. Some participants were working under government sector, others in private sector etc. Caring children with disability is a time consuming and challenging task. For a working mother of child having disability, the responsibility may be increased. Identifying the influence of job on psychological distress will be beneficial for policy makers in designing job settlements for mothers of children with disabilities. However, for the present study, there were no enough data for reaching a precise conclusion or for applying higher level statistical designs. For identifying the trend the investigator calculated the cell means of Psychological distress by sector of job and results presented in table 69.

Table 69

Mean, number of participants and Standard deviation of Psychological distress by working sector of mothers

Working Sector	Statistic	Psychological distress
House wife	Mean	32.56
	N	256
	S D	13.542
Government service	Mean	30.59
	N	17
	S. D	13.748
Private sector	Mean	30.50
	N	2
	S. D	33.234
Own Initiative	Mean	19.71
	N	7
	S. D	12.406
Coolie	Mean	38.29
	N	7
	S. D	16.132
Total	Mean	32.26
	N	289
	S. D	13.795

Table 69 shows the mean, standard deviation, and number of participants of psychological distress in each working sector. The highest Mean score of psychological distress can be seen daily labours (Coolie) (Mean=38.29; N=7). The less income and additional responsibilities may be a reason for this result. The limited sample size may also be another reason. At the same time, the lowest Mean score can be seen in the Own initiative/self-employed category (Mean=19.71; N=7). People may feel more freedom while engaging in their own business than that of working under supervision. The same may be the case of mothers of children with disability. Innovative programs to empower poor women through small micro-credit programs have been successful in Bangladesh (Hashemi & Schuler, 1996).Working on own business simultaneously with doing all household chores may be work as a coping method too for this people. That may be reason for less mean scores on psychological distress. Although the result has to be verified with extensive studies, the policy makers can note this result for enhancing self reliant job opportunities for mothers having children with disabilities.

For the present study, participants were from different socio economic back ground. They were categorized as above average, average and below average category. Caring children with disability is a time consuming and challenging task. It may also demand financial assurance. Identifying the influence of Socio economic status on psychological distress will be beneficial for policy makers in assuring the minimum financial and social requirements for the families of children having disabilities. As in the case of other variable, here also no enough data are available. It limits statistical inferences. Even though for identifying the trend, the investigator calculated the cell means of Psychological distress by socio economic status. The results are presented in table 70.

Table 70
Mean, number of participants and Standard deviation of Psychological distress by Socio Economic Status

Socio Economic Status	Statistic	Psychological Distress
Above Average	Mean	36.93
	N	14
	S. D	16.241
Average	Mean	30.87
	N	178
	S. D	14.970
Below average	Mean	34.13
	N	97
	S. D	10.569
Total	Mean	32.26
	N	289
	S. D	13.795

Table 70 shows the Mean scores, standard deviation and number of participants of psychological distress in above average, average and below average category of SES. The lowest Mean score on psychological distress can be seen in the average level of SES (mean=30.87; N=178). As they live with sufficient resources, they may get enough access to services. It may be a reason for lowest score on psychological distress. At the same time, the highest score is for the above average level of SES (36.93; N=13). Living in a better socio economic background with child having disability may be painful for them. Highest score might also be due to the limited sample size in this category. Below average level has a mean score of 34.13(N=97). Compared to the lowest Mean score (30.87; N=97), the score can be considered as high. The minimum resources and accessibilities may be a reason for the high score. According to Millaku and Kraja-Bardhi (2023), families of lower income expressed more depressive than higher ones. Islam(2019) reported that being very poor or wealthy was linked with higher prevalence of psychological distress compared to those of moderate socio-economic status. Masulani-Mwale et al., (2018) showed that area of residence, low socio-economic status , significantly predicted psychological distress among the parents for children with disabilities.

Anuar et al., (2021) demonstrated parents of children having learning disability as well as higher educational background and socioeconomic status tend to feel more stressful than those with lower educational background and socioeconomic status. Policy makers can ensure better life opportunities for the families of children with disabilities.

As a lifelong commitment, mothers of children with disabilities may feel more distress in variety of ways. The quantitative phase enabled a framework of how social support, parental self efficacy, affiliate stigma and psychological distress are related. It also sheds light on the predictors of psychological distress. The study yielded information on how these variables interact with each other to produce effect on psychological distress of mothers of children with disabilities. The comparison of various socio demographic data provided insight in understanding psychological distress. The research suggests the importance of inclusion of caretakers/mothers in rehabilitation programmes. A need based intervention is required. It is not just giving mere training programmes to be an effective parent. The policy makers can assure the quality of life of the mothers. Being a mother of disabled children is to be considered in practical way to resolve the mental health issues. Many of them sacrifice their career and education for their children. There should have enough support for them in terms of financial, emotional etc. There should have attempts in developing programmes for the parents to have better mental health. The society also to be educated about the disability conditions.

CHAPTER 5

SUMMARY AND CONCLUSION

Motherhood is considered as the most precious and blissful events of everyone's life. Having a healthy baby is what everyone dreams of. But because of many reasons some children are unhealthy, with mental and physical difficulties, partly caused by congenital or genetic factors or psychosocial factors. Physical deformities like cleft foot, cleft lips can be cured by medical surgeries. But developmental disorders like intellectual disability, autism etc. cannot be cured completely by medical treatment but they can be managed or severity can be controlled through proper therapies and interventions. Parenting a child with some kind of disability adds additional challenges of expense, time, adaptations, and less time for other relationships (Fields, 2006). A child's disability affects parents' level of stress and the entire family system (Holroyd & McArthur, 1976).

Mostly mothers, the primary care takers, invest their lifetime for their children without look after their own concerns. When the requirements are not met, it becomes more challenging. For instance, severity of the disability, excess financial requirements etc. will make the condition worsen. Psycho social factors like low support from family or society may also contribute negatively to the mental health of the mothers. The feeling of lack of confidence in managing the child condition may also lead to lessen the mental health. Likewise, there may be various issues pertaining to the distress of mothers. For getting more clarity in this regard, a detailed study is needed. The present study is focused on exploring the psychological distress of mothers of children with disability.

Statement of the Problem

The study is entitled as "PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION"

Objectives

1. To explore the psychological distress of mothers of differently abled children
2. To find out the relationship between social support, parental self-efficacy, affiliate stigma and psychological distress of mothers of disabled children
3. To find out the predictors of psychological distress of mothers of disabled children

4. To find out the influence of social support, parental self-efficacy, affiliate stigma on psychological distress of mothers of disabled children
5. To find out the influence of certain demographic variables on psychological distress of mothers of disabled children

Hypotheses

1. There is a significant correlation between social support, parental self-efficacy, affiliate stigma and psychological distress of mothers of disabled children
2. Social support, parental self-efficacy, affiliate stigma are the significant predictors of psychological distress of mothers of disabled children
3. There is a significant influence of social support, parental self-efficacy and affiliate stigma on psychological distress of mothers of disabled children
4. There is a significant influence of certain demographic variables on psychological distress of mothers of disabled children.

The present study followed a mixed method design. Here the investigator initially used qualitative method to collect information regarding the nature and extent of psychological distress in relation to certain psychosocial problems. Later based on the findings of qualitative study, the investigator approached the problem in a quantitative manner. The details of procedure and results of the study are presented as sections.

Section 1: Exploration of Psychological distress among mothers of children with disability

- **Section 2**: Quantitative data collection and analysis

Section 1: Exploration of Psychological distress among mothers of disabled children

In this stage the investigator planned to explore the factors associated with psychological distress among mothers of children with disabilities.

