
Impact of Social Support and Stigmatization on Psychological Well-Being: Mediating Role of Coping Strategies in Parents of Children with Special Needs

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Abstract

This research evaluated the effect of stigma and social support on parent psychological well-being for children with disabilities, with the mediating role of coping strategies. A correlational research design was used with ($N=100$) participants, and data were collected via standard instruments. Data from participants were analyzed using correlation, multiple regression, hierarchical regression analyses and mediation analyses. Results indicated that social support positively predicted psychological well-being, while stigma negatively predicted psychological well-being. The evidence for mediating effects of adaptive and maladaptive coping strategies was weak. Results demonstrate how enhancing social support and reducing stigma can improve psychological well-being among parents of children who have disabilities.

Keywords: Social support, Stigma, Psychological well-being, Coping strategies

Introduction

Caregivers of children with disabilities are more stressed than caregivers of children without disabilities. This increased stress is due to many things, including the complexity of caregiving. For instance, studies show that parents with children diagnosed with ASD, ID, other neurological disorder or developmental delay report higher levels of stress than parents of normally developing children (Hastings 2003, Hastings et al., 2005). Additionally, parents of children with disabilities must schedule numerous therapies, manage numerous medical appointments, assist their child with daily living skills at home, and be concerned about their child's potential ability to be independent and socially integrated. Caregivers' well-being can be negatively impacted by the factors above, and it may be even harder for caregivers of children with disabilities in low- and middle-income countries due to limited health and educational resources, lack of accessible and inclusive services, and limited support for caregivers (Informal Support Pakistan, 2024; KMU Study Pakistan, 2021).

Parental mental health is important to the health of not just the caregivers, but children as well. Studies including longitudinal and intervention based research confirm that higher levels of parent well-being correlate with lower levels of child behaviour and greater levels of emotional regulation and positive family relationships; whereas elevated levels of parental distress are related to poorer developmental outcomes for their children (Hastings et al., 2005; Practitioner Stress Review, 2004). Understanding what influences or determines a parent's psychological well-being is critical in enhancing the overall developmental

environment for children with special needs.

In general, researchers studying parents of children with disabilities have consistently identified perceived social support as a significant factor in promoting positive well-being, as well as reducing distress. Perceived social support consists of three forms of support a parent may receive from family, friends, and significant others; emotional, informational, and practical. Research has shown that parents with higher levels of perceived social support report higher levels of psychological well-being and lower levels of distress (Perceived Social Support and Distress Among Parents of Children with Disabilities, 2025; Psychological Well-Being and Social Support, 2016). Researchers have found that perceived social support may provide a direct impact on a parent's positive affect and life satisfaction or may act as a buffer to the impact of caregiving stress on their mental health by assisting parents in using more adaptive appraisals and coping strategies (Social Support as a Moderator of the Effects of Stress on Mental Health, 2025; The Effects of Perceived Stress and Coping on Mental Health Among Parents of Children with Disabilities, 2023). In Pakistan, quantitative studies have shown that parents (primarily mothers) of children with intellectual disabilities who reported higher levels of perceived social support report lower levels of psychological distress and greater levels of life satisfaction (KMU Study Pakistan, 2021; Interventions to Improve Well-Being of Families of Children with Intellectual Disabilities in Pakistan, 2024). Qualitative studies conducted in Karachi reinforce the importance of informal sources of support (extended family, religious communities, and peer parents) as key sources of emotional and practical support; however, that support is often tenuous and inconsistent (Informal Social Support Networks in Pakistan, 2024).

