PSYCHO-SOCIAL DETERMINANTS OF QUALITY OF LIFE AMONG MOTHERS OF INTELLECTUALLY DISABLED AND HEARING-IMPAIRED CHILDREN

A Thesis Submitted

To

Sikkim University

In Partial Fulfilment of the Requirement for the

Degree of Doctor of Philosophy

By

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Department of Psychology

School of Human Sciences

December 2021

DECLARATION

I declare that the thesis entitled **"Psycho-Social Determinants of Quality of Life among Mothers of Intellectually Disabled and Hearing-Impaired Children"** submitted to Sikkim University for the Degree of **Doctor of Philosophy in Psychology** is my original research work carried out by me during the period from August 2017 to December 2021 under the supervision of Dr. Satyananda Panda, Associate Professor and Head, Department of Psychology, Sikkim University. Any part or content of the thesis has not been submitted to this or any other University or Institution for the award of any degree or diploma.

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"PSYCHO-SOCIAL DETERMINANTS OF QUALITY OF LIFE AMONG MOTHERS OF INTELLECTUALLY DISABLED AND HEARING-IMPAIRED CHILDREN"

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Lists of Abbreviations and Symbols

WHO	World Health Organization
NSO	National Statistical Office
ICD 10	International Statistical and Classification of Diseases
DSM 5	Diagnostic and Statistical Manual of Mental Disorders
ADHD	Attention Deficit Hyperactivity Disorder
QOL	Quality of life
N	Neuroticism
E	Extraversion
O	Openness
A	Agreeableness
C	Conscientiousness
EI	Emotional Intelligence
FQOL	Family's quality of life
ID	Intellectual Disabilities
HI	Hearing Impaired

ABSTRACT

Mothers living with a disabled child experience physical and psychological distress, thus compromising their quality of life. The present study emphasizes on understanding the psycho-social determinants of quality of life among mothers of intellectually disabled and hearing-impaired children.

A total of 240 eligible mothers (120 mothers of intellectually disabled and 120 mothers of hearing-impaired children) was taken, with age group 25 years to 55 years. For the purpose of data collection nine different rehabilitation institute/ centre of Assam, Kamrup (Metro), India was chosen. The purposive sampling technique was adopted to select the mothers of children within the age group of 5 years to 15 years. Data was collected using standardized questionnaires such as The World Health Organization Quality of Life-BREF, Multidimensional scale of Perceived Social Support, Big Five Inventory-2, Emotional Intelligence Scale. Collected data was analyzed through SPSS software.

The findings revealed that significant correlation existed between different dimensions of quality of life, social support, personality and emotional intelligence among mothers of intellectually disabled children and hearing-impaired children. It was also seen that there was a significant difference in all the dimensions of quality of life, social support, personality and emotional intelligence among the mothers of mild and moderate hearing-impaired children. In addition, there was a significant difference in all the dimensions of quality of life, social support, personality and emotional intelligence was found among the mothers of mild and moderate intellectually disabled children. Mothers of mild hearing-impaired children scored high on all the dimensions of quality of life, social support and emotional intelligence than the mothers of mild intellectually disabled

children. Significant difference was found in all the dimensions of quality of life, social support, emotional intelligence among mothers of moderate intellectually disabled children and moderate hearing-impaired children. There is a significant difference in agreeableness, conscientiousness, negative emotions and open-mindedness but there is no significant difference in extraversion among mothers of moderate hearing-impaired children and mothers of moderate intellectually disabled children. Regression analysis revealed that extraversion, conscientiousness, negative emotions, social support from friends, motivation predict quality of life among mothers of intellectually disabled children. Furthermore, among mothers of hearing-impaired children extraversion, conscientiousness, social support from family and friends, motivation and social awareness predict quality of life. Additionally, qualitative research with a semi-structured interview was conducted among 30 mothers (15 intellectually disabled and 15 hearing impaired). The thematic analysis revealed that quality of life among mothers of intellectually and hearing-impaired children were mostly associated with financial problems, mothers worried about the future of the child, whereas mothers of hearing-impaired children revealed that their children are somewhat independent as a result of which they are able to adjust in the face of adversity.

Key words: Mothers of Intellectually disabled children, mothers of hearing-impaired children, quality of life, social support, personality, emotional intelligence

CHAPTER I

INTRODUCTION

The concept of 'Disability' varies from person to person. The term cannot be generalized as a group of people but are a diverse group with a wide range of needs, broadly categorized as *Impairment, Activity Limitation,* and *Participation Restrictions*. Disability should not be considered an obstacle to success. The collective contribution should be given to remove the barriers for such people towards involvement and to finance adequate capital. Governments are also demonstrating their assurance to many individuals with disabilities who are denied access to health, rehabilitation, assistance, education, and work, and who will never have the opportunity to shine. To curtail the disabled birthrate, health, and wellbeing of mothers of children with special needs, as a vulnerable group in society, is very important. Studies have been conducted and successful outcomes are also initiated. Mothers feel that others put a label on their children and pity them. They feel uneasy to interact with others because of this emotion. As a result, they prefer to stay at home the most of the time, which can lead to sadness, loneliness, and despair.

Family is the most fundamental unit of analysis, and it has always been vital to research. A family is the safest and secure social setup for everyone, including the newborn. When a family member has a disability or special need, families often have to adjust family roles. Such added roles can often lead to stress, frustration, and conflict but empathizing with the situation can often find calmer grounds. This is the time to talk about what is to be expected from each family member. The acceptance of a special child

in the family may not be easy. The home of such children is a ‘clinic’, the father has to play the role of a ‘doctor’ and mother has to be a trained ‘nurse’ and other members of the house ‘nursing assistants. An extra source to generate income can also be a family challenge. Every ordinary task becomes more difficult and more stressful.

Disabilities are more social in nature than medical in nature. Social support means being offered equal acceptance or held in high esteem and offering help to one’s emotional state. Social support has been linked to increasing overall quality of life by promoting good physical and psychological health, alleviate and preventing sickness by promoting good physical and mental health. However, people with disabilities are more likely to have limited access to social support and its benefit. The capacity to remain calm under difficult conditions is a good indicator of emotional stability. Emotional stability on the other hand comes from emotional intelligence, which gives them support to adapt to their emotional environment. There are times when their impairment frustrates them because they realize that without it, some of the difficult situations they confront on a regular basis would not exist.

Mothers with special children face issues of compatibility. A child's good upbringing is dependent on the parenting style, much as the parent's mental health is related to the child's growth. A special child’s syndrome and observation context are related to the mother’s parenting behavior. These parents experience difficulties in dealing with their children's learning and other developmental problems, as well as difficulties in implementing preventative and supportive treatments. These parents and their children face stereotype prejudices regarding their situation. They seem to have access to less support from external sources and society. Overwhelming factors such as community attitudes, cultural beliefs, as well as institutional challenges are common for

them. They are constantly faced by guilt, believing that heredity, stressful periods during pregnancy, or alcohol abuse are directly responsible for the impairment. They have a high risk of experiencing depression, physical health problems, and decreased quality of life.

Disability influence people's marriage patterns and spouse selection. People with physical disabilities display more depressive symptoms and thus this directly affects their marital status. The lower psychological well-being may reflect unmet social needs as functional limitations restrict the abilities of these people to perform desired social roles and spur changes in the quality of social relations that lead to less perceived social support. They aspire to their social relations as less satisfying and report greater loneliness. Support from family and friends may be associated with loneliness for disabled men and women. Rather than deteriorating, however, the commitment, proximity, mutual investments, and routinized social interactions inherent in a marital relationship make it well suited to moderate the psychosocial consequences of the physically disabled.

1.1 Disability Defined

Deficit or lack of capability to perform an action (due to an impairment) is referred to as a disability. in the manner or within the range considered usual for a human being in the sense of health experience (WHO, 1993). According to this description, it defines the concept of disability is a mechanism through which an individual's expected normal behavior or action is avoided (either by excess or by deficiency) of an anatomical, physiological and psychological reason.

Another definition given by World Health Organization (WHO, 2001) says that disability is an umbrella term that covers impairments, activity limitations, and participation restrictions. Impairment refers to the problem in body function or structure; an activity limitation is a difficulty encountered by an individual in the implementation of a task.

The concept of disability is considered to be a multidimensional experience for the individual who is involved. It is also considered to be a spontaneous state that restricts regular activities. The Disability Services Act (1993) signifies disability as an attribute to intellectual, psychiatric, cognitive, sensory, or neurological impairment. Disability is permanent most of the time or likely to be that. As per the act, it may not be a chronic or episodic type but it results in substantially lowered capability of an individual to communicate as well as interact socially (Taderera & Hall, 2017).

In terms of disability and impairment, disability is commonly misunderstood. The World Health Organization (WHO, 1976) drew a threefold distinction) between impairment, disability, and handicap:

Impairment: is any psychological, physiological, or anatomical structure or function loss or abnormality.

Disability: is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being (resulting from an impairment).

Handicap: For a particular person, a handicap is a disadvantage resulting from impairment or disability, which prevents that person from fulfilling a role that is considered normal (depending on age, gender, and social and cultural factors).

The terms *disability, handicap, and impairment* have been used interchangeably in the present study. 'Disability refers to the absence or loss of function or capability because of an injury, accident, or inheritance. Disability is seen not only as an individual's trait but also as a dynamic series of conditions that are generated by the social environment.

1.2 Demographic Trends on Disability

According to 'The World Disability Report 2011', the global estimate of the disabled population is 15 % out of which between 2 to 4 % of the population has a severe disability. In our country, as per the reports of the National Statistical Office (NSO), the population of disabled was 2.2 % of the national population of India in 2018. According to the 2011 Census, the overall number of disabled people was 26,810,557, with 55.8% of males and 44.1 percent of females. This survey was considered 5 types of disability including Vision, hearing, motor, speech, and mental retardation. Disability In seeing at 48.5% emerges as the top category. Others in sequence are: In movement (27.9%), Mental (10.3%), In the speech (7.5%), and in hearing (5.8%), 52.42% females had a disability in seeing whereas 47.57% males had the same. There were 52.8% males and 47.1% females who had a hearing disability, whereas 56.1% males and 43.8% females had a speech disability, 61.9% males and 38% females had movement disability, 57.8% males and 42.1% females had mental retardation, Mental illness was found among 57.5%

males and in 42.4% females, 55.3% males and 44.6% females had any other disability and 54.9% males and 45% females had multiple disabilities.

1.3 Models of Disability

There are various models which provide significant inputs for defining and understanding disabilities. These models also help in understanding the impact of disability.

Medical Model of Disability: Medical model of disability considers ‘disability’ as a defect that the field of medicine and healthcare professionals must fix. It equates pathological problems with inherent disability. According to this concept, the disability must be cured by medicine or proper medical attention. Hence, it largely indicates that disability is an ‘individual’ concern and others have nothing to do with it. It is like a ‘disease’ with which only the suffering person has to live and others can treat them ‘differently’ like they treat cancer or HIV patient. That is why this model is also known as an individual model or at times personal tragedy model. This model views persons with disabilities as feeble, defective, and incapable of living on their own or fully participating in anything. As they are considered the ‘weaker’ section of the society, levels of expectation in terms of national productivity are also less from them. Such a view is equally harmful to them as well as the whole society.

Another important thing to notice here is that the medical model puts all the blame on the disabled itself and does not put any responsibility on society to create an adaptable system to utilize their qualities and skills and provide them support to grow. As a result,

the disabled feel inferior and even sometimes useless and thus refrain to be part of mainstream society (Retief & Letsosa, 2018).

The Social Model of Disability: This model was developed by Mike Oliver in the 1980s. According to this view, disability is a concern of society not only of the disabled himself. It is the responsibility of society and so-called 'Normal' people to create and provide an ecosystem in which the disabled can perform and grow. According to Oliver, this is not an individual's problem that he cannot perform well due to his physical or mental disability. But, it's a social failure for not providing appropriate services and adequately ensuring that the needs of disabled people are taken into account in societal organizations. Being disabled means unable to participate within the mainstream of society as a result of physical, organizational, and attitudinal barriers. They are unable to obtain equitable access to information, education, job, public transportation, housing, and social/recreational activities because of these hurdles. Thus, the social model aims to achieve the acceptance by society of individual differences and maximize (Retief & Letsosa, 2018).

The Individual-Environment Model of Disability

Both medical and social models were one-sided in their view. The medical model focused on an individual's failures and limitations, whereas the social model emphasizes society's flaws. Considering this, a third model was introduced by the World Health Organization (WHO, 1980) termed as International Classification of Impairments, Disabilities, and Handicaps (ICIDH). As its title suggests, the ICIDH focused on classification within three domains: impairment, disability, and handicap. Anomalies in

bodily structure, appearance, and/or organ system and function are all considered impairments. Disabilities are defined as the results of limitations in an individual's functional performance and activities. The disadvantages that an individual suffers as a result of impairments and disabilities are referred to as handicaps.

The most current revision of this paradigm is known as the International Classification of Functioning, Disability, and Health (ICF). In the ICF, disability and functioning are considered to be outcomes of interactions between health conditions and contextual factors (Retief & Letsosa, 2018).

Other Models: Other ways of defining or looking at disability also exists. They are as follows:

Moral Model: In various cultures including our very own, sometimes disability, like mental retardation or physical handicap, is considered as a result of previous sins or as a punishment of bad deeds of past births. A disabled person is considered as ‘cursed by God’ for his bad intentions or wrong deeds. People even see disability as a result of evil actions of parents or as a result of practicing witchcraft if it occurs after birth. (Retief & Letsosa, 2018).

Tragedy/ Charity Model: This model suggests that disabled people deserve soft corners and sympathy as it is not their fault or mistake that they have to live this way. A disabled person is the victim of situations and hence deserves compassion. It advocates considering them weak and helpless and show pity as they have this tragedy in their life. If anyone helps any disabled, he shows it like he has done some charity. This model,

along with the medical one, is most often used by so-called ‘normal’ people to justify their attitude and conduct towards the disabled (Retief & Letsosa, 2018).

Economic Model: Another way of looking at disability is through the economic point of view. Due to disability, it becomes difficult for the individual to actively participate in economic activities, i.e., to work efficiently to ensure regular income. From an economic point of view, disability refers to a person’s incapability to perform various tasks which are compulsory to do any job and thereby putting in loss all the parties involved including the individual himself, the employer, and the society by and large. As a consequence, the disabled are in pity of the government for monetary support, and hence, this model is closely associated with the Charity model of disability (Retief & Letsosa, 2018).

Empowerment Model: This allows the person with a disability and the family to decide the course of their treatment and the services prefer to take. The empowerment model describes empowerment as a process of liberation in which disabled people are empowered to exercise their rights, achieve equal access to services, and actively engage in social change and decision-making. The empowerment model works as the opposite of the expert model with the individual with a disability and his/her family granted control to decide on and choose resources that are deemed acceptable by seeing the person with a disability as a consumer (Retief & Letsosa, 2018).

1.4 Types of Disability

Who exactly should be considered as ‘Disable’? Someone who is born with physical or mental functionality? What if someone has acquired a disability due to some accident or hazardous working condition, like in coal mines or X-ray labs? To clarify this, we have a distinct legal act that defines and categorizes disability and also ensures the rights of disabled people. The act is called as “Rights of Person with Disability Act, 2016”. Earlier, this was called as Person with Disability act 1995, in which various amendments were made to give it the present shape. This act came into practice to ensure that the disabled should be treated at par with other citizens of this country. This act defines different types of disability including those related to vision, hearing, speaking, movement (motor functions), mental illness, mental retardation, and multiple disabilities in which two or more disabilities are present. After amendments, the list of disabilities has included 21 categories as an expansion to earlier mentioned 7 categories such as 1. Locomotor disability; 2. Leprosy cured person; 3. Cerebral palsy; 4. Dwarfism; 5. Muscular dystrophy; 6. Acid attack victims; 7. Blindness; 8. Low-vision; 9. Hearing impairment; 10. Speech and language disability; 11. Intellectual disability; 12. Specific learning disabilities; 13. Autism spectrum disorder; 14. Mental illness; 15. Chronic Neurological Conditions; 16. Multiple sclerosis; 17. Parkinson’s disease; 18. Haemophilia; 19. Thalassemia; 20. Sickle cell disease; and 21. Multiple Disabilities.

Disabilities acquired during a young child's early developmental stage may be the most difficult to overcome, since they can be debilitating for a long time, if not their whole lives, for both the child and his or her family. The severity of the disability determines the prognosis, and the more impaired the child is, the more difficult it is to

train him or her to be self-sufficient, thus the child's mothers and family members must make more modifications to cope with the condition. During the early years of life, a child's development might be hampered by a handicap of any portion of the body. A child can become impaired from a disability of any part of the body during the early years of life.

The present study focuses on long-term or chronic caregiving for children with disabilities namely intellectual and hearing impaired supported by mothers. Although, the selected disabilities differ in signs and symptoms Children with either of these conditions end up needing almost constant treatment for a long period.

1.5 Intellectual Disability Defined

The International Statistical and Classification of Diseases and Related Health Problems ICD -10 (WHO,1993) defines mental retardation as a condition or incomplete development of the mind which is especially characterized by impairments of skills like cognitive, language, motor, and social abilities. It is worth noting that retardation is not limited to any special condition. It can be caused by any reason including accident during pregnancy, poor diet, and effect of any drug, exposure to hazardous radiation, or anything else.

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition/DSM-5 (APA, 2013), describes the intellectual disability, previously recognized as mental retardation. Neurodevelopmental disorder onset during the developmental stage of the child includes impairments in intellectual and adaptive functioning.

***Diagnostic Criteria*:** The DSM-5 (APA, 2013) has the following diagnostic criteria for the diagnosis of intellectual disability:

i. Reasoning, problem-solving, planning, and abstract thinking deficiencies are all examples of cognitive deficits., judgement, academic learning, and learning from experience, as determined by clinical examination and personalized, standardized intelligence testing.

ii. Adaptive functioning deficits: Adaptive deficits impair functioning in one or more everyday tasks, such as communication, social involvement, and self-care.

iii. The onset of intellectual and adaptive deficits during the developmental period.

Specifiers: According to DSM-5 (APA, 2013) the amount of severity of the incapacity is set on the premise of adjustive functioning that determines the quantity of support required by him/her of a person instead of his/her. According to ICD-10 (WHO, 1994), IQ scores ranging from 50 to 69 are indicative of mild retardation, 35 to 49 is indicative of moderate retardation, 20 to 34 is indicative of severe retardation and IQ scores below 20 is indicative of profound retardation. ICD-10-CM (WHO, 2015) describes an individual to be in the category of mildly intellectually disabled if his/her IQ scores range in between 50-55 to approximately 70. Individuals whose IQ scores range from 35-40 to 50-55 are categorized as moderately intellectually disabled, those having IQ scores from 20-25 to 35-40 are categorized as severely intellectually disabled, and those individuals whose IQ scores are below 20-25 are classified as profoundly mentally retarded.

Intellectual Disability: Mental retardation characterized by below-average intelligence or mental aptitude is referred to as intellectual disability**.:**. It also expresses the deficiency of skills that are essential for daily life. An individual with an intellectual disability can learn new skills but more slowly than others (Taderera & Hall, 2017). It can vary from mild to profound degrees. The intellectually disabled person has limitations in two factors. They are:

Intellectual functioning- It is considered as IQ that refers to an individual's capability to learn, reason, decision-making, and problem-solving. IQ or intelligence quotient is measured by an IQ test assuming the average IQ to be 100. Most people score between 85 and 115. If individual scores are less than 70-75, he/she would be considered intellectually disabled (Schuengel et al., 2017).

Adaptive behaviors- It refers to the skills that are essential for daily life likeability like effective communication, interacting with others, and taking care of oneself. To measure adaptive behavior, an expert compares a child's different skills with other children of similar age groups.

The intellectually disabled persons are a little slower than the others in terms of acquiring information or skills. If proper support can be given, most of them would be able to live independently (Taderera & Hall, 2017).

1.5.1 Associated Co-morbidities

Another important issue with intellectual disabilities is that it accompanies other problems too. There are frequently found Co-morbidities associated with intellectual disorders. They are:

Attention Deficit Hyperactivity Disorder (ADHD): Under this disorder, children are unable to concentrate 0n any one thing at a time. They continuously keep moving and show impulse behaviors. It is often observed that they remain hyperactive, to the extent that they can't even sit properly for a while. Due to ADHD, making them learn something becomes very challenging. If the child is intellectually disabled, the challenge is even bigger. There are three subtypes, predominantly inattentive, predominantly hyperactive-impulsive, combined type i.e., inattention, hyperactivity-impulsivity (Fowler et al., 2009).

Visual Impairment: Children with intellectual disabilities may have one of the challenges related to vision. They can have short-sightedness to partial or total blindness. Some other problems include drifting of one inward or outward, frequent blinking, seeing double or not seeing clearly, low vision. It also includes squint that is the misalignment of the two eyes (Jauhari et al., 2012).

Hearing Impairment: Hearing troubles can add more challenges for the intellectually disabled. Hearing impairment may become a strong barrier in the learning and developing process, which can result in problems related to speech development, communication, language, and academic performance.

Autism: Autistic disorder, which causes uneven skill development, notably in communication and social capacities, and is characterized by repetitive and ritualistic behavior, is another probable co-morbidity. Autism problem suffer from communication and socialization. Speech is normally delayed and if it does develop it may be peculiar or echolalic (Jauhari et al., 2012). It is a lifelong developmental delay often associated with mental retardation.

Down's Syndrome: Down's syndrome is a genetic disorder caused by an excess of specific genes on chromosome 21 due to faulty cell division. It is also known as 'Trisomy21'. Down's syndrome causes a distinct facial appearance, intellectual disability, and developmental delays. It is found to occur in one out of every 700 births. It accounts for about 10% of moderate to severe mentally retarded children (Jauhari et al., 2012).

Cerebral Palsy: It is a chronic disorder of movement and posture. It leads to severe orthopedic problems include discrepancy in skeleton growth, deformities of hand, feet, pelvic, dislocated or sub located joints, contractures at joints. It affects the overall motor development and skills building of the children. It is a result of brain injuries occurring in the pre-natal, perinatal, or infant period of development (Jauhari et al., 2012).

Behavior Problems: For a child with intellectual disabilities, behavioral issues are very natural, as they cannot develop social and communication skills as their normal counterparts; they cannot express their emotions and at the same time, cannot understand others' expressions as well. Behavioral disorders imply a child causing trouble for others and harming themselves. (Jauhari et al., 2012).

1.5.2 Causes of Intellectual Disability

Childbirth is a complex process. From inception till birth, there are various environmental risks through which this journey goes on. Even a small mistake can result in a severe impact on the development of the baby. Usually, Intellectual, or even any other deformity, happens either during the pregnancy or during the process of childbirth or after the birth in the first few days. In general, the following factors can be responsible for an intellectually disabled child:

- Age of mother (Either very young or old) at the time of conception
- Poor nutrition and improper care
- Bad habits of the mother (like alcohol or smoking)
- Side effects of the medicine
- Any accident (physical injury) during pregnancy
- Exposure to radiations
- Various Infections
- Premature delivery
- Prolonged labour
- A head injury to the neonate during/after birth
- Poor care and nutrition after birth

1.6 Hearing Impairment

Hearing loss is a sensory disability affecting the ability to hear optimally. Around the globe, 5 neonates per 1000 births have a severe to profound nature of hearing

disability **(**Garg et al., 2009). Hearing-impaired is the general term that comprises both the hard of hearing (partially hearing) and deaf. Hard of hearing and deaf are came up because of newer testing methods and the person who falls under deaf has been also falling under the category as hard- of-hearing. Hearing aids and auditory training can help a person with hearing loss to acquire speech and language more slowly and gradually. A person classified as deaf is those people whose sense of hearing is completely lost as a result of injuring in the auditory channel, therefore such people's sense of hearing is rendered inactive and non-functional with or without hearing aids for day-to-day life purposes .It was observed that deaf children suffer more than hard-of-hearing and normal children in arithmetic problems involving reading skills, so proper diagnosis is important to categorize and accordingly line of treatment they receive to the fullest potential (Nwadinobi, 2019).

Sense of hearing of each ear is calculated independently and the severity/degree of hearing impairment/ hearing loss is usually classified in seven categories as per Goodman (1965) classification and an extra classification that is slight hearing loss is added between the normal hearing and mild hearing loss especially when assessing the hearing sensitivity of young children.

Table 1.1: Classification of Severity of Hearing Impairment

Classification	*PTA range in Dbhl*
Normal Hearing	-10 to 15
Slight Hearing Loss	16 to 25
Mild Hearing Loss	26 to 45
Moderate Hearing Loss	46 to 55
Moderately-severe Hearing Loss	56 to 70
Severe Hearing Loss	71 to 90
Profound Hearing Loss	91 and more

Causes of Hearing Impairment

Several factors can cause both conductive and hearing impairment. Okeke (2001) identifies 13 causes of hearing impairment:

1. Hardened wax or external object blocking the external auditory meatus.

2. Swelling of the middle ear (Otitis media).

3. Contamination of the middle ear such as sinuses, adenoids, tonsils.

4. Genetics, e.g., otosclerosis, which is an inherited situation that stiffens the small bones of the middle ear;

5. Infections such as German measles (rubella), small pox, mumps, influenza, cerebrospinal meningitis, maternal syphilis;

6. Drugs, poisons, e.g., carbon monoxide, quinine taken by expectant mothers;

7. Birth injuries such as prematurity, prolonged labour, difficult birth, anoxia (lack of oxygen);

8. Pathological conditions of the fetus, erythroblastosis fetalis;

9. Development anomalies;

10. Lack of the right vitamins (avitaminosis);

11. Noise and blast;

12. Accident in the form of head injuries;

13. Brain tumours or an abscess caused by a condition such as birth injuries, degeneration of circulatory structures (Nwadinobi, 2019).

Hearing loss has an adverse influence on a child's educational and social performance. Hearing, with or without amplification, is insufficient for the child to process language information. The educational performance of the child is affected adversely by this disability (Schuengel et al., 2017).

Quality of Life Defined

World Health Organization (WHO, 2013) defined quality of life as "An individuals' perception of their position in life in the context of the culture and value systems in relation to their goals, expectations, standards, and concerns". According to Oxford University Press (2006) "quality of life is an overarching label that includes all of the emotions, experiences, appraisals, expectations, and accomplishments that figure into a good life".

Theoretical Model of Quality of Life

(i) *Dynamic Process Model*– According to this model, quality of life can be achieved by continuous adaptation of the present demands and adjustment of the level of aspiration accordingly. Nothing remains constant, neither the social demand nor individual expectations from self and society. One needs to continuously alter the demands and aspirations, to live a life of containment.

(ii) *The Satisfaction Model* – Satisfaction is one of the supreme factors which define a great deal about the quality of life of any individual. If an individual is living as per the desires and expectations, his level of satisfaction will be higher. If not, then he will feel dissatisfied. Satisfaction or dissatisfaction produces a sense of well-being, which can be positive or negative depending on the situation. This experience is dependent on three variables i.e., personal characteristics (age, gender), objective evaluation of QoL (income level), and subjective QoL (satisfaction with income).

(iii) *The Role Functioning Model*– We all are supposed to play different roles in our life. Some are simply materialistic like doing a job to earn money, whereas, others can be based on our emotional needs like our role within the network of friends and family. Apart from this, we play some social roles too to serve society. Our quality of life depends on two aspects: One, how we are playing our role, and two, how others are playing their roles. If we are playing our roles properly and others are also playing their role as per the need and expectation, the level of happiness and satisfaction will be maximum. In general, this is subjected to adjustment and gradually the individual is adjusted to his situation and environment and enjoys a good quality of life (Bigelow et al., 1982).

(iv) *Meditational Model* – This model focuses on how perceived well-being is mediated by several interrelated variables. For good quality of life, we need to mediate with the surrounding environment. The external conditions and our subjective evaluations of those conditions should be in sync. Otherwise, the amount of contentment will decrease, lowering the level of happiness. This model considers the function of mediators of subjective quality of life and an appraisal process that may mediate between external living circumstances and subjective assessments.

(v) *The Combined Importance Model* – As per the theory proposed by Becker et al. (1993), the subjective satisfaction of an individual is equally important as the value one attaches with that domain of life. Everyone has a different set of preferences and values and these preferences affect the quality of life. Although to maintain the level of satisfaction and overall quality of life, people do negotiate on their preferences and try to

reduce any cognitive misinterpretations by devaluing those things or goals that they subjectively find unattainable (Becker et al.,1993).

The parents with a disabled child may get burdened by their child's disabilities and distresses, and children with disabilities create particular challenges for parents (Cooper, 1991; Ellis et al., 2000; Elmstahl et al., 1996). According to Evans et al. (1993), the parent's quality of life (QOL) may get affected by their children's disability. To take care of their disabled child, parents spend more time with them and thus are unable to indulge themselves in social life and this negatively affects their QOL. Previous research findings also indicate that caregivers experience lower QOL depending on the more intensive care given to the disabled child, as per (Unalan et al., 2001). The presence of a disabled child in the family results not only in increased parental stress but also disturbs the healthy family and marital functioning like disrupted parent-child relationships and reduced parenting efficacy. In another study by Cousino and Hazen (2013), it is found that the additional demands on parents of chronically ill children cause stress. Further, the study reveals that the stress level of parents of chronically ill children is not as severe as for the mentally challenged children's parents.

Parents of disabled children are frequently found to have physical and psychological stress associated with caring for their offspring and therefore affecting their quality of life. The responsibilities of a parent of taking care of their child with proper attention, dedication, and support can overwhelm them. Parents with especially disabled children face several socioeconomic challenges other than the typically normal parents. Several studies and research have found that parents' wellbeing factors and quality of life are detrimentally influenced by taking care of a child with physical, psychological, or

developmental disabilities. The studies evaluated the affecting factors related to the child, family, and contextual. The research found that parents with disabled children possess high levels of anxiety, depression, and stress. The quality of life of the parents can be affected negatively by the caregiving situation that impacts the parent's physical health, social bonding, and economic responsibilities (Lingen et al., 2016). The most common factors among parents are physical disorders, including chronic disease, visionary and hearing disorders, and physical pains like musculoskeletal and lower back pain. According to all the quantitative studies that incorporate the measurement of quality of life, caregiving has a negative influence on it (Kvarme et al., 2016).

The birth of a child with special needs in a family always seeks a lot of adjustments of the parents and the entire family. Although the unfulfilled requirements of the parents of those children are universally connected to stress, some cultural differences could be there in such a way where the stress affects the quality of life of the parents. It has been observed in several research studies that parents of intellectually disabled children showed a significant disorder of quality of life (QoL) in comparison with the normal healthy group. Particularly, important differences in the mentally retarded and autism groups in comparison to the normal group were present in both mothers and fathers with a disorder in four different domains of QoL. Those domains are- physical domain, psychological domain, social domain, and environment domain.

To be more specific, it can be asserted that mothers of the especially needed children exist with lower physical health, disturbance in social relationships along with stressed psychological state, and poor environmental perspectives. The studies also displayed those mothers of children with different disabilities have a lower quality of life

than fathers (Imanishi et al.,2017). The studies also showed more depression in mothers than in fathers. The mothers of disabled children face increased levels of anxiety and stress. The parents often feel incompetent and helpless, especially mothers. In terms of an educational level, higher education is associated with higher QoL. Higher education generally refers to better socioeconomic status; therefore, the impact of educational level could have been mediated by the effects of socioeconomic status (Lingen et al., 2016). Higher-income refers to less exposure to emotional and physical anxieties and can lead to higher QoL.

The domain of physical well-being consists of the factors related to physical health, sleep, pain, and adjustment with everyday life as well as disorders in socio-adaptive activities in children with disorders along with growing dependency on parents is time taking and impacts regular physical functioning. In the research study, it has been observed that both the father and mother of autism and mentally retarded groups have faced impaired functioning in the physical domain of QoL. The mothers seem to have more stress as they have the responsibility to look after the regular responsibilities of their offspring (Jones & Prinz, 2005).

The domain of psychological well-being is related to frequent mood swings, sadness, and self-dissatisfaction. The parents of disabled children are significantly connected with a feeling of isolation and incompetence (Friedrich, 2017). Moreover, the disorder in this domain is related to the anxiety about the future of the child as well as oneself. This anxiety causes sadness with a feeling of guilt, social shame, and depressive self-blame.

The social relationship domain consists of the factor of satisfaction with personal and social relationships. It was seen that these relationships are often affected by the disorders of the child. As the presence of an especially needed child with a chronic condition requires long-term care and concerns, the relationship between parents is affected. The parents often assume themselves responsible for the condition of the child. As friends and relatives may not be conscious about the child's condition, therefore they can treat the disabilities as a taboo to be ashamed of despite providing support **(**Flynn, 2020). It was also seen that relatives and friends are avoiding contact with those families. On the other hand, the parents also sometimes avoid social connections, so that their relatives and friends do not get information about the child. The parents want to escape from the embarrassment they feel sometimes due to the child's disabilities and behavioral problems (Roy et al., 2020). Therefore, the parents are supposed to have a lower quality of social life in comparison to the parents of normal children.