Participants

Participants of the study consisted of 21 mothers of differently abled children including intellectual disability, cerebral palsy, autism, learning disability, ADHD,

speech and language problems and the like; selected from Community Disability Management and Rehabilitation Programme (CDMRP) advanced clinic at Calicut University campus. Participants were aged between 23 to 46 years. Out of which 17 mothers were qualified matriculation and the rest 4 were educated at degree level. Out of 21, fourteen mothers had male children and seven had female children with certain kind of disability. Children were aged between four to 14 years.

Instruments

1. A semi structured interview schedule was used to elicit information on psychological distress of mothers of disabled children. The interview comprised of questions that focused on different areas such as demographic information, experiences of having a disabled child, and how they adapt with the situation. Probing questions were also asked where necessary to obtain information, clarify a point, or expand on ideas.

Procedure

Investigator first contacted the Director and other professionals at Community Disability Management and Rehabilitation Programme (CDMRP) in the Department of Psychology, University of Calicut to get permission for collecting data from different community clinics. After getting approval from the authorities, a comfortable place in the clinic was selected and arranged for the data collection. The investigator selected the mothers who were visiting with their child for therapies randomly from the clinic. All the participants were approached personally, a self introduction was given. They were first informed about the details of current study.They are also requested to sign in the consent form. After establishing a good rapport, face to face semi structured interview was carried out to collect the research data. Each interview took approximately 20 to 40 minutes.

With the permission of the participants, the researcher also used a voice recorder to record the interviews. Thus, use of audio recorder ensured that a detailed account of the interview was captured.

Data Analysis

Thematic content analysis was employed to analyse data. Thematic content analysis involves identifying, analysing and reporting patterns (themes) within data

and minimally organises it and frequently it goes further than this, and interprets various aspects of the research topic (Braun & Clarke, 2006). The researcher made recordings and notes of the interviews conducted. The recorded tapes were encoded and interpreted using the tones and contrast in the voices of the participants. This data was then transcribed. The researcher repeatedly read the transcribed data as well as listening to recording to pin point key words, trends, and themes. The key themes were identified and transformed into codes.

Section 2: Quantitative Data collection and analysis

To measure the variables which are derived from the qualitative study, different research instruments were selected from authorized publishers. It was assured that the instruments were suitable for the culture, where the study was conducting.

Data collection and analysis

In this stage, the researcher collected data using the selected and constructed instruments to assess the variables under investigation

At the same time researcher did not get relevant instruments on variables such as, parental self-efficacy and affiliate stigma of the special population concerned in Malayalam language. Thus, researcher decided to develop research instruments on these two variables.

The instruments used for the study were:

1. Psychological Distress Scale (Saheera& Manikandan,2015)
2. Perceived Social Support Scale(Zimet, et al., 1988)
3. Affiliate Stigma Scale(developed by the investigator along with the supervisor)
4. Parental Self-Efficacy Scale(developed by the investigator along with the supervisor)
5. Personal Information Schedule.

Test Development

Based on the qualitative study, researcher identified major factors associated with psychological distress of mothers of children with disability. For the next step, the relevant variables were selected for the further study. The investigator developed

scale for Affiliate Stigma and Parental Self-efficacy. Brief descriptions of these scales are given below.

- Affiliate Stigma Scale: Affiliate Stigma scale is a three dimensional Malayalam scale which provides an extent of person's affiliate stigma experiences. It is a five point Likert scale with response category as Strongly Agree (5), Agree (4), Undecided (3), Disagree (2) and Strongly disagree (1). All the items in the scale are worded positively and scored 1 to 5. It consists of 17 items. The reliability of the scale was calculated by Cronbach alpha and it is found to be .92 for whole scale. Reliability of the three dimensions were calculated by the method of Cronbach Alpha and found to be .91 for the cognitive component and .82 for the affective component and .82 for behavioural component. Face validity of the scale was also assured by experts' opinion.
- Parental self-efficacy: Parental self-efficacy is a five point Likert type 17 item scale with response category as Strongly Agree (5), Agree (4), and Undecided (3), Disagree (2) and Strongly disagree (1) in Malayalam language. All the items in the scale are worded positively and scored 5 to 1. Sum of the scores of all items in the scale constitute an index of the individuals' parental self-efficacy. Reliability of the scale was established by calculating the internal consistency of items (Cronbach Alpha) and it was found to be .90. The scale was distributed among experts for comments regarding the items and its content, and they commended its suitability to measure parental self-efficacy

Participants

In the present study, participants consisted of 289 mothers of disabled children including mental retardation, cerebral palsy, autism, learning disability, ADHD, speech and language problems and the like; selected from Community Disability Management and Rehabilitation Programme (CDMRP) advanced clinic at Calicut university campus and different community clinics of CDMRP at Calicut, and Kannur Districts. Participants are aged between 26 to 65 years.

Procedure

Primarily, for the permission to collect data from Community Disability Management and Rehabilitation Programme (CDMRP) at the Department of Psychology, University of Calicut, as well as from different community clinics of CDMRP, investigator contacted the Director and other professionals. After getting approval from the authorities, a comfortable place in the clinic was selected and arranged for the data collection. The investigator randomly selected the mothers who were visiting with their child for therapies randomly from the clinic. All the participants were approached personally and a self-introduction was given. They were first informed about the details of current study. They are also requested to sign in the consent form. After getting the signed consent form and establishing a good rapport, the research instruments including personal data sheet were administered to the mothers of disabled children from different localities of Malappuram and Kozhikode, and Kannur districts who have been consulting for therapies in CDMRP clinics. They were asked to read instruction carefully and were briefly told about the purpose of the study and assured about the confidentiality of the responses. They were requested to respond to all the items in the research instruments. After completion, the instruments were collected back and scored as per the scoring scheme; then the collected data were entered into spread sheet for further statistical analysis.

Statistical Analysis

Based on the objectives and hypotheses set forth earlier for the current study, appropriate statistical techniques were selected. The statistical techniques used by the investigator were descriptive statistics, Correlation, Regression, and ANOVA.

Major findings of the study

Findings of Section 1

- Various social and personal factors play a major role in developing the distress in mothers.
- Mothers described their psychological distress mainly from following themes- cognitive, emotional, behavioural, physical, economic, social, and spiritual as well as child characteristics.

- Concerns of mothers include themes such as cognitive, emotional, physical, economic, social, and spiritual aspects. Child related themes are current functioning, available training and programmes, other children and siblings, concerns of future, unexpected behaviour, and ambiguous nature of child care.
- In cognitive level the subthemes are self-doubt, helplessness etc. The emotional level is comprised of the themes- anxiety, stress, extreme sadness etc. Concerns on physical aspects are composed of health related issues and ailments of the participants. Economic concerns are pertaining to the financial burdens associated with the participants.
- Social perspective includes the support availing from family, friends, society, stigmatization etc. Spiritual level includes the activities related to manage the distress levels-visiting religious centres, following rituals etc.

Findings of Section 2

- Perceived social support, parental self efficacy, affiliate stigma were significantly related with psychological distress of mothers of children with disabilities
- Perceived support from significant others, family, friends, parental self-efficacy, and affiliate stigma were significantly related with psychological distress of mothers of children with disabilities
- Perceived support from significant others, family, friends, parental self-efficacy, affective component of affiliate stigma and of affiliate stigma were significantly predict psychological distress of mothers of children with disabilities.
- Perceived support from significant others, family, friends, affective component affiliate stigma and of affiliate stigma were significantly predict stress of mothers of children with disabilities.
- Perceived support from significant others, family, friends, parental self-efficacy, affective component of affiliate stigma and of affiliate stigma were significantly predict anxiety of mothers of children with disabilities.