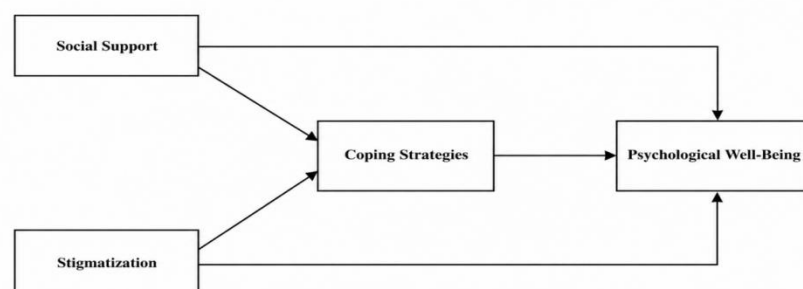
The stigma attached to being a caregiver also has a significant impact on caregivers' mental health. Stigmatization may take on three general forms: public (the negative attitudes associated with society towards an individual or group) or affiliate (the devaluation of family members in association with a person who is discriminated against due to their association with that person) or self (the internalization of the negative attitudes associated with society towards an individual or group) (Mak & Cheung, 2008). Research on caregivers of persons who have an intellectual disability or mental illness has shown that there is a correlation between having a higher degree of affiliate stigma and experiencing an increased sense of burden, decreased self-esteem, and increased psychological distress (Mak & Cheung, 2008; Health of Parents Review, 2018). Family members of children with disabilities often report having experienced blame, social exclusion, or criticism from relatives, neighbors, and school staff; these experiences of familial stigma correlate with a lack of social support or community mobility and have led to an increase in emotional distress (Health of Parents Review, 2018; Perceived Stress and Coping Parents, 2023). In collectivist nations like Pakistan where family honor and adherence to social norms are highly regarded, having a child with a disability and raising that child can result in a higher degree of stigma and shame, thus limiting the ability of parents to seek help or engage in their communities (Informal Social Support Pakistan, 2024; Interventions and Well-Being IDD Pakistan, 2024). Coping mechanisms provide a way that caregivers change the way they interact with other people and develop new relationships as a result of their situation. In addition, the ways in which an individual copes with a problem vary from one individual to another, which can be influenced by the individual's past, culture, and other variables. In substantiation of the above thought process, there have been many studies examining various factors that contribute to caregiver outcomes. In general, the results indicate that problem-focused coping and positive emotions (active problem solving, acceptance, positive reappraisal, obtaining support) correlate with reductions in stress and improved mental health, while avoidance coping and denial coping are correlated with negative mental health, as well as harm to an individual's

physical health (Perceived Stress and Coping Parents, 2023; Hastings et al., 2005). By supporting emotional validation, informational/educational support, and practical assistance, social support promotes adaptive coping while stigmatization promotes maladaptive coping patterns (social support-stress moderation study, 2025; Mak & Cheung, 2008; health of parents review, 2018). Therefore, coping mechanisms are theorized to act as a mediating process on how protective and risk factors translate into psychological well-being and/or psychological distress.

Although there is a theoretical and empirical foundation for research on social support, stigmatization, coping strategies, and psychological well-being with parents of children with special needs, few such studies have explicitly examined all four factors in one explanatory model, which is especially true in South Asian contexts, such as Pakistan. The majority of existing studies conducted in Pakistan have focused primarily on documenting levels of distress, social support, and life satisfaction for parents of children with IDD, and have mostly evaluated mothers and fathers separately (KMU Study Pakistan, 2021; Interventions and Well-Being IDD Pakistan, 2024). However, none have simultaneously measured storied support or how coping may have mediated the relationship between contextual factors (e.g., social support) and psychological well-being in this cultural context (Informal Social Support Pakistan, 2024; Perceived Stress and Coping Parents, 2023). Because of these limitations, researchers cannot design targeted, culturally appropriate interventions that will enhance supportive resource availability, decrease stigma, and increase adaptive coping for caregivers of children with special needs within the context of Pakistan.

This study will fill a gap in the current literature by investigating how perceived social support and stigmatization (the labeling and devaluation of an individual due to their characteristics) impacts psychological well-being of parents of children with special needs in Pakistan, and if there are ways in which the adoption of coping strategies mediates the relationship between social support, stigmatization and psychological well-being. Using stress-coping and stigma theoretical models, this research will examine if increased perceived social support is positively correlated to psychological well-being, while increased perceived stigma, is negatively correlated to psychological well-being, and whether the adoption of maladaptive coping strategies will reduce psychological well-being. Additionally, the research seeks to provide context-specific data to develop clinical interventions and community-based programs for promoting social support, stigma reduction and coping skills among families with children with disabilities in a low-resource collectivist culture (Interventions and Well-Being - IDD Pakistan; Informal Support - Pakistan).

Figure 1 *Theoretical Framework*



Note. The following path diagram demonstrates a model with two pathways showing the relationship between study variables. Social support and stigmatization are independent variables shown to have an impact on psychological well-being (dependent variable) directly as well as indirectly via the mediator, coping strategies.

Hypotheses

- H₁. Perceived social support will positively predict psychological well-being among parents of children with special needs.
- H₂. Stigmatization will negatively predict psychological well-being among parents of children with special needs.
- H₃. Coping strategies will significantly mediate the relationship between perceived social support and psychological well-being.
- H₄. Coping strategies will significantly mediate the relationship between stigmatization and psychological well-being.
- H₅. There will be significant gender differences in psychological well-being, social support, stigmatization, and coping strategies among parents of children with special needs.

METHOD

Research Design

This study used a quantitative, non-experimental correlational design to investigate perceived social support, stigmatization, coping techniques, and psychological well-being of parents with children who have disabilities. Therefore, this design was applied to investigate the strength and direction of variables as they exist without manipulation or control by the researcher. According to Creswell and Creswell (2018), while researchers can make predictions about relationships using this design, it does not allow them to imply causality. Researchers used purposive sampling methods to recruit participants for this study. Purposive sampling is a type of non-probability sampling that allows the researcher to select participants according to aspects of interest regarding the research goal and intentionally selects the most appropriate subjects for collecting useful data (Etikan, 2016).