The environmental domain includes the factors of social safety, home atmosphere, health, and social care, and wellness factors of daily life. As the parents of developmentally disabled children experience a higher level of anxiety, worry, and danger about the physical safety of the child, lower scores are added in their environmental domain due to this. From the environmental perspective, the differences of QoL of the parents of disabled children and the normal children can be attributed to the environmental influences like more burden of having a disabled child, restricted socio-adaptive activities, behavioral problems along temper tantrums, aggressiveness, self-abusiveness, impulsive behavior. They often feel teased and rejected, added with the tension of not understanding their offspring or lack of communication **(**Chakraborty et al.,

2019). The children seek constant supervision and assistance in all the living skills, the parents can feel a lack of support. They can also experience financial strain, problems related to school and other services, difficulties in treatment, worries about the future, living arrangements, poor communication, and several unmet needs.

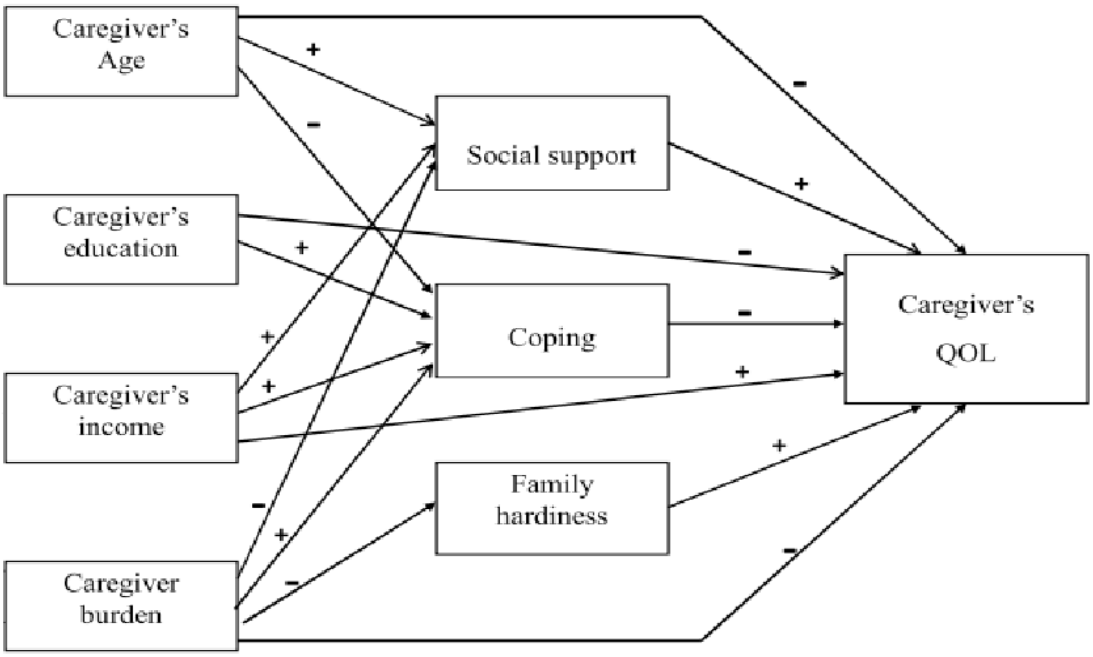


Figure 1.1: *Caregiver's Quality of Life (Source: Flynn, 2020)*

The parents of disabled children seem to have a life with a higher burden, stress, and significant impairment in their quality of life. Therefore, more attention must be provided to the parents, particularly the mothers' requirements. Social support is a must for the parents to get relief from the stress and helplessness of having a disabled child (Kazou, 2017). Effective and significant psycho-social programs are required to provide essential support for children with special needs as well as their families.

Personality Defined

Allport (1949) stated personality as what an individual is. He defined it as an internal something that guides and directs all human activity.

Neuroticism/emotional stability (N), extraversion (E), openness (O), agreeableness (A), and conscientiousness (C) are the "Big Five" personality qualities or variables, have been linked to the experience of stress in diverse groups facing tension.

People with high neuroticism, or lack emotional stability, have feelings of powerlessness, low self-esteem, and poor impulse control (Costa & McCrae, 1987). These characteristics cause people to have a poor perception of their circumstances, especially when they are in difficult situations, such as chronically stressful living situations. The undesirable condition leads to the growth of physical and psychological (Widiger & Trull, 1992) ailments in these individuals. People with high levels of neuroticism, according to Bolger (1990) and (Heppner et al., 1995), those individuals engage in inefficient coping techniques, such as avoiding and diverting coping tactics, which increases more stress and results in physical and psychological difficulties. Fearfulness, anger, and social anxiety are common personality traits.

Extraversion, one of the "Big Five" personality factors, is related to attributes like optimism, self-confidence, sociability, and a higher frequency and intensity of interpersonal interactions (Costa & McCrae, 1992). Individuals with a higher degree of these attributes are more able to adapt to reasonable, problem-solving coping mechanisms, seek social support, and reappraise their surroundings in a good light, even when they are worrying (Dorn & Matthews, 1992; Watson & Hubbard, 1996).

The openness element is linked to curiosity and adaptability of viewpoint (McCrae & Costa, 1985), and those who score high on its endeavour to learn from their experiences (Costa & McCrae, 1992; Goldberg, 1993). These characteristics allow people to view their conditions positively, even when they are in bad situations, and to experience less stress. Individuals with a high level of openness, according to Watson and Hubbarb (1996), adopt a more flexible, inventive, and intellectually curious approach to stress management.

Altruism, kind-heartedness, cooperativeness, nurturance, and caring are characteristics of people who score high on the agreeableness dimension or factor of personality (Costa & McCrae, 1986, 1992). They deal positively with stressful situations and are more sympathetically involved in caregiving tasks.

Individuals with a high conscientiousness score are more disciplined, responsible, hardworking, persevering, and diligent (McCrae & Costa, 1986; Costa, McCrae & Dye, 1991; Costa & McCrae, 1992). Although these characteristics do not directly influence whether a stressful situation is rated positively or negatively, individuals with high conscientiousness (Watson & Hubbard, 1996) use problem-solving coping strategies that help them deal with stressful situations, such as chronic caregiving, more effectively.

Disability among children provokes a series of vulnerability among the parents subconsciously, which directly or indirectly affect their various social and mental well beings. After getting to know that their ward is disabled, the parents show a series of reactions like guilt, sorrow, denial, anger, and it varies from individual to individual. Still, one thing is common that these stressors not only affect their personality but also lead them to physical and mental health problems. Plotkin et al. (2013) conducted a study to

see the impact and predictive capability of parental personality and perceived stress on behavior problems of their deaf child. Greater internalizing behaviors in younger deaf children were strongly predicted by higher parental neuroticism, which represents vulnerability to emotional and psychological discomfort. Results suggest a complicated interaction between parent personality and parent stress-related. According to National Health Survey in India and other Western countries, approximately 3 to 5 percentage of the population of children get affected with physical and mental health problems, which causes prevalent stress and emotional problems like depression among their parents which indirectly impose a significant burden on the society (Elgar et al., 2003).

Social Support Defined

The concept of social support has variously been defined by the researchers as social bonds (Henderson, 1977), social networks (Mueller, 1980) meaningful social contact (Cassel, 1976), availability of social confidence (Brown et al., 1975), Social support is defined as the amount of kindness, comrade, and attention of family members, friends, and other people (Sarfino, 2002).

Types of Social Support

Various researchers have divided the social support into the following 5 categories:

1. *Emotional Support:* Like a normal person, a disabled person also needs emotional support. They seek emotional support from their family, relatives, and society in general. They expect empathetic behavior and a concerned response from society. A

careful response, a feeling of being loved by the supporting group gives them a sense of comfort, reassurance, and belongingness.

2. *Esteem Support:* Disabled people deserve respect. They need support due to their functional defect, but that doesn't mean they have to be in the pity of society. It is the responsibility of society to treat them with respect and provide an environment of support that encourages the maintenance of their self-esteem.
3. *Tangible or Instrumental Support or Functional Support:* Maintenance of disability demands materialistic resources. It can be a machine or medical aid or other resources. Sometimes this support is in form of human service. Sometimes, this support required financial assistance, to pay for the required machine or service.
4. *Informational Support:* We all need different forms of information is day to day basis. This information helps us to remain connected and updated with society and it also helps us to grow personally and professionally. Disabled persons are not different. They also need various information in terms of various government schemes, various nutritional tips, advice and suggestions about the scope of improvement, and information related to other useful resources. Informational support is very crucial for them.
5. *Network Support:* Although disabled people face difficulty in sharing their thoughts and communicating, they too seek a network, a group with which they can belong to. This is very crucial as a feeling of belongingness with a group helps to maintain their self-esteem and to give them emotional support as well as a motivation to keep on trying or actively participating.

Social support is of two types perceived support and received support. Perceived support refers to the perception of what is being delivered by the support system or supportive person. Whereas received support refers to what is being delivered during the time of need (Cohen et al., 1985).

Furthermore, Lakey (2010) has defined social support as structural support and functional support. Structural support refers to the extent to which a person is connected with a group of people (Wills, 1991). Structural support can be taken as a protective atmosphere surrounding any individual which consists of different supporting systems. Strong ties with people in and out of a family are indicators of strong structural support. Functional support refers to specific functions on which support is required or received. Disabled people need various functional supports. It can be in terms of tangible things or financial aid or human service (Uchino, 2004).

Social support can come from a variety of sources, including family, friends, romantic partners, pets, and co-workers (Heaney & Israel, 2008). Social support is beneficial for both mental and physical health (Thoits, 1995). Researches show that social support is very crucial to fight stress and other mental health issues.

Intellectually disabled is not only a challenge for the individual or the caregivers alone. It is a serious challenge for society as a whole (Bigby & Frawley, 2010). A supporting social structure is essential for handling such individuals. A proper support system should be provided by society as a whole to take care of mentally retarded people.

Social support has a greater impact on families of children with hearing loss are insidious. The previous study shows that families who have strong social support could

able to handle problems as well as challenges effectively (Dunst &Trivette, 1994; Poon & Zait,2014) and social support help the parents of children with hearing loss to cope up and to have a better quality of life (e.g., Asberg, Vogel, & Bowers, 2008; Hintermair, 2006; Zaidman-Zait, 2007; Poon & Zait,2014). At times, it is observed that even the families of the disabled are incapable of taking care of them. In such cases, social support is of utmost importance.

Emotional Intelligence Defined

Serrat (2017) emotional intelligence is a strong medium by which one can regulate his emotion to adapt to any critical environment or achieve his or her goal. But later a lot of research was done on this matter, and later it was refined. This refined version consists of four proposed abilities. These four proposed abilities include managing emotions, understanding, using, and perceiving. Though these capabilities of individuals are distinctive, it is directly related to the theory of emotional intelligence. According to Ashkanasy (2017), the improvised theory of emotional intelligence also reflects the capability of an individual to understand interpersonal dynamics. However, concerning terminology and operationalization, substantial disagreement exists regarding the theory of emotional intelligence.

Theories of Emotional Intelligence

Intelligence is a human mental ability by which a person carefully handles situations. After the innovation of the theory in 1964, different types of research were done on it. As a result, different scientists have propounded their opinion regarding emotional

intelligence in different theories, models, and frameworks. These theories and models are discussed below:

A. Theory of Goleman on Emotional Intelligence (EI)-

As argued by Goleman (2001), a psychologist propounded the theory of Emotional intelligence. The theory of Goleman includes four elements of Emotional Intelligence. According to Eketu (2017), these are a few primary elements that are essential for Emotional Intelligence and they ae as follows:

Self-Awareness: Self-awareness, an individual can identify himself or herself. Self-awareness enables an individual to determine his or her strengths and weaknesses and as a person, and it helps oneself to identify his or her good emotions.

Self-Management: Self-management is considered as the second element of Goleman's theory of Emotional Intelligence. By this element, Goleman defines that if an individual has his control over what he says and does and also on his decision-making ability, his action can be controlled by him, and therefore he does not have to compromise with his value (Goleman, 2001).

Social Awareness: The third element of Goleman's theory is social awareness. It is considered as the capability of an individual or a leader to understand the emotion of surrounding people to get a good acceptance of their emotion. This element is linked with empathy: to see a matter from the point of view of other people.

Social Skills: It is the last and final component of the theory of Goleman. Social skill is essential to every leader and individual for social communication. Good social skill helps

to implement good teamwork which leads to achieving the goal. By this ability, a leader can achieve reliability from its team members.

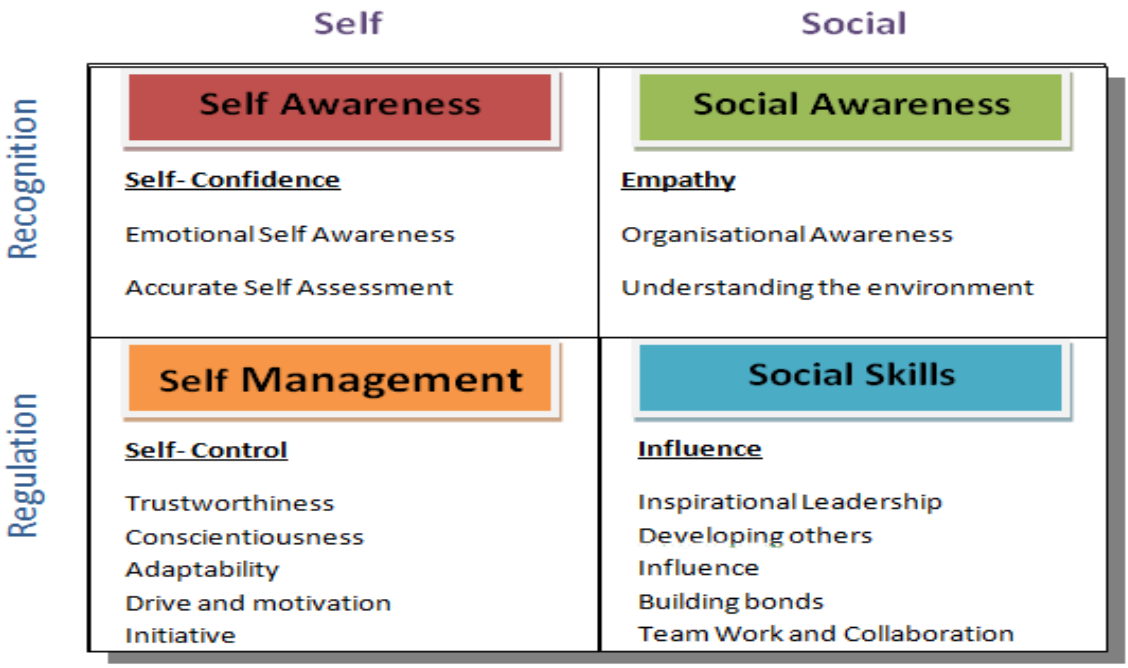


FIGURE 1.2: *DANIEL GOLEMAN'S THEORY*

Though Goleman's theory is considered the fundamental theory of emotional intelligence, many other scholars propounded their theory on emotional intelligence. The other models or theories of the Emotional Intelligence Concept are as follows:

a) Mayer, Salovey, and Caruso's EI ability theory

b) Competencies model of Bar-On

a) Mayer, Salovey, and Caruso's Emotional Intelligence Ability Theory-

Mayer et al. (2004) propounded the Emotional Intelligence theory. According to Caruso, et al. (2015), understanding and managing emotions help in decision making. They divided the skill and ability of Emotional Intelligence into Four parts:

- Manage emotion
- Emotional understanding
- emotion to express thoughts
- Perceive emotion

b) Competencies Model of Bar-On

According to Bar-On, a system of interconnected behavior that is related to social competence can be defined as Emotional intelligence. The five elements of the theory of Bar-On includes;

- Stress-management
- Decision-making
- Self-expression
- Self-perception
- Interpersonal

Emotional Intelligence and Quality of Life

Research in Frontiers in Psychology suggests emotional intelligence is directly linked with the well-being of human beings. As argued by Boyer (2017), emotional intelligence makes every effort of an individual meaningful by which that individual feels a sense of well-being. Emotional intelligence has few perceptions of features like adaptability, self-awareness, and self-control. All these features of emotional intelligence facilitate enhancing the quality of life. As suggested by Zhang (2017), the psychologist has categorized personal well-being into two categories:

a) Hedonic Well-being: Our nature of seeking pleasure and avoiding pain from our circumstances is called Hedonic well-being. And it is considered a universal human nature.

b) Eudaimonic Well-being: As argued by Pritchard (2019), our needs for self-fulfillment and personal realization are considered as Eudaimonic well-being. Emotional intelligence targets to develop of positive personal challenges. An individual with higher Emotional intelligence can handle any situation and develop friendly relationships in the working atmosphere. All these positive aspects fulfill the requirement of an individual's well beings. Thus, emotional intelligence can enhance the quality of life of an individual.

When parents of young children with some disability receive their child's diagnosis, they face the information they may not understand, do not know how to cope with the emotions, and have no idea about their child's immediate and long-term future. A significant challenge encountered by parents is the disgrace and sensed judgment associated with special needs. For many young parents of disabled children, support

gained from society, particularly a combination of emotional and informational support can guide them to successfully operate the medical information and services necessary to help their child. Parents of children with hearing impairment are at greater risk of mental health morbidities. Low educational attainment and domestic violence were found to be associated with caregiving strain dissatisfaction with social support from family, behavioral problems in children, and domestic violence strongly predicted psychological morbidity (Driessche et al., 2014).

Human beings are living creatures, and emotion is an integral part of every living being. But the power to manipulate emotion is also a great ability that is necessary for every sphere of life. Emotional leadership (EL), Emotional Quotient (EQ), and Emotional Intelligence Quotient (EIQ) are the few components that are directly related to emotional intelligence. Beldoch and Davitz (1964) coined this term in their paper called “The Communication of Emotional Meaning”. But after different research, it got its popularity in 1995 by the book called “Emotional Intelligence” Goleman. In this report, a brief analysis has been done on emotional intelligence. EQ (Emotional Quotient) is considered as the pillar of success in life.

CHAPTER II

REVIEW OF RELATED LITERATURE

An effort to conduct research would not be ideal without outlining the studies that apply to the present study. The review may be defined as an examination of something with the intention of changing it if necessary. It may also be defined as to carefully examine or consider something or subject matter again, especially so that one can decide if it is necessary to make changes or to think about past events, for example, to try to understand why they happened. A review of literature that compliments or contradicts supports or opposes will be of immense help in understanding the present study from various perspectives. Therefore, an effort is given to go through studies that are done previously in the field of the present study.

Research takes advantage of the knowledge that had accumulated in the past as a result of constant human endeavor. For this, the theoretical and empirical context from which the problem comes must be examined. The latest research trends pertinent to the problems should be mentioned. The researcher has to be clear that his/her problem has roots in the existing literature, but it needs further research and exploration. A summary of related studies found in journals, magazines, articles, abstracts, and reports should be made. This shows that the research is aware of what is previously known as well as what is unknown and may be improved.

Researches on Quality of Life of Mother of Intellectually and Hearing-Impaired Children

From the beginning of Human evolution, mothers have been at the centre of the human transformation of events. There are some cardinal limitations in the functioning of children for their developmental disabilities. For there, it requires long-term care for achieving the usual needs of children while they grow to develop the expectations of their families as a parent. Thus, caregiving being the moral part of a caretaker parent to provide a high level of care needed to a child warrants long term functional limitations; of course, it may be burdensome and may have some kind of impact on both the physical and psychological health of the caregiver (Malhotra et al., 2012).

Yeun et al. (2003) investigated a study to understand the quality of life among parents who have children with or without disabilities. In the study, data were collected from 147 parents (71 had children with disabilities and 76 had children without disabilities). To assess the quality of life among parents the World Health Organization Quality of Life (WHO-QOL BREF) was used. To measure the level of children's disabilities the Wee Functional Independence Measure was used. Socio-demographic such as financial conditions and family background were also recorded. The result was found that social relationships and environmental domains of Quality of Life differed significantly between the two groups of parents, and no significant differences in physical health and psychological domains were found in Quality of life between the two groups. It was found that parents of children with severe disabilities were found to have lower scores in physical, psychological, and environmental domains.

Malhotra et al. (2012) carried out a study to assess the quality of life of parents having children diagnosed with developmental delays. Caregivers of children diagnosed

with Mental Retardation (MR), Autism and control group (CG) were selected for the study. 240 participants were selected for the study to assess their quality of life. It was found that there was a significant difference in all the four domains of the quality-of-life questionnaire between mothers of children without developmental disabilities as compared to the other two groups of mothers having children with developmental delays. Alike results were revealed among the fathers' group, with fathers having children with MR or Autism having a poor quality of life in all the four domains of physical, psychological, social, and environment. Gender differences were seen in the study, mothers having children with developmental delays experience poor quality of life as compared to fathers.

Each family including those impacted with a disability feels like to have a better opportunity in life and to have a good quality of life. A study conducted by Boehm and Carter (2019), among 529 parents of children with intellectual disability to understand the quality of life and their contributing factors t. It was found through hierarchical linear regression that there was a significant contribution of both informal (i.e., family, friends) and formal (i.e., professional) social relationships, as well as the relevance of spirituality/religiosity, in Quality of Life.

Kumar et al. (2020) conducted a study among parents of children with intellectual disabilities and found that quality of life is negatively related to an economic family burden, family functioning, family relations, and interpersonal relations of parents, other family burdens, and quality of life positively related with intellectual functioning. It seems that the level of intellectual functioning increases the quality of life increase among parents of intellectually disabled children.

Aras et al. (2014) carried out a study to understand the health-related quality of life in parents of children with speech and hearing impairment. The study reported that mothers had poorer scores in health-related quality of life as compared with the fathers. It was also observed that quality of life also depends on the child's impairment. The parents of preschool-aged speech-and hearing-impaired children experience poorer HRQOL than parents of healthy children of the same age.

Raimires et al. (2016) conducted a study on the quality of life of parents of children with severe or profound bilateral hearing loss. It was found that the most excellent performance was achieved in the physical domain and the nastiest in the environment domain. The main factor associated with all domains of the WHOQOL-BREF, as well as the overall score was being satisfied with social support. Mothers of hearing-impaired children are particularly affecting representing a negative impact in almost all health domains.

Kazmi et al. (2014) conducted a study among mothers of disabled children (42 children with speech and hearing problems, 31 children with mental retardation, and 27 with physical disability). It was found that in comparison to their male counterparts, they were depressed and had a poor quality of life. Furthermore, it was found that parents of disabled children felt overburden and suffer from mental health problems.

Rathee et al. (2019) conducted a study among parents of children with intellectual impairment to assess the role of gender in the account of the quality of life and family burden. Data was collected from a Day Care Centre of a Non-Government Organization (NGO), Muzaffarpur, and Bihar. Results were found that both parents had an equal level of quality of life and family burden.

Kumar (2016) carried out a study among parents of children with intellectual disability and healthy controls to assess and compare the quality of life. Data were collected from 50 parents of intellectual disability and 50 parents of healthy controls P.G.I.M.S. Rohtak. Quality of life was assessed with the help of the WHO Quality of Life (BREF) Scale. Results were found that poor quality of life was there among parents of intellectually disabled children. There was a significant difference was found between the healthy control and the study group. The study group showed significantly lower quality of life than the healthy control group.

Gocmenler et al. (2021) aimed to understand the quality of life of parents having children with hearing disabilities. The study was conducted with a semi-structured questionnaire and in-depth interviews. Results suggest that the use of cochlear implants at an early age with an oral communication mode is associated with higher family satisfaction. It seems that hearing aids are important factors for the well-being of families with hearing-impaired children.

Researches on Personality and Quality of Life of Mothers of Intellectually Disabled and Hearing-Impaired Children

Jenaabadi (2018) done research among mothers of children with exceptional needs. includes physical, mental retardation, and autism, cerebral palsy to understand the general health and personality traits of mothers. Data was collected through a general health questionnaire and NEO personality inventory from 240 mothers of special children. Results were found that there was a significant difference between mothers of children with cerebral palsy, autism, mental retardation, or physical retardation in general health. No significant relationship was found between openness and the mother's general health. The subscales of neuroticism, conscientiousness, agreeableness, extraversion, and

openness of the NEO five-factor personality characteristics performed a significant influence in predicting the degree of overall health among the mothers.

Glidden et al. (2006) conducted a study on personality, coping style, and well-being of parents, rearing children with developmental disabilities. Data were collected from 97 mothers and fathers rearing a child with developmental disabilities. Results were found that both mothers and fathers used problem-focused than emotion-focused strategies. The personality factor, neuroticism, which was predictive of coping strategy, was used. Higher levels of positive reappraisal were associated with higher levels of subjective well-being and higher levels of escape avoidance were associated with lower levels of subjective well-being for mothers.

Jankowska et al. (2015) carried out a study among mothers of children to compare and to understand the parenting relationships, attitudes, personality traits, self–efficacy, stress, and coping strategies among mothers of children with cerebral palsy and mothers of typically developing children. Data was collected from twenty-seven mothers of children with cerebral palsy and twenty-eight mothers of typically developing children. Parenting Attitudes Scale (SPR), the NEO Five-Factor Inventory (NEO-FFI), the Generalized Self-Efficacy Scale (GSES), and the COPE Inventory were used. Maternal stress and the amount of social support were also assessed. Results were found that mothers of children with Cerebral Palsy had a strong tendency towards overprotective and demanding attitudes. Mothers of children with Cerebral Palsy obtained higher scores in neuroticism and lower openness compared to mothers of typically developing children. It was also found that mothers of children with cerebral palsy had a higher level of distress compared to mothers of typically developing children. No statistically significant differences between the two groups of mothers regarding self-efficacy, the level of social

support, or the most often used coping strategies. Neuroticism was found to be the best predictor of overprotective and demanding parental attitudes.

Yamada et al. (2012) conducted a study among parents of children with pervasive developmental disorders to better understand their quality of life and the factors that influence it. Parents of children with pervasive developmental disorders are often between the ages of 6 and 15. MOS 36- item Short – Form Health Survey was used to measure the quality of life, NEO Five-Factor Inventory to assessed personality and to understand marital relationships Intimate Bond Measure was used. Results were found that there were significantly lower scores in the areas of Role Physical (RP) Social functioning (SF), General health perceptions (GH), Vitality (VT), Role Emotional (RE), and Mental Health (MH) among mothers than the general female population. It was also found that the maternal mental component summary (MCS) was also significantly lower. However, neither the maternal nor paternal physical component summary (PCS) nor the maternal and paternal physical component summary (MCS) scores were lower. The high Care and low Control ratings were both strongly related with maternal PCS and MCS scores, however only the paternal PCS values were significantly connected with the low Control levels. Maternal PCS and MCS scores, as well as paternal MCS scores, were found to be substantially linked to high Agreeableness and low Neuroticism. Neuroticism was shown to be substantially associated to mothers' and dads' poor MCS scores in multiple regressions.

Studies on personality and health revealed that conscientious people are reliable, organized and they like to work in planning. Conscientious people tend to take responsibility for their health and try to follow medical advice. On the other hand, people who are neurotics are prone to anxiety, depression and they have poor coping strategies,

and are prone to chronic conditions, as a result of poor quality of life (Matthews et al., 2009; Friedman &Kern, 2014).

Narumoto et al. (2008) inspected character styles and adapting techniques utilizing the Maslach Burnout Stock (MBI) and the NEO Five-Factor Stock (NEO-FFI) to quantify burnout and personality traits. Significantly, higher burnout rates are decidedly associated with higher neuroticism and higher feeling-focused adapting.

Researches on Social Support and Quality of Life of Mothers of Intellectually Disabled and Hearing-Impaired Children

Hassanein et al. (2021) conducted a study among mothers of children with intellectual disabilities to determine whether social support and resilience account for variance in Family Quality of Life. Regression results indicate that giving and receiving social support accounted for significant variance in FQOL, explaining 62 % of the variance. A family's quality of life (FQOL) has been shown to impact the quality of life for the child with intellectual disabilities. Therefore, it is important to understand the factors that contribute to FQOL to inform the types of interventions and supports that are provided to families.

Jenero et al. (2020) hypothesized that it is feasible to anticipate nurturing pressure by paying attention to the significance families provide for themselves and their conditions while controlling for the effect of different factors like family abilities and attributes of the family member with disabilities. Parental stress was predicted with dysfunctional relationship, challenging behaviors, low emotional wellbeing, bad family interaction, kinship as parents, and the degree of both medical requirements and intellectual impairment, according to hierarchical multiple regression analysis. Using the Family Adjustment and Adaptation Response paradigm, this study analyses the quality of

life in families with a member who has an intellectual handicap. The participants in the research were 515 Spaniards with disabled family members ranging in age from infancy to maturity. As a criteria measure, the Parenting Stress Index–Short Form subscale on parental stress was used. Other possible indicators include the Beach Center Family Quality of Life Scale and the Supports Intensity Scale section on Exceptional medical and behavioral support requirements.

Staunton et al. (2020) carried out a study to understand stress and quality of life in parents of children with an intellectual disability (moderate-severe–profound), who attend a Child and Adolescent Mental Health Intellectual Disability Service (CAMHS ID) and to approximation the perceived levels of challenging behavior and satisfaction with supports. This study supports previous research that shows parents of children with intellectual disabilities, especially those with comorbid ASD and problematic behavior, endure higher psychological discomfort and have a worse quality of life. Parental stress was shown to be linked to challenging behaviors and ASD, but support perceived was found to be inversely associated with stress. A decline in perceived family quality of life was linked to intellectual impairment, ASD, and parental stress.

Gebeyehu et al. (2019) conducted a study to find out that the burden, social support, and life satisfaction experienced by caregivers of children with intellectual disabilities. A systematic sample approach was used to obtain data from 74 caregivers. The data was analyzed using descriptive statistics, one-sample t-tests, Pearson correlation coefficients, independent sample t-tests, and one-way analysis of variance. According to the findings, carers are burdened by a lack of social support and are dissatisfied with their lives The burden of life is inversely associated to social support, but social support is

positively related to life enjoyment... Caregivers appear to require social assistance in order to reduce their stresses and increase their overall happiness.

Meadow (1994) carried out a study on parenting stress, life stress, and social support. Data were collected from 20 mothers and 16 fathers among infants' who were diagnosed with hearing impairments and from comparable parents whose infants are hearing (HI group). Parents of the deaf children were found lower levels of parenting stress as for good social support than hearing impairment group. The above results gave an idea to understand the importance of early diagnosis and intervention for parents as well as for their children. The result highlighted the importance of social support and the relationship with parenting stress.

Sipal and Sayin (2013) carried research on parental attitude on depression and perceived social support were used to collect data. Results showed that 24.4 % of the mothers had depression and perceived social support was found to be predicting factor of depression. The findings showed that having a child who is hard of hearing causes undeniable degrees of wretchedness in mothers which prompts inadequate and additionally improper nurturing mentalities. Then again, social help is a defensive source from depression as well as it helps mothers to maintain a better quality of life.

Faramarzi (2016) conducted a study to compare the quality of life and psychological well–being in mothers of children with hearing loss and mothers of children with special needs. In Isfahan, data was collected from 200 mothers of special-needs children and categorized into four categories: hearing loss, visual impairment, mental retardation, and physical motor disability. Results were found that there was a significant difference in the quality of life among mothers of children with hearing loss, visual impairment, mental retardation, and physical motor disability. No significant

difference was found among four groups of mothers in psychological well-being. The quality of life of mothers of hearing impaired and visually impaired was higher than that of mothers of children with mental retardation and physical motor disability.

Researches on Emotional Intelligence and Quality of Life of Mothers of Intellectually Disabled and Hearing-Impaired Children

Anjum and Swathi (2017) conducted a research study on the impact of emotional intelligence on quality of life among secondary school teachers. Data were collected from 60 secondary school teachers from Hyderabad within the age range of 20 to 60 years. The emotional intelligence scale by Schutte (1998) and the Quality-of-life scale by WHO were used. Results were found that there was a difference in the quality of life in the two groups. It was also found that teachers with low emotional intelligence had a poor quality of life and teachers with high emotional intelligence had a high quality of life. The results showed that there was a positive correlation between emotional intelligence and quality of life.

Aljarboura et al. (2020) conducted a study to understand emotional intelligence and its relation to the level of emotional intelligence and social skills of parents and female teachers of intellectually disabled children. Data was collected from (32) children with mild intellectual disability (15 males, and 17 females), and (32) parents and (20) female teachers. The emotional intelligence scale by Wong et al. (2007) and Social Skills Assessment Scale by Mubarak (2016) was used. The result was found that the level of emotional intelligence of the parents and the female teachers was moderate, whereas the regulations of emotions in parents were the lowest, followed by the use of emotions, the evaluation of self-emotions, and then understanding the feelings of others The utilization of emotions was the lowest among female instructors, followed by self-evaluation,

emotion management, and finally comprehending other people's feelings... Results also showed there was no difference in the nature of the correlation between the emotional intelligence of parents and female teachers and the social skills of the children.

Parents with chronic disabilities children face challenges, obstacles, suffer from mental health problems and had an impact on the wellbeing and development of their children. A study was conducted on the effect of emotional intelligence on the quality of life of mothers of children with Autism. Data were collected from 50 mothers of children with autism from Autism Clinics in Tehran. Results showed that there was a significant correlation between the scores of qualities of life and emotional intelligence, a significant correlation also existed between the subscales test in the physical performance and mental health. Therefore, based on the above results it was concluded that the quality of life in mothers of children with autism is affected by emotional intelligence (Alibakshi et al., 2018).