- Perceived support from significant others, family, friends, parental self-efficacy, affective component of affiliate stigma and of affiliate stigma were significantly predict depression of mothers of children with disabilities.
- There is a three-way interaction of perceived social support, affiliate stigma and parental self-efficacy on psychological distress of mothers of children with disabilities.
- There is an independent effect of perceived social support, affiliate stigma and parental self-efficacy on psychological distress of mothers of children with disabilities.
- Mothers who have high perceived social support, high parental self-efficacy, and low affiliate stigma scored low mean scores in psychological distress.
- Mothers who have low perceived social support, low parental self-efficacy, and high affiliate stigma scored high mean scores in psychological distress.
- There is an independent effect of perceived social support, parental self-efficacy, and affiliate stigma on stress of mothers of children with disabilities
- There is a three-way interaction of perceived social support, affiliate stigma and parental self-efficacy on stress of mothers of children with disabilities.
- Mothers having high perceived social support, high parental self-efficacy, and low affiliate stigma scored low mean scores in stress.
- Mothers having low perceived social support, low parental self-efficacy, and high affiliate stigma scored high mean scores in stress.
- There is an independent effect of perceived social support, parental self-efficacy and affiliate stigma on anxiety of mothers of children with disability.
- There is a three-way interaction of perceived social support, affiliate stigma and parental self-efficacy on anxiety of mothers having children with disability.
- There is a two-way interaction of affiliate stigma and parental self-efficacy on anxiety of mothers having children with disability.
- Mothers having high perceived social support, high parental self-efficacy, and low affiliate stigma scored low mean scores in depression.

- Mothers having low perceived social support, low parental self-efficacy, and high affiliate stigma scored high mean scores in depression.
- There is an independent effect of perceived social support, parental self-efficacy and affiliate stigma on depression of mothers of children with disability.
- There is an independent effect of perceived support from significant others, parental self-efficacy and affiliate stigma on psychological distress of mothers having children with disabilities.
- Perceived support from significant others, parental self-efficacy, and affiliate stigma did not interact each other on psychological distress of mothers of children with disabilities.
- There is an independent effect of perceived support from significant others, parental self-efficacy, and affiliate stigma on stress of mothers having children with disability.
- There is a three-way interaction of perceived support from significant others, affiliate stigma and parental self-efficacy on stress of mothers having children with disability.
- Mothers having high perceived support from significant others, high parental self-efficacy, and low affiliate stigma scored low mean scores in stress.
- Mothers having low perceived support from significant others, low parental self-efficacy, and high affiliate stigma scored high mean scores in stress.
- There is an independent effect of perceived support from significant others, parental self-efficacy, and affiliate stigma on anxiety of mothers having children with disability.
- There is no three-way interaction of perceived support from significant others, affiliate stigma and parental self-efficacy on anxiety of mothers having children with disability.
- There is an independent effect of perceived support from significant others, parental self-efficacy, and affiliate stigma on depression of mothers having children with disability.

- Perceived support from significant others, affiliate stigma and parental self-efficacy did not interact each other on depression of mothers having children with disability.
- There is a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on psychological distress of mothers having children with disability.
- Mothers having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in psychological distress.
- Mothers having low perceived support from family, low parental self-efficacy, and high affiliate stigma scored high mean scores in psychological distress.
- There is an independent effect of perceived support from family, parental self-efficacy, and affiliate stigma on stress of mothers having children with disability.
- There is a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on stress of mothers having children with disability.
- Mothers having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in stress.
- Mothers having low perceived support from family, low parental self-efficacy, and high affiliate stigma scored high mean scores in stress.
- There is an independent effect of perceived support from family, parental self-efficacy, and affiliate stigma on anxiety of mothers having children with disability.
- There is an independent effect of perceived support from family, parental self-efficacy, and affiliate stigma on depression of mothers having children with disability.
- There is a 3-way interaction of perceived support from family, affiliate stigma and parental self-efficacy on depression of mothers having children with disability.

- Mothers having high perceived support from family, high parental self-efficacy, and low affiliate stigma scored low mean scores in depression.
- Mothers having low perceived support from family, low parental self-efficacy, and high affiliate stigma scored high mean scores in depression.
- There is no significant interaction of perceived support from friends, affiliate stigma on parental self-efficacy on stress of mothers having children with disabilities
- There is a two-way interaction of affiliate stigma and perceived support from friends on stress of mothers of children with disabilities
- There is no 3-way interaction between perceived support from friends, affiliate stigma and parental self efficacy on stress of mothers having children with disabilities
- There is a 3-way interaction of perceived support from friends, affiliate stigma and parental self efficacy on depression of mothers having children with disabilities.
- Mothers having high perceived support from friends, high parental self-efficacy, and low affiliate stigma scored low mean scores in depression.
- Mothers having low perceived support from friends, low parental self-efficacy, and high affiliate stigma scored high mean scores in depression.
- Mothers with high perceived support from friends, high parental self-efficacy and low affiliate stigma scored low mean scores on depression.
- There no independent effect of sex of the child on psychological distress of mothers of children with disabilities.
- There is no interaction between sex of the child, perceived social support and affiliate stigma on psychological distress of mothers having children with disabilities.
- There no independent effect of sex of the child on stress of mothers of children with disabilities.
- There is no interaction of sex of the child, perceived social support and affiliate stigma on stress of mothers having children with disabilities
- There is no interaction of sex of the child, affiliate stigma and perceived social support on anxiety of mothers of children with disabilities.

- There is a two way interaction of sex of the child and perceived social support on depression of mothers having children with disabilities.
- In the present study, mothers of children with autism scored highest mean scores on psychological distress. At the same time, mothers of children with ADHD scored lowest mean scores on psychological distress.
- In the present study, highest mean scores on psychological distress can be found among coolie workers, whereas participants having own business scored lowest mean scores in psychological distress.
- Mothers belong to above average socioeconomic status scored highest mean scores on psychological distress. Mothers in the average SES scored lowest mean scores on psychological distress

Conclusion

The present study sheds light on the wide range of social, psychological, physical, and financial problems experienced by the mothers of children with disabilities. Social support is considered as a major concern of this community. The lack of support from family and of significant people made them to feel more distress. Thus researchers in this field can further explore the nature and impact of social support on distress of this community. Social support is also found to be used as an adaptive technique here. While seeking help from society (in terms of finance, knowledge, emotional) they tend to feel lesser negative emotions. They could handle the situations. The lack of confidence as an effective parent to deal the problems of "disabled" children is also found to be a major concern for this community. They could not address the problems of the children in effective manner. This in turn makes them to feel guiltier. The attitude of society also found to be a factor in determining the distress. The negative labelling of society made them to internalize the stigma. This also contributes to negative emotions. Physical problems of the participants/other family members are also found to be a factor in determining distress levels. The financial status also found to contribute to the negative emotions. The severity of disability, lack of knowledge regarding the child condition etc. made more distress among mothers.