Omori and Yoshika (2016) conducted a study to compare emotional intelligence, mental health, and ego-resilience between the mothers of children with disabilities (study group) and those without disabilities (control group). Data was collected through a self-administered questionnaire that is an emotional intelligence quotient scale, general health questionnaire, and ego resiliency from 79 members from the study group and 33 members from the control group. Results were found that there was no significant difference in emotional intelligence and ego resiliency among mothers of children with and without disabilities. The general health questionnaire score was lower in the control group than the study group. A negative correlation was also observed among mothers of disabilities between general health and emotional intelligence. The findings of the results indicate that appropriate use of management skills positively influences mental health.

Veisson (1999) conducted a study on depression symptoms and emotional states in parents of disabled and non-disabled children in Estonia. Results revealed that mothers of disabled children had significantly more negative emotional states and significantly more depressive symptoms Between the disabled and non-disabled groups, there was a significant difference in depressive symptoms. Parents with non-disabled children were much happy and had more positive feelings.

Joshi and Panchal (2017) carried out a study on emotional maturity among parents of disabled adolescents. Data were collected from 50 parents of intellectually disabled, 50 parents of visually impaired adolescents from different institutes and NGOs working in the disability field in Ahmedabad. The emotional maturity scale by Sinha and Bhargava (2012) was used. Results were observed that parents of visually impaired adolescents were more emotionally stable than parents of intellectually disabled adolescents. No significant difference was found between parents of intellectually disabled adolescents and parents of visually impaired adolescents concerning emotional progression. It was also observed that parents of visually impaired adolescents had social adjustment compared to intellectually disabled adolescents. Parents of the visually impaired had personality integration and more independence than parents of intellectually disabled adolescents.

Svensons (2004) conducted research to determine the emotional intelligence of parents of children with autism spectrum disorder and how it influences their acceptance of such a child. The research was conducted on a group of 33 parents of autistic children aged 3 to 6 years in Sacramento, California. According to the findings, parents accepted their autistic children and that their emotional intelligence level was moderate. It was also

noted that no statistically significant difference between fathers and mothers in emotional responses, with appropriate acceptance by both fathers.

Researches on Demographic Factors of Mothers of Intellectually Disabled and Hearing-Impaired Children

Financial stability, subjective judgement, and experience of social class and social position, as well as educational attainment, are all included in socio-economic status. Socio-economic status also covers a person's quality of attributes in life, the opportunities, and the privileges affordable for the people in a society (Williams et al., 2016). The socio-economic status of a person is pertinent to every aspect of social and behavioral science covering research, education, practice, and many more. Low economic status leads to poverty, lower education, and poor health and negatively affects society. Poverty is not just a socio-economic factor, but it is structured by a range of physical and psychosocial stressors (Dalton et al., 2016). So, the socio-economic status between parents with normal children and parents with disabled children varies. The paper focused on the comparison between the socio-economic status of a normal and disabled child's parent.

Family Quality of Life (QOL) is the degree to which families with disabled children can meet their needs, take time for enjoyment, and pursue leisure hobbies (Emily & Grace, 2015). Following the data collected by researchers, families with disabled children face barriers to achieving a family quality of life such as low socioeconomic status, increased parental areas, and lower social service support. Parents with disabilities are likely to face key socio-economic challenges such as poor social life with vulnerable economic status. On the contrary, parents having normal children do not face such

challenges as they do not have to cope with the stress and monetary adversities that come with nurturing a child with a disability (Centre for Disease Control and Prevention, Government, [CDCPG], 2020). Parents with children with disabilities face various socio-economic difficulties which affect the livelihood of affected children and also their siblings.

The majority of the normal children are likely to have normal developmental stages with small needs, and expectations desired by every parent. Nonetheless, challenges emerge when the children face limitations in functioning and require dependence from family. A child's impairment impacts the entire family, especially if the child's issues necessitate long-term special care. Following the World Health Organization (WHO), disability can be referred to as the impairment of body and mind that restricts an individual to do particular activities or interacting with people. So, disability has three aspects such as impairment, activity limitation, and participation restrictions. As per the statistics of the World Health Organization (WHO, 2020), over 1 billion people are experiencing different forms of disability. The majority of these individuals need assistive technologies like hearing aids, low-vision devices, and wheelchairs. It is expected that the number can be 2 billion by 2050.

Disability cannot be characterized in one particular health disorder as it is extremely diverse. Some of the health disorders associated with disability lead to lower heath and higher needs of health care when others do not. Parents of disabled children face difficulty as the children seek more health care than children without disabilities and usually have various unmet needs (World Health Organization [WHO], 2020). Lower levels of socio-economic status have always been associated with poor health and lower

quality of life. The presence of any form of disability contributes to the emotional instability of children and their responsible families. When the disability status directly affects the family's socioeconomic status, it can be said that the family will be at higher risk of poor health and poor quality of life. Hence, parents with normal children are less likely to have poor socio-economic status as there is no existence of a disability.

The majority of children with disabilities receive special education within the public education system to address individual needs. Parents feel relieved and less insecure about financial well-being when children with disabilities can receive educational benefits without any cost. On the other hand, parents of disabled children feel more satisfied when they receive transportation services at no cost. Such no-cost services are highly helpful for parents with disabled children lacking reliable transportation. Nonetheless, parents with normal children are not likely to face all these courses of life to secure proper education for their children. Henceforth, these parents do not seek no-cost services free services if they are economically sound already. But, even though the family with disabled children is economically sound, they can feel strain in financial stability to keep up with the needs of the children.

The WHO recognized that disability is a global health issue, and the socio-economic challenges are to all strata of society but recognized the scarcity related to family experiences of having children with neuro-disorders (WHO, 2020). Neurological disorders lead to prolonged dependency and learning disability; thus, causing enormous socio-economic challenges to parents. But the challenges are severe for people having less knowledge about the children and how to address the problems of children. Socio-economic tiredness is prevalent in parents with disabled children. Marital relationships of

parents' face challenge because of anxiety and guilt. The disability causes a fertile ground of conflict by attacking the fabrics of marriage. Another social challenge includes inadequate social support. For example, the family's social life becomes non-existent, and the parents may get fearful of getting rejected by peers or relatives.

Financially, a family has more requirements to raise a disabled child as the child needs a multidisciplinary approach along with a series of investigations like tomography. Parents face financial implications because of the requirements and the absence of these resources creates a barrier (Keskinova et al., 2013). Parents with normal children do not need to take off time for taking care of sick children. So, parents with disabled children face financial stress and problems in receiving insurance coverage to pay medication and other treatment charges. Henceforth, the critical illness of a child is linked with employment loss, financial stress, and a negative economic impact on families.

Villaseca et al. (2019) investigated the association between demographic factors, parental traits, and the development of cognitive, verbal, and motor skills in children with intellectual impairments (ID). The study gathered demographic information as well as parental anxiety, depression, parental stress, conjugality, and familial functioning from parents. The bivariate analysis revealed that baby cognitive development was highly influenced by the mother's and father's emotions, as well as the father's teaching scores. Infant language development was linked to a number of mother characteristics (educational level, anxiety, depression, maternal responsiveness) as well as the father's teaching abilities. None of the variables were statistically linked to the development of a child's motor skills. A multivariate regression study revealed that a linear combination of mother responsiveness and father teaching ratings can predict children's cognitive

progress. A linear combination of mother anxiety and responsiveness, as well as paternal teaching scores, can predict language development. The present study highlights the importance of paternal involvement and the development of the child. Understanding and knowing the knowledge about parental contributions to children's development is important for improving positive parenting styles in early intervention programs.

Dadkhah et al. (2009) carried out a study on the quality of life for disabled children of mothers. The purpose of the study was to evaluate the quality of life of mothers with disabled children. Data was collected from forty mothers with a cerebral palsy child and forty mothers with health problems participated in a study. Health Survey tool was used to assess a mother's quality of life. Results were found that the mean scores on Health Survey were significantly lower in mothers of children with the disabled child than those of the other group. It was also observed that the quality-of-life scores were correlated with the severity of the disability. Coping strategies were clear correlates of health-related quality of life when socio-demographic, disability-related, and social support variables were studied. From the results, it was suggested that different coping strategies and psychosocial programmes need to be planned and implemented to reduce the burden of care.

Wang et al. (2004) conducted a study to understand the associations between family income and severity of the disability and fathers' and mothers' satisfaction with their Family Quality of Life. The study was conducted with 130 fathers and 234 mothers of families in early childhood programs. Results showed that severity of the disability is a significant predictor of fathers 'and mothers' satisfaction ratings of Family Quality of Life. Other factors like family income were also a significant predictor of mothers' satisfaction in their Family Quality of Life.

People's socioeconomic situation has an influence on a variety of life outcomes, including psychological and physical health. Families with impaired children are more likely to face financial difficulties as a result of the requirement for special care. Families with impaired children experience social hardship as a result of their inability to socialise like other children. The impaired child's family also confronts economic difficulties as a result of spending more time with children, which results in job loss and a lack of appropriate resources.

CHAPTER III

THE PRESENT STUDY

3.1 Need and Justification of the Study

Disability is considered as a "tragedy" in India, with a "better dead than disabled" and as a result, disabled individuals are isolated and left out from enjoyment and living a healthy life (Girimaji & Srinath, 2010). Assam is the land of cultural diversity surrounded by hills, valleys, and the mighty river Brahmaputra. Assam is a state that belongs to the Northeast part of India. The state is bordered by two countries Bhutan and Bangladesh. Assam covers an area of 78,438 km² (30,285 sq mi). Districts of Assam are 27, and it is also divided into 145 revenue circles. According to the Census (2011), Assam has a population of 3.12 crores where 15,939,443 are male and 15,266,133 are female. Assam is a perfect fusion state of heritage, tradition, faiths, and beliefs of numerous races and blessed with abundant flora, fauna, scenic beauty, cultural heritage, and mineral resources. During the last years, Assam strides in many fields but there is a lot more to be done for the welfare of society. Disabilities vary from place to place, state to state, and vary across districts, from rural to urban and by sex. Family has been given the pivotal role of care; parents are getting minimal support from the professionals (Ayer, 1984). The maximum impact of a child's disability is borne by the parents (Dupont, 1980). In developing countries, there are extremely few research on parenting issues (Sharma & Gupta, 1985). Singhi et al. (1990) explored at the psychological issues that mothers and other family members with physically and mentally challenged children experienced in India. In India, informal caregiving is more widespread than formal caregiving, and it is

traditionally accepted that caring for an ill or disabled family member requires the most time and effort, especially for mothers in the case of children.

According to the Census 2011, Assam has a total number of 48,0065 disabled people out of which 80,553 are in the category of seeing, 1,01577 hearing, 39,750 speech, 76,007 movements, 26,374 mental retardations, 18,819 mental illness, 87,461 any other category, and 49,524 were multiple disabilities. Keeping in view such a huge number of different categories of disabilities in Assam in mind, the researcher focused to give a theoretical understanding of the psychosocial aspects of quality of life, personality, social support, and emotional intelligence among mothers of intellectually and hearing-impaired children. The review of literature also shows that mothers of disabled children perceived greater financial problems, disturbance in family routines and programs, poor social interactions, and marital adjustment, and showed higher neurotic reactions. Therefore, there is a need for more researches on psycho-social factors and quality of life among mothers of intellectually and hearing-impaired children. Psycho-social predictors are important for the quality of life among parents of intellectual and hearing-impaired children; a better understanding of the relationship between these factors will support optimal health for this population Despite the fact that the illness or disability is only temporary, the problem of caregiving for a temporarily ill or disabled person poses a difficult situation, despite the fact that the caregiver is aware that once the illness or disability is alleviated, the caregiver's responsibilities will be over or reduced. However, in cases where the illness or disability is long-term such as intellectually disabled, hearing impaired, the informal caregiver's entire life, as well as the life of the person being cared for, must be planned around the demands of the illness or disability, which can increase

stress and make it more difficult to deal with the consequences. The quality of life of the disabled individual is highly dependent on the caregiver's well-being, hence more research is focused on the aspects that contribute to the caregiver's quality of life that should be prioritized. While studies in western countries have looked into factors that contribute to reducing the negative impact of caregiving, the findings may not necessarily apply to the Indian context because, in the absence of informal caregiving facilities, formal caregiving support, which is much more organized, is available in more developed western countries. Only a few people in India have access to such a service. Therefore, a thorough research investigation on the effects of informal caregiving of disabled children by their mothers in the Indian setting is required for the betterment of these children. These researches will definitely support in guiding future intervention strategies dedicated to creating a better quality of life among mothers of intellectually disabled and hearing disabled children.

3.2 Statement of the Problem

In India, giving birth to a child with a disability is often viewed as a personal failure on part of the mother. Even though some understanding exists in the society regarding disabilities and causes, parents, especially mothers, remain targets of suspicion for their children's behavior and their disabilities. Few studies have examined how families in diverse contexts, especially developing countries, make sense of their child's disability, the type of stressors they encounter, or the resources they draw upon to adapt to the crisis. Indian mothers nurture a child in a context that is unlike the Western developed nations. Although the majority of Indian households are comprised of joint families that share childcare responsibilities, mothers of children with disabilities are

often the sole caregiver (John & Roblyer, 2017). When compared to fathers, mothers with disabled children are more likely to be associated with child behavioral disorders and encounter more psychological crises that necessitate additional care. In reality, parents' primary source of tension is their children's disruptive and abusive actions. They love their disabled children so much that it affects every aspect of their lives: physical, emotional, moral, and social. Mothers with special children face issues of compatibility. They feel constant subjection to guilt, feeling that they may be directly responsible for the disability. They have a high risk of experiencing depression, physical health problems, relationship issues, social support, and decreased quality of life (Jenaabadi, 2018). The problem under investigation in the present study is to gain a deeper understanding of the psychosocial factors which are responsible for the quality of life of mothers of intellectual and hearing-impaired children. The study will aid in visualizing the value of formal and informal assistance, as well as the mental health of mothers, such that a child's healthy upbringing is dependent on the parenting style, just as the parent's mental health is related to the child's growth and development.

The statement of the problem is "*psycho-social determinants of quality of life among mothers of intellectually disabled and hearing-impaired children*".

3.3 Hypothetical Framework

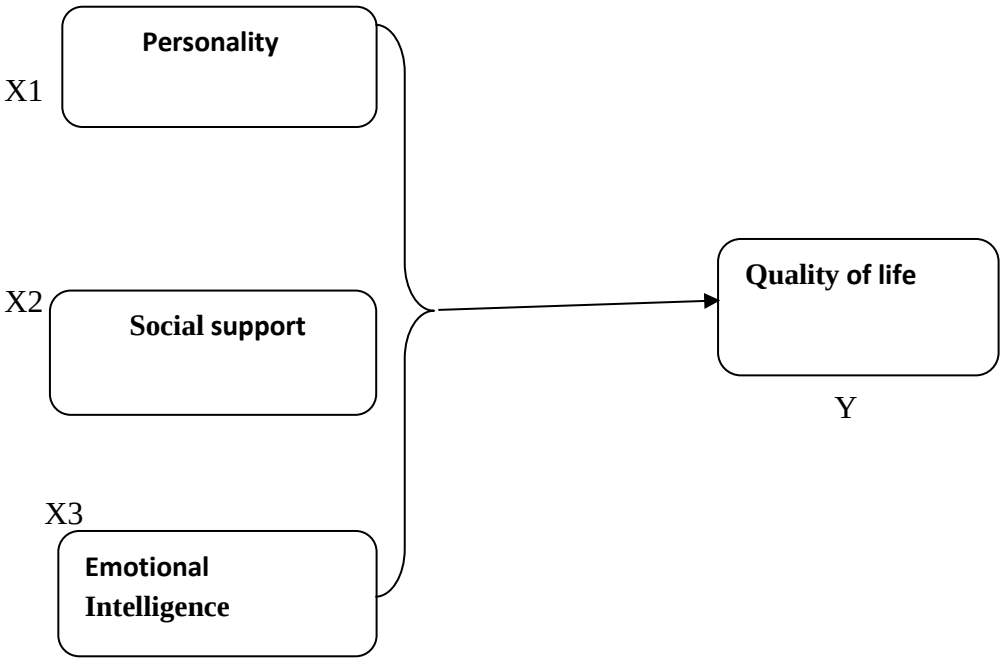


Figure 3.1: *Personality (X1), Social support (X2), Emotional Intelligence (X3) is associated with Quality of Life (Y)*

3.4 Objectives

Objective 1: To find out the relationship between quality of life (i.e., physical, psychological, social relationship, environment), personality (i.e., extraversion, agreeableness, conscientiousness, negative emotion, open-mindedness), social support (i.e., from others, family, friends), emotional intelligence (i.e., self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of intellectually and hearing-impaired children.

Objective 2: To make a comparison on different dimensions of personality, social support, emotional intelligence, and quality of life among mothers of intellectually disabled and hearing-impaired children.

Objective 3: To determine the significant predictor of selected demographic variables on the quality of life among mothers of intellectually and hearing-impaired children.

Objective 4: To determine the significant predictors of different dimensions of personality, social support and emotional intelligence on quality of life among mothers of intellectually and hearing-impaired children independently and conjointly.

Objective 5: To explore various issues and challenges faced by mothers of intellectually disabled and hearing-impaired children.

3.5 Hypotheses

Hypothesis 1: A significant relationship would exist between quality of life (i.e., physical, psychological, social relationship, environment), personality (i.e., extraversion, agreeableness, conscientiousness, negative emotion, open-mindedness), social support (i.e., from others, family, friends), emotional intelligence (i.e., self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of intellectually disabled and hearing-impaired children.

Hypothesis 2: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate hearing-impaired children.

Hypothesis 3: Mothers of mild hearing-impaired children will score high on all the dimensions of social support (i.e., others, family, friends) compared to the mothers of moderate hearing-impaired children

Hypothesis 4: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to the mothers of moderate hearing-impaired children

Hypothesis 5: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) than the mothers of moderate hearing-impaired children.

Hypothesis 6: Mothers of mild intellectually disabled children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Hypothesis 7: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild intellectually disabled children.

Hypothesis 8: Mothers of mild intellectually disabled children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Hypothesis 9: Mothers of mild intellectually disabled children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation,

social awareness, social skills) than the mothers of moderate intellectually disabled children.

Hypothesis 10: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of mild intellectually disabled children.

Hypothesis 11: Mothers of mild intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild hearing-impaired children.

Hypothesis 12: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of mild intellectually disabled children.

Hypothesis 13: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) emotional intelligence than the mothers of mild intellectually disabled children.

Hypothesis 14: Mothers of moderate hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Hypothesis 15: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of moderate hearing-impaired children.

Hypothesis 16: Mothers of moderate hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Hypothesis 17: Mothers of moderate hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) emotional intelligence than the mothers of moderate intellectually disabled children.

Hypothesis 18: Selected socio-demographic variables would predict the quality of life among mothers of intellectually disabled children and mothers of hearing-impaired children.

Hypothesis 19: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of intellectually disabled children.

Hypothesis 20: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of hearing-impaired children.

3.6 Operational Definition of Variables Used

a. ***Intellectual or mental disability*:** Intellectual Developmental Condition is a developmental disorder characterized by cognitive and adaptive functioning deficiencies in the conceptual, social, and practical domains.
b. ***Mild intellectually disabled***: Mild intellectually disabled is characterized by difficulties in abstract/theoretical thinking skills. They don't require much monitoring. As a result, this group is seen to be educable. They are capable of exhibiting social behavior. They may be taught to be self-sufficient and earn a living on their own with particular training and care.
c. ***Moderate intellectually disabled:*** Moderate intellectually disabled can learn to speak and perform basic daily tasks to some extent; nevertheless, their academic

performance is likely to be low, and they will struggle in school. These youngsters can have some autonomy, but they cannot be self-sufficient for lengthy periods.

d. ***Hearing-impaired****:* Hearing-impaired, often known as hearing loss, happens when some or all of one's hearing capacity is lost. The labels deaf and hard of hearing are also used to describe the hearing loss.

e. ***Mild hearing-impaired:*** The minimum sound that may be heard with mild hearing-impaired is between 25 and 40 decibels. People with this level of hearing loss are unable to hear subtle noises and have difficulty following interactions in noisy environments.

f. ***Moderate hearing-impaired:*** The least sound that may be heard with moderate hearing loss is between 40 and 70 decibels. At this level, people can't hear mild or moderately loud noises and may have hearing problems and, in most cases, those individuals wear a hearing aid.

g. ***Quality of Life****:* Individuals' general well-being is referred to as quality of life. Individuals' conceptions of their place in life in relation to their objectives, aspirations, standards, individual growth and purposeful activity and concerns in the context of the culture and value systems in which they live.

h. ***Social Support*****:** Social support is the sense of being loved and cared for, respected and cherished, and a part of a social network of mutual help and duties. The interpersonal and socio-psychological process that sustains and promotes well-being and health is known as social support. Inner circles, which inhabit social support sources, are often made up of family members and close acquaintances.

i. ***Personality****:* Personality is the dynamic arrangement of those psychophysical processes within an individual that influence his particular adaptability to his environment.

j. ***Emotional Intelligence:*** The capacity to monitor one's own and others' moods and emotions, to determine between them, and to utilize this knowledge to guide one's thinking and actions.

CHAPTER IV

METHODOLOGY

This chapter covers the research methodology and technique used in this study, as well as the sample design, a brief overview of the instruments used in the investigation, and the statistical design used for data analysis and interpretation. Reading books and conducting research are both essential. For a better reality with information, both scientific and non-scientific disciplines of study require investigation. The challenges that develop on a daily basis seek answers and recommendations. Scientists are among a group of regular people who are attempting to determine the causes, reasons, and consequences of their findings. Research is being conducted to both comprehend and actualize effective yet abstract phenomena. The research's major objectives are to produce new and relevant facts, verify and test them, investigate an event to discover its cause-and-effect link, and develop new technologies. The research's main goals are to invent new and relevant facts, to verify and test them, and to analyze an event in order to see its cause-and-effect relationship, to develop new scientific tools, concepts, and theories to solve and understand problems, to find solutions to them, and to overcome upcoming ones, and to develop new scientific tools, concepts, and theories to solve and understand problems, to find solutions to them, and to overcome upcoming ones (Rajasekar et al., 2013). Research is a technical term that is most commonly associated with academic pursuits. According to Clifford Woody, research is a series of methodical stages that include defining a problem, formulating a hypothesis, collecting, organizing, and evaluating data, making deductions, drawing conclusions, and lastly testing if they are

comparable to the original hypothesis (Fisher, 1930). Furthermore, research is a scientific study focusing on an inquiry aimed at discovering new facts, a concept that encompasses the systematic collection, analysis, and interpretation of data. “Psycho-Social Determinants of Quality of Life among Mothers of Intellectually Disabled and Hearing-Impaired Children” Chapter IV included research design, variables, sample, tools, procedure and statistical techniques for analysis.

4.1 Research Design

The present study is the descriptive type and followed by mixed methods- i.e., quantitative and qualitative. The underlying idea of this technique is that integrating quantitative and qualitative data. The rationale for doing a quantitative analysis is that it is based on ideas that have already been created. Those hypotheses might aid in reaching a decision. The current portion, on the other hand, will aid in the investigation of the operational arrangement and preparation of the population, sample, technique, instruments, and so on. The use of qualitative research is that to have a better understanding of the other prevalence factors base on the objective. The study was exploratory in nature understanding the day-to-day psycho-social problems of the mothers with intellectually disabled and hearing-impaired children. The purpose was to gather in-depth information from mothers. The steps in the research data collection and analysis have been shown in Figure 4.1 and Fig 4.2.

Phase I: Quantitative Method

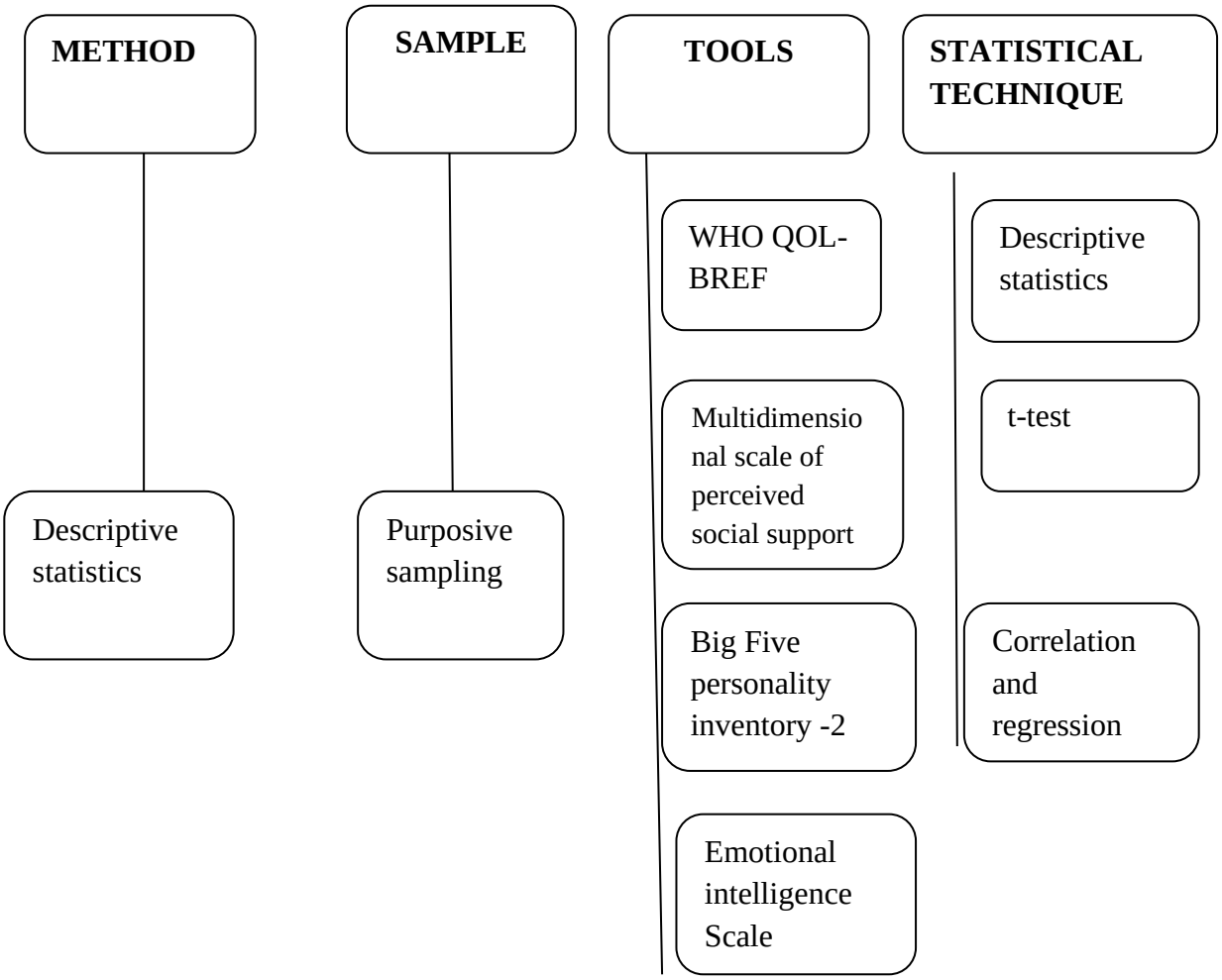


Fig 4.1: *Graphical representation of research design of quantitative data*

Phase II: Qualitative Method

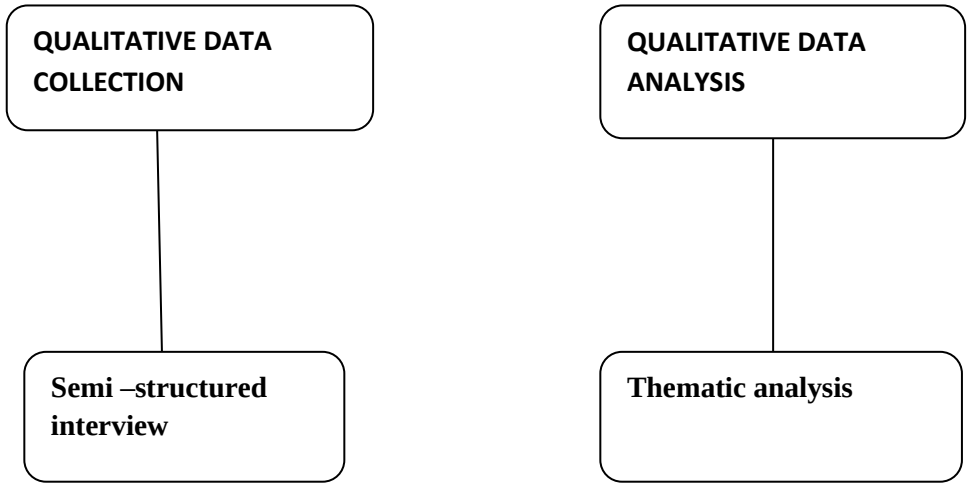


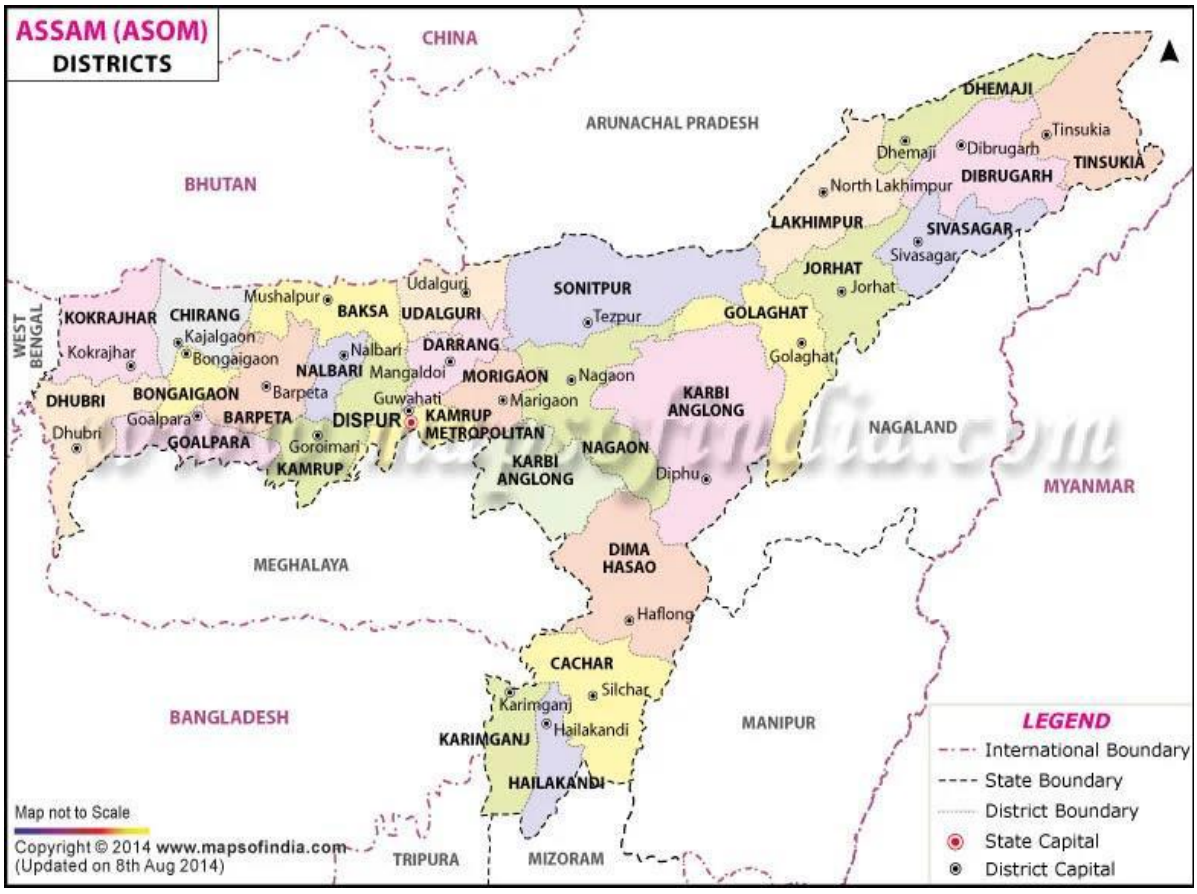
Fig 4.2: *Graphical representation of research design of qualitative data*

4.2 ***Geographical Area***

Assam is a vast land rich in cultural variety, surrounded by hills, valleys, and the Brahmaputra River. Assam is a state belongs to North east part of India. The state is bordered by two countries Bhutan and Bangladesh. Assam covers an area of 78,438 km² (30,285 sq mi). Districts of Assam are 27, and it is also divided into 145 revenue circles. According to the Census (2011), Assam has population of 3.12 crores where 15,939,443 are male and 15,266,133 are female. Assam is a perfect fusion state of heritage, tradition, faiths and beliefs of numerous races and blessed with abundant flora, fauna, scenic beauty, cultural heritage and mineral resources. During the last years Assam strides in many fields but there is lot more to be done for the welfare of the society. Disabilities vary from place to place, state to state and vary across districts, from rural to urban and by sex. Family has been given the pivotal role of care; parents are getting minimal support from the professionals (Ayer, 1984). The maximum impact of a child's disability

is borne by the parents (Dupont, 1980). There are very few studies done on parental problems in developing countries (Sell, 1984; Seshadri, Verma, & Pershad, 1983; Sharma & Gupta, 1985). Singhi et al. (1990) investigated in India the psychosocial problems faced by mothers and other members of the family with physically and mentally disabled children. According to the Census (2011), Assam has a total number of 48,0065 disabled people out of which 80,553 are in the category of seeing, 1,01577 hearing, 39,750 speech, 76,007 movements, 26,374 mental retardations, 18,819 mental illness, 87,461 any other category, and 49,524 were multiple disabilities. Keeping in view of this problem in mind the researcher focused to give a theoretical understanding the psychosocial effects of quality of life, personality, social support, and emotional intelligence among mothers of intellectually disabled and hearing-impaired children. Data was collected from Guwahati, Kamrup (M), Assam. Guwahati was given into consideration for collecting data because most of the rehabilitation center situated in Guwahati. Furthermore, Assam is located in the northeast area's central region, and Guwahati serving as the doorway. The facility of rehabilitation centers and the special schools has the maximum standard among the other entire district. Therefore, data was collected from the rehabilitation centers from Guwahati, Assam, India.