Beyond the level of designing interventions/therapies for the children with disability, the mothers are also to be addressed. In order to enhance the effectiveness

of therapies as well as to boost the mental health of mothers, training programmes can be developed. Assuring the support system is a major point to be included in the programmes. Training programmes can be developed to get more knowledge on disabilities and of management of the same can ensure the competency level of mothers. The policy makers can ensure financial support for the family of children with disability. It may be done through assuring job opportunities for family members. Policy makers can assure the quality of life of children with disability, thereby lessen the worries of mothers. For this residential set up can be developed in government settings. Providing job opportunities for mothers in the residential programmes designed for children with disability may be beneficial for some. By this set up, based on the education and abilities, mothers can also avail other job opportunities. Thus the current study points out the relevance of conducting tremendous studies in the field.

Limitations of the study

Each study has its own limitations. The present study also had its own limitations. The major limitations of the study were:

- The study is focused on the term ‘disability’; not any particular disability. (For example, intellectual disability, autism etc.). The results may vary with the type of disability.
- The researcher did not get enough data to study the impact of severity /type of disability on psychological distress.
- Participants were from different districts of Malabar. It is not representing the state.
- Those mothers who were not attending clinical set up (for treatment /therapy for children with disability) were not participated in the study.

CHAPTER 6

IMPLICATIONS

Mothers of children having disabilities may experience additional challenges in their lives. This can have an impact on many aspects of life, including the personal, social, and economic spheres. The stress can be exhibited via constant and time consuming caretaking, type or severity of the disability, the management of the child etc. Timely changes have come in the field of rehabilitation of differently-abled persons. Making public spaces disabled- friendly is a clear example of this. However, the well-being of the caregivers of differently-abled persons is often not addressed. By understanding this, the researcher is scientifically studied the personal, social and economic problems experienced by mothers of children with disabilities.

While going through the results, it is clear that most of the participants in the study experience distress in varying levels. For the identification and interventions on this issue, the caregivers are also to be included in the rehabilitation programmes for children with disability. While including the caregivers in the rehabilitation process, the problems of them should also to be addressed. Most of the study participants were mothers who perceived professional support as a great support. In this way, if professional support can be arranged at the government level for everyone, the difficulties may be eased.

Most of them adapt to the stress by having a hopeful approach to life, learning about the disability and how to deal with it, trying to get to know it, ensuring family or partner support, and spirituality. Meanwhile, stress has been reported to be higher in those who get involved without trying to figure out the problem. Furthermore, Psychological distress is reduced when it includes better family support, social environment, and belief in one's own abilities. Based on these observations, stress management programs/training programmes can be developed.

Mothers reported less stress when the family played a role in caring for the child with disability. Neglect from families has largely led to psychological distress for mothers. Therefore, it would be advisable to include the families while organizing the training program. In other words, professionals need to be able to involve the family as a whole in the rehabilitation process.

Concerns on lack of knowledge about their children's disability and lack of understanding about how to deal with it have fueled psychological distress for many. At the same time, mothers who understand the disability better and understand its limitations and how to overcome it at least to some extent are happier in life. Therefore, the training program can be organized in such a way that the disability can be clearly understood.

The thought that "no one will look after this child after me" was a concern shared by all study participants. Despite programmes such as Legal parenting are available at Government level, people are not well informed about it. Policy makers/NGOs need to be able to intervene clearly in this regard. Providing information of such government programmes for person with disability is essential. Further programmes can also to be introduced.

It is clear from the study that, society still views disability in terms of disappointment/sympathy. By understanding the limitations of disability, we need to be able to empower such individuals to the maximum extent possible.

Mothers who were worried about losing their education and career by taking care of such children also participated in the study. If the government/society can start residential setups (Buds school or an institution which can cater the needs of such mothers; day care centers for people with special needs) so that differently abled children do not become such a liability, it will be possible to overcome their personal pressure to some extent. The rehabilitation process can be extended to ensure employment according to each person's education and skills to ensure their economic security. These mothers also need to provide an environment in which to study, work and live while ensuring the well-being of their children in the process of community disability management.

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APPENDICES

Appendix A

INTERVIEW SCHEDULE

I. Opening

A. (Establish Rapport) *My name is Greeshma. I am doing PhD in psychology at university of Calicut. My topic of research is psychological distress of mothers of children with disability.*

B. (Purpose) *I would like to ask you some questions about your background, experiences you have with your differently abled child, and challenges of raising the child in order to get more ideas on the experiences of mothers of children with disability for my study.*

C. (Motivation) *I hope to use this information to formulate a framework of distress/challenges of mothers of differently abled children. Even though there is no immediate benefit for you to participate in this study, the study can be extended for further research to assist you in caring for the child and for a better life. It will become more comfortable speaking to and with you by knowing you better.*

D. (Time Line) *The interview should take about 30-40 minutes. Are you available to respond to some questions at this time?*

E. *(At the same time I will record your responses for future references and for avoiding missing data. Are you agreeing with it?)*

(Transition: Let me begin by asking you some questions about you and your family)

II **Body**

A. (Topic) General demographic information

1. (detailed personal information schedule given)

(Transition to the next topic: What is your child's disability? How do you explain the disability of your child?

B. *Tell me about the experiences of the event you first identified the condition of your child?*

(Necessary prompts were added according to the responses of participants)

C. *Are you getting support from family, friends etc.? Do they help you in care giving tasks?*

(Necessary prompts were added according to the responses of participants)

D. *How do people in society behave to you and your child?*

(Necessary prompts were added according to the responses of participants)

E. *How do you manage struggles?*

(Necessary prompts were added according to the responses of participants)

F. *Do you have any negative experiences as a mother of differently abled children?*

(Necessary prompts were added according to the responses of participants)

G. *As a parent, how do you describe yourself?*

(Necessary prompts were added according to the responses of participants)

H. *Based on your experiences, what are the major challenges of mothers with children having disability?*

(Necessary prompts were added according to the responses of participants)

I. *How do you explain the experiences of consulting professionals for therapies etc.*

(Necessary prompts were added according to the responses of participants)

Transition: Well, it has been a pleasure finding out more about you. Let me briefly summarize theinformation that I have recorded during our interview.)

III Closing

A. (Maintain Rapport*) I appreciate the time you took for this interview. Is there anything elseyou think would be helpful for me to know so that I can describe more about the experiences you.*

B. (Action to be taken) *I should have all the information I need. Would it be alright to call you at home if I have any more questions? Thanks again.*

Appendix B

DEPARTMENT OF PSYCHOLOGY

UNIVERSITY OF CALICUT

PSYCHOLOGICAL DISTRESS SCALE

നിർദേശങ്ങൾ: നിങ്ങളുടെ അനുഭവങ്ങളുമായി ബന്ധപ്പെട്ട ചില പ്രസ്താവനകളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്.ഓരോ പ്രസ്താവനയും ശ്രദ്ധാപൂർവ്വം വായിച്ച് തന്നിരിക്കുന്ന സൂചിക പ്രകാരം ഓരോ പ്രസ്താവനയ്ക്കും ആദ്യം മനസ്സിൽ തോന്നുന്ന ഉത്തരം രേഖപ്പെടുത്തുക.എല്ലാ പ്രസ്താവനക്കും ഉത്തരം നൽകാൻ ശ്രദ്ധിക്കുക.നിങ്ങൾ നൽകുന്ന വിവരങ്ങൾ രഹസ്യമായി സൂക്ഷിക്കുന്നതും ഗവേഷണ ആവശ്യത്തിന് മാത്രം ഉപയോഗിക്കുന്നതും ആണെന്ന് ഉറപ്പു തരുന്നു.