4.3 Map of Assam



Source: *www.mapsofindia.com* (Retrieved on 10.09.2018)

4.3 Sample

The total sample consists of 240 participants out of which 120 were mothers of intellectually disabled children and 120 were mothers of hearing-impaired children. Samples were collected from Kamrup Metro, Assam from various Nongovernment organizations/rehabilitation centers/ Government schools that serve children with intellectually disabled and hearing-impaired children. A purposive sampling technique was used for the collection of data.

4.4 *Participant Inclusion Criteria (Intellectually Disabled and Hearing-Impaired Children)*

The study sample was limited to the state of Assam.

- Age group of the child is 5 to 15 years
- Mothers of healthy control
- Mothers living with the child
- Intellectually disabled (IQ level between 50 to 70)
- Intellectual disability diagnosed by qualified Clinical psychologist
- Hearing-impaired diagnosed by specialized doctors
- Hearing-impaired should have total loss of sixty decibels or more in the better ear in the conventional range of frequencies
- Child who has completed at least one week of indoor treatment
- Mothers who co-operate and comprehend the test/instruments properly
- Urban population of Assam
- Children belonging to all the communities or social category
- Mothers able to read and write
- Mothers who are staying with their husband, and child/children

- Mothers who gave consent to participate in the study

4.5 *Participant Exclusion Criteria (Intellectually and Hearing-impaired Children*)

- Mothers having a history of chronic life-threatening illness
- Mothers having any major psychiatric illness
- Those who are not willing to participate
- Children with major psychological problems

4.6 *Ethical Considerations*

- For the purpose of collection of data, permission was taken from Ethical Committee of Sikkim University.
- Consent was taken from the participants.
- Confidentiality was maintained.
- Exclusion of subject's individual information in data files.

Table 4.1 *Rehabilitation Centers for Intellectually disabled and Hearing-impaired children in Guwahati, Assam*

Sl. No.	Name of Rehabilitation Centres/Institutions	District
1.	Udayachal	Guwahati
2.	Ashadeep	Guwahati
3.	Aarohan	Guwahati
4.	Sahayika Sishu Nirdeshan Kendra	Guwahati
5.	Shishu Sarothi Spastic Society of Assam	Guwahati
6.	Saraswati Baghdhani Prashikshyan Kendra	Guwahati
7	HOPE Multispecialty and Rehabilitation Centre	Guwahati
8.	Govt. Bhauri Devi Sarawgi Deaf & Dumb School	Guwahati
9.	Aarohan	Guwahati

4.7 Tools Used

Keeping in view the objectives of the present study, the selected sample was assessed using the following tests:

1. **Socio-demographic and Clinical Data Sheet (Self, 2018):** It is a Semi-structured Performa. It contains information about socio-demographic variables like age, sex,

education, religion, marital status, occupation, etc. and clinical details like the age of onset, other illnesses.

2. **The World Health Organization Quality of Life –BREF (WHOQOL-BREF):** The World Health Organization Quality of Life –BREF was developed by the World Health Organization group (1995). It produces a quality-of-life profile and contains a total of 26 questions. It is a self-report questionnaire that assesses four domains of quality of life and they are:

a. *Physical health:* typical everyday activities, dependence on medicine and medical devices, energy and exhaustion, mobility, discomfort and pain, rest and sleep, capacity for work**.**

b. *Psychological health*: image and look of the body, negative emotions, positive emotions, self-esteem, spirituality, religion, and personal beliefs, thinking, learning, memory, and concentration).

c. *Social relationships:* relationships with others, social support, and sexual activity.

d. *Environment:* monetary resources, physical safety and security, as well as freedom, accessibility and quality of health and social care, home environment, possibilities for gaining new knowledge and abilities, recreation/leisure activities participation and possibilities environmental factors such as pollution, noise, traffic, climate and transport.

In addition, two items are examined separately: question 1 asks about an individual's overall perception of quality of life and question 2 asks about an individual perception of

their health that measures overall QOL and general health. The four domain scores are scaled in a positive direction (i.e., higher scores denote a higher quality of life). WHOQOL-BREF domain scores demonstrated good content validity, discriminant validity and internal consistency for domains were 0.80 for physical health, 0.76 for psychological, 0.66 for social relationships and 0.80 for the environment. The test-retest reliabilities for domains were 0.66 for physical health, 0.72 for psychological health, 0.76 for social relationships and 0.87 for the environment.

e. **Multidimensional Scale of Perceived Social Support:** It was developed by Zimet et al. (1988). Zimet, Dahlme, Zimet, and Farley created the Multidimensional Scale of Perceived Social Support (MSPSS) (1988). It has 12 items, each of which is assessed on a 7-point Likert scale (1, very strongly disagree to 7 very strongly agree). The measure assesses the extent to which people feel their social support to be adequate. Family, friends, and significant others are three diverse sources of information. The items numbers 3, 4, 8, and 11 indicate family support; numbers 6, 7, 9, and 12 measure support from friends and 1,2,5 & 10 measure support from significant others.

   High scores imply a strong sense of social support. It is a 12-item scale and divides perceived social support from family members, friends, and significant others. Norms for the general 15 population have been published with higher scores indicating more social support. Its internal consistency reliability is 0.88.

f. **Big Five Inventory -2:** The Big Five Inventory–2 (Soto & John,2017) is a 60-item questionnaire that assesses the Big Five domains and 15 facets of personality structure: extraversion (with facets of sociability, assertiveness, and energy level),

agreeableness (compassion, respectfulness, and trust), conscientiousness (organization, productivity, and responsibility), and negative emotionality (anxiety, depression, and emotional volition) Open-mindedness (Intellectual Curiosity, Aesthetic Sensitivity, and Creative Imagination). The reliabilities of the BFI-2 scales typically range from .75 to .90 and average above .80.

g. **Emotional Intelligence Scale:** Shailendra Singh (2004) created and validated the Emotional Intelligence Scale (EIS). This scale had 60 statements, all of which were positive. The 60 assertions were categorized into five categories: self-awareness (emotional self-awareness, correct self-assessment, and self-confidence are all aspects of self-awareness), Self-control (trustworthiness, conscientiousness, flexibility**,** and inventiveness), motivation (a desire to succeed, dedication, initiative, and optimism), social awareness (understanding others, developing others, service orientation, leveraging diversity, and political awareness, among other things) ,social skills(persuasion, communication, conflict resolution, leadership, relationship building, collaboration and cooperation)

Each of the five dimensions has 12 statements. A higher score suggests that you have a higher level of emotional intelligence. Construct validity exists for the scale. The inherent validity of the test-retest technique is 0.90, and the reliability of the approach is 0.81. The content and face validity of the test are also determined.

4.8 Procedure for Collection of Data

Phase I: Quantitative Phase

Permission was taken from the Head/Directors of various non-government organizations/rehabilitation centres/schools meant for intellectually disabled and hearing-

impaired children of Guwahati, Assam. Within a Rehabilitation Centre/school, the data was collected from the mothers of intellectually disabled and hearing-impaired children. The date and time of the data collection purely was depending on the convenience of the participants. Once the appointment is confirmed, the researcher visited non-government organizations/rehabilitation centres, or other venues decided upon. Informed consent for participation was taken from the participants. The researcher developed an initial rapport with the participants and it was assured of the confidentiality of their responses. The questionnaires were administered and asked one by one to the participants. The respondents were asked to clarify any doubt without hesitation.

Phase II: Qualitative Phase

Interviews were conducted in a semi-structured way and explore the issues and problems of the mothers of intellectually disabled and hearing-impaired children. Interview was conducted one to one according to the mothers' convenient time. They were informed that information will remain confidential. The total number of participants was 30, 15 from mothers of intellectually disabled children and 15 from mothers of hearing-impaired children. The interviews were recorded. The results of the quantitative data have been integrated into the discussion of the qualitative data.

4.9 Statistical Techniques Used

Keeping in view of objectives and hypothesis, different statistical techniques were used for analyzing the data. The quantization data was analyzed using SPSS version 23. For the descriptive statistics techniques like mean, SD, the frequency was used. For the inferential statistics techniques like correlation, t-test and regression were used to measure the significant relationship, significant differences and significant prediction among the

variables and groups. Qualitative data was analyzed separately by using thematic analysis.

Descriptive statistics

The following descriptive statistics were calculated to depict the type and commitment of scores obtained through various scales:

Mean

In this study, the mean value was used to depict the average scores of different groups and measure of central tendency of the scores of different variables of quality of life, social support, personality, emotional intelligence among subjects and to portray the average scores of different groups and in addition to managing target that goes for concentrating the pattern of previously mentioned factors among subjects.

Percentage

The data were analyzed with the purpose of highlighting the distribution of socio-demographic characteristics of the participants.

Standard Deviation

The difference in scores of several variables' different variables such as quality of life, social support, personality, emotional intelligence was calculated using the standard deviation of the scores of components. This came in handy for calculating other statistical metrics as well.

t-test

Quality of life, social support, personality, emotional intelligence among mothers of intellectually disabled and hearing-impaired children were all studied using a t-test to discover whether there were any significant differences.

Correlational Analysis

The correlation was calculated to determine the link between factors as well as if the variables of quality of life, social support, personality, emotional intelligence were related to each other.

Regression Analysis

Regression is a statistical procedure that uses one or more independent variables to predict the dependent variable. The researcher's primary goal while performing a regression analysis is to determine the relationship between the dependent and independent variables.

Thematic Analysis

Thematic analysis is one of the most prevalent types of qualitative research analysis. It focuses on finding, analyzing, and interpreting meaning patterns (or "themes") in qualitative data.

CHAPTER V

ANALYSIS AND INTERPRETATION OF THE DATA

After gathering the information from the participants, the vital step of the researcher is to analyze the data. This chapter brings out the analysis technique used by the investigator and the interpretation of the results obtained. The data may have adequate, legitimate, and reliable features; yet, it will serve no useful purpose unless it is thoroughly and methodically categorized, tabulated, scientifically analyzed, interpreted, and logically inferred.

The data of the present study included quantitative as well as qualitative components. First, the researcher carried out the quantitative analysis and later with the qualitative analysis.

The present study was conducted with the aim of understanding the psychosocial determinants of quality of life among mothers of intellectually disabled and hearing-impaired children. The data was collected from 240 mothers of disabled children belonging to two groups viz., 120 mothers of intellectually disabled children and 120 mothers of hearing-impaired children. Data were analyzed by calculating the “coefficient of correlation” (r), “t” test and “regression”. Data was also analyzed and presented with descriptive statistics (frequency, percentage, mean and standard deviation). Qualitative analysis was carried out with semi-structured interviews for a better understanding of other factors associated with the quality of life of mothers of intellectually disabled and hearing-impaired children.

The qualitative information was first meticulously transcribed. It necessitated going over the elements of the interview again in order to avoid missing any crucial information. After all of the interviews had been transcribed, the data was evaluated using thematic analysis.

Statistical Interpretation Section: This section brings out the analysis technique used by the researcher and the interpretation of the results obtained. It was carried out in four sections:

SECTION I: *Descriptive Statistics of Selected Socio-Demographic Variables*

This section contains the analyses of the respondents' socio-economic backgrounds are presented in this section. Percentages are used to discuss the relationships between the respondents' socio-demographic backgrounds.

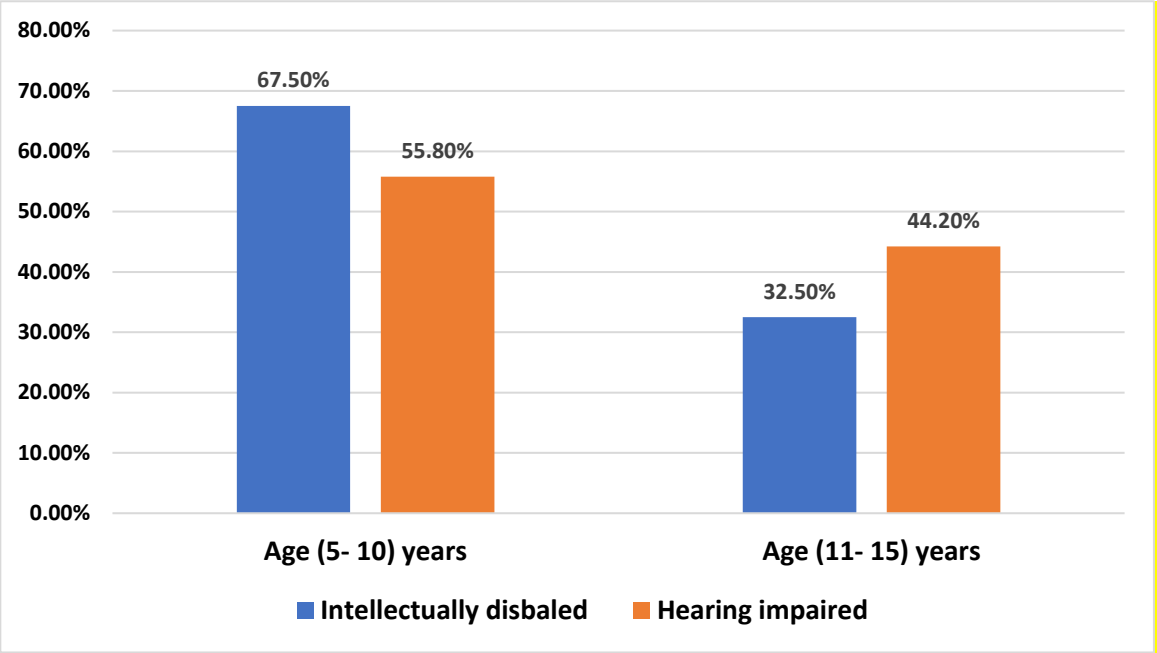
1. Age-wise Distribution of Intellectually and Hearing-Impaired Children

Table 5.1 *Frequency and Percentage-wise Distribution of Age of the Intellectually Disabled and Hearing-Impaired Children as Reported by their Mothers (N=240)*

Variable						
Age of the child	**ID (N=120)**		**HI (N=120)**		**Total (240)**	
	Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
5-10 years	81	67.5	67	55.8	148	61.7
11-15 years	39	32.5	53	44.2	92	38.3
Total	120	100.0	120	100.0	240	100.0

ID= Intellectual Disabilities; HI= Hearing Impaired

Figure 5.1 *Age-wise Percentage of Intellectually and Hearing-impaired Children (N=240)*



Data presented in Table 5.1 shows that the age of the children was divided into two groups, 5-10 years and 11-15 years. The total data which included both intellectually disabled and hearing-impaired children showed that 61.7 per cent were in the age group of 5 -10 years and 38.3 per cent were in the age group of 11-15 years. The above table shows that intellectually disabled children age group 5-10 years (67.5 per cent) and 11-15 years (32.5 per cent). Hearing-impaired children in the above table show 55.8 per cent in the age group of 5-10 years and 44.2 per cent in the age group of 11-15 years. The bar diagram depicted in Figure 5.1 also shows the same trend.

Previous studies have shown that disabilities would be higher in the younger age than that of later age. In a prior research developmental screening tests were performed and that those children with developmental impairments received postnatal care and

assistance from a rehabilitation centre, and that as time and age passed, disabilities would be less likely to decrease. (Ao et al., 2021). In the current study, few mothers of intellectually disabled and hearing-impaired children were found within the age group of 11-15 years. One of the possible reasons might be that in a rehabilitation centre that particular group of children already received early intervention training during their early childhood period. So, those children become independent to carry out necessary daily living activities and gradually discontinue seeking assistance from the rehabilitation centre. Moreover, mothers received training simultaneously when they used to visit the rehabilitation centre with their child for intervention. Therefore, mothers turned out to be self-reliant and conduct those learning activities and help their children to cope up with their day-to-day life.

2. Gender-wise Distribution of Intellectually and Hearing-Impaired Children

Table 5.2 *Frequency and Percentage-wise Distribution of Gender of Intellectually Disabled and Hearing-impaired Children as Reported by Mothers (N=240)*

Variable	ID (N=120)		HI (N=120)		Total (240)	
Gender	**Frequency**	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Boys	61	50.8	68	56.7	127	52.9
Girls	59	49.2	52	43.3	113	47.1
Total	120	100.0	120	100.0	240	100.0

Figure 5.2 *Gender-wise Percentage of Intellectually Disabled and Hearing-impaired Children as Reported by Mothers (N=240)*

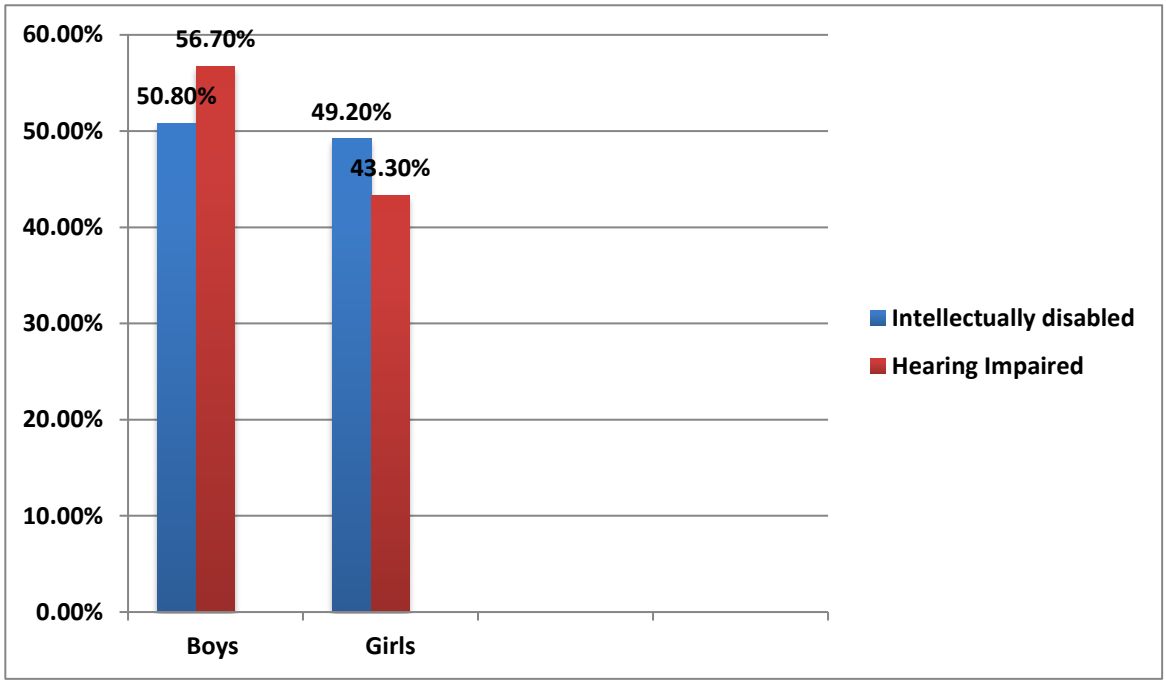


Table 5.2 shows that boys 50.8 per cent and girls 49.2 per cent belong to intellectually disabled children. 56.7 per cent of boys and 43.3 per cent of girls fall under hearing-impaired children as reported by mothers. Data presented in Table 5.2 shows that 52.9 per cent of boys and 47.1 per cent of girls include both intellectually disabled and hearing-impaired children. The bar diagram depicted in Figure 5.2 also shows the same trend.

It was found in the earlier studies that a higher prevalence in hearing and speech-language delay is in males as compared to females because of the central nervous system maturation and testosterone's influence (Silvia et al., 2013). Table 5.2 indicates that subjects from the intellectually disabled group boys were more as compared to girls.

These findings line up with earlier studies where males were more in number than females (Singh et al., 2019).

3. Behavioural Problems-wise Distribution of Intellectually and Hearing-Impaired Children

Table 5.3 *Frequency and Percentage of Behavioral Problems of Intellectually Disabled and Hearing-Impaired Children as Reported by Mothers (N=240)*

Variables	ID (N=120)		HI (N=120)		Total(N=240)	
Behavioural problems	**Frequency**	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Hyperactive	27	22.5	8	6.7	35	14.6
Stubborn	5	11.7	7	5.8	12	5.0
Nil	14	4.2	84	70.0	22	9.2
Tantrum	17	14.2	13	10.8	30	12.5
Others	57	47.5	8	6.7	141	58.8
Total	120	100.0	120	100.0	240	100.0

Figure 5.3 *Percentage of Behavioral Problems of Intellectually and Hearing-impaired Children as Reported by Mothers (N=240)*

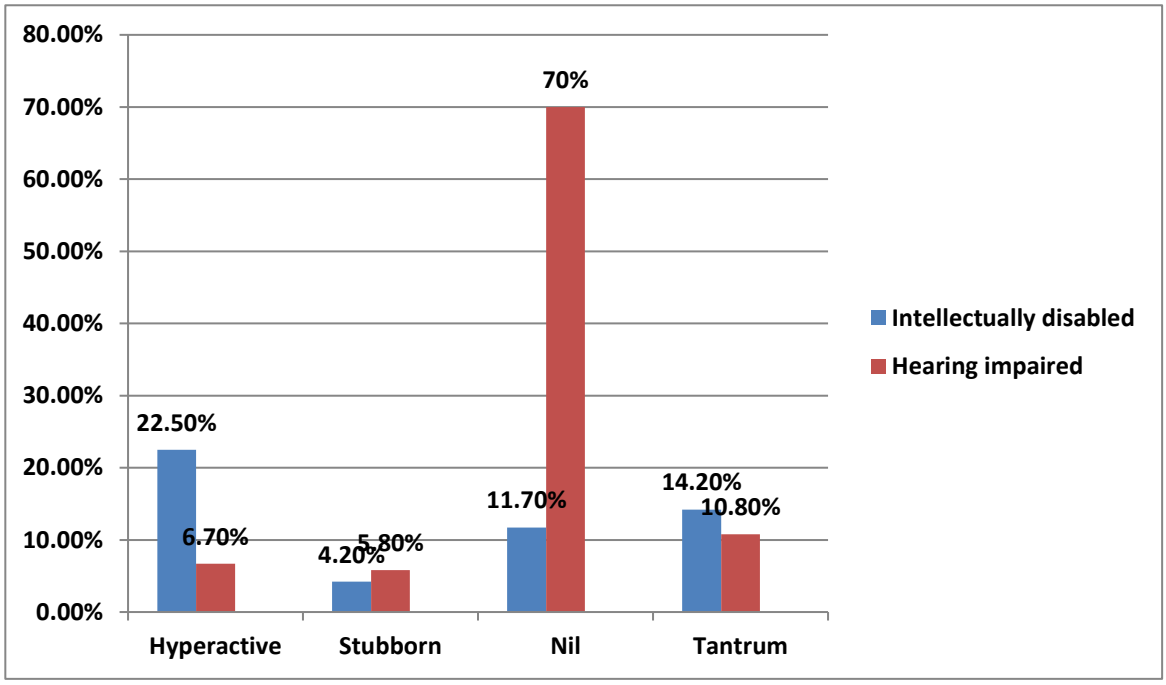


Table 5.3 represents the frequencies of behavioral problems of both intellectually disabled and hearing-impaired children. From the above table, it was observed that 22.5 per cent of intellectually disabled had attention deficit problems whereas 6.7 per cent of hearing-impaired children. Stubborn problem is more among intellectually disabled children (11.8 per cent) and slightly less among hearing-impaired children (5.8 per cent). Tantrums showing behaviors are more among intellectually disabled (14.2 per cent) as compared to hearing-impaired groups (10.8). Other disturbing behaviors like crying, poor concentration, misbehavior with others, odd behavior, violent and destructive behavior 47.5 per cent were from the intellectually disabled group and 6.7 per cent of the hearing-impaired group. The bar diagram depicted in Figure 5.3 also shows the same trend.

From Table 5.3, it was observed that subjects were there without any behavioral problems, fewer subjects from intellectually disabled and more subjects from hearing-impaired children. When behavioral problems are severe and persistent, it becomes challenging for mothers to deal with and it becomes a source of stress and quality of life gets deteriorated. Thus, attention must be paid to decreasing such behavior while providing treatment and care. Roy and Ara (2017) conducted a study among intellectually disabled children and normal children. that among children with intellectually disabled showed behavioral problems. Results showed that children with intellectually disabled showed higher levels of behavioral characteristics and behavioral disturbance as compared to normal children, reported by their mothers. Another study was carried out to understand the behavioral problems between preschool-aged children with hearing loss and normal hearing. It was found that children with hearing loss had a higher prevalence of disruptive behaviors than normal children (Fiorillo et al., 2017). Overall behavioral problems of children with intellectually disabled seem to be higher as compared to hearing-impaired children. One of the reasons could be children need almost continuous support from caregivers to meet their physical support and emotional support and they are sometimes not able to fulfil their basic needs, as a result, those suppressed needs turn out in the form of some behavioral problems. Whereas among hearing-impaired children they are to some extent capable to fulfill their basic day to day activities by themselves and satisfy their needs. These children are less likely to get the help they need with their conduct. More research into the influence of disruptive behaviors among intellectually disabled and hearing-impaired rehabilitation is needed. Methods to enhance this population's access to effective behavioral therapies are required.

4. Intervention Period by the Rehabilitation Centre to the Intellectually Disabled and Hearing-Impaired Children

Table 5.4 Frequency and Percentage of Intervention Period by the Rehabilitation Centre to the Intellectually Disabled and Hearing-Impaired Children (N=240)

Variables	Code					
	ID (N=120)		HI (N=120)		Total (N=240)	
Duration	**Frequency**	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
>5 years	13	10.8	13	10.8	26	10.8
4 years	24	20.0	21	17.5	45	18.8
3 years	37	30.8	34	28.3	71	29.6
2 years	25	20.8	31	25.8	56	23.3
1 years	21	17.5	27	22.5	42	17.5
Total	120	100.0	120	100.0	240	100.0

Figure 5.4 *Percentage of Intervention Period by the Rehabilitation Centre to Intellectually Disabled and Hearing-Impaired Children (N=240)*

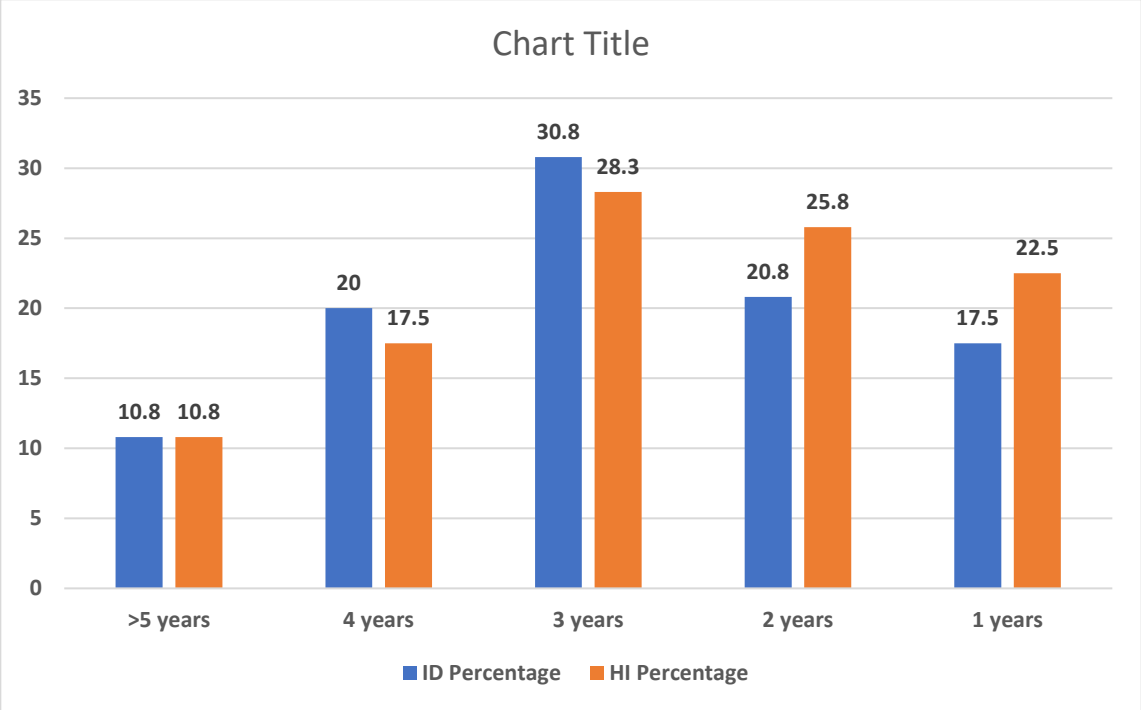


Table 5.4 represents the duration of intervention taken from the rehabilitation centre where they are admitted. From Table 5.4, it was observed that the percentage of intellectually disabled children who received support from their rehabilitation centre for more than 5 years was 10.8 per cent. However, 17.8 per cent of these children stayed in their center for 4 years, 28.3 per cent of such children stayed in their rehabilitation centre for 3 years, 25.8 per cent of such children stayed for 2 years, and 17.5 per cent of such children stayed for only 1 year for intervention. From Table 5.4, it was also observed that the percentage of hearing-impaired children who received support from their rehabilitation centre for more than 5 years was 10.8 per cent. However, 20 percent of these children stayed in their center for 4 years, 30 per cent of such children stayed in their rehabilitation centre for 3 years, 20.8 per cent of such children stayed for 2 years,

and 22.5 per cent of such children stayed for only 1 year for intervention. The bar diagram depicted in Figure 5.4 also shows the same trend.

One of the possible reasons for the low percentage in the 5 years category could be the shifting of these children by their parents to another rehabilitation centre. Initially, for children who are diagnosed with an intellectually disabled and hearing-impaired, their parents visit the rehabilitation centre to seek multiple facilities like therapy and training for the development of these children. After a period of early recovery, many children discontinue the rehabilitation centre. One of the reasons for discontinuation is because they visit other rehabilitation centres having multiple facilities for their development.

5. Age and Educational Qualifications of Mothers of Intellectually Disabled and Hearing-Impaired Children

Table 5.5 *Frequency and Percentage of A*ge *and Educational Qualification among Mothers of Intellectually Disabled and Hearing-Impaired Children (N=240)*

Variables		ID (N=120)		HD (N=120)		Total (N=240)	
		Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Age	25 – 35	26	21.7	27	22.5	53	22.1
	36 – 45	79	65.8	62	51.7	141	58.8
	46 – 55	15	12.5	31	25.8	46	19.2
	Total	120	100.0	120	100.0	240	100.0
Edu	10^{th} pass	31	25.8	10	8.3	41	17.1
	12th Pass	38	31.7	45	37.5	93	38.8
	Graduate	45	37.5	55	45.8	90	37.5
	Post Graduate	6	5.0	10	8.3	16	6.7
	Others	0	.0	0	.0	0	.0
	Total	120	100.0	120	100.0	240	100.0

Figure 5.5 *Age-wise Percentage among Mothers of Intellectually and Hearing-Impaired Children (N=240)*

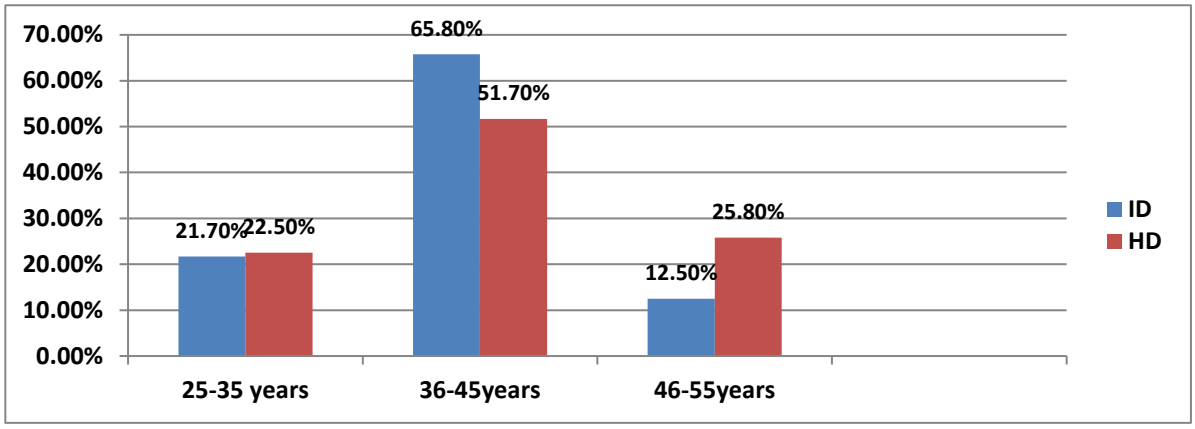


Table 5.5 showed that the demographic characteristics of mothers of intellectually disabled and hearing-impaired children. It shows that the majority (65.8 per cent in intellectually disabled and 51.7 per cent in hearing impaired) of the mothers belongs to the age group of 36-45 years. The bar diagram depicted in Figure 5.5 also shows the same trend.