No.	പ്രസ്താവന	ഒരിക്കലുമില്ല	വല്ലപ്പോഴും	ചിലപ്പോൾ	മിക്കപ്പോഴും	എല്ലായ്പ്പോഴും
1	വളരെ പെട്ടെന്ന് തന്നെ ഞാൻ അസ്വസ്ഥൻ ആവാറുണ്ട്					
2	അനാവശ്യമായി ഊർജ്ജം ചെലവാക്കാറുണ്ട്					
3	പൊതുവേ ഒരു തൊട്ടാവാടി ആണ്					
4	എന്തെങ്കിലും വിഷമം സംഭവിച്ചാൽ അതിൽ നിന്ന് മുക്തി നേടാൻ ബുദ്ധിമുട്ടാണ്					
5	ഞാൻ അമിതമായി വേഗതയിൽ വിശ്വസിക്കാറുണ്ട്					
6	മരിക്കാൻ പോകുന്നു എന്ന് തോന്നാറുണ്ട്					
7	അമിതമായ നെഞ്ചിടിപ്പ് ഉണ്ടാവാറുണ്ട്					
8	എൻറെ ശരീര ഭാഗങ്ങൾ തളരുന്നതായി അനുഭവപ്പെടാറുണ്ട്					
9	എനിക്ക് വിറയൽ അനുഭവപ്പെടാറുണ്ട്					
10	എനിക്ക് അകാരണമായ ഭയം ഉണ്ടാകാറുണ്ട്					
11	പരവേശം ഉണ്ടാകാറുണ്ട്					
12	കാരണം ഇല്ലാതെ മ്ലാനത തോന്നുന്നു					
13	ജീവിതം അർഥശൂന്യമായി തോന്നുന്നു					
14	മരിച്ചെങ്കിൽ നന്നായിരുന്നു എന്ന് തോന്നുന്നു					
15	മരിച്ചു കഴിഞ്ഞ ഒരു ഹൃദയമാണ്					
16	എല്ലാ കാര്യങ്ങളിലും എനിക്ക് താല്പര്യക്കുറവ് അനുഭവപ്പെടുന്നു					
17	എനിക്ക് വിഷാദം അനുഭവപ്പെടാറുണ്ട്					
18	ഞാൻ ഒരു ഭാഗ്യദോഷിയാണ്					

Appendix C

DEPARTMENT OF PSYCHOLOGY

UNIVERSITY OF CALICUT

Perceived Social Support Scale

There are some statements given below which describes how you perceive your world around you. Read each statement and decide how far it is true to you. Rate your response in the column given in the right side. Your answers will be kept confidential and will be used only for research purpose.

SN	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
1	There is a special person who is around me when I am in need					
2	There is a special person whom I can share my joys and sorrows					
3	My family really tries to help me					
4	I get emotional help and support I need from my family					
5	I have a special person who is a real source of comfort to me					
6	My friends really try to help me					
7	I can count on my friends when things go wrong					
8	I can talk about my problems with my family					
9	I have friends with whom I can share my joys					
10	There is a special person in my life who cares about my feeling					
11	My family is willing to help me make decisions					
12	I can talk about my problems with my friends					

Appendix D

DEMOGRAPHIC DETAILS

കുട്ടിയെ കുറിച്ചുള്ള വിവരങ്ങൾ

1. കുട്ടിയുടെ പേര് :
2. വയസ്സ് & ജനനതിയ്യതി :
3. ലിംഗം :
4. എത്രാമത്തെ കുട്ടിയാണ് :
5. വിദ്യാഭ്യാസം :
6. സ്കൂൾ :
7. കുട്ടി ആരുടെ കൂടെയാണ് താമസിക്കുന്നത് :
8. കുട്ടിയുടെ കാര്യങ്ങൾ നോക്കുന്നതും പരിചരിക്കുന്നുതും ആരൊക്കെയാണ്?
9. കുട്ടിയുടെ രോഗാവസ്ഥ :
10. നിങ്ങൾക്ക് കുട്ടിയുമായുള്ള ബന്ധം :
11. കുടുംബത്തിൽ ആർക്കെങ്കിലും മാനസിക/വളർച്ചാ വൈകല്യം ഉണ്ടോ? ഉണ്ടെങ്കിൽ എന്ത്?

രക്ഷിതാവിനെ കുറിച്ചുള്ള വിവരങ്ങൾ

1. പേര് :
2. വയസ്സ് :
3. ലിംഗം :
4. വിദ്യാഭ്യാസം : അച്ഛൻ : അമ്മ :

5. ജോലി : അച്ഛൻ : അമ്മ :
6. മറ്റു കുട്ടികൾ :
7. വിവാഹ സമയത്തെ വയസ്സ് :
8. കുട്ടി ജനിക്കുമ്പോഴുള്ള വയസ്സ് :
9. ഗർഭകാലത്ത് അമ്മ മറ്റസുഖങ്ങൾക്കായി ഏതെങ്കിലും തരം മരുന്നുകൾ കഴിച്ചിരുന്നോ?
10. പ്രസവം നടന്ന സ്ഥലം :
11. സാമ്പത്തികാവസ്ഥ :
12. കുട്ടിയെ കൂടുതൽ പരിചരിക്കുന്നത് ആരാണ് ?
13. വളർച്ച/മാനസിക വൈകല്യമുള്ള മറ്റ് കുട്ടികൾ നിങ്ങൾക്കുണ്ടോ?
14. ഉണ്ടെങ്കിൽ എന്ത്?

Appendix E

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
AFFILIATE STIGMA SCALE

താഴെ കൊടുത്തിരിക്കുന്ന ഓരോ പ്രസ്താവനയും നിങ്ങളുടെ ഭിന്നശേഷിയുള്ള കുട്ടിയോടൊത്തുള്ള ജീവിതവുമായി എത്രത്തോളം ബന്ധപ്പെട്ടിരിക്കുന്നുവെന്ന് അനുയോജ്യമായ കോളത്തിൽ (x) മാർക്ക് ഇട്ട് വ്യക്തമാക്കുക.നിങ്ങളുടെ വിവരങ്ങൾ രഹസ്യമായി വക്കുന്നതും ഗവേഷണത്തിനു മാത്രം ഉപയോഗിക്കുന്നതുമായിരിക്കും.

Sl. No.	പ്രസ്താവന	പൂർണമായി യോജിക്കുന്നു	ഭാഗികമായി യോജിക്കുന്നു	പ്രത്യേക അഭിപ്രായമില്ല	ഭാഗികമായി വിയോജിക്കുന്നു	പൂർണമായി വിയോജിക്കുന്നു
1	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവർ എന്നെ വേർതിരിച്ച് കാണുന്നു					
2	കുട്ടി കൂടെയുള്ളപ്പോൾ ആളുകളുടെ മനോഭാവം മാറുന്നു					
3	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരുടെ മുന്നിൽ ഞാൻ മോശക്കാരിയാവുന്നു					
4	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരുടെ മുന്നിൽ ഞാൻ കഴിവുകെട്ടവളാവുന്നു					
5	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരെക്കാളും താഴെയാണ് എന്ന ചിന്ത ഉണ്ടാകുന്നു					
6	കുട്ടി കൂടെയുള്ളപ്പോൾ വീട്ടുകാരും മറ്റും എന്നെ അകറ്റിനിർത്തുന്നതായി തോന്നുന്നു					
7	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് എന്നിൽ അപകർഷത ഉണ്ടാക്കുന്നു					
8	കുട്ടിയുടെ പെരുമാറ്റം എന്നെ നാണം കെടുത്തുന്നു					
9	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് എന്നെ നിസ്സഹായയാക്കുന്നു					
10	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് മറ്റുള്ളവർ അറിയുന്നതിൽ വിഷമം തോന്നുന്നു					
11	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് മാനസികസമ്മർദ്ദം ഉണ്ടാക്കുന്നു					
12	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായതിൽ എപ്പോഴും വിഷമിക്കുന്നു					
13	മറ്റുള്ളവരോട് ഇക്കാര്യത്തെക്കുറിച്ച് സംസാരിക്കാതെ ശ്രദ്ധിക്കുന്നു					
14	കുട്ടിയുമായി പുറത്ത് പോകുന്നത് പരമാവധി ഒഴിവാക്കുന്നു(കല്യാണം, സിനിമ, ഷോപ്പിങ്ങ്...)					
15	സുഹൃദ്ബന്ധങ്ങൾ പരമാവധി കുറയ്ക്കുന്നു					
16	കുടുംബക്കാരുമായി അകലം വെക്കുന്നു					
17	അയൽവാസികളുമായി പരമാവധി വിട്ട് നിൽക്കുന്നു					

Appendix F

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
AFFILIATE STIGMA SCALE

താഴെ കൊടുത്തിരിക്കുന്ന ഓരോ പ്രസ്താവനയും നിങ്ങളുടെ ഭിന്നശേഷിയുള്ള കുട്ടിയോടൊത്തുള്ള ജീവിതവുമായി എത്രത്തോളം ബന്ധപ്പെട്ടിരിക്കുന്നുവെന്ന് അനുയോജ്യമായ കോളത്തിൽ (x) മാർക്ക് ഇട്ട് വ്യക്തമാക്കുക.നിങ്ങളുടെ വിവരങ്ങൾ രഹസ്യമായി വക്കുന്നതും ഗവേഷണത്തിനു മാത്രം ഉപയോഗിക്കുന്നതുമായിരിക്കും.

Sl. No.	പ്രസ്താവന	പൂർണമായി യോജിക്കുന്നു	ഭാഗികമായി യോജിക്കുന്നു	പ്രത്യേക അഭിപ്രായമില്ല	ഭാഗികമായി വിയോജിക്കുന്നു	പൂർണമായി വിയോജിക്കുന്നു
1	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവർ എന്നെ വേർതിരിച്ച് കാണുന്നു					
2	കുട്ടി കൂടെയുള്ളപ്പോൾ ആളുകളുടെ മനോഭാവം മാറുന്നു					
3	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരുടെ മുന്നിൽ ഞാൻ മോശക്കാരിയാവുന്നു					
4	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരുടെ മുന്നിൽ ഞാൻ കഴിവുകെട്ടവളാവുന്നു					
5	കുട്ടി കൂടെയുള്ളപ്പോൾ മറ്റുള്ളവരെക്കാളും താഴെയാണ് എന്ന ചിന്ത ഉണ്ടാകുന്നു					
6	കുട്ടി കൂടെയുള്ളപ്പോൾ വീട്ടുകാരും മറ്റും എന്നെ അകറ്റിനിർത്തുന്നതായി തോന്നുന്നു					
7	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് എന്നിൽ അപകർഷത ഉണ്ടാക്കുന്നു					
8	കുട്ടിയുടെ പെരുമാറ്റം എന്നെ നാണം കെടുത്തുന്നു					
9	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് എന്നെ നിസ്സഹായയാക്കുന്നു					
10	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് മറ്റുള്ളവർ അറിയുന്നതിൽ വിഷമം തോന്നുന്നു					
11	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായത് മാനസികസമ്മർദ്ദം ഉണ്ടാക്കുന്നു					
12	ഭിന്നശേഷിയുള്ള കുട്ടിയുടെ അമ്മയായതിൽ എപ്പോഴും വിഷമിക്കുന്നു					
13	മറ്റുള്ളവരോട് ഇക്കാര്യത്തെക്കുറിച്ച് സംസാരിക്കാതെ ശ്രദ്ധിക്കുന്നു					
14	കുട്ടിയുമായി പുറത്ത് പോകുന്നത് പരമാവധി ഒഴിവാക്കുന്നു(കല്യാണം, സിനിമ, ഷോപ്പിങ്ങ്...)					
15	സുഹൃദ്ബന്ധങ്ങൾ പരമാവധി കുറയ്ക്കുന്നു					
16	കുടുംബക്കാരുമായി അകലം വെക്കുന്നു					
17	അയൽവാസികളുമായി പരമാവധി വിട്ട് നിൽക്കുന്നു					

English Translation Affiliate Stigma Scale)

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
AFFILIATE STIGMA SCALE

Mark (x) in the appropriate column,the extent to which each of the following statements connects to you as a mother of child with disability. Your information will be kept confidential and used for research purposes only .

SN	Statement	Never	Rarely	Occasionally	Often	All the time
1	When I am with my child, others see me differently.					
2	When I am with my child, other people's attitudes change.					
3	When I am with my child, others see me as bad.					
4	I am incompetent in front of others when the child is with me					
5	When my child is with me, it makes me think that I am lesser to others					
6	Family members and others would discriminate against me if I am with my disabled child					
7	I feel inferior because I have a child with disability					
8	The behavior of my disabled child makes me feel embarrassed					
9	I feel helpless for having a child with disability					
10	I worry that other people would know I have a child with disability					
11	I feel that I am under great pressure because I have a child with disability					
12	I feel sad because I have a child with disability					
13	I dare not tell others that I have child with disability					
14	I reduce going out with my child with disability					
15	I reduce contact with my friends and relatives					
16	I avoid communicating with family members					
17	I avoid communicating with neighbors					

Appendix G

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
MATERNAL SELF EFFICACY SCALE

താഴെ കൊടുത്തിരിക്കുന്ന ഓരോ പ്രസ്താവനയും നിങ്ങളുടെ ജീവിതത്തിലെ വെല്ലുവിളികളുമായി യോജിച്ച് പോകാൻ എത്രത്തോളം സഹായകമായി എന്നു അനുയോജ്യമായ കോളത്തിൽ (x) മാർക്ക് ഇട്ട് വ്യക്തമാക്കുക.നിങ്ങളുടെ വിവരങ്ങൾ രഹസ്യമായി വക്കുന്നതും ഗവേഷണത്തിനു മാത്രം ഉപയോഗിക്കുന്നതുമായിരിക്കും.