Similar research was conducted by George and Gandhimathi (2020) among mothers towards the care of disabled children and the demographic characteristics of mothers of disabled children and the majority of the mothers belong to the age group of 36- 45 years.

Figure 5.6 *Educational Qualifications among Mothers of Intellectually and Hearing-Impaired Children (N=240)*

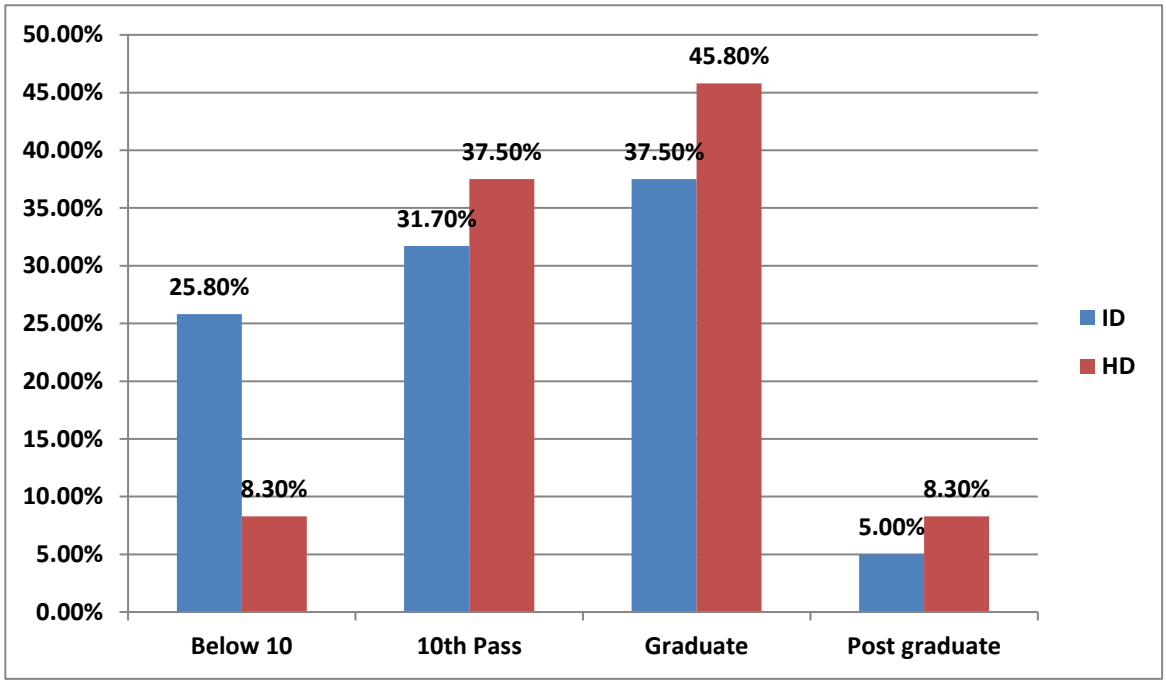


Table 5.5 present the frequency and percentages of educational qualifications of mothers. The findings from the above table the educational qualification of mothers of intellectually disabled, class 10 passed (25.8 per cent) mothers, class 12 passed (31.7 per cent), graduate 37.5 per cent, and postgraduate 5.0 per cent. From the above table, it was observed that mothers of hearing-impaired children educational qualification class 10 passed (8.3 per cent), class 12 passed (37.5 per cent), graduate45.8 per cent and post graduate 8.3 per cent. The bar diagram depicted in Figure 5.6 also shows the same trend.

The results obtained in the present study were similar to the study done by Rani et al. (2014). They conducted research among mothers of cerebral palsy and the findings for the mothers' educational qualification signify that 13 per cent of mothers were educated till primary school, 19 per cent till high school, 21 per cent till secondary education and

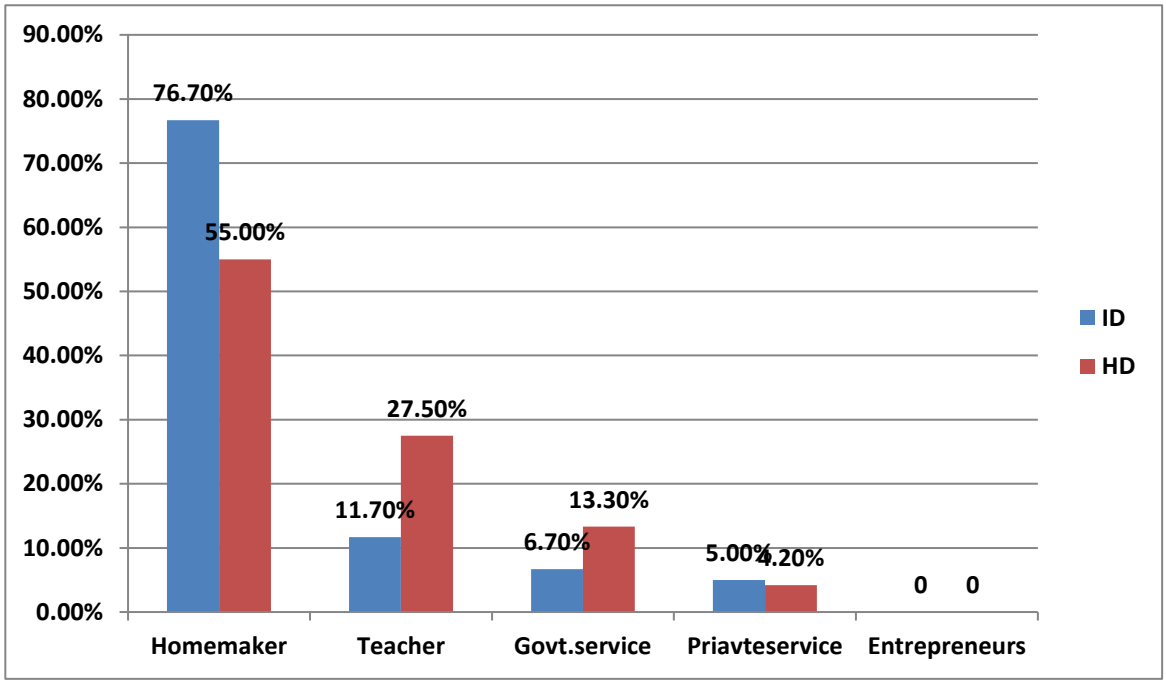
47 per cent till higher education. The educational qualification of mothers is important to some point because if they are educated, they could understand the clinical problems of their children and could easily get formal and informal training from the therapist whom they could implement those techniques at home. On the other hand, the educational qualification of mothers would impact stress because they require to face more competition with colleagues, friends, family and expectations are more (Singh & Panday, 2015). According to Suldo et al. (2008), parents with a high level of education have been impacted by a heavy focus on job acceptance, the ability to cope with a demanding workload, a high-pressure family environment, and internalization of high expectations from family and peers.

6. Occupation and Income of Mothers of Intellectually Disabled and Hearing-Impaired Children

Table 5.6 *Frequency and Percentage of Occupation and Income of the Family among Mothers of Intellectually Disabled and Hearing-Impaired Children (N=240)*

Variables		**ID**		**HD**		**Total**	
		Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**
Occupation	Home maker	92	76.7	66	55.0	158	65.8
	Teacher	14	11.7	33	27.5	47	19.6
	Govt. Service	8	6.7	16	13.3	24	10.0
	Private Service	6	5.0	5	4.2	11	4.6
	Entrepreneurs	0	.0	0	.0	0	.0
	Total	120	100.0	120	100.0	240	100.0
Income per month (Rs)	Less than 20000	4	3.3	9	7.5	13	5.4
	20000 - 40000	73	60.8	83	69.2	156	65.0
	Above 40000	43	35.8	28	23.3	71	29.6
	Total	120	100.0	120	100.0	240	100.0

Figure 5.7 *Occupation of Mothers' of Intellectually Disabled and Hearing-Impaired Children (N=240)*



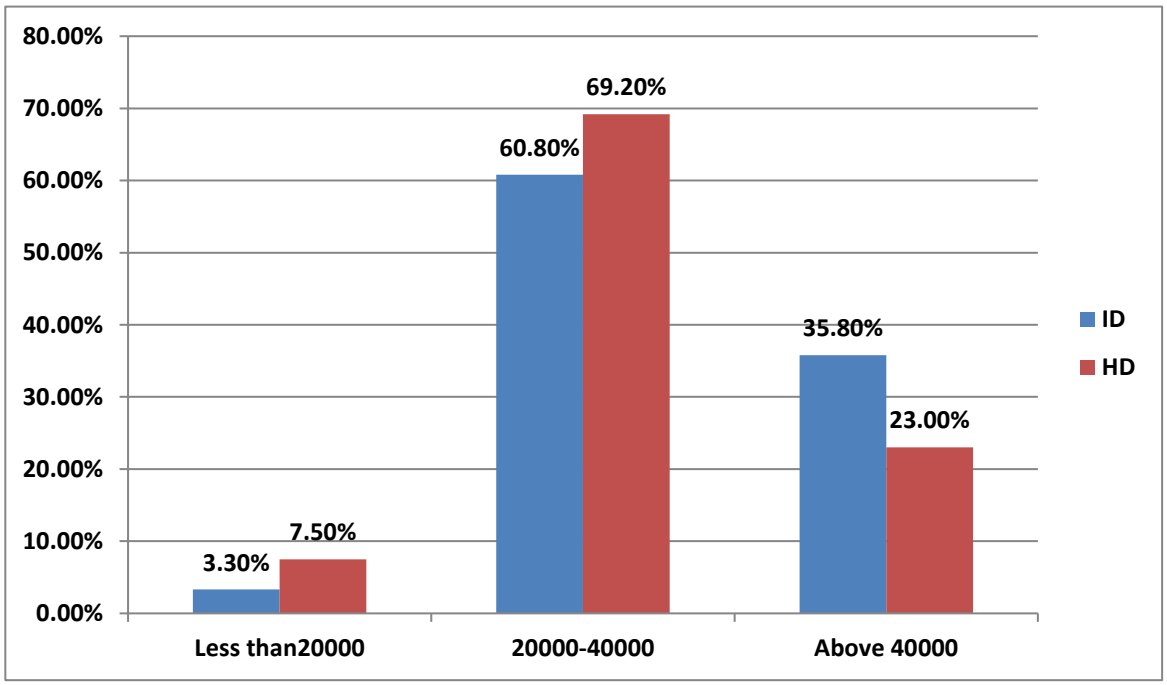
Mothers' Occupation

Table 5.6 showed that mothers of intellectually disabled and hearing impaired had the highest percentage as homemakers. The findings of the above table among mothers of intellectually disabled homemaker 76.7 per cent, teacher 11.7 per cent, government service 6.7 per cent, and private service 5.0 per cent. Mothers of hearing-impaired children in homemaker 55.0 per cent, teacher 27.5 per cent, government service 13.3 per cent, and private service 4.2 per cent. The bar diagram depicted in Figure 5.7 also shows the same trend.

It could be observed that in both the group's maximum percentage of mothers were homemakers. Similar research was conducted by Gogoi et al. (2016) among mothers

of children with intellectually disabled and mothers of healthy children. Data were collected from 60 mothers of intellectually disabled and 60 mothers of healthy children. From the distribution of socio-demographic profile of both groups, it was found that mothers who are unemployed were more that was 31.7 per cent. Few mothers were service holders. One of the reasons that the majority of mothers stay at home is that they are concerned about their children's ability to perform in day-to-day activities. Mothers of children with special needs face the normal difficulties and tensions of family life, as well as adjusting to the presence of the disabled child; as a result, mothers are forced to leave their jobs and sacrifice in order to properly care for their children.

Figure 5.8 *Percentage of the Income of the Family (Per Month) of the Mothers of Intellectually Disabled and Hearing-Impaired Children (N=240)*



Income of the Family (As Reported by the Mothers of Intellectually Disabled and Hearing-Impaired Children)

The income and economic status are important factors of the studied population. It is presented in terms of occupation; socio-economic category and average monthly income. From the above table 5.6, the findings revealed that maximum respondents in both the groups were from the category of Rs. 20000 to 40000. The bar diagram depicted in Figure 5.8 also shows the same trend.

Parents of children identified with disability face more challenges due to the child's specific care needs and additional costs including expenses related to transport, rehabilitation care. Finance and economic status were very important factors for upbringing the special child. Less income might create problems and burdens to the family because parents had to invest a huge proportion of their income amount for child's treatment. The typical monthly costs of caring for disabled children are an important consideration.

7. Religion of Mothers of Intellectually Disabled and Hearing-Impaired Children

Table 5.7 *Frequency and Percentage of Religion of Mothers of Intellectually Disabled and Hearing-Impaired Children (N=240)*

Variables	ID (N= 120)		HI (N=120)		TOTAL (N=240)	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Hindu	72	60.0	64	53.3	136	56.7
Islamic	45	37.5	53	44.2	98	40.8
Others	4	3.3	9	7.5	13	5.4
Total	120	100.0	120	100.0	240	100.0

Figure 5.9 *Percentage of Religion of mothers of Intellectually and Hearing-Impaired Children (N=240)*

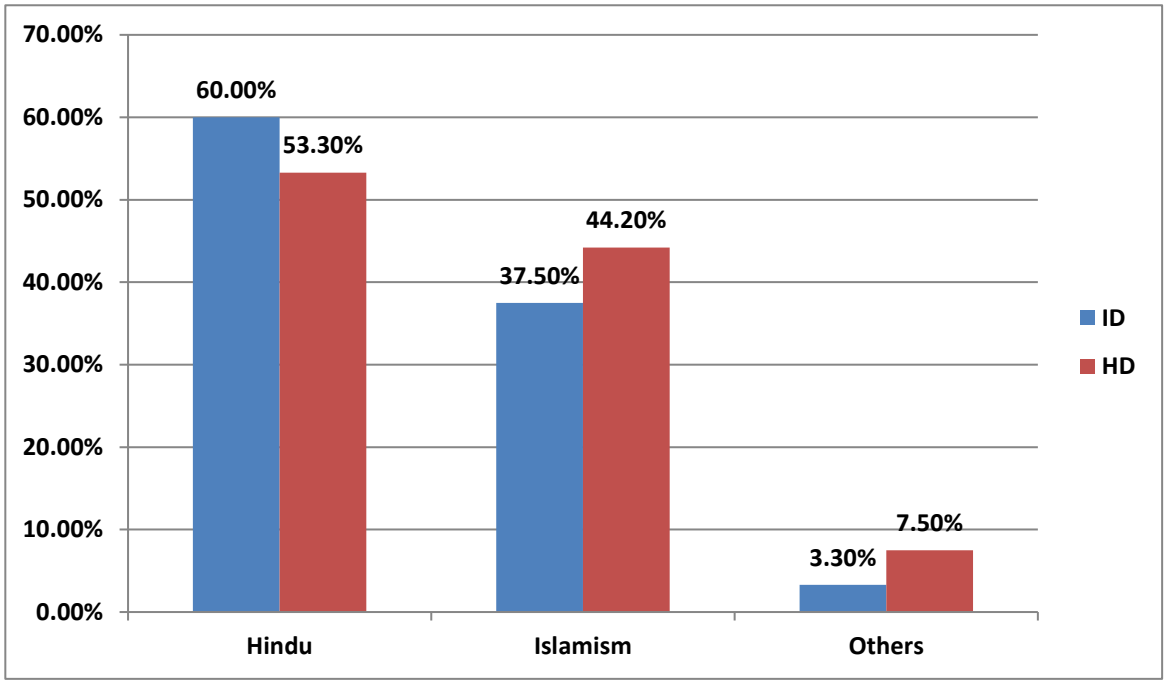


Table 5.7 represents the frequency and percentage of the religion of mothers with intellectually disabled and hearing-impaired children. As illustrated in Table 5.7, most of the mothers of intellectually disabled and hearing-impaired children belonged to the Hindu religion,60 per cent of mothers with intellectually disabled children (n=120) and 53.3 per cent of mothers with hearing-impaired children(n-120). Islamism occupied 37.5 per cent of the mothers with intellectually disabled children and 44.2 per cent of the mothers. Other religions covered only 3.3 per cent of mothers with intellectually disabled children and 7.5 per cent of mothers with hearing-impaired children. The bar diagram depicted in Figure 5.9 also shows the same trend.

The findings of the study may be impacted by religious beliefs as well as different aspects of religion. Chronic conditions of disability, place additional demands

on parents, resulting in physical and emotional disability Parenting stress and adaptation are said to be dependent on the type of impairment, the family's coping resources, and community formal and informal assistance. Family cohesion, religion, spirituality, and socioeconomic position have all been investigated as coping tools for the family. It has been discovered that proximal support from a spouse and immediate relatives might help a family adjust and lessen stress. Religious coping has been shown to help parents cope with the problems. Dunst and Trivette (1990) identified two types of social support systems in terms of community support. Professional services such as school programmes, parent education specialists, therapists, and respite-care agencies provide formal social supports. Family members, relatives, neighbours, friends, community groups, the religious group are all examples of informal social supports (Gupta et al., 2012).

SECTION II: ***Correlation Coefficients***

Hypothesis 1: A significant correlation would exist between quality of life (physical, psychological, social relationship, environment), social support (support from others, support from family, support from friends), personality (extraversion, agreeableness, conscientiousness, negative emotions, open-mindedness) and emotional intelligence (self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of intellectually disabled and hearing-impaired children.

Table 5.8: *Correlation Coefficients among different Dimensions of Quality of Life, Social Support, Personality and Emotional Intelligence among Mothers of Intellectually Disabled and Hearing-Impaired Children (N=240)*

Variables	Mean	SD	Phy	Psy	SR	E	S0	SF	Fri	E	A	C	NE	O	SA	SR	SM	SE	SSS
Physical (Phy)	43.95	22.82	1																
Psychological (Psy)	44.20	26.24	.91**	1															
Social relationship (SR)	49.36	23.84	.82**	.85**	1														
Environment (E)	50.62	18.39	.88**	.86**	.83**	1													
Support from others (SO)	4.25	1.69	.89**	.87**	.82**	.86**	1												
Support from family (SF)	4.30	1.75	.91**	.90**	.84**	.88**	.96**	1											
Support from friends (Fri)	4.20	1.76	.93**	.93**	.87**	.90**	.95**	.97**	1										
Extraversion(E)	38.57	5.17	.77**	.78**	.66**	.72**	.73**	.75**	.74**	1									
Agreeableness(A)	40.90	3.41	.18**	.24**	.28**	.23**	.22**	.21**	.25**	.18**	1								
Conscientiousness (C)	40.80	4.26	.70**	.69**	.70**	.69**	.65**	.65**	.70**	.63**	.29**	1							
Negative emotions (NE)	37.80	5.32	-.78**	-.79**	-.78**	-.72**	-.73**	-.76**	-.78**	-.65**	-.29**	-.65**	1						
Open-mindedness (O)	41.20	3.17	.36**	.40**	.40**	.39**	.39**	.38**	.41**	.34**	.41**	.35**	-.39**	1					
Self-awareness (SA)	38.87	12.83	.86**	.89**	.83**	.82**	.86**	.89**	.90**	.70**	.26**	.64**	-.76**	.37**	1				
Self-regulation (SR)	38.96	14.24	.83**	.88**	.86**	.79**	.84**	.84**	.87**	.66**	.27**	.70**	-.78**	.36**	.93**	1			
Motivation (M)	40.38	12.94	.84**	.87**	.86**	.80**	.85**	.84**	.89**	.66**	.26**	.70**	-.77**	.38**	.92**	.95**	1		
Social awareness (SA)	38.38	15.42	.84**	.86**	.86**	.81**	.85**	.85**	.89**	.67**	.28**	.71**	-.78**	.34**	.91**	.96**	.95**	1	
Social skills (SSS)	39.48	13.71	.85**	.86**	.85**	.82**	.88**	.88**	.91**	.66**	.25**	.68**	-.76**	.35**	.92**	.95**	.95**	.97**	1

*P< .05; ** P<.01, ***P < .001

Table 5.8 shows correlation coefficients among different dimensions of quality of life, social support, personality and emotional intelligence among mothers of intellectually disabled and hearing-impaired children (N=240). The four dimensions of quality of life show a significant correlation with the study variables. The study portrayed positive intra-correlation among the dimensions of quality of life, i.e., physical, psychological, social relationship and environment. Additionally, physical, psychological, social relationship and environment dimensions positively correlated with the various dimensions of social support, personality and emotional intelligence at .01 level respectively. However, the negative emotion dimensions negatively correlated with at .01 level.

Physical health is positively correlated with various dimensions such as psychological health, social relationship, environment, social support from others, social support from family, social support from friends, extraversion, agreeableness, conscientiousness, open-mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r= .91, r=.82, r=.88, r=.89, r=.91, r=.93, r=.77, r=.18, r=.70, r=.36, r=.86, r=.83, r=.84, r=.84, r=.85), respectively. However, physical health is negatively correlated with negative emotions (r=.78). Psychological health is positively correlated with various dimensions such as social relationship, environment, social support from others, social support from family, social support from friends, extraversion, agreeableness, conscientiousness, open-mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=.85, r=.86, r=.87, r=.90, r=.93, r=.78, r=.24, r=.69, r=.40, r=.89, r=.88, r=.87, r=.86, r=.86) respectively. Psychological health is negatively correlated with negative emotions (r=-.79). The social relationship is positively

correlated with various dimensions such as environment, social support from others, social support from family, social support from friends, extraversion, agreeableness, conscientiousness, open-mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=.83, r=.82, r=.84, r=.87, r=.66, r=.28, r=.70, r=.40, r=.83, r=.86, r=.86, r=.86, r=.85) respectively. The social relationship is negatively correlated with negative emotions (r=-.78). The environment is positively correlated with various dimensions such as social support from others, social support from family, social support from friends, extraversion, agreeableness, conscientiousness, open-mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=.86, r=.88, r=.90, r=.72, r=.23, r=.69, r=.39, r=.82, r=.79, r=.80, r=.81, r=.82). The environment is negatively correlated with negative emotions (r=-.72).

Social support from others is positively correlated with various dimension such as social support from family, social support from friends, extraversion, agreeableness, conscientiousness, open mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=.96, r= .95, r=.73, r= .22, r=.65, r=.39, r=.86, r=.84, r=.85, r=.85, r=.88). Social support is negatively correlated with negative emotions (r=-.73). Social support from family is positively correlated with various dimension such as social support from friends, extraversion, agreeableness, conscientiousness, open- mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r = .97, r = .75, r=.21, r = .65, r = .38, r =.89, r = .84, r= .84, r= .85, r=.88) respectively. Social support from family is negatively correlated with negative emotions (r=-.76). Social support from friends is positively correlated with extraversion, agreeableness, conscientiousness, open mindedness, self-awareness, self-regulation, motivation, social

awareness and social skills (r =.74, r=.25, r= .70, r=.41, r=.90, r= .87, r= .89, r=.89, r=.91). Social support is negatively correlated with negative emotions (r=-.78).

Extraversion is positively correlated with agreeableness, conscientiousness, open mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r =.18, r=.63, r=.34, r= .70, r=.66, r=.66, r=.67, r=.66) respectively. Extraversion is negatively correlated with negative emotions (r=-.65). Agreeableness is positively correlated with conscientiousness, open mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=.29, r= .41, r=.26, r= .27, r= .26, r= .28, r= .25). Agreeableness is negatively correlated with negative emotion (r=-.29). Conscientiousness is positively correlated with, open-mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r= .35, r=.64, r= .70, r= .70, r =.71, r=.68) respectively. Conscientiousness is negatively correlated with negative emotions (r=-.65). Negative emotions is negatively correlated with, open mindedness, self-awareness, self-regulation, motivation, social awareness and social skills (r=-.39, r=-.76, r=-.78, r=-.77, r=-.78, r=-.76). Open-mindedness is positively correlated with self-awareness, self-regulation, motivation, social awareness and social skills (r =.37, r= .36, r= .38, r=.34, r=.35) respectively.

Self-awareness is positively correlated with self-regulation, motivation, social awareness and social skills (r = .93, r= .92, r= .91, r = .92) respectively. Self-regulation is positively correlated with motivation, social awareness and social skills (r= .95, r=.96, r=.95) respectively. Motivation is positively correlated with social awareness and social skills (r =.95, r=.95) respectively. Social awareness is positively correlated with social skills (r=.97).

The dimensions of quality of life positively correlated with all the dimensions of perceived social support. These findings revealed that various types of perceived social support, such as friends and significant others, had a favorable impact on the quality of life of mothers of children with intellectual disabilities and hearing impairments. The positive correlation between social support and quality of life suggests that when mothers get perceived social support from their family members, their friends and other significant members of the society like neighbours, therapist of the child, teachers, colleagues then their confidence increases which lead to a better quality of life. If they suffer from any problems like physical, psychological and environmental, the perceived social support from significant members of their life facilitates them to tackle and overcome their problems more effectively. The findings of the present study are supported by a similar study conducted by Boyd (2002) who reported that social support acts as a mediator of stress by influencing how well parents were able to cope with the demands of raising a child with a disability, as families who reported higher levels of social support generally report lower levels of stress and better quality of life. In a correlation study, Maurya and Singh (2016) discovered that perceived social support, a healthy familial environment, and a positive coping style were all positively related with quality of life.

Several studies indicated that factors of personality may be closely associated with quality of life and wellbeing (Dogan, 2012; Steel et al., 2008) and other individual strengths (Walker & Gorsuch, 2002; Wood et al., 2009). It can be observed that the results of the current study indicated that extraversion, agreeableness, conscientiousness and open-mindedness are positively associated with all the dimensions of quality of life, while neuroticism is negatively associated.

Extraversion includes features such as active, energetic, assertive, warmth, gregariousness, excitement- seeking and positive emotions (Kaiseler et al., 2012) and therefore a person high on these aspects would be suitable to tackle any kind of stress. The present findings indicated that mothers of intellectually disabled and hearing-impaired children would be able to handle any stress due to extraversion characteristics.

Studies showed that agreeableness is associated with facets like trust, modesty, compliance, altruism, straightforwardness and tender-mindedness (Aslan, 2012; Mutlu et al., 2010). When the altruistic nature of the personality and warmth are excluded by mothers, it would make them handle the task more effortlessly and thereby make them protective against negative consequences. Conscientiousness is associated with punctuality, hardworking, self-discipline, competency, achievement-striving, dutifulness, order and deliberation (McCrae & Costa, 1987) characteristics. Mothers of intellectually disabled and hearing-impaired children who possess these traits would be protected from negative consequences and would have a better quality of life.

Negative emotion, a sub-dimensions of personality characteristics like anxiety, anger, hostility, depression, self –consciousness, vulnerability and impulsiveness (Costa & McCrae, 1992; Ryan & Frederick, 1997) would be associated with negative consequences. Bumin et al. (2008) found that mothers with disabled children have higher anxiety, depression and lower quality of life. Additionally, increased depression and anxiety affects severely mother's quality of life. Shanbhag and Krishnamurthy (2011) observed that there was a significant ($p<0.05$) correlation between the General Health Questionnaire (GHQ) scores and quality of life (QOL). They assessed the association between the mental health status and quality of life through WHOQOL –BREF and

mental health status was assessed through GHQ-28 which included the subscales of somatic illness, anxiety, social dysfunction and depressions. They showed a significant association between the GHQ scores and quality of life. The entire domain was negatively correlated with GHQ and the values were found to be statistically significant. Therefore, mothers with high negative emotions experience low quality of life thereby affecting their physical and psychological health, social relationship and environmental determinants.

Furthermore, open-mindedness is associated with aspects such as fantasy, aesthetics, feelings, actions, ideas, and values. Individual high on this aspect is more likely to explore novel things and places. Mothers who are engaged with caregiving duties are hardly likely to be in a state of positive wellbeing.

Moreover, numerous studies have been conducted to comprehend the link between the quality of life and personality traits. For instance, Naletilic et al. (2017) conducted a study on personality traits and quality of life among mothers of cerebral palsy. They found that a high level of extraversion had a better quality of life. A high level of neuroticism and psychoticism had worse physical and mental health. In another study, Kentros et al. (1997) examined the effects of personality traits and quality of life in persons with schizoaffective disorder and schizophrenia. It was found that the relationship between quality of life and specific personality domains were assessed. They found that quality of life was positively correlated with extraversion and agreeableness and negatively correlated with the domain of neuroticism. Likewise, a study conducted by Joshi (2020) examined the difference between neuroticism, hope and quality of life among parents of normal children, parents of intellectually disabled children and parents

of physically disabled children. The study found a significant difference in the quality of life among parents with normal children and intellectually disabled children.

The results of the present study showed a significant positive correlation with the dimension of quality of life and the dimensions of emotional intelligence among mothers of intellectually disabled and hearing-impaired children. Different studies confirm this finding and express the significant relationship between emotional intelligence and quality of life (Extremera & Fernandez, 2002; Saadat et al., 2009). It could be explained from the point that individuals who have high emotional intelligence have the ability to control, identify and use emotional competence can deal with life events and problems with expanding their insight by developing a positive attitude towards events through using proper strategies in order to confront problems and improve their mental health and the quality of life (Min, 2014).

People with better emotional intelligence deal chronic stressful experiences and viewed as a challenge and a chance for new learning by. As a result, they experience fewer physiological and emotional disorders and have a good quality of life.

Moreover, in Indian families, family plays an important role in providing a helping hand to the distressed members to some extent. Family support and cooperation play a significant role to cope with emotion in the situation in a more proper way. Sometimes it seems that mother left their jobs, so as to take care of the child by accompanying them to the rehabilitation centre or special school to understand what therapy and activities are carried out with their child so that they could learn to some extent. Accordingly, they could carry out those activities at home by engaging intensively

with the child. This would help mothers to release negative emotions and to find a sense of satisfaction by devoting most of their time towards their children to have a better quality of life (Burr et al., 1994; Barbarin et al., 1985). Information received formally from schools, rehabilitation centres and other agencies help mothers to develop positive attitudes towards the child's future. Mothers of special children meet other parents who are dealing with similar issues and sharing their worries and challenges allows them to manage better. Friends and family members were seen to be crucial in providing informal support (Ganjiwale et al., 2016).

Therefore, Hypothesis 1 "A significant correlation would exist between quality of life (physical, psychological, social relationship, environment), social support (support from others, support from family, support from friends), personality (extraversion, agreeableness, conscientiousness, negative emotions, open-mindedness) and emotional intelligence (self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of intellectually disabled and hearing-impaired children" is accepted.

SECTION III: ***Inferential Analysis (t-test)***

Hypothesis 2: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate hearing-impaired children.

Table 5.9 *Mean, SD and t-value among Mothers of Mild and Moderate Hearing-Impaired Children on Quality of Life (N=120)*

Variables	Category	N	Mean	SD	SEM	M	t	df	Sig (2 tailed)
Physical	Mild Hearing Impaired	60	74.03	6.91	0.89	32.57	26.63	118	.000
	Moderate Hearing Impaired	60	41.47	6.48	0.84				
Psychological	Mild Hearing Impaired	60	79.67	6.28	0.81	42.68	32.18	118	.000
	Moderate Hearing Impaired	60	36.98	8.13	1.05				
Social Relationship	Mild Hearing Impaired	60	73.13	10.91	1.41	28.90	14.15	118	.000
	Moderate Hearing Impaired	60	44.23	11.47	1.48				
Environment	Mild Hearing Impaired	60	71.13	8.55	1.10	19.78	13.63	118	.000
	Moderate Hearing Impaired	60	51.35	7.29	.942				
Overall_ WHOQOL	Mild Hearing Impaired	60	297.97	21.62	2.79	123.93	35.05	118	.000
	Moderate Hearing Impaired	60	174.03	16.82	2.17				

Significant difference: P< 0.001

From Table 5.9, it can be observed that the t-value for physical health dimension of quality of life is 26.63; for psychological health, the t-value is 32.18; for social relationship, the t- value is 14.15; for environment, the t-value is 13.63; and for overall quality of life, the t-value is 35.05 which are significant ($p < 0.001$).

The t-value on overall quality of life among mothers of mild and moderate hearing-impaired children is 35.05 ($p < 0.001$) which is significant.

Mothers of mild hearing-impaired children have a better quality of life because mild hearing-impaired children manage to cope with day-to-day activities, whereas mothers of moderate hearing-impaired children are burdened with additional needs dealing with their children in the habilitation process. As the level of disability increases, the responsibility of mothers also increases and they were unable to engage in other activities, curtailing their social life and negatively affecting their quality of life (Yuen & Wai, 2003). According to O'Neill et al. (2014), hearing-impaired children are more likely to develop problems in spoken language and it used to be somewhat difficult to understand by their teachers. They may mishear in the classroom, have smaller vocabularies, and have more difficulty understanding information over long distances and in noisy environments than their hearing counterparts; all of these factors may have a substantial impact on their learning experiences and educational outcomes. Parents who have a child with hearing impairment confront a variety of long-term challenges such as frequent visits to speech therapists' debate over oral versus manual communication and school placement issues are among them. Parents' energy, time, and money resources may be depleted as a result of these chronic problems and stresses, potentially leading to emotional reactions such as irritation, despair, and social isolation and as a result, the quality of life deteriorated.

Therefore, Hypothesis 2 stated that "mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social

relationship, environment) than the mothers of moderate hearing-impaired children" is accepted.

Hypothesis 3: Mothers of mild hearing-impaired children will score high on all the dimensions of social support (i.e., others, family, friends) compared to the mothers of moderate hearing-impaired children.

Table 5.10 *Mean, SD and t-value among Mothers of Mild and Moderate Hearing-Impaired Children on Social Support (N=120)*

Variables	Category	N	Mean	SD	SEM	M	t	df	Sig (2 tailed)
Social support others	Mild Hearing Impaired	60	5.92	0.52	0.07	1.38	17.34	118	.000
	Moderate Hearing Impaired	60	4.55	0.34	0.04				
Social support family	Mild Hearing Impaired	60	6.21	0.29	0.04	1.61	26.70	118	.000
	Moderate Hearing Impaired	60	4.59	0.36	0.05				
Social support friends	Mild Hearing Impaired	60	6.29	0.31	0.04	2.18	36.24	118	.000
	Moderate Hearing Impaired	60	4.12	0.35	0.05				
Overall Social support	Mild Hearing Impaired	60	6.15	0.22	0.03	1.73	45.08	118	.000
	Moderate Hearing Impaired	60	4.42	0.20	0.03				

Significant difference: P< 0.001

Table 5.10 shows that there is a difference between mothers of children with mild and moderate hearing impairments. From Table 5.10, it can be observed that the t-value for social support from others is 17.34; for social support from family, the t-value is 26.70; for social support from friends, the t- value is 36.24; and for overall social support, the t-value is 45.08 which are significant ($p < 0.001$).

Regardless of the level of disability, his or her child is experiencing, social support plays a crucial role in helping disabled children's mothers. Hearing loss (HL) in children has ramifications for the child's family (Jackson & Turnbull, 2004). Parenting deaf or hard-of-hearing (D/HH) children presents unique long-term challenges, putting them at a higher risk of parental stress (e.g., Lederberg & Golbach, 2002; Quittner et al., 2010; Zaidman-Zait, 2008). Families of children with hearing loss need timely and relevant assistance and intervention because the majority of these children are born to parents who have normal hearing and were not expecting the diagnosis. The amount of perceived social support obtained in confronting parenting issues is also important in reducing the problems that come in dealing with children's disabilities. In general, social support refers to the exchange of interpersonal relationships between people individuals through a variety of approaches with the goal of improving the recipient's well-being (Zimet et al., 1988). Polita and Tacla (2014) further divided the qualities of perceived social support into three categories: emotional support, informational, and cognitive assistance. In the perspective of parenting, a strong social support system can act as a medium to reduce parenting stress and improve parenting well-being among parents, particularly among parents of disabled children (Jeong et al., 2013; Kissel & Nelson, 2014; Suzuki, 2010). Furthermore, Jeong et al. (2013) pointed out that informal support,

rather than formal support, has a discernible impact on the reduction of parenting problems among mothers of children with impairments. In addition, institutional support among mothers of children with severe forms of disorder has been identified as a type of social support that is necessary for the successful implementation of parental caregiving for children with disabilities (Krstic & Oros, 2012).

Therefore, Hypothesis 3 stated that "mothers of mild hearing-impaired children will score high on all the dimensions of social support (i.e., others, family, friends) compared to the mothers of moderate hearing-impaired children." is accepted.

Hypothesis 4: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to the mothers of moderate hearing-impaired children.

Table 5.11: *Mean, SD and t-value among Mothers of Mild and Moderate Hearing-Impaired Children on Different Dimensions of Personality (N=120)*

Variables	Category	N	Mean	SD	SEM	M	t	df	Sig (2 tailed)
Extraversion	Mild Hearing Impaired	60	44.82	2.49	.322	6.73	12.92	118	.000
	Moderate Hearing Impaired	60	38.08	3.17	.410				
Agreeableness	Mild Hearing Impaired	60	41.77	3.38	.437	2.03	3.19	118	.002
	Moderate Hearing Impaired	60	39.73	3.58	.462				
Conscientiousness	Mild Hearing Impaired	60	45.00	2.95	.381	5.85	11.04	118	.000
	Moderate Hearing Impaired	60	39.15	2.85	.368				
Negative emotions	Mild Hearing Impaired	60	31.80	2.80	.362	-8.17	-16.25	118	.000
	Moderate Hearing Impaired	60	39.97	2.69	.348				
Open mindedness	Mild Hearing Impaired	60	42.90	2.93	.378	1.73	3.33	118	.001
	Moderate Hearing Impaired	60	41.17	2.78	.359				

Significant difference: P< 0.001

In the present study, it was found that in each dimension of personality there was a significant difference between mothers of mild and moderate hearing-impaired children. From Table 5.11, it can be observed that the t-value for extraversion dimension of personality is 12.92; for agreeableness, the t-value is 3.19; for conscientiousness, the t-value is 11.04; for negative emotion, the t-value is 16.25; and for open-mindedness, the t-value is 3.33 which are significant ($p < 0.001$).

Personality is another factor to understand the personal structure of the mothers of hearing-impaired children. Studies conducted by Chen et al. (1992) among mothers of learning-disabled children, with attention deficit disorder children, hyperactive disorder children and it was found that mothers of those disabled children scored higher levels of depression, anxiety, and/or neurotic personality disorders than mothers of non-disabled children. Neuroticism scores were significantly higher in families with impaired children (Singhi et al., 1990). The positive relationship between extraversion scores and maternal adaptation to the child was shown to be substantial. Longitudinal studies of personality, stress and coping have demonstrated that extraversion has a positive effect on the mother-child connection. Extraversion has also been linked to good coping strategies (McCrae & Costa, 1986). A number of other studies about personality traits in parents of disabled children were carried out.

Therefore, Hypothesis 4 “mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to the mothers of moderate hearing-impaired children.” is accepted.

Hypothesis 5: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, and social skills) than the mothers of moderate hearing-impaired children.

Table 5.12 *Mean, SD and t-value among Mothers of Mild and Moderate Hearing-Impaired Children on Emotional Intelligence (N=120)*

Variables	Category	N	Mean	SD	SEM	M	t	df	Sig (2 tailed)
Self-awareness	Mild Hearing Impaired	60	52.68	3.37	0.44	18.00	17.31	118	.000
	Moderate Hearing Impaired	60	34.68	7.32	0.95				
Self regulation	Mild Hearing Impaired	60	53.50	2.29	0.30	22.13	30.63	118	.000
	Moderate Hearing Impaired	60	31.37	5.11	0.66				
Motivation	Mild Hearing Impaired	60	53.62	2.03	0.26	20.07	35.92	118	.000
	Moderate Hearing Impaired	60	33.55	3.82	0.49				
Social awareness	Mild Hearing Impaired	60	53.82	1.50	0.19	23.72	40.73	118	.000
	Moderate Hearing Impaired	60	30.10	4.25	0.55				
Social skills	Mild Hearing Impaired	60	52.28	2.51	0.32	17.62	30.84	118	.000
	Moderate Hearing Impaired	60	34.67	3.64	0.47				
Total emotional intelligence	Mild Hearing Impaired	60	265.90	7.88	1.02	101.53	49.11	118	.000
	Moderate Hearing Impaired	60	164.37	13.94	1.80				

Significant difference: P< 0.001

From Table 5.12, it can be observed that the t-value for the self-awareness dimension of emotional intelligence is 17.31; for self-regulation, the t-value is 30.68; for motivation, the t- value is 35.92; for social awareness, the t-value is 40.73; for social skills, the t-value is 30.84; and for total emotional intelligence, the t-value is 49.11 which are significant ($p < 0.001$).

In the present study, mothers of mildly hearing-impaired children had higher emotional intelligence than mothers of moderately hearing-impaired children. Because the severity of the condition was fewer among the children, mothers with mild hearing children were able to deal with and manage emotional problems. Emotions are a necessary and important element of every human being. Being a parent is a blessing in and of itself, with the mother-child relationship evoking tremendous feelings. This relationship is special, fulfilling, and demanding for a parent of a child with a Disability. These parents' lives are more challenging and stressful than those of other parents of ordinary children. Emotional Intelligence skills can help to deal with problems more effectively. According to Nowack (2013), and an Emotional Intelligence expert, parents with a high Emotional Intelligence score may have a better quality of life and experience less stress than those with a low score. Emotional Intelligence help to improve their overall Quality of Life, which would benefit the child and help him, grow.

Therefore, Hypothesis 5 “mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) than the mothers of moderate hearing-impaired children” is accepted.

Hypothesis 6: Mothers of mild intellectually disabled children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Table 5.13 *Mean, SD and t-value among Mothers of Mild and Moderate Intellectually Disabled Children on Quality of Life (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Physical	Mild Intellectually Disabled	60	47.53	7.87	1.02	34.77	28.21	118	.000
	Moderate Intellectually Disabled	60	12.77	5.39	0.70				
Psychological	Mild Intellectually Disabled	60	50.48	7.23	0.93	40.83	32.22	118	.000
	Moderate Intellectually Disabled	60	9.65	6.64	0.86				
Social relationship	Mild Intellectually Disabled	60	63.02	8.45	1.09	45.97	25.20	118	.000
	Moderate Intellectually Disabled	60	17.05	11.32	1.46				
Environment	Mild Intellectually Disabled	60	55.37	7.06	.912	30.75	23.29	118	.000
	Moderate Intellectually Disabled	60	24.62	7.39	.955				
Overall _WHOQOL	Mild Intellectually Disabled	60	216.40	13.82	1.78	152.32	52.04	118	.000
	Moderate Intellectually Disabled	60	64.08	17.97	2.32				

Significant difference: P< 0.001

From Table 5.13, it can be observed that the t-value for the physical dimension of quality of life is 28.21; for psychological, the t-value is 32.22; for a social relationship, the t- value is 25.20; for the environment, the t-value is 23.29; and for overall quality of life, the t-value is 52.04 which are significant ($p < 0.001$).

The data in Table 5.13 involves the significant differences in quality of life. It has been found that the mothers of children with mild intellectually disabled children have a higher quality of life than mothers of moderate intellectually disabled. The above finding

is supported by Dizdarevic et al. (2020) who conducted a study to find out the family quality of life (FQOL)in relation to parental demographics (gender, age, work position), children's gender and age, type of disability (mild and moderate intellectual disability, autistic spectrum disorder), and parent sadness, anxiety, and stress. Data was collected 90 parents of children with autism spectrum disorder, 90 parents of children with mild intellectual disabilities, and 90 parents of children with moderate intellectual disabilities. Results found that parents of children with autism spectrum disorder and parents of children with moderate intellectual disability had statistically significantly poorer FQOL than parents of children with mild intellectual disability and parents of normally developing children. The gender of the child had a significant impact on FQOL. In addition, sadness, anxiety, and stress levels had a substantial impact on FQOL, whereas the gender, age, and work position of the parents had no effect.

Therefore, Hypothesis 6 “mothers of mild intellectually disabled children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.” is accepted.

Hypothesis 7: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild intellectually disabled children.

Table 5.14: *Mean, SD and t-value among Mothers of Mild and Moderate Intellectually Disabled Children on Social Support (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Social support others	Mild Intellectually Disabled	60	1.57	0.43	0.06	3.37	39.22	118	.000
	Moderate Intellectually Disabled	60	4.93	0.51	0.07				
Social support family	Mild Intellectually Disabled	60	1.53	0.42	0.05	3.33	43.42	118	.000
	Moderate Intellectually Disabled	60	4.87	0.42	0.06				
Social support friends	Mild Intellectually Disabled	60	1.55	0.32	0.04	3.29	51.23	118	.000
	Moderate Intellectually Disabled	60	4.84	0.38	0.05				
Overall Social Support	Mild Intellectually Disabled	60	1.55	0.36	0.05	3.33	49.38	118	.000
	Moderate Intellectually Disabled	60	4.88	0.38	0.05				

Significant difference: P< 0.001

From Table 5.14, it can be observed that the t-value for the social support from others dimension of social support is 39.22; for social support family, the t-value is 43.42; for social support friends, the t- value is 51.23; and for overall social support, the t-value is 49.38 which are significant ($p < 0.001$).

The present study shows that mothers of moderately intellectually disabled children have a higher perception of social support than mothers of mild intellectually disabled children. Previous research has shown that as the level of intellectual disability rises, so does the burden of care for caregivers also increases (Oymak & Arslan, 2020). Mothers of children with intellectual disabilities are under a lot of stress when it comes to

raising their children because of the child's constant demands, and they need support for their overall well-being. Mothers of disabled children are under a lot of stress when it comes to raising their children, and they need a lot of support. The importance of social support in the care of mothers of special children cannot be overstated. As the child's severity grows, the mother's life becomes increasingly restricted. They are aided in overcoming and coping with the help of social support.

Therefore, Hypothesis 7 “mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, and friends) as compared to the mothers of mild intellectually disabled children.” is accepted.

Hypothesis 8: Mothers of mild intellectually disabled children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Table 5.15: *Mean, SD and t-value among Mothers of Mild and Moderate Intellectually Disabled Children on different Dimensions of Personality (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Extraversion	Mild Intellectually Disabled	60	38.27	3.02	.39	5.15	8.55	118	.000
	Moderate Intellectually Disabled	60	33.12	3.56	.46				
Agreeableness	Mild Intellectually Disabled	60	42.18	3.02	.39	2.28	4.16	118	.002
	Moderate Intellectually Disabled	60	39.90	2.99	.39				
Conscientiousness	Mild Intellectually Disabled	60	42.32	2.65	.34	5.58	10.52	118	.000
	Moderate Intellectually Disabled	60	36.73	3.14	.41				
Negative emotion	Mild Intellectually Disabled	60	35.93	3.25	.42	-7.58	-12.75	118	.000
	Moderate Intellectually Disabled	60	43.52	3.27	.42				
Open mindedness	Mild Intellectually Disabled	60	41.47	2.49	.32	2.20	4.06	118	.001
	Moderate Intellectually Disabled	60	39.27	3.38	.44				

Significant difference: P< 0.001

From Table 5.15, it can be observed that the t-value for the extraversion dimension of personality is 8.55; for agreeableness, the t-value is 4.16; for conscientiousness, the t- value is 10.52; for negative emotion, the t-value is 12.75; and for open-mindedness, the t-value is 4.06 which are significant ($p < 0.001$).

In the present study, there is a difference in the dimensions of personality among mothers of mild and moderate intellectually disabled children. For instance, mothers of

mild intellectually disabled children scored more in extraversion as compared to mothers of moderate intellectually disabled children. It could be that mothers who scored more in extraversion, have extrovert personalities, are social, are outgoing, tend to be more active and would be able to deal with social problems. All mothers of children with intellectually disabled children are not alike. They hold different personality traits; those are accountable for their behavioral expression. Therefore, the personality traits of mothers of children with mild and moderate intellectually disabled have a significant impact on the development of their children. Similar research was conducted by Lisa et al. (2001) recommended that a mother's affectionate, encouraging relationships with a child, has an impact on a child's internalizing problems, externalizing problems, in society. Therefore, the personality traits of parents, particularly, mothers have a significant impact on the development of children with Intellectually Disabled (Santosh & Prakash, 2020). Caregiver personality and family styles play an important role in the upbringing and personality development of children in the family.

Therefore, Hypothesis 8 "mothers of mild intellectually disabled children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children." is accepted.

Hypothesis 9: Mothers of mild intellectually disabled children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, and social skills) than the mothers of moderate intellectually disabled children.

Table 5.16: *Mean, SD and t-value among mothers of mild and moderate intellectually disabled children on emotional intelligence (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Self-awareness	Mild Intellectually Disabled	60	46.75	2.28	.29	25.38	50.59	118	.000
	Moderate Intellectually Disabled	60	21.37	3.15	.41				
Self-regulation	Mild Intellectually Disabled	60	50.78	1.75	.23	30.60	59.85	118	.000
	Moderate Intellectually Disabled	60	20.18	3.55	.46				
Motivation	Mild Intellectually Disabled	60	51.10	1.55	.20	27.85	49.63	118	.000
	Moderate Intellectually Disabled	60	23.25	4.06	.52				
Social awareness	Mild Intellectually Disabled	60	51.88	1.63	.21	34.18	84.25	118	.000
	Moderate Intellectually Disabled	60	17.70	2.69	.35				
Self-social skill	Mild Intellectually Disabled	60	51.27	1.63	.21	31.58	72.45	118	.000
	Moderate Intellectually Disabled	60	19.68	2.96	.38				
Total emotional intelligence	Mild Intellectually Disabled	60	251.78	4.68	.60	149.60	121.84	118	.000
	Moderate Intellectually Disabled	60	102.18	8.28	1.07				

Significant difference: P< 0.001

From Table 5.16, it can be observed that the t-value for the self-awareness dimension of emotional intelligence is 50.59; for self-regulation, the t-value is 59.85; for motivation, the t- value is 49.63; for social awareness, the t-value is 84.25; and for self-

social skill, the t-value is 72.45, and for total emotional intelligence, the t-value is 121.84 which are significant ($p < 0.001$).

In the present study, it can be seen that emotional intelligence among mothers of mild intellectually disabled children scores higher as compared to mothers of moderate intellectually disabled children. As mothers of mild intellectually disabled scored high they might be able to cope with stress and better adapt to their surroundings and would be able to manage their emotions, may receive more social support and be more satisfied (Ciarrochi et al., 2001). Emotions are a necessary and important element of every human being. Being a parent is a blessing in and of itself, with intense emotions associated with the mother-child bond. This relationship is special, fulfilling, and demanding for a parent of a child with an Intellectual Disability. These parents' lives are more challenging and stressful than those of other parents of ordinary children. As a result, it is reasonable for these parents to have higher levels of emotional intelligence skills that can help to deal with stress more effectively. This would assist them in maintaining their position keep their stress levels under control and enjoying a higher quality of life and subjective well-being. People with high emotional intelligence are able to manage their emotions effectively and appear to have a better knowledge of their emotional lives (Salovey et al., 2002). Mild intellectual impairment children can be educable through special education; this group can develop some skills such as practical skills, reading capacity, and math ability (Lin, 2003). This implies that they are capable of gaining fundamental academic and vocational skills and living semi-independently (Maloney & Ward, 1976).

Therefore, Hypothesis 9 “mothers of mild intellectually disabled children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-

regulation, motivation, social awareness, social skills) than the mothers of moderate intellectually disabled children" is accepted.

Hypothesis 10: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of mild intellectually disabled children.

Table 5 .17: *Mean, SD and t-value among Mothers of Mild Hearing-Impaired Children and Mild Intellectually Disabled Children on Quality of Life (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Physical	Mild hearing impaired	60	74.03	6.91	.89	26.50	19.59	118	.000
	Mild Intellectually Disabled	60	47.53	7.88	1.0				
Psychological	Mild hearing impaired	60	79.67	6.28	.81	29.18	23.59	118	.000
	Mild Intellectually Disabled	60	50.48	7.23	.93				
Social relationship	Mild hearing impaired	60	73.13	10.91	1.41	10.12	5.68	118	.000
	Mild Intellectually Disabled	60	63.02	8.45	1.09				
Environment	Mild hearing impaired	60	71.13	8.55	1.10	15.76	11.01	118	.000
	Mild Intellectually Disabled	60	55.37	7.06	.912				
Overall _WHOQOL	Mild hearing impaired	60	297.90	21.62	2.79	81.57	24.63	118	.000
	Mild Intellectually Disabled	60	216.40	13.82	1.78				

Significant difference: P< 0.001

From Table 5.17, it can be observed that the t-value for the physical health dimension of quality of life is 19.59; for psychological health, the t-value is 23.59; for social relationships, the t- value is 5.68; for the environment, the t-value is 11.01; and for overall quality of life, the t-value is 24.63 which are significant ($p < 0.001$).

From the above Table 5.17, it could be observed that quality of life is low among mothers of intellectually disabled children than mothers of hearing-impaired children. The birth of a child with a disability could have profound effects on the family, especially mothers. Because the mothers are responsible for satisfying the demands of the individual variation of the disabled child, they are burdened in terms of child-rearing. This, in turn, might have a negative impact on mothers' quality of life. A similar study was conducted by Firdous et al. (2019) to examine the level of psychological stress among parents of children with intellectually disabled children and hearing-impaired children. It was found that parents of hearing-impaired children have a low level of stress as compared to parents of intellectually disabled children. In some cases, mild hearing-impaired children have similar interests to what normal functioning children do, they can learn music, painting, engage in play activities, etc. As a result, mothers may be less concerned because their children are coping with day-to-day and extracurricular activities. Disability causes a great deal of stress, especially for parents resulting in physical, psychological, and social consequences that disrupt normal life functioning and quality of life. Intellectual disability is a prevalent majority of childhood and most cases (85%) belong to mild intellectually disabled children (Harris, 2009; Ganguly, 2000).

Therefore, Hypothesis 10 "mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social

relationship, and environment) than the mothers of mild intellectually disabled children" is accepted.

Hypothesis 11: Mothers of mild intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild hearing-impaired children.

Table 5 .18: *Mean, SD and t-value among Mothers of Mild Hearing-Impaired Children and Mild Intellectually Disabled Children on Social Support (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Social support others	Mild hearing impaired	60	4.93	.51	.07	1.00	10.74	118	.000
	Mild Intellectually Disabled	60	5.94	.52	.07				
Social support family	Mild hearing impaired	60	4.87	.42	.05	1.34	20.22	118	.000
	Mild Intellectually Disabled	60	6.21	.30	.04				
Social support friends	Mild hearing impaired	60	4.84	.32	.04	1.46	25.41	118	.000
	Mild Intellectually Disabled	60	6.29	.31	.03				
Overall Social support	Mild hearing impaired	60	4.88	.36	.05	1.27	23.33	118	.000
	Mild Intellectually Disabled	60	6.15	.22	.023				

Significant difference: P< 0.001

From Table 5.18, it can be observed that the t-value for the social support others dimension of social support is 10.74; for social support family, the t-value is 20.22; for

social support friends, the t- value is 25.41; and for overall social support, the t-value is 23.33 which are significant ($p < 0.001$).

Social support has far-reaching and far-reaching effects on families of children with hearing loss. Research consistently shows that families with strong social support systems are better able to deal with challenges than families with few supports (Dunst & Trivette, 1994) and that social support has a positive impact on the coping and well-being of hearing parents of children with hearing loss in particular (Dunst & Trivette, 1994; Asberg, Vogel, & Bowers, 2008; Hintermair, 2006; Zaidman-Zait, 2007). Social supports depend upon parents' individual demands and problems in raising a child with hearing loss, as well as their ongoing relationships with various support providers. While parenting a child with a disability can result in beneficial parent outcomes such as additional insight into family priorities and a renewed sense of purpose, parents of hearing-impaired children face unique and long-term problems as a result of early childhood deafness (Poon & Zait, 2014).

Therefore, Hypothesis 11 “mothers of mild intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild hearing-impaired children.” is accepted.

Hypothesis 12: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of mild intellectually disabled children.

Table 5 .19: *Mean, SD and t-value among Mothers of Mild Hearing-Impaired Children and Mild Intellectually Disabled Children on Different Dimensions of Personality (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Extraversion	Mild hearing impaired	60	44.82	2.49	.32	5.15	6.55	118	.000
	Mild Intellectually Disabled	60	38.27	3.02	.39				
Agreeableness	Mild hearing impaired	60	41.77	3.38	.44	2.28	-.42	118	.478
	Mild Intellectually Disabled	60	42.18	3.02	.39				
Conscientiousness	Mild hearing impaired	60	45.00	2.95	.38	5.58	2.68	118	.000
	Mild Intellectually Disabled	60	42.32	2.65	.34				
Negative emotion	Mild hearing impaired	60	31.80	2.80	.36	-7.58	-4.13	118	.000
	Mild Intellectually Disabled	60	35.93	3.25	.42				
Open-mindedness	Mild hearing impaired	60	42.90	2.93	.38	2.20	1.43	118	.005
	Mild Intellectually Disabled	60	41.47	2.49	.32				

Significant difference: P< 0.001

From Table 5.19, it can be observed that the t-value for the extraversion dimension of personality is 6.55; for conscientiousness, the t- value is 2.68; for negative emotion, the t-value is -4.13; and for open-mindedness, the t-value is 1.43 which are

significant ($p < 0.001$). However, the t-value for the agreeableness dimension of personality is -.42, which is not significant.

In Table 5.19, it could be observed that in each dimension of personality there is a significant difference except in agreeableness. One of the reasons there was no significant difference in agreeableness between mothers of mild hearing-impaired children and mothers of mild intellectually disabled children, that they both encounter similar challenges in raising their children. A similar study that supports the above result found that there was no significant difference in agreeableness among mothers of disabled children and Estonian women (Veisson, 2001). In order to overcome the difficulties mothers, form a positive attitude, feelings and actions towards their child's needs to provide warmth and protection to respect the child's autonomy. According to Piven et al. (1994), personality functioning deficiencies have been documented among parents of disabled children. Singhi et al. (1990) discovered that mothers with impaired children had considerably higher neuroticism scores. An increasing number of studies on children with disabilities show that parenting, marital relationship quality, parental personality, and overall family functioning are all linked to child outcomes (Rutter, 1988; Powers et al., 1989). Personality traits have a tendency to affect the caregiver situation in various ways. For example, physical symptoms and caregiver stress, have been linked to neuroticism, extraversion, and conscientiousness (Koermer & Kenyon, 2007). Personality characteristics also affect the caregivers' quality of life. Lockenhoff et al. (2011) found that caregivers' health was influenced by relationship strain and personality characteristics.

Therefore, Hypothesis 12 “mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of mild intellectually disabled children” is partially accepted.

Hypothesis 13: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., self-awareness, self-regulation, motivation, social awareness, social skills) than the mothers of mild intellectually disabled children.

Table 5 .20: *Mean, SD and t-value among Mothers of Mild Hearing-Impaired Children and Mild Intellectually Disabled Children on Emotional Intelligence (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Self-awareness	Mild hearing impaired	60	52.68	3.37	.44	5.93	11.31	118	.000
	Mild Intellectually Disabled	60	46.75	2.27	.29				
Self-regulation	Mild hearing impaired	60	53.50	2.29	.30	2.72	7.31	118	.000
	Mild Intellectually Disabled	60	50.78	1.75	.23				
Motivation	Mild hearing impaired	60	53.62	2.03	.26	2.52	7.63	118	.000
	Mild Intellectually Disabled	60	51.10	1.55	.20				
Social awareness	Mild hearing impaired	60	53.82	1.50	.19	1.93	6.76	118	.000
	Mild Intellectually Disabled	60	51.88	1.63	.21				
Social skills	Mild hearing impaired	60	52.28	2.51	.32	1.02	2.63	118	.010
	Mild Intellectually Disabled	60	51.27	1.63	.21				
Total emotional intelligence	Mild hearing impaired	60	265.90	7.88	1.02	14.12	11.93	118	.000
	Mild Intellectually Disabled	60	251.80	4.68	.60				

Significant difference: P< 0.001

From Table 5.20, it can be observed that the t-value for the self-awareness dimension of emotional intelligence is 11.31; for self-regulation, the t-value is 7.31; for

motivation, the t- value is 7.63; for social awareness, the t-value is 6.76; and for self-social skill, the t-value is 2.63, and for total emotional intelligence, the t-value is 11.93 which are significant ($p < 0.001$).

Emotional intelligence is a vital part of having a healthy lifestyle unless they have significant developmental issues; the majority of the population has normal emotional intelligence. However, when people are disturbed and there is a lack of support, they could lose the way of paving and could suffer from psychological equilibrium and have difficulty in expressing their emotions. These disturbances have an impact on people's emotional and cognitive abilities and can also have an impact on related aspects of emotional intelligence like interpersonal relationships and social intelligence. Parents can become distressed as a result of their social intelligence and interpersonal relationships with their family members suffer and it has a negative impact on their child's development. Parenting has a significant influence on a child's growth. Mothers of mild hearing impaired children scored high in emotional intelligence than mothers of mild intellectually disabled children because intellectually disabled children require more involvement as their behaviors are more challenging and overwhelming which in turn affects mothers of intellectually disabled children's and they show emotional demandingness, a wide range of negative emotional reactions, which sometimes become difficult to manage and cope with such kind of situations (Bromley & Emerson, 1995; Hastings, 1995; Hatton et al.,19 95).

Therefore, Hypothesis 13 "mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation,

motivation, social awareness, social skills) than the mothers of mild intellectually disabled children" is accepted.

Hypothesis 14: Mothers of moderate hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Table 5.21: *Mean SD and t-value among Mothers of Moderate Hearing-Impaired Children and Moderate Intellectually Disabled Children on Quality of Life (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Physical	Moderate hearing impaired	60	41.47	6.48	.84	28.70	26.37	118	.000
	Moderate Intellectually Disabled	60	12.77	5.39	.70				
Psychological	Moderate hearing impaired	60	36.98	8.13	1.05	27.33	20.17	118	.000
	Moderate intellectually Disabled	60	9.65	6.64	.86				
Social relationship	Moderate hearing impaired	60	44.23	11.47	1.48	27.18	13.07	118	.000
	Moderate Intellectually Disabled	60	17.05	11.32	1.46				
Environment	Moderate hearing impaired	60	51.35	7.29	.94	26.73	19.94	118	.000
	Moderate Intellectually Disabled	60	24.62	7.39	.96				
Overall_ WHOQOL	Moderate hearing impaired	60	174.03	16.82	2.17	109.95	34.59	118	.000
	Moderate Intellectually Disabled	60	64.08	17.98	2.32				

Significant difference: P< 0.001

From Table 5.21, it can be observed that the t-value for the physical health dimension of quality of life is 26.37; for psychological health, the t-value is 20.17; for social relationships, the t- value is 13.07; for the environment, the t-value is 19.94; and for overall quality of life, the t-value is 34.59 which are significant ($p < 0.001$).

Parents who take care of disabled children for the long term may distress and burden the whole family members as result the quality of life get affected. Especially mothers who take care and spend most of the time taking care of the disabled child and are unable to engage in others activities need to curtail their social life and it negatively affects their quality of life (Cooper, 1991; Ellis, Upton & Thompson, 2000; Elmstahl et al.,1996). In the present study, it could be observed that mothers of moderate intellectually disabled scored less in quality of life than mothers of moderate hearing-impaired children because mothers might spend most of their time taking care of their disabled child, especially if the child has severe disabilities. It was also found in the previous research that the more rigorous the care or level of assistance given to the disabled child, the lower the quality of life of the caregiver (Unalan et al., 2001). Disability causes a lot of stress, especially for mothers of disabled children, which does have a physical, psychological, and social impact on normal functioning and quality of life (QoL). Mothers with hearing impairments (HI) and intellectual disabilities (ID) children are likewise affected.

Therefore, Hypothesis 14 “mothers of moderate hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children” is accepted.

Hypothesis 15: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, and friends) as compared to the mothers of moderate hearing-impaired children.

Table 5.22: *Mean, SD and t-value among Mothers of Moderate Hearing-Impaired Children and Moderate Intellectually Disabled Children on Social Support (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Social support others	Moderate hearing impaired	60	1.57	.43	.06	2.98	42.03	118	.000
	Moderate Intellectually Disabled	60	4.55	.34	.04				
Social support family	Moderate hearing impaired	60	1.53	.42	.06	3.063	42.72	118	.000
	Moderate Intellectually Disabled	60	4.59	.36	.05				
Social support friends	Moderate hearing impaired	60	1.55	.38	.05	2.57	38.65	118	.000
	Moderate Intellectually Disabled	60	4.13	.35	.05				
Overall _Social support	Moderate hearing impaired	60	1.55	.38	.05	2.87	51.95	118	.000
	Moderate Intellectually Disabled	60	4.42	.20	.03				

Significant difference: P< 0.001

From Table 5.22, it can be observed that the t-value for the social support others dimension of social support is 42.03; for social support family, the t-value is 42.72; for social support friends, the t- value is 38.65; and for overall social support, the t-value is 51.95 which are significant (p <0.001).