Sl. No.	പ്രസ്താവന	ഒരിക്കലുമില്ല	അപൂർവമായി	ചിലപ്പോൾ	പലപ്പോഴും	എല്ലായ്പ്പോഴും
1.	സാഹചര്യങ്ങൾക്കനുസരിച്ച് എന്റെ കുട്ടിയുടെ പെരുമാറ്റം എങ്ങനെയാവുമെന്ന് എനിക്കറിയാം					
2.	കുട്ടിക്ക് ദേഷ്യം വരുമ്പോഴൊക്കെ അവനെ നിയന്ത്രിക്കാൻ എനിക്കറിയാം					
3.	രക്ഷിതാവെന്ന നിലയ്ക്കുള്ള ഏതു പ്രശ്നങ്ങൾക്കും പരിഹാരം കാണാൻ എനിക്ക് സാധിക്കാറുണ്ട്					
4.	രക്ഷിതാവെന്ന നിലയ്ക്കു ഞാനൊന്നും ചെയ്യുന്നില്ല എന്നു തോന്നാറുണ്ട്					
5.	അമ്മയെന്ന നിലയ്ക്ക് വേണ്ട എല്ലാ കഴിവുകളും എനിക്കുണ്ടെന്നു ഞാൻ കരുതുന്നു					
6.	എന്റെ കുട്ടിയുടെ പ്രശ്നങ്ങളെ നേരിടുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
7.	അപ്രതീക്ഷിതമായി ഉണ്ടാകുന്ന അവന്റെ പെരുമാറ്റത്തെ നിയന്ത്രിക്കുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
8.	ദൈനംദിന ജീവിതത്തിൽ അവനു വേണ്ട അത്യാവശ്യ സഹായം ചെയ്യുകൊടുക്കാൻ എനിക്ക് കഴിയാറുണ്ട്					
9.	കുട്ടി വാശി കാണിക്കുമ്പോൾ അവനെ നിയന്ത്രിക്കുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
10.	കുട്ടിക്ക് വേണ്ട അത്യാവശ്യം തെറാപ്പി സഹായങ്ങൾ വീട്ടിൽ ചെയ്യാൻ എനിക്ക് സാധിക്കുന്നു					
11.	തെറാപ്പിസ്റ്റ് നിർദേശിക്കുന്ന ഹോംവർക്ക് കുട്ടിയെ കൊണ്ട് ചെയ്യിക്കാൻ എനിക്ക് കഴിയാറുണ്ട്					
12.	കുട്ടിയുടെ പെരുമാറ്റത്തിൽ മാറ്റം വരുത്താൻ എനിക്ക് സാധിക്കുന്നു					
13.	കുട്ടിയോട് വേണ്ടുന്ന കാര്യങ്ങൾ പറഞ്ഞ് ബോധ്യപ്പെടുത്താൻ എനിക്ക് കഴിയാറുണ്ട്					
14.	പ്രതികൂല സാഹചര്യം മറികടക്കാൻ എനിക്ക് കഴിയും					
15.	കുട്ടിയുടെ വികൃതി നിയന്ത്രിക്കാൻ കഴിയാറുണ്ട്					
16.	പ്രതികൂല സാഹചര്യം നേരിടാൻ കുടുംബക്കാരുടെ സാനിധ്യം ഉറപ്പ് വരുത്താൻ എനിക്ക് കഴിയുന്നു					
17.	കുട്ടിയുടെ അവസ്ഥയെക്കുറിച്ച് മറ്റുള്ളവരെ പറഞ്ഞ് ബോധ്യപ്പെടുത്താൻ എനിക്ക് കഴിയാറുണ്ട്					
18.	അവശ്യഘട്ടങ്ങളിൽ കുട്ടിക്ക് വേണ്ടുന്ന മരുന്ന്/തെറാപ്പി എത്തിച്ച് കൊടുക്കാൻ കഴിയാറുണ്ട്					

Appendix H
DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
PARENTAL SELF-EFFICACY SCALE

താഴെ കൊടുത്തിരിക്കുന്ന ഓരോ പ്രസ്താവനയും നിങ്ങളുടെ ജീവിതത്തിലെ വെല്ലുവിളികളുമായി യോജിച്ചു പോകാൻ എത്രത്തോളം സഹായകമാകുന്നുഎന്ന് അനുയോജ്യമായ കോളത്തിൽ (x) മാർക്ക് രേഖപ്പെടുത്തി വ്യക്തമാക്കുക.നിങ്ങളുടെ വിവരങ്ങൾ രഹസ്യമായി വയ്ക്കുന്നതും ഗവേഷണത്തിന് മാത്രം ഉപയോഗിക്കുന്നതും ആയിരിക്കും.

NO	പ്രസ്താവന	ഒരിക്കലുമില്ല	അപൂർവ്വമായി	ഇടയ്ക്ക്	പലപ്പോഴും	എപ്പോഴും
1	സാഹചര്യങ്ങൾക്ക് അനുസരിച്ച് എൻറെ കുട്ടിയുടെ പെരുമാറ്റം എങ്ങനെയാവും എന്ന് എനിക്കറിയാം.					
2	കുട്ടിക്ക് ദേഷ്യം വരുമ്പോഴൊക്കെ അവനെ/അവളെ നിയന്ത്രിക്കാൻ എനിക്കറിയാം					
3	രക്ഷിതാവ് എന്ന നിലക്കുള്ള ഏതു പ്രശ്നങ്ങൾക്കും പരിഹാരം കാണാൻ എനിക്ക് സാധിക്കാറുണ്ട്					
4	രക്ഷിതാവ് എന്ന നിലയ്ക്ക് വേണ്ട എല്ലാ കഴിവുകളും എനിക്കുണ്ടെന്ന് ഞാൻ കരുതുന്നു					
5	എൻറെ കുട്ടിയുടെ പ്രശ്നങ്ങളെ നേരിടുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
6	അപ്രതീക്ഷിതമായി ഉണ്ടാകുന്ന കുട്ടിയുടെ പെരുമാറ്റത്തെ നിയന്ത്രിക്കുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
7	ദൈനംദിന ജീവിതത്തിൽ കുട്ടിക്കു വേണ്ട അത്യാവശ്യ സഹായം ചെയ്യ കൊടുക്കാൻ എനിക്ക് കഴിയാറുണ്ട്					
8	കുട്ടി വാശി കാണിക്കുമ്പോൾ അവനെ/അവളെ നിയന്ത്രിക്കുവാൻ എനിക്ക് കഴിയാറുണ്ട്					
9	കുട്ടിക്ക് വേണ്ട അത്യാവശ്യം തെറാപ്പി സഹായങ്ങൾ വീട്ടിൽ ചെയ്യാൻ എനിക്ക് സാധിക്കുന്നു					
10	തെറാപ്പിസ്റ്റ് നിർദ്ദേശിക്കുന്ന ഹോംവർക്ക് കുട്ടിയെ കൊണ്ട് ചെയ്യിക്കാൻ എനിക്ക് കഴിയാറുണ്ട്					
11	കുട്ടിയുടെ പെരുമാറ്റത്തിൽ മാറ്റം വരുത്താൻ എനിക്ക് സാധിക്കുന്നു					

12	കുട്ടിയോട് വേണ്ടുന്ന കാര്യങ്ങൾ പറഞ്ഞു ബോധ്യപ്പെടുത്താൻ എനിക്ക് കഴിയാറുണ്ട്					
13	പ്രതികൂല സാഹചര്യങ്ങളെ മറികടക്കാൻ എനിക്ക് കഴിയും					
14	കുട്ടിയുടെ വികൃതി നിയന്ത്രിക്കാൻ കഴിയാറുണ്ട്					
15	പ്രതികൂല സാഹചര്യങ്ങളിൽ കുടുംബക്കാരുടെ സാന്നിധ്യം ഉറപ്പുവരുത്താൻ എനിക്ക് കഴിയുന്നു					
16	കുട്ടിയുടെ അവസ്ഥയെക്കുറിച്ച് മറ്റുള്ളവരെ പറഞ്ഞു ബോധ്യപ്പെടുത്താൻ എനിക്ക് കഴിയാറുണ്ട്					
17	കുട്ടിക്ക് വേണ്ടുന്ന അവശ്യ മരുന്ന്/തെറാപ്പി എത്തിച്ചുകൊടുക്കാൻ കഴിയാറുണ്ട്					

(English Translation parental self-efficacy Scale)
DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
PARENTAL SELF-EFFICACY SCALE

Mark (x) in the appropriate column the extent to which each of the following statements helps you adapt with your life challenges. Please specify . Your information will be kept confidential and used for research purposes only
.

NO	Statement	Never	Rarely	Occasionally	Often	All the time
1	I know how my child will behave depending on the situation.					
2	Whenever the child gets angry I know how to control him / her					
3	I am able to solve any problems as a parent					
4	I think I have all the skills needed for parenting					
5	I am able to deal with my child's problems					
6	I can control my child's unexpected behavior					
7	I am able to help the child in daily life					
8	I am able to control the child when he / she is fussy					
9	I am able to provide the necessary therapeutic support for the child at home					
10	I am able to do the suggested homework for the child, as therapist suggested					
11	I can change the child's behavior					
12	I can convince the child by telling him what he wants					
13	I can overcome negative situations					
14	I can controll child’s naughty behaviour					
15	I am able to ensure the presence of family members in adverse situations					
16	I am able to convince others about the child's condition					
17	Whenever the child needs, I can ensure the essential medicines / therapy					

Appendix I

CONSENT FORM

RESEARCH TITLE: PSYCHOLOGICAL DISTRESS OF MOTHERS OF DISABLED CHILDREN: AN EXPLORATION

- ഈ ഗവേഷണം ഭിന്നശേഷി ഉള്ള കുട്ടികളുടെ അമ്മമാരുടെ മാനകി വിഷമങ്ങളും ബുദ്ധിമുട്ടുകളും മനസ്സിലാക്കുന്നതിന് വേ ിയുള്ളതാണ്.
- ഭിന്നശേഷി ഉള്ള കുട്ടിയെ പരിചരിക്കുന്ന ആൾ എന്ന നിലയിൽ ഉള്ള വിവരങ്ങൾ അഭിമുഖത്തിലൂടെ ഗവേഷകയോട് പങ്കുവെക്കുകയാണ് ചെയ്യേ ത്.
- നിങ്ങൾ പങ്കുവക്കുന്ന വിവരങ്ങൾ പൂർണമായും രഹസ്യമായി സൂക്ഷിക്കുന്നതായിരി ക്കും. നിങ്ങൾക്ക് വിവരങ്ങൾ വിമുഖത കൂടാതെ പങ്കുവെക്കാം. യാതൊരു വിധ ത്തിലും വ്യക്തഗതമായോ മുൻവിധിയുടെ അടിസ്ഥാനത്തിലോ നിങ്ങളുടെ ഉത്തര ങ്ങൾ കണക്കാക്കപ്പെടുകയില്ല.
- ഗവേഷണത്തിന്റെ ഭാഗമാവുന്നതിൽ നിങ്ങൾക്ക് നേരിട്ട് വ്യക്തിപരമായ നേട്ടങ്ങൾ ഉ ായിരിക്കുകയില്ല.
- ഗവേഷണത്തിൽ നിന്നും എപ്പോൾ വേണമെങ്കിലും പിൻവാങ്ങാനുള്ള അവസരം നിങ്ങൾക്കു ്.
- നിങ്ങൾ നൽകുന്ന വിവരങ്ങൾ ഗവേഷണാവശ്യാർത്ഥം ഉപയോഗിക്കണോ വേ യോ എന്ന് തീരുമാനിക്കാനുള്ള അവകാശം നിങ്ങൾക്കു ്.
- നൽകുന്ന വിവരങ്ങൾ ഒട്ടും തന്നെ നഷ്ടപ്പെടാതെ ശേഖരിക്കാൻ അഭിമുഖം ഓഡിയോ റെക്കോർഡ് ചെയ്യുന്നു ്. ഗവേഷകയെ കൂടാതെ മറ്റൊരാൾക്കും അത് കൈമാറ്റം ചെയ്യുകയില്ല. ഓഡിയോ ഗവേഷണത്തിനുശേഷം ഡിലീറ്റ് ചെയ്യുന്നതാണ്.
- അഭിമുഖത്തിലെ വിവരങ്ങളുടെ ക്രോഡീകരണമായിരിക്കും ഗവേഷണം. നിങ്ങളുടെ അഭിമുഖത്തിന്റെ പൂർണ്ണരൂപം ഒരിക്കലും പ്രസിദ്ധപ്പെടുത്തുന്നതല്ല.

ഗവേഷണം സംബന്ധിച്ച് എന്തു വിവരങ്ങൾക്കും താഴെക്കൊടുത്ത വിലാസത്തിൽ ബന്ധ പ്പെടാവുന്നതാണ്.

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- ഞാൻ ..... സ്വമനസ്സാലെയാണ് ഈ പഠനത്തിന്റെ ഭാഗമാകുന്നത്
- ഈ ഗവേഷണത്തിന്റെ ഉദ്ദേശവും ആവശ്യകതയും എനിക്ക് വിശദീകരിച്ച് നൽകിയിട്ടു ്.
- ഗവേഷണത്തിന്റെ ഭാഗമായ അഭിമുഖത്തിൻരെ ഉള്ളടക്കവും പ്രകൃതവും എനിക്ക് വ്യക്തമാണ്.
- ഈ അഭിമുഖത്തിൽ നൽകുന്നവിവരങ്ങൾ ഗവേഷണാർത്ഥം മാത്രം ഉപയോഗിക്കുന്നതായിരിക്കുമെന്നും എന്റെ വ്യക്തിഗതവിവരങ്ങൾ വെളിപ്പെടുത്തുകയില്ലയെന്നും എനിക്ക് ഉറപ്പ് നൽകിയിട്ടു ്.
- ഈ ഗവേഷണത്തിൽ നിന്നും എപ്പോൾ വേണമെങ്കിലും ഭാഗികമായോ പൂർണ്ണമായോ പിൻവാങ്ങാനുള്ള അവസരം എനിക്കു ്.
- ഈ പഠനത്തിന്റെ ഭാഗമാകുന്നതിൽ എനിക്ക് നേരിട്ട് നേട്ടങ്ങളൊന്നുമില്ല.
- ഈ അഭിമുഖം ഓഡിയോ റെക്കോർഡ് ചെയ്യുന്നതിനോട് ഞാൻ യോജിക്കുന്നു. റെക്കോർഡിങ് പ്രക്രിയ നടക്കുന്നത് എന്റെ അഭിപ്രായം പരിഗണിച്ചാവും. റെക്കോർഡ് ചെയ്ത ഓഡിയോ ഗവേഷകയെ കൂടാതെ മറ്റാർക്കും കൈമാറ്റം ചെയ്യപ്പെടുകയില്ല.
- ഈ അഭിമുഖത്തിന്റെ പൂർണ്ണരൂപം (ശബ്ദരേഖ/എഴുത്ത്) പ്രസിദ്ധീകരിക്കപ്പെടുകയില്ല എന്ന് ഞാൻ മനസ്സിലാക്കുന്നു.
- ഗവേഷണത്തെക്കുറിച്ചുള്ള സംശയങ്ങൾ ദൂരീകരിക്കാൻ ഗവേഷകയേയോ സ്ഥാപനത്തെയോ ബന്ധപ്പെടാവുന്നതാണ്.

ആയതനാൽ ഈ ഗവേഷണത്തിന്റെ ഭാഗമാകുന്നതിനോട് ഞാൻ യോജിക്കുന്നു.