Social support has a positive effect on stress and overall quality of life in families of children with disabilities (Lederberg, 2002). Mothers and families of disabled children faced many challenges such as school, income, and childcare responsibilities could be overcome through using social networks, support groups, and even social services. The mean score of overall social support among mothers of moderate hearing impaired were lower than the scores of mothers of moderate intellectually disabled children. Parents of exceptional children with hearing impairments or intellectual disabilities, particularly mothers, confront considerable challenges in raising their children. Mothers of intellectually disabled children face more burdens as compared to hearing impaired children because of cognitive deficits. Social support encompasses a wide range of activities beyond emotional support, including direction, social reinforcement, practical assistance with everyday duties, and social stimulation (Dunst, 1994). Social support can come from a spouse, grandparents, other family members, other parents, friends, and professional agencies, among other sources. Mothers often seek support from other family members first, as informal sources of support are seen to be more effective than official sources at relieving stress (Boyd, 2002). According to a study conducted by Bodla and Saima (2012), parents who have children with mental impairment require enormous social support from their family members.

Therefore, Hypothesis 15 “mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of moderate hearing-impaired children” is accepted.

Hypothesis 16: Mothers of moderate hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Table 5.23 *Mean, SD and t-value among Mothers of Moderate Hearing-Impaired Children and Moderate Intellectually Disabled Children on different Dimensions of Personality (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Extraversion	Moderate hearing impaired	60	39.73	3.58	.46	-.17	-.28	118	.782
	Moderate Intellectually Disabled	60	39.90	2.99	.39				
Agreeableness	Moderate hearing impaired	60	38.08	3.17	.41	4.97	8.06	118	.000
	Moderate Intellectually Disabled	60	33.12	3.56	.46				
Conscientiousness	Moderate hearing impaired	60	39.15	2.85	.37	2.42	4.41	118	.000
	Moderate Intellectually Disabled	60	36.73	3.14	.41				
Negative emotion	Moderate hearing impaired	60	39.97	2.69	.35	-3.55	-6.49	118	.000
	Moderate Intellectually Disabled	60	43.52	3.26	.42				
Open mindedness	Moderate hearing impaired	60	41.17	2.78	.36	1.90	3.36	118	.001
	Moderate Intellectually Disabled	60	39.27	3.38	.44				

Significant difference: P< 0.001

From Table 5.23, it can be observed that the t-value for the agreeableness dimension of personality is 8.06, conscientiousness, the t- value is 4.41; for negative emotion, the t-value is -6.49; and for open-mindedness, the t-value is 3.36 which are significant ($p < 0.001$). However, the t-value for the extraversion dimension of personality is -.28, which is not significant.

Personality traits have also been found as strong factors that potentially explain individual differences in how parents deal with chronic stress when caring for impaired children (Tifferet et al., 2010; Boll et al., 1978; Vermaes et al., 2008). According to another study, in such a critical scenario as when the child is disabled, the mother's personality is primarily influenced by her responsibilities and function in the family. All mothers do not react to their child's impairment in the same way. It is up to them to determine how they respond to and adapt to challenging life situations. When mothers are overburdened with the needs of a disabled child, income challenges, and other daily responsibilities, it can be extremely stressful (Ganong et al., 2003). Parents experience a huge burden because of some special needs and problems related to child disability. Due to the numerous problems, they experience a high level of stress and their personality also get affected (Bumin et al., 2008). Azim et al. (2018) carried out a study to see the effects of parental personality traits and resilience on the adaptive functioning of intellectually challenged children. The study population consisted of 60 children with intellectual disabilities ($n = 60$) ranging in age from 6 to 14 years ($M = 12.03$; $SD = .66$) and their mothers ($n = 60$). A representative sample was taken from various special education institutions in Rawalpindi and Islamabad. The mothers of these children completed the Ego Resilience Scale (Chishti, 2002) and the Urdu version of the Neo Personality

Inventory-Revised (Chishti, 2002; Nangiana, 2002). The children's adaptive functioning was assessed using the Vineland Adaptive Behavior Scale Interview Edition Survey Form (Sparrow et al., 1984). The result was found that children whose mothers have high Neuroticism personality traits had lower adaptive functioning. Personality traits such as extraversion, openness to experience, conscientiousness, and agreeableness had an impact on the adaptive functioning of their intellectually impaired children. Resilience influenced the association between maternal personality qualities of extraversion and conscientiousness and their children's adaptive performance.

Therefore, hypothesis 16 “mothers of moderate hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children” is partially accepted.

Hypothesis 17: Mothers of moderate hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) emotional intelligence than the mothers of moderate intellectually disabled children.

Table 5.24: *Mean, SD and t-value among Mothers of Moderate Hearing-Impaired Children and Moderate Intellectually Disabled Children on Emotional Intelligence (N=120)*

Variables	Category	N	Mean	SD	SEM	MD	t	df	Sig (2 tailed)
Self-Awareness	Moderate hearing impaired	60	34.68	7.32	.95	13.32	12.95	118	.000
	Moderate Intellectually Disabled	60	21.37	3.15	.41				
Self-Regulation	Moderate hearing impaired	60	31.37	5.11	.66	11.18	13.92	118	.000
	Moderate Intellectually Disabled	60	20.18	3.55	.46				
Motivation	Moderate hearing impaired	60	33.55	3.82	.49	10.30	14.31	118	.000
	Moderate Intellectually Disabled	60	23.25	4.06	.52				
Social awareness	Moderate hearing impaired	60	30.10	4.25	.55	12.40	19.08	118	.000
	Moderate Intellectually Disabled	60	17.70	2.69	.35				
Self-Social Skill	Moderate hearing impaired	60	34.67	3.64	.47	14.98	24.72	118	.010
	Moderate Intellectually Disabled	60	19.68	2.96	.38				
Total-Emotional intelligence	Moderate hearing impaired	60	164.37	13.94	1.80	62.18	29.71	118	.000
	Moderate Intellectually Disabled	60	102.18	8.28	1.07				

Significant difference: P< 0.01

From Table 5.24, it can be observed that the t-value for the self-awareness dimension of emotional intelligence is 12.95; for self-regulation, the t-value is 13.92; for motivation, the t- value is 14.31; for social awareness, the t-value is 19.08; and for self-social skill, the t-value is 24.72, and for total emotional intelligence, the t-value is 29.71 which are significant ($p < 0.001$).

The emotional capacity of parents has an impact on their children's emotional development, underlining the importance of the family environment in the development of children's emotional control. Parents play important role models for their children, and there is a strong link between the two. Parents' emotional intelligence and their children's, both in terms of their ability to control emotions and paying attention to and comprehending their feelings (Morris et al., 2007; Cumberland et al., 2013). According to Omori and Yoshioka (2016) emotional intelligence, shows that effective use of emotional intelligence might help mothers deal more effectively with difficult situations. In table 5.23, the overall emotional intelligence means the score is more among mothers of moderate hearing-impaired children than mothers of moderate intellectually disabled children. With the long-term problems of children with intellectually disabled children and the continuous need for constant care, mothers of these children experience negative emotions. Considering the long-term problems of children and continuously engaging in taking care of children, changes in daily activities can impact the emotional health of mothers (Naeinian et al., 2011).

Therefore, Hypothesis 17 "mothers of moderate hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-

regulation, motivation, social awareness, and social skills) emotional intelligence than the mothers of moderate intellectually disabled children." is accepted.

SECTION V: Regression Analysis

Hypothesis 18: Selected socio- demographic variables would predict quality of life among mothers of intellectually disabled children and mothers of hearing-impaired children**.**

Table 5.25: *Model Summary (Quality of life among Mothers of Intellectually Disabled Children)*

Model	R	R Square	Adjusted R square	Std. Error of the estimate	Df1	Df2	F	P
1	.420	.18	.101	74.084	10	109	2.334	.016*

Table 5.26 *Linear Regression Analysis (Quality of life among Mothers of Intellectually Disabled Children; N=120)*

Model	***Unstandardized coefficients***		***Standardized coefficients***	*t*	*Sig.*
	B	*Std. error*	*Beta*		
Constant	287.345	58.574		4.752	.000
Age child	8.058	15.810	.049	.510	.611
Gender	-9.191	14.341	-0.59	-.641	.523
Behavioural problem	-9.137	4.918	-.170	-1.858	.066
Duration	-7.725	6.250	-.122	-1.236	.219
Age of mothers	-33.914	12.396	-.252	-2.736	.007**
Education qualification of mothers	.950	7.828	.011	.121	.904
Occupation	-2.788	9.512	-.029	-.293	.770.
Income	13.357	13.176	.092	1.014	.313

Religion	-20.253	13.029	-.137	-1.554	.123
Family type	-25.673	17.896	-.132	-1.435	.154

Table 5.27: *Model Summary (Quality of life among Mothers of Hearing-Impaired Children)*

Model	R	R Square	Adjusted R square	Std. Error of the estimate	Df1	Df2	F	P
1	.526	.28	.211	57.878	10	109	4.177	.000**

Table 5.28: *Linear Regression Analysis (Quality of life among Mothers of Hearing-Impaired Children; N=120)*

Model	Unstandardized coefficients		Standardized coefficients	t	Sig.
	B	Std. error	Beta		
Constant	425.991	44.840		9.500	.000
Age child	-32.848	11.138	-.251	-2.949	.004**
Gender	-30.978	11.158	-.237	-2.776	.006**
Behavioural problem	-9.183	4.124	-.187	-2.227	.028*
Duration	-7.152	4.573	-.136	-1.564	.121
Age of mothers	8.677	7.935	.093	1.094	.277
Education qualification of mothers	-5.555	8.050	-.065	-.690	.492
Occupation	11.036	6.516	.146	1.694	.093
Income	-12.333	11.535	-.101	-1.069	.287
Religion	-3.864	9.996	-.032	-.387	.700
Family type	-49.153	15.107	-.288	-3.254	.002**

The above Tables (5.25, 5.26, 5.27, 5.28) showed the results of separate multivariate analysis of the socio-demographic variables of the study viz. age of the

children, gender, behavioral problem, duration, age of mothers, education qualification of mothers, occupation, income, family type, religion, predicts the quality of life among mothers of intellectually disabled and hearing-impaired children. Table 5.25 shows that the independent variables of the study together predict 18% of the variance in quality of life can be accounted for by the ten predictors, collectively (F=2.334) which found to be significant at 0.05 level. Table 5.26 reveals that individually only one variable viz. age of the mothers predicts quality of life.

The independent variables of the study are the age of the child, gender, behavioral problem, family type of mothers of hearing-impaired children, as shown in Tables 5.28. Table 5.27 shows that the independent variables of the study together predict 28% of the variance in quality of life which is found to be significant at 0.001 level (F=4.177). Table 5.27 reveals that individually only four variables viz. age of the child, gender of the child, behavioral problem and family type predict the quality of life.

The analyzes showed the contribution of family and child characteristics on overall quality of life. Understanding quality of life and the socio-demographic factors associated can help to design better policies and the way of better programmes to support the mothers of intellectually disabled and hearing-impaired children. Mothers of intellectually disabled children accounted for 18% variability in overall quality of life. Mothers of hearing-impaired children accounted for 28% of the variance in overall quality of life.

From the socio-demographic variables, the age of mothers individually predicts quality of life among mothers of intellectually disabled. The needs of disabled children

change over time and it is crucial to look at the long-term effects of raising a disabled child. Age differences in the stress of parenting disabled children may affect the quality of life of mothers. According to the adaptation paradigm (Folkman 1984), the longer time an individual spends with a source of stress, the better he or she adapts to the challenge. As they gain abilities to better respond to their family's circumstances, parents adjust to the stress of their child's impairment over time. The cumulative stress model, on the other hand, claims that the wear and tear of caregiving stress accumulate over time and that people who have been exposed to chronic stressors for a longer period of time are more vulnerable than people who have been exposed for a shorter period of time (Hoyert & Seltzer 1992; Townsend et al. 1989). As a result, according to this model, the stress of parenting a disabled child would be amplified as the child grew older. Non-caregivers, on the other hand, show a generally positive relationship between age and affective well-being, according to the study. For example, researchers have found that older persons have higher levels of positive well-being and lower levels of negative affect (Carstensen & Charles, 1998; Mroczek & Kolarz, 1998). Furthermore, several dimensions of psychological well-being are rated higher by older adults than by younger adults (Ryff & Keyes 1995). Although other studies have found a curvilinear relationship between age and depression, with levels of depressive symptoms lowest in midlife and highest among younger and older adults, Lawton et al. (1993) revealed that elderly persons have lower levels of sadness and anxiety than younger adults. (Drentea, 2005; Mirowsky & Ross 1992). In conclusion, while the data on age variations in caregiving stress and quality of life is ambiguous, a large body of evidence suggests that psychological distress in the general population decreases with age. The approach of the present study is to see if the quality of life and parenting of a disabled child have an effect on the age of mothers. The

age factor of mothers could indicate a pattern of adaptability among both categories of impaired children.

Various factors predict the quality of life among mothers of hearing-impaired children. From the above Table, 5.28, the age of the child is a factor that predicts quality of life. Lederberg (2002) found that age plays a significant influence in their research. Mothers' experience more problems as their children grow older, which causes them to become more worried and their quality of life gets affected. Age of the child of hearing-impaired children may affect the quality of life of children and mothers, although support from family and other members could help them to cope up with the situation (Looi et al., 2016). Quality of life among mothers of hearing-impaired children also depends on the family how they respond to stressful events and problems, children's behaviors, parental and child age, levels of social support, economic resources, and parent-child relationships (Mazaheri & Sadeghi, 2005).

In Indian culture, the mother is entirely responsible for her children's upbringing, therefore having a child with a disability or chronic illness, has an influence on their social life. The quality of life is predicted by family type, as shown in Table 5.28. The type of family, such as nuclear or joint, has an impact on one's quality of life. When compared to joint family families or three-generation families were grandmothers and aunts are significantly contributing to the caregiving of the child, nuclear families with children with disabilities have placed a greater burden on caregivers because there was no one to help in sharing the caregiving. The quality of life of mothers of hearing-impaired children is determined by the type of family they belong (Shanbhag & Arasu, 2021).

Hypothesis 19: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of intellectually disabled children.

Table 5.29: *Prediction of Quality of Life by Personality, Social Support and Emotional Intelligence among Mothers of Intellectually Disabled Children (N=120)*

	Model I			*Model II*			*Model III*		
	SB	SE B	t	SB	SE B	t	SB	SE B	t
Personality(I)									
Extraversion	.957	1.02	4.19***	.260	.576	2.02*	.084	.453	.827
Agreeableness	.140	1.19	0.45	-.337	.639	-2.05*	-.141	.515	-1.06
Conscientiousness	1.39	1.12	5.01***	.484	.632	3.09***	.140	.512	1.10
Negative emotion	-1.82	.610	-11.98***	-.329	.474	-2.77***	-.210	-.376	-2.24*
Open-mindedness	.208	1.25	.658	.055	.659	.329	-.004	.519	-.029
Social Support (II)									
Family				.224	7.702	1.29	.085	6.01	.623
Friends				.722	7.55	4.25***	.020	6.78	.132
Support from others				-.108	6.56	-.715	-.065	5.12	-.547
Emotional intelligence (III)									
Self-awareness							.177	.539	1.45
Self-regulation							.029	.604	.197
Motivation							.296	.508	2.35*
Empathy							.556	.561	2.04
Social skills							.003	.704	.019
R	.967			.991			.995		
R^2	.935			.983			.990		
Adjusted R^2	.932			.981			.989		
R^2 change	.935			.048			.008		
F	328.98***			103.35***			16.43***		

*P< .05; ** P<.01, ***P < .001

A hierarchical regression analysis was carried out to identify the predictors of quality of life by personality, social support and emotional intelligence among mothers of intellectually disabled children. The results of the analysis are shown in Table 5.29. In the first model (Model 1) different dimension of personalities such as extraversion,

agreeableness, conscientiousness, negative emotion and open-mindedness was included, where R2 was found to be 93.5% and the variables contributed significantly to the model (F= 328.98, p< 0.001 level). Dimension of personalities such as extraversion, conscientiousness and negative emotion significantly contributed to the quality of life at (.001). In Model 2, the overall model remained significant (F=103.35, p< 0.001 level) with the additional dimensions of social support. However, social support from friends significantly contributed to the overall model (p<.001), explaining an additional variance of 4.8% (R^2 change=.048). While adding the variables of social support in model 2, agreeableness was found to significantly contribute to the quality of life, besides, to the contributors of Model 1. In Model 3, emotional intelligence consisting of five dimensions (self-awareness, self-regulation, motivation, social awareness, social skills) explained a total of .8 % (R2 change=.008) of variance. Dimension motivation significantly contributed to the quality of life at (.05 levels) respectively.

Quality of life depends on the interaction of different factors like personality, social support, and emotional intelligence. The quality of one's life is the result of a complicated interaction between internal and external factors. Personality is a key factor in determining life satisfaction (Larsen & Buss, 2005). Personality is described as a person's distinct pattern of behavior. When it comes to reacting to changes in the external and internal environment, there are significant interindividual variances (Costa & McCrae, 1976). Several research studies explored the prediction of personality traits on quality of life (Aastad et al., 2003; Straten et al., 2006). The above table highlighted that extraversion significantly contributed to the quality of life. Prior studies have shown the association between extraversion to higher levels of self-confidence, positive thoughts, all

of these factors contributed to a higher quality of life (Strobell et al., 2011). It was revealed that the extraversion personality factor predicts quality of life among moms of intellectually challenged children.it could be argued that because mothers are emotionally stable to some extend by experiencing new and challenging situations through participation and coping up with the new circumstances in order to maintain quality of life. Extraversion, which could be regarded as a pleasant emotion is characterized by a flexible nature that permits an individual to adjust to current environments readily, thereby preventing possible dissatisfaction (Olawa & Erhabar, 2019).

In addition, the results of this study have indicated that other personality traits, conscientiousness significantly predicted quality of life. Conscientious individuals are motivated to accomplish major goals; appear to overcome unanticipated barriers more easily in life. These people are more likely to seek out life situations that will improve their quality of life, such as by setting greater goals, a higher degree of motivation and ambitions (DeNeve & Cooper,1998). Mothers of intellectually disabled children with conscientiousness are more concerned and could control their actions and thoughts. Conscientiousness individuals used to be competence, orderliness, dutifulness, achievement striving, self-discipline, and deliberation (Roberts et al., 2005; McCrae & Löckenhoff, 2010) and expect the use of effective behavioural engagement strategies such as problem-solving and cognitive restructuring that may influence them to have a better quality of life (Augustine et al., 2010).

Regarding negative emotions, the finding has portrayed significant predictability for quality of life among mothers of intellectually disabled children. One possible explanation could be that among the mothers of intellectually disabled children quality of

life was negatively predicted by negative emotion. Since, they have poor emotion regulation and low self-efficacy, which may lead them to believe that life problems are beyond their control and thus unmanageable and that their efforts will not be enough to solve them. The findings, which are consistent with previous research (Matthews & Zeidner 2004; Pocnet et al., 2016), suggest that negative emotions individuals may underestimate their personal skills or resources, as evidenced by poor self-efficacy, and that emotion regulation appears to channel this effect on the quality of life. Therefore, it could be inferred that personality traits are an important predictor of quality of life among mothers of intellectually disabled children.

Model 2 reported the significant influence of social support on quality of life. Social support from friends significantly and positively predicts quality of life. This result in support of the previous studies shows that social support from friends was significantly correlated with quality of life (Sharir, 2007). A study conducted by Tsai and Wang (2009) found that mothers' health, social support, and amount of time spent as a caregiver with intellectually impaired children depend on the degree of daily living activity. In contrast to the previous studies, it has been observed that due to lack of social support by the caregiver of disabled children suffer from social and psychological issues (Killian et al., 2001; Moti et al., 2005). It could be observed that children with special needs and their parents have to face negative attitudes regarding their disability (Law et al., 2014). One could develop positive interaction with one’s surroundings and environment and could easily cope with psychological ailments (Alptekin et al., 2005). Family support, peer support is positively associated with psychological functioning and active physical participation. Previous studies revealed that social support and social acceptance improve

quality of life and enhance his/her willpower (Moran et al., 2011). Mothers of intellectually disabled children continuously go through stressful situations and they tend to have more psychological and moral support from friends so as to have a better quality of life (Hale et al., 2005).

Model 3 highlighted the significant impact of emotional intelligence on quality of life. Motivation significantly and positively predicts the quality of life among mothers of intellectually disabled children.

Other findings of the study showed the prediction in motivation dimension of emotional intelligence and quality of life among mothers of intellectually disabled children. These findings are in line with the research study conducted by Animasahun (2008). It is believed that people who have higher motivation have a better quality of life (Animasahun, 2008).

In the previous review of literature, it was found that emotional intelligence is one of the most significant personal resources. Emotional intelligence is defined as the ability for dealing out emotional information as well as information concerning recognize, constructing and regulating emotions, expressing emotions in oneself and to others, and managing emotions for emotional growth (Extremera & Fernández, 2006). In the above result motivation, the dimension of emotional intelligence predicts quality of life among mothers of intellectually disabled children. Motivation is the ability to have control over individual's self-efficacy, behavior and social environment (Amirian & Behshad, 2016). It was found in the previous study that increasing the level of emotional intelligence will improve the quality of life through the stress reduction process and emotional

management (Slakshi & Cartwright, 2002). Psychoeducational intervention programs should be planned by concentrating on special elements of emotional intelligence like self-awareness, self-regulation, motivation, social awareness and social skills to improve quality of life among mothers of intellectually disabled children.

Hypothesis 20: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of the hearing-impaired children.

Table 5.30: *Prediction of Quality of Life by Personality, Social Support and Emotional Intelligence among Mothers of Hearing-Impaired Children (N=120)*

	Model I			*Model II*			*Model III*		
	SB	SE B	t	SB	SE B	t	SB	SE B	t
Personality									
Extraversion	.81	.90	5.29***	.12	.72	1.01	.037	.703	.308
Agreeableness	.06	.96	.355	.06	.65	.597	.134	.621	1.29
Conscientiousness	.69	.96	4.17***	.22	.68	1.86	.275	.674	2.36*
Negative emotion	-.79	.46	-11.62***	-.39	.39	-6.83	-.256	.429	-4.03**
Open-mindedness	.19	1.05	.29	-.01	.719	-.085	-.069	.684	-.588
Social Support									
Family				.363	4.91	3.30	.210	4.91	1.92
Friends				.556	4.13	6.18***	.353	4.69	3.45***
Support from others				.059	4.19	.653	-.102	4.29	-1.09
Emotional intelligence									
Self-awareness							.094	.381	1.35
Self-regulation							.046	.495	.514
Motivation							.237	.557	2.32*
Empathy							.240	.525	2.56*
Social skills							-.209	.600	-1.92
R		.992			.997			.997	
R^2		.985			.993			.995	
Adjusted R^2		.984			.993			.994	
R^2 change		.985			.009			.001	
F		1471.36***			2121.22***			1509.33***	

*P<.05; **P<.01, P < .001

A hierarchical regression analysis was carried out to identify the predictors of quality of life by personality, social support and emotional intelligence among mothers of hearing-impaired children. The result of the analysis was shown in Table 5.30. In the first model (Model 1) different dimension of personalities such as extraversion, agreeableness, conscientiousness, negative emotion and open-mindedness was included, where R2 was found to be 98.5% and the variables contributed significantly to the model (F= 1471.36 p< 0.001 level). Dimension of personalities such as extraversion, conscientiousness and negative emotion significantly contributed to the quality of life at (.001). In Model 2, the overall model remained significant (F=2121.22, p< 0.001 level) with the additional dimensions of social support. However, social support from family and friends significantly contributed to the overall model (p<.001), explaining an additional variance of 0.9% (R^2 change=.009). While adding the variables of social support in model 2, negative emotion was found to significantly contribute to the quality of life, besides, to the contributors of Model 1. In Model 3, emotional intelligence consisting of five dimensions (self-awareness, self-regulation, motivation, social awareness, social skills) explained a total of .1 % (R2 change=.001) of variance. Dimension motivation and social awareness significantly contributed to the quality of life at (.05 levels) respectively.

The study showed that the personality dimension is significantly linked to the quality of life. Particularly, extraversion, conscientiousness has been positively significant to the quality of life, while negative emotion is negatively significant to the quality of life. Extrovert people are likely to have a conversation and good in verbal information processing which support their sociability and they have the advantage (Matthews & Gilliland, 1999). Furthermore, extraversion, which includes the capacity to experience

good emotions, appears to be particularly linked to positive occurrences with a strong interpersonal component, which may influence how happy people are (Lockenhoff et al., 2009). Conscientious people are well organized, hardworking and efficient which might have to help them to have a better quality of life (Zhang & Tsingan, 2014). On the other hand, negative emotions are negatively significant to the quality of life. Overestimation of risks, underestimating of personal coping and poor forms of emotion-focused coping, such as self-criticism and maladaptive metacognition, which maintain awareness of negative self-beliefs, all contribute to unproductive and persistent concern. As a result, negative emotions influence how stresses are assessed, which has a significant impact on quality of life (Matthews & Zeidner, 2004).

Model 2 reported that social support from family and friends significantly predict the quality of life among mothers of hearing-impaired children. The existence of a hearing-impaired child may have an impact on family life, in terms of family relations, family resources, parenting style and support for the child, (Rose, 1991; Lampropoulou & Konstantareas, 1998). Parents frequently report that communicating and interacting with their hearing-impaired child in the family is tough, irritating, and demanding (Freeman et al., 2002). Social support, regardless of the degree of mother stress, was found to be a key predictor of maternal adjustment. Morton (2000) emphasized the importance of extended family members and their grandparents support both at the time of diagnosis and later on in the development of the hearing-impaired child. Mothers of hearing-impaired children if they get good social support than they can take care in a better way and have positive interactions with them which will help both mother and child to improve their quality of life (Meadow & Steinberg, 1993).

Mothers are concerned about a variety of issues, including the nature of deafness, social issues, and their children's future lives. As a result of the many concerns that mothers of children with hearing loss affect emotional, sentimental, and psychological components. Jackson and Turnbull (2004) reviewed the literature on the consequences of deafness on family quality of life across many domains or categories, including emotional well-being, family interaction, parenting, physical well-being, and special needs support. For mothers of hearing-impaired children, dimensions of emotional intelligence like motivation and social awareness predict the quality of life in Model 3. Motivation is that which pushes one to achieve and fulfil goals and to improve better quality of life. One of the reasons that mothers of children with hearing impaired motivation predict the quality of life is because, some of them are even in distress since the demands placed on these children's caregivers have an impact on the parents' quality of life (Fonseca et al., 2012). Other investigations have shown that hearing challenged children have an impact on their parents' quality of life since they require more time to address their child's requirements, especially if the rate of impairment is severe. When parents are having trouble, they should and self-motivated to engage in other activities and seek out other social activities.

Maintaining meaningful relationships is critical for people with chronic problems and their families to maintain their quality of life. Several aspects of a caregiver's interpersonal and emotional repertoire, such as empathy and emotion control abilities, can enhance or lower both the person suffering from the disorder and the caregiver's quality of life (Longchamp et al., 2015). The social awareness dimension of emotional

intelligence showed predictions with quality of life are in line with results conducted by Ahmadi (2012).

Parents of deaf children are under a lot of pressure dealing with their own children's growing needs, and thus have a lower quality of life than other parents (Quittner et al., 1990). Previous studies demonstrate that to alleviate pressure and enhance the quality of life of parents of children with physical and mental problems is to allow them to attend a training program on how to deal with their children (Sanders et al., 2005).

Section VI Analysis of Qualitative Data (Thematic Analysis)

The qualitative data was meticulously transcribed. Each interview took a long time to transcribe. It necessitated going through the sections of the interview over and again in order to prevent missing any crucial information. Following that, all of the interviews were transcribed, and the data were evaluated using thematic analysis methods.

Table 5.31: *Socio-demographic Profile of the Participants (N=30)*

Demographic Variables	**N=30**	**Percent (%)**
Age of the child (Intellectually disabled and hearing impaired)		
Below 6 years	12	40
Above 6 years	18	60
Gender of the child		
Male	8	26.7
Female	22	73.3

Education of mothers		
Middle school	3	10
High school	4	13.3
Graduate	18	60.0
Professional	5	16.7
Occupation of mothers		
Govt. employee	14	46.7
Business/entrepreneurship	7	23.3
Homemaker	9	30.0

It can be observed from the Table 5.31 that most of the children with intellectually disabled and hearing impaired were above 6 years of age (60%). About 73.3% of the participants were female and 26,7% participants were male. The majority had studies up to Graduate level (60%) and about 46.7% participants were government servants.

Data was analyzed by evaluating using thematic analysis. The interview recordings were transcribed verbatim and coding used to categorize the data. Concepts were analyzed and accordingly grouped into categories and subcategories. Finding of the analysis presented in the below table.

Table 5.32: ***Theme Analysis***

Sl no	Themes	Mothers of intellectually disabled children	Mothers of hearing-impaired children
1	Personal problems faced by parents	Continuously busy, difficultly in managing all the obstacles faced by the child, imbalance in their personal and professional life clashed with household activities.	Partial problems faced while managing their day-to-day activities. Children can manage their functional activities.
2	Social Support	Involvement in social events was condensed, interaction with relatives and neighbours were reduced, parental stress and worries, satisfied with special schools and rehabilitation centres.	Communicating in a society, parental stress and worries, satisfied with special schools and rehabilitation centres.
3	Financial Well-Being	Money played a crucial role in the upbringing of the child, face greater financial	Money played a crucial role in the upbringing of the child, face greater

		problems, government and state should take initiatives	financial problems, government and state should take initiatives
4	Psychological and physical health problems experienced	Negative emotions ranging from mild anger to frustration, tiredness and stress, bodily pain and other health issues	Embarrassment outdoors, environment adaptation which would help them regain their independence in activities without much help, children need constant help outdoors.
5	Fear for the future of the child	Belief in destiny and religion. Quality of life deteriorate because of continuous worries about the future of the child	Belief in destiny and religion. Quality of life deteriorate because of continuous worries about the future of the child

1. Personal problems faced by parents:

Various personal problems were faced by mothers of intellectually and hearing-impaired children while caring for the child. The parents were continuously busy as they have to manage all the obstacles faced by the child. Due to which there is an imbalance in their personal and professional life. Mothers reported that more involvement with the child often clashed with household activities.

The comments made by the mothers of intellectually disabled children were "*Our child keeps us busy all the time. He cannot express his feelings. Therefore, we have to monitor each and every need of the child. This makes me dedicate myself towards my child more than my professional life"* (Participant12).

Mothers of hearing-impaired children reported partial problems faced while managing their day-to-day activities. Children can manage their daily functional activities. For the hearing-impaired children, mothers reported "*partial involvement is required to take care of our children as they could manage to do their day-to-day activities by themselves. This enables us to devote some time to ourselves. But sometimes there are times where we face some difficulties"* (Participant 7).

2. Social support:

One common problem reported by all the mothers of intellectually disabled children was that involvement in social events such as marriage and other family programs was condensed as well as interaction with relatives and neighbours were reduced.

Mothers reported, *"We avoid most of the social place as friends and relatives perpetually raise queries relating to the treatment that results in stress and worries among us."* Mothers also added that *"I still try and take our kid to go to some gathering, outdoor activities to make him socialize, but we need continuous supervision depending upon the situation"* (Mothers with intellectually disabled children 15). Mothers additionally added that "*neighbours, relatives they try to help us by sharing sometimes some information concerning about the treatment".* Communication is one of

the problems reported by the mothers of sensorily disabled children. "*We often have problems when the child wants to communicate because to communicate with the other people we have to translate into their language. Other than that, we feel comfortable in taking out to social events because they understand, obey and are well mannered."*

In some cases, society does not support intellectually and hearing-impaired children. In this regard, one of the participants says*" It was very difficult for me to tolerate others staring at me and my child.* (Participant no. 6: Mothers of hearing-impaired children and participant no. 2: Mothers of intellectually disabled children,). Lack of information gathered by society leads to such behaviors with these children and families. This causes parental stress and worries.

Moreover, the mothers of intellectually disabled and hearing-impaired -children showed satisfaction with the trainees, therapies, special educator and the staff of the special school and the rehabilitation centre:

"We are very satisfied with the therapies and the love, care and support of the teachers and therapist for our child". Mothers added.

They reported that the organization have provided minimal support to the mothers of disabled children. Mothers had the feeling that the institutions should provide family-child intervention programs, family therapy and other psychotherapy for the betterment of their quality of life.

3. Financial wellbeing:

Mothers of both intellectually and hearing-impaired children agreed that money played a crucial role in the upbringing of the child. However, mothers of both groups face greater financial problems as they need to pay for therapies, doctor's consultation, medicine, transport and special school. Mothers pointed out that, in order to match financial requirements for the treatment and care of the child, a compromise had to be made.

One of the mothers commented, "*we may minimize our own daily needs but we don't compromise the requirement that is to be fulfilled for the child*". Another mother said that "*I have a grocery shop, so when I have to get the child to the rehabilitation centre sometimes, I have to keep the shop closed and I have to face a loss, so it does impact some financial instability.*". Finance resource is an essential factor in upbringing the child as well as for running the family. Therefore, financial stability improves the quality of life and wellbeing.

Mothers of both groups argued "*government should not ignore about the financial problems that the low-income families are facing. Many times, it was difficult for us to get the medicines and go for therapies. As everyday income is not sufficient*"

Financial problems would be stabilized only if the government provided some financial assistance. Government and state should take initiatives for the betterment of the disabled child as well as the family. Monitory aid will be useful for providing better medications and therapies for the child.

4. Psychological and physical health problems experienced:

Mothers of intellectually disabled children experience a greater series of negative emotions ranging from mild anger to frustration, tiredness and stress. Along with it bodily pain and other health issues were constantly accompanying them which deteriorated their physical health.

One of the mothers commented "*At times I got so frustrated with his work that I have ended beating up my child. I have to move around with him in every step of his life. This sometimes makes me feel angry and tired. I have also been going through sleeplessness. Due to improper food intake, my health is deteriorating"* (participant no 11).

Another mother has reported "*sometimes I feel to kill myself or feel that it would have been better if I had died. There would be no problems for me. The child is not normally developed which stresses me, increasing my blood pressure and headache*." (Participant no 6). Mothers reported back pain, shoulder pain and leg pain as they have to carry their children. Mothers suffered from general body ache due to excessive caring for the child.

Negative emotions experienced by the mothers of hearing-impaired children were fewer than the other group. Mothers mostly experienced embarrassment outdoors as the child frequently bump into people/objects. However, mothers reported that there was an environmental adaptation that would help them regain their independence in activities without much help.

One of the mothers said "*my child does more or less a lot of his own things at home, which makes me relief and concentrates in household and professional activities.*"

(Participant no. 2). All mothers stated that their children need constant helps outdoors; therefore, the mothers are frequently worried when they are taken out.

5. Fear for the future of the child:

Mothers continuously worry for the child's future. Most mothers of intellectually disabled children expressed that "*Who would take care of the child in our absence"*. *"Looking by the development of the child give us some relief and hope because he has an only visual impairment, but other than that he tries to do day to day activities, sometimes he needs assistance if he comes across some new situation*" mentioned by mothers of hearing-impaired children number 11. But most of the mothers of both intellectually and hearing children try to console their worries by believing in destiny as well as some specific religious beliefs and the comments made by them were "*My child is a gift of God"; "God will take care of her and will give strength to live in this world"*. The continuous worries about the future of the child deteriorate the mothers' quality of life. Mothers expect welfare support from the state after they pass away and they need a sensitized society that warmly accepts their children.

Mothers of both intellectually disabled and hearing-impaired children faced a wide range of psychosocial problems. However, the intensity of the problem is different among both the groups of mothers.

Caring for the children, taking them for assessment, therapy and medical treatment (Ayrault, 2001) distressed the mothers affecting their personal and professional life, hindering the relationship with the relatives, neighbours', friends and other family members. Such complexity in sustaining social relationships was reported in the study

done by Davis et al, 2010. As a result, their quality of life is decreased, which is supported in the present study.

The participants experienced both positive and negative feelings because they get support from near ones and at the same time, they experience several unpleasant questions from neighbours and relatives. The analysis of the data highlighted that both the group of parents undergo a feeling of insecurity for their children's future due to minimal level of knowledge as well as formal support which will be provided by the state. Families' quality of life is also affected by the severity of the child disabilities. Child-rearing with disabilities become challenging also reported in the previous studies (Barlow and Ellard, 2006; Gerhardt et al., 2003; Murphy, Christian, Caplin and Young, 2007). Families try to plan out their daily tasks so as they could manage time to some extent.

Studies have reported that parents of disabled children face greater financial trouble as they need to pay for health care services (Yau & Li-Tsanf, 1999). Parents have to take into consideration their children's needs above their own (Yau & Li-Tsanf, 2001). Thus, the psychological quality of life among the parents is lowered.

In the group of parents with intellectually disabled children, children's functional dependency was found to be associated with physical and psychological health domains. These results are consistent with the previous studies (Glasscock, 1997). Mothers experience severe physical exhaustion as they suffered from various bodily aches, assisting their children in daily chores. Mothers also experienced a higher level of psychological problems such as sleep disturbance, anxiety, stress, frustration and no free time (Johnson, 2000; Dardas & Ahmad, 2014).

One common problem highlighted by almost all the participants' emphasis on the future of the child and is also supported by a previous study conducted by Heaman (1995). Mothers want a society that expects their child inclusion in society. Moreover, mothers expect children to be independent enough to take care of him or themselves and expect some formal support from the state.

CHAPTER VI

SUMMARY, CONCLUSION AND RECOMMENDATION

FOR FURTHER RESEARCH

Mothers with disabled children experience physical and psychological distress, which has a substantial impact on life quality. Families that have a disabled child think they are burdened with difficulties. Parenting a child with a disability of any kind is a challenging task that can result in a lot of stress, unpleasant feelings, dissatisfaction, anxiety, financial difficulties, and personality issues.

Mothers used to be at risk, both physically and emotionally, and their quality of life suffered as a result. Children with disabilities require caregiver assistance because they have limitations in one or more daily functions; these limitations necessitate extra attention, and as a result, parents of disabled children face a variety of issues that negatively impact their physical health, wellbeing, and social lives.

The presence of a disabled child might put a family's finances in jeopardy by raising the family's consumption needs while diminishing its producing capability. When a child suffers from a chronic illness or impairment, parenting becomes more difficult. Psychosocial issues are unfavourable emotional reactions experienced by parents of children with vision impairment as a result of poor information and knowledge available to caregivers about the child's potential. There is a significant need for knowledge on present and future services accessible in society and community, as well as basic expenses, teaching methodologies, counselling, and daycare services.

Many studies have been conducted in developed countries to better understand the interaction between parents and their children, as well as the psychological issues that parents with impaired children face. Few studies have been conducted in India to better understand and address the psychological issues that parents of differently-abled children face. Furthermore, Assam is a state in India's north-eastern region. According to the 2011 Indian census, the following forms of disability are the most common: Sensorily challenged people number 80553, hearing-impaired people number 101577), and cognitively handicapped people number 26374. Family members expect to be treated with respect, for Non-Governmental Organizations to step up and give vocational training, for the government to provide financial aid, and for emotional support through therapy.

Justification of the Study

· Children with exceptional needs such as hearing loss, intellectually disabled or physical-motor disability, have unique challenges that can adversely impact their parents' quality of life, physical and mental health.

· Family has been given the pivotal role of care; parents are getting minimal support from the professionals. The maximum impact of a child’s disability is borne by the parents. There are very few studies done on parental problems in developing countries that investigated in India the psychosocial problems faced by mothers and other members of the family with physically and mentally disabled children.

· According to the Census 2011, Assam has a total of 480065disabled people where 80553 seeing, 101577 hearing, 39750speech, 76007movements, 26374mental retardations, 18819mental illness,87461 any other category, and 49524 were multiple

disabilities. Keeping in view this problem in mind, the researcher focused to give a theoretical measurement to understand the psychosocial predictors of quality of life, personality, social support, and emotional intelligence among parents of intellectually disabled and hearing-impaired children.

· Previous research has shown that mothers of disabled children perceived greater financial problems, disturbance in family routines and programs, poor social interactions, and marital adjustment, and showed higher neurotic reactions.

· Very few studies have examined the psycho-social factors such as social support, personality, emotional intelligence and quality of life among mothers of intellectually and hearing-impaired children.

· Psycho-social predictors are very much important for determining the quality of life among mothers of intellectual and hearing-impaired children; a better understanding of the relationship between these factors will support optimal health for this population. This study represents an effort to report this void in the literature. Recognition of factors in relation to the quality of life would help to improve the conditions of mothers and families as well of this group. Furthermore, it would be useful for having a general view of the relationship between variables of this research. This study would provide an insight for a better understanding of factors, which have an influence on the quality of life among mothers.

· This research would help in guiding future intervention strategies dedicated to creating quality of life among parents of intellectual disabled and hearing-impaired children.

Objectives

Objective 1: To find out the relationship between different dimensions of personality, social support, emotional intelligence, and quality of life among mothers of intellectually and hearing-impaired children.

Objective 2: To make a comparison on different dimensions of personality, social support, emotional intelligence, and quality of life among mothers of intellectually disabled and hearing-impaired children.

Objective 3: To determine the significant predictor of selected demographic variables on the quality of life among mothers of intellectually and hearing-impaired children.

Objective 4: To determine the significant predictors of different dimensions of personality, social support and emotional intelligence on quality of life among mothers of intellectually and hearing-impaired children independently and conjointly.

Objective 5: To explore various issues and challenges faced by mothers of intellectually disabled and hearing-impaired children.

Hypotheses

Hypothesis 1: A significant relationship would exist between quality of life (physical, psychological, social relationship and environment), personality (extraversion, agreeableness, conscientiousness, negative emotion, open-mindedness) social support (from others, family, friends), emotional intelligence (self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of intellectually disabled and hearing-impaired children.

Hypothesis 2: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate hearing-impaired children.

Hypothesis 3: Mothers of mild hearing-impaired children will score high on all the dimensions of social support (i.e., others, family, friends) compared to the mothers of moderate hearing-impaired children

Hypothesis 4: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to the mothers of moderate hearing-impaired children

Hypothesis 5: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) than the mothers of moderate hearing-impaired children.

Hypothesis 6: Mothers of mild intellectually disabled children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Hypothesis 7: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild intellectually

Hypothesis 8: Mothers of mild intellectually disabled children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Hypothesis 9: Mothers of mild intellectually disabled children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) than the mothers of moderate intellectually disabled children.

Hypothesis 10: Mothers of mild hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of mild intellectually disabled children.

Hypothesis 11: Mothers of mild intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild hearing-impaired children.

Hypothesis 12: Mothers of mild hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of mild intellectually disabled children.

Hypothesis 13: Mothers of mild hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) emotional intelligence than the mothers of mild intellectually disabled children.

Hypothesis 14: Mothers of moderate hearing-impaired children will score high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.

Hypothesis 15: Mothers of moderate intellectually disabled children will score high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of moderate hearing-impaired children.

Hypothesis 16: Mothers of moderate hearing-impaired children will score high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.

Hypothesis 17: Mothers of moderate hearing-impaired children will score high on all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) emotional intelligence than the mothers of moderate intellectually disabled children.

Hypothesis 18: Selected socio-demographic variables would predict the quality of life among mothers of intellectually disabled children and mothers of hearing-impaired children.

Hypothesis 19: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of intellectually disabled children.

Hypothesis 20: The hierarchical model would predict the quality of life by dimensions of personality, social support and emotional intelligence among mothers of hearing impaired.

Method

Representativeness of the sample, inclusion/exclusion criteria, tools and statistical investigations are exhibited as follows

Sample

The total number of samples was 240 participants out of which 120 participants consisted of mothers of intellectually disabled children, and 120 participants were mothers of hearing-impaired children. Samples were collected from various non-government organizations/rehabilitation centres/schools of Kamrup Metro, Assam who deal with children with intellectually disabled and hearing-impaired children. A purposive sampling technique was used for the collection of data.

Participant Inclusion Criteria (Intellectually Disabled and Hearing-Impaired Children)

- The study sample limited to the state of Assam
- Age group of the child is 5 to 15 years
- Mothers of healthy control
- Mothers living with the child
- Intellectually disabled (IQ level between 50 to 70)
- Intellectual disability diagnosed by qualified clinical psychologist
- Hearing-impaired diagnosed by specialized doctors

- Hearing-impaired should have a total loss of sixty decibels or more in the better ear in the conventional range of frequencies child who has completed minimum one week of indoor treatment
- Population of urban area, Assam
- Children belonging to all the communities or social categories
- Mothers able to read and write
- Mothers who would co-operate and comprehend the test/instruments properly
- Mothers who are staying with their husband, and child/children
- Mothers who gave consent to participate in the study

Participant Exclusion Criteria (Intellectually Disabled and Hearing-impaired Children)

- Mothers having a history of chronic life-threatening illness
- Mothers having any major psychiatric illness
- Those who are not willing to participate
- Children with major psychological problems

Ethical Consideration

- Purpose of collection of data, permission taken from Ethical Committee of Sikkim University.
- Consent was taken from the participants.
- Confidentiality was maintained.
- Exclusion of subject's individual information in data files.

Tools used

Keeping in view the objectives of the present study, the selected sample was assessed using the following tests:

1. Socio-demographic and Clinical Data Sheet: It is a semi-structured proforma. It contains information about socio-demographic variables like age, sex, education, religion, marital status, occupation, etc. and clinical details like the age of onset, other illnesses.

2. The World Health Organization Quality of Life –BREF (WHOQOL-BREF): The World Health Organization Quality of Life –BREF was developed by the World Health Organization group (1995). It produces a quality-of-life profile and contains a total of 26 questions. It is a self-report questionnaire that assesses four domains of quality of life and they are physical health, psychological health, social relationships and environment. WHOQOL-BREF domain scores demonstrated good content validity, discriminant validity and internal consistency for domains were 0.80 for physical health, 0.76 for psychological, 0.66 for social relationships and 0.80 for the environment. The test-retest reliabilities for domains were 0.66 for physical health, 0.72 for psychological health, 0.76 for social relationships and 0.87 for the environment.

3. Multidimensional Scale of Perceived Social Support: It was developed by Zimet et al. (1988). It is a 12-item scale and divides perceived social support from family members, friends, and significant others. Norms for the general 15 population have been published with higher scores indicating more social support. Its internal consistency reliability is 0.88.

4. Big Five Inventory -2: The Big Five Inventory–2 (Soto & John,2017) is a 60-item questionnaire that assesses the Big Five domains and 15 facets of personality structure: extraversion, agreeableness, conscientiousness, negative emotion and open-mindedness. The reliabilities of the BFI-2 scales typically range from .75 to .90 and average above .80.

5. Emotional Intelligence Scale: Shailendra Singh created and validated the Emotional Intelligence Scale (EIS) (2004). This scale had 60 statements, all of which were positive. The 60 assertions were categorized into five categories: self-awareness, self-control, motivation, social awareness, and social skills. Construct validity exists for the scale. The inherent validity of the test-retest technique is 0.90, and the reliability of the approach is 0.81.

Procedure for Collection of Data

Phase I Quantitative Method

Permission was taken from the Head/Directors of various non-government organizations/rehabilitation centres/schools meant for intellectually disabled and hearing-impaired children of Guwahati, Assam. Within a Rehabilitation centre/school, the data was collected from the mothers of intellectually disabled and hearing-impaired children. The date and time of the data collection purely was depending on the convenience of the participants. Once the appointment is confirmed, the researcher visited non-government organizations/rehabilitation centres, or other venues decided upon. Informed consent for participation was taken from the participants. The researcher developed an initial rapport with the participants and it was assured of the confidentiality of their responses. The

questionnaires were administered and asked one by one to the participants. The respondents were asked to clarify any doubt without hesitation.

Phase II Qualitative Method

Interviews were conducted in a semi-structured way and explored the issues and problems of the mothers of intellectually disabled and hearing-impaired children. The interview was conducted one to one according to the mothers' convenient time. They were informed that information will remain confidential. The total number of participants was 30, 15 from mothers of intellectually disabled children and 15 from mothers of hearing-impaired children. The interviews were recorded. The results of the quantitative data have been integrated into the discussion of the qualitative data.

Statistical Techniques used

Keeping in view the objectives and hypothesis, different statistical techniques were used for analyzing the data. The quantization data was analyzed using SPSS version 23. For the descriptive statistics techniques like mean, SD, the frequency was used. For the inferential statistics techniques like correlation, t-test and regression were used to measure the significant relationship, significant differences and significant prediction among the variables and groups. Qualitative data were analyzed separately by using thematic analysis.

Major Findings

- Age of intellectually disabled children between 5-10 years is 67.5 % and between 11-15 years is 32.5%
- Age of hearing-impaired children between 5-10 years was 55.8 % and between 11-15 years was 44.2 %
- Gender of intellectually disabled boys was 50.8 % and girls was 49.2%.
- As far as the behavioral problems of intellectually disabled children are concerned, 22.5 % were hyperactive, 11.7 % were stubborn, 14.2 % were showing tantrums and 47.5 % had other behavioral problems.
- As far as the behavioral problems of hearing-impaired children are concerned, 6.7 % were hyperactive, 5.8% were stubborn, 70% with no behavioral problems, 10.8 % were tantrums and 6.7 % had other behavioral problems.
- 30.8% of intellectually disabled children availed service from the rehabilitation centre for up to 3 years duration.
- Duration of service availed from the rehabilitation centre by intellectually disabled and hearing impaired, it can be observed that intellectually disabled children for >5 years 10.8%, 4 years 20%, 3 years 30.8 %, 2 years 20.8 %, 1 year 17.5 %.
- 28.3% of hearing-impaired children availed service from the rehabilitation centre up to 3 years duration.
- It can be observed that the maximum percentage of mothers of intellectually disabled children fall in the age category of 36-45 years (i.e., 56.8 %).
- It can be observed that the maximum percentage of mothers of hearing-impaired children fall in the age category of 36-45 years (i.e., 51.7 %).

- 25.8 % of mothers of intellectually disabled children had passed class 10th, 31.7 % mothers had passed 12th whereas 37.5 % mothers were graduate and only 5% mothers were post-graduate.
- 8.3 % of mothers of hearing-impaired children had passed class 10th, 37.5% mothers had passed 12th whereas 45.8% mothers were graduate and only 8.3% mothers were post-graduate.
- Educational qualification of mothers of hearing-impaired children were class 10 passed 8.3 %, class 12 th passed 37.5 %, graduate 45.8 % and post-graduate 8.3 %.
- 76.7 per cent of mothers of intellectually disabled children were homemakers, 11.7 per cent were teachers, 6.7 per cent were government service holders, and 5.0 per cent of the mothers had private service.
- 55 per cent of mothers of hearing-impaired children were homemakers, 27.5 per cent were teachers, 13.3 per cent were government service holders, and 4.2 per cent of the mothers had private service.
- Mothers of hearing-impaired children in homemaker 55.0 per cent, teacher 27.5 per cent, government service 13.3 per cent, and private service 4.2 per cent.
- Family income per month of mothers of intellectually disabled children was less than Rs. 20,000 was 33 %, Rs. 20,000 -40,000 was 60.8 % and above Rs. 40,000 was 35.8%.
- Family income per month of mothers of hearing-impaired children was less than Rs. 20,000 was7.5 %, Rs. 20,000 -40,000 was 69.2% and above Rs. 40,000 was 23.3%.
- Most of the mothers of intellectually disabled and hearing-impaired children belonged to the Hindu religion, 60 per cent of mothers with intellectually disabled children and 53.3 per cent of mothers with hearing-impaired children.

- Islamism occupied 37.5 per cent of the mothers with intellectually disabled children and 44.2 per cent of the mothers.
- Other's religion covered only 3.3 per cent of mothers with intellectually disabled children and 7.5 per cent of mothers with hearing-impaired children.
- Correlation coefficients among different dimensions of quality of life, social support, personality and emotional intelligence among mothers of intellectually disabled and hearing-impaired children.
- The four dimensions of quality of life show a significant correlation with the study variables. The study portrayed positive intra-correlation among the dimensions of quality of life, i.e., physical, psychological, social relationship and environment.
- Additionally, physical, psychological, social relationship and environment dimension positively correlated with the various dimensions of social support, personality and emotional intelligence at .01 level respectively. However, the dimensions negatively correlated with negative emotion at the 0.01 level.
- Significant differences in all the dimensions of quality of life (i.e., physical, psychological, social relationship, and environment) was found among mothers of mild and moderate hearing-impaired children.
- Significant differences in all the dimensions of social support (i.e., others, family, and friends) was found among mothers of mild and moderate hearing-impaired children
- Mothers of mild hearing-impaired children scored high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to the mothers of moderate hearing-impaired children.
- Significant differences in all the dimensions of emotional intelligence (i.e., Self - awareness, self-regulation, motivation, social awareness, self- social skills) among

mothers of mild hearing-impaired children than the mothers of moderate hearing-impaired children.

- Significant differences in all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) was found among mothers of moderate intellectually disabled and mothers of mild intellectually disabled children.
- Significant differences in all the dimensions of social support (i.e., others, family, friends) was found among mothers of moderate intellectually disabled children and mothers of mild intellectually disabled children.
- Mothers of mild intellectually disabled children scored high on extraversion, agreeableness, conscientiousness and open-mindedness but low on negative emotions as compared to mothers of moderate intellectually disabled children.
- Significant difference was found in all the dimensions of emotional intelligence (i.e., Self-awareness, self-regulation, motivation, social awareness, social skills) among mothers of mild intellectually disabled children and mothers of moderate intellectually disabled children.
- Mothers of mild hearing-impaired children scored high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of mild intellectually disabled children.
- Mothers of mild intellectually disabled children scored high on all the dimensions of social support (i.e., others, family, friends) as compared to the mothers of mild hearing-impaired children.
- There is a significant difference in extraversion, conscientiousness, negative emotions and open-mindedness but there is no significant difference in agreeableness among

mothers of mild hearing-impaired children and mothers of mild intellectually disabled children.

- Significant difference in all the dimensions of emotional intelligence (i.e., Self - awareness, self-regulation, motivation, social awareness, social skills) among mothers of mild hearing impairment and mothers of mild intellectually disabled children.
- Mothers of moderate hearing-impaired children scored high on all the dimensions of quality of life (i.e., physical, psychological, social relationship, environment) than the mothers of moderate intellectually disabled children.
- Mothers of moderate intellectually disabled children scored high on all the dimensions of social support (i.e., others, family, and friends) as compared to the mothers of moderate hearing-impaired children.
- Significant difference in agreeableness, conscientiousness and open-mindedness was found among mothers of moderate hearing-impaired children and intellectually disabled children.
- The socio-demographic variables of the study viz. age of the children, gender, behavioral problem, duration, age of mothers, education qualification of mothers, occupation, income, religion, family type predicts the quality of life among mothers of intellectually disabled and hearing-impaired children.
- Mothers of intellectually disabled children, it was found that extraversion, conscientiousness, negative emotions personality dimension predicts quality of life.
- Social support from friends significantly and positively predicts quality of life among mothers of intellectually disabled children.
- Motivation significantly and positively predicts quality of life among mothers of intellectually disabled children.

- Personality dimension significantly linked to the quality of life. Particularly, extraversion, conscientiousness has been positively significant to the quality of life, while negative emotion is negatively significant to the quality of life.
- Social support from family and friends significantly predicts quality of life among mothers of hearing-impaired children.
- Mothers of hearing-impaired children, dimensions of emotional intelligence like motivation and social awareness predict the quality of life.
- The present study portrayed a wide range of psychological, social, and physical issues experienced by mothers of both intellectually disabled and hearing-impaired children.

Suggestive Interventions Based on Findings

- The findings of this study can be used to raise public awareness about the need of providing maximum assistance to mothers and families in order to avoid stress and ensure healthy living and good functioning and have a better quality of life.
- The findings of this study can help counsellors, therapists, and clinicians to design intervention programme for family caregivers, particularly for mothers who take care of children with chronic disabilities, so that they can live a psychologically and physiologically better life while providing optimal care to their disabled children.
- Based on the findings, the governmental and non-governmental organizations can develop a structured plan for the caregivers of disabled children. This structured plan would help families and mothers of disabled children to live a better quality of life, and for providing better care to their children as well
- In order to increase the quality of life, social support plays an important role. Therefore, society should be given psycho-education to be sensitized and responsible

towards the special child and their families and gradual change in people's positive attitude towards disabled children.

- Society has to understand that disability is not by choice but are caused due to poor nutrition, improper medication, exposure to disease, physical/mental trauma of the child during or after birth, malnutrition, infections such as polio and accidents.
- If these causative factors for disabilities can be addressed and improved through various government and non-government organizations by proving support to the parents and their children.
- Meditation, motivational speeches, mental health camps, workshops, and yoga camps should be held for mothers of special children in the rehabilitation centres and schools to maintain a decent level of psychological well-being and life satisfaction of these mothers.
- A weekly program by the self-help group of disabled parents should be conducted by non-governmental and governmental organizations which would allow parents to share their success stories, accomplishments, and the methods they used to train their disabled children to attain them.
- Professionals in various fields should also be made aware of the challenges and problems experienced by people with disabilities, and priority should be given to them.
- Accepting reality is a huge issue for the majority of parents. If they accept the amount of impairment as it is, they do their utmost to ensure the child's upbringing. Without embracing reality, parents set a goal for their child that is extremely difficult to fulfil within the time frame set by the parents.

- In order to raise a healthy child with a disability, it is important to enhance good family bonding by minimizing unnecessary quarrels among family members. For this, hard and fast rules and regulations in the family should be eased. Everyone in the family should focus on raising a child with a disability which is their primary goal.
- The government may organize a mobile rehabilitation team to give assistance to persons who live in distant and remote places without access to public transportation.

Strengths and Limitations of the Study

The study's strengths and limitations have been discussed. No study combining social support, personality, emotional intelligence among mothers of intellectually disabled and hearing-impaired children has been conducted so far. The study provides a new perspective to the current literature on how social support, personality and emotional intelligence impact quality of life among mothers of intellectually disabled and hearing-impaired children. As a result, the research is not only theoretical but also practical. This research will help organizations to plan proper strategy programs for mothers and families who take care of disabled children. Study findings also point to the need for interventions that assist mothers in better managing feelings and to have a better quality of life. The study has enlightened how different domains of social support, personality and emotional intelligence might be related to the quality of life among mothers of intellectually disabled and hearing-impaired children. Furthermore, the strength of the study is that the questionnaires have facilitated the identification of the causes and the determinants of quality of life. The qualitative approach gave some more domains and themes to understand some other factors which are responsible to have a better quality of life among mothers of intellectually disabled and hearing-impaired children.

It is important to discuss some limitations as well. The present study is confined only to the mothers of children with intellectually disabled and hearing-impaired children residing and taking therapy from the centre which is situated in the Kamrup (M) district of Assam. Only one of the parents participated in the study for each child, that is mothers participated and took into considerations. So, the differences between mothers and fathers could not be investigated. In terms of psychological and cultural concerns, we must evaluate how people perceive each other. The number of participants in the present study was very less i.e., 240. The study was also confined only to variables of mothers' quality of life, social support, personality and emotional intelligence. Further investigation can be made by taking other variables like stress, depression, anxiety, mental health inventory, adjustment and other coping scales. The study was conducted with mothers of intellectually and hearing disabled children, it could be conducted with other categories of disability.

Conclusion

The study adds to the expanding body of knowledge about the intricacies and compositions involved in determining the psycho-social determinants of quality of life among mothers of intellectually disabled and hearing-impaired children. The present study portrayed a wide range of psychological, social, and physical issues experienced by parents of both intellectually disabled and hearing-impaired children. With social support and personality traits, for instance, high extraversion, agreeableness, conscientiousness and low neuroticism, the caregiving role is estimated to be more favourable. In spite of the challenges and problems encountered by parents might damage their mental health, however, the availability of enough social support, particularly instrumental, practical,

and companionship support, as well as personality factors like extraversion, openness, agreeableness, and conscientiousness, might facilitate and enhance their positive mental health and quality of life. Additional problems faced by mothers are social issues such as isolation, a lack of participation in social interactions and social events. As a result, they have less social contact with their loved ones (Rahimi et al., 2018) leading to mental, social, physical and emotional deterioration.

In order to facilitate healthier and productive parent-child interaction, family-centred programmes should be established for mothers and address a few management and coping strategies to maintain a better parent-child relationship. Social support and understanding from family, friends, neighbours, and society as a whole play a vital part in improving one's quality of life. The study found that maintaining physical, psychological, social, and economic well-being is required for a higher quality of life. According to the findings, understanding the domains that is responsible for maintaining the quality of life of mothers of intellectually disabled and hearing-impaired children is not enough; it is also necessary to plan effective rehabilitation for the child and to provide professional support, counselling, coping strategies, and training programmes for their mothers. The study will assist women in being aware of their internal struggle in order to approach their children with special needs successfully and be excellent mothers in that specific condition. Family-centred programs for the parents could be considered and addressed in order to have a better and effective parent-child relationship, in order to increase the quality-of-life social support plays an important role. Therefore, society should be given psycho-education to be sensitized and responsible towards the special child and their families. It leads to a gradual change in people’s attitudes regarding disabilities. Society has to

understand that disability is not by choice but are caused due to poor nutrition, improper medication, exposure to disease, physical/mental trauma of the child during or after birth, malnutrition, infections such as polio and accidents.

Suggestions for Further Research

The current study looked at the quality of life, social support, personality and emotional intelligence of mothers of children with intellectually disabled and hearing-impaired children. There are a few additional areas that need to be looked into to ensure that mothers of children with intellectually disabled and hearing-impaired children have a better quality of life. Here is a list of a few of them:

- Mothers and family living skills can be assessed, and appropriate recommendations made to help them enhance their quality of life.
- The current research is limited to the Kamrup (M) district of Assam, region. However, future research can be undertaken on the entire state, and even by covering all the north-eastern states.
- A comparative study of mothers who take care of other disabilities such as cerebral palsy, autism, multiple disabilities may be undertaken.
- A comparative study with the above-mentioned variables can be conducted between father and mother.
- It is also crucial to investigate the impact of spirituality on mothers and parent caregivers, as spirituality plays a significant part in the perspective of one's living circumstances in Indian culture.

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APPENDIX I

CONSENT FORM

From

_____

_____

_____

I am herby willing to participate in the study initiated by Ms Kakoli Das on "**Psycho-social determinants of Quality of Life among Mothers of Intellectually Disabled and Hearing-Impaired ChildrMs**. Ms. Kakoli Das has explained in detail the procedural aspects of the study well in advance. I agree to be part of the study on my own wish and not by force. I have not been paid any amount by the researcher for the purpose of providing information.

Signature of the Participants:

Name and signature of the Researcher:

APPENDIX II

SOCIO-DEMOGRAPHIC DATASHEET

SECTION 1

1	Name of the child		
2	Age & D.O.B		
3	Gender (Put a tick Mark)	Boy	Girl
4	Educational qualification :		
5	Name of the institution/hospital :		
5	I.Q Point and category/Hearing impaired category:		
6	Any major medical illness :		
7	Any major neuro-psychiatric illness		
8	Any other behavioral problems		
9	Duration of availing service from the institute		

DETAILS OF THE PARENTS OF INTELLECTUALLY DISABLED CHILDREN/HEARING-IMPAIRED CHILDREN

1	Name of the parent	
2	Address	

3	Age					
4	Relationship with the child	Mother/Father				
5	Educational Qualification					
6	Occupation					
7	Total Family Income (per month)					
8	Locality	Rural/urban				
8	Social Group (Put a tick Mark)	General	OBC	SC	ST	Other
9	Religion (Put a tick Mark)	Hindu	Muslim	Buddhist	Christian	Any Other
10	Family type					
11	Any other child/children having intellectual disability/hearing impaired					

APPENDIX III

Multidimensional Scale of Perceived Social Support

Circle the “1” if you Very Strongly Disagree

Circle the “2” if you Strongly Disagree

Circle the “3” if you Mildly Disagree

Circle the “4” if you are Neutral

Circle the “6” if you Strongly Agree

Circle the “7” if you Very Strongly Agree

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2.	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3.	My family really tries to help me.	1	2	3	4	5	6	7
4.	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6.	My friends really try to help me.	1	2	3	4	5	6	7

APPENDIX IV

The Big Five Inventory–2 (BFI-2)

Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

1 Disagree Strongly

3 Neutral; no opinion

4 Agree a little

5Agree strongly

I am someone who...

1. Is outgoing, sociable.

2. Is compassionate, has a soft heart.

3. Tends to be disorganized.

4. Is relaxed, handles stress well.

5. Has few artistic interests.

6. Has an assertive personality.

7. Is respectful, treats others with respect.

8. Tends to be lazy.

9. Stays optimistic after experiencing a setback.

10. Is curious about many different things.

11. Rarely feels excited or eager.

12. Tends to find fault with others.

APPENDIX V

THE WHOQOL-BREF

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks.

		Very poor	*Poor*	*Neither poor nor good*	*Good*	*Very good*
1.	How would you rate your quality of life?	1	2	3	4	5
		Very dissatisfied	*Dissatisfied*	*Neither satisfied nor dissatisfied*	*Satisfied*	*Very satisfied*
2.	How satisfied are you with your health?	1	2	3	4	5

\

The following questions ask about how much you have experienced certain things in the last two weeks.

		Not at all	*A little*	*A moderate amount*	*Very much*	*An extreme amount*
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in	1	2	3	4	5

	your daily life?					
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5

APPENDIX VI

Emotional Intelligence Scale (EIS)

Instructions: Below are given a number of statements and you are requested to read carefully each and to respond in the following manner.

Assign “1” to the statements when you have a strong disagreement.

Assign “2” to the Statements when you have a disagreement.

Assign “4” to the statements when you have an agreement.

Assign “5” to the statements when you have a strong agreement.

1. I am able to identify my feelings. 1 2 3 4 5

2. I have learned a lot about myself through my feeling and emotions. 1 2 3 4 5

3. I understand the reasons for my moods. 1 2 3 4 5

4. I am clearly able to see how my feelings impact my performance. 1 2 3 4 5

5. My values and goals are very clear in my mind. 1 2 3 4 5

6. I am aware of my strengths and weaknesses. 1 2 3 4 5