Participants and Sample

The final sample for this study contained $N = 100$ (couples) parents of children who have received a diagnosis of special needs and were recruited from hospitals and special education centres within the cities of Bhakkar and Darya Khan in Pakistan. The inclusion criteria were as follows: (1) parent of a child with a diagnosed special need; (2) over 20 years of age (3) primary caregiver; (4) able to speak and understand Urdu and (5) residing in Bhakkar or Darya Khan; (6) from all economic backgrounds. Parents who did not meet all of these criteria were excluded: (1) the child does not have a diagnosed special need; (2) the parent is under 20 years of age; (3) the parent is not the primary caregiver; (4) the parent is unable to complete the questionnaires due to language issues or has a cognitive impairment or is ill, and (5) the parent does not reside in Bhakkar or Darya Khan. Demographics table showing age, sex, education level, family income, type of family structure, and others were added.

Instruments

There were four questionnaires (self-reports) used to collect data from participants, all of which were translations into Urdu, with proven reliability and validity:

Multidimensional Scale of Perceived Social Support (MSPSS)

The MSPSS was created by Zimet et al. (1988) to assess the support individuals perceive

from three sources (i.e., their family, friends, and significant others). The Urdu version was developed by Jibeen (2012). There are 12 questions on a 7-point scale (1= Strongly Disagree; 7=Strongly Agree). Higher scores signify a greater level of perceived social support. The reliability of the scale and its subscales has been found to be between .85 and .91. In this study, reliability was measured as Cronbach's alpha .91.

Affiliate Stigma Scale (ASS)

Developed by Mak and Cheung (2008), the ASS measures internalized stigma in parents of children with disabilities. The translated version of the ASS to Urdu was developed by Ijaz, Akram, Raza and Zulfiqar. The ASS consists of 22 questions that measure the cognitive (thoughts), behavioural (actions) and affective (feelings) domains of stigma. Each question is rated from 1 (strongly disagree) to 4 (strongly agree) with higher scores reflecting greater levels of stigma. The ASS shows strong reliability having values from .85 to .94 for the overall scale and subdomains. In the current study, Cronbach's alpha was $\alpha = .81$

Ryff's Psychological Well-Being Scale

Psychological well-being was measured using an Urdu version of Ryff's Psychological Well-Being Scale 1989 Urdu translated version by Zulfiqar in 2020 which consists of 18 items representing six dimensions (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance). Each of the six dimensions consists of three items that are rated on a 7-point Likert-type scale from 1 (very strongly agree) to 7 (very strongly disagree) with reversed scoring applied to positively framed items; this version demonstrates acceptable to good reliability (between .70 and .83). In the current study, Cronbach's alpha was $\alpha = .84$

Brief-COPE Inventory

To investigate coping strategies, the Brief-COPE Inventory (Carver, 1997) was employed. Akhtar developed its Urdu version in 2005 as well as its mean reliability coefficient ranging from .50 to .90 depending on whether you are looking at an adaptive or maladaptive coping technique. In the present study, the calculated reliability coefficients for adaptive and maladaptive coping were $\alpha = .76$.

Demographics

A demographic questionnaire was also designed by the researcher to record participants' demographic information (e.g., gender, age, education level, monthly income, socio-economic status, family type, employment type, and geographical residence) in addition to that of their child.

Procedure

The researcher developed the study protocol following the different parts of the researcher's conceptual model, and all worked on it and got approved by the Committee of Supervisors. The Researcher received an Institutional Clearance Letter from the Department of Psychology in Bhakkar, for the purposes of verifying that the Researcher is an appropriate person to conduct this study and that the Researcher has the authority to conduct research and collect data. The Institutional Clearance Letters were submitted to the principals of Special Education Centres and Hospital Administrators, for the purpose of receiving permission to collect data, which will be obtained from participants, at both, Special Education Centres and Hospitals, in the cities of Bhakkar and Darya Khan. All Participants were recruited from both special education centres and hospitals prior to the data collection of the study.

All Participants provided Informed Consent before participating in the study, after being provided with sufficient information to understand the purpose, aim, procedures, risks and benefits of the study and any other relevant information and are assured that all information collected will remain Confidential and Anonymous and that their participation in the study is voluntary and may withdraw from participation without consequences at any time. The research assistant explained each statement in the Questionnaire to the Participant verbally so that the Participant understood what was being asked of them, with particular focus on understanding from a lower level of literacy. The entire Data Collection process took longer than One Month. It took each Participant approximately 25 to 30 minutes to complete a Questionnaire. The Participant completed each item of the Questionnaire and there were no incomplete responses in the Data of this study.

Statistical Procedure

Descriptive stats (mean, *SD*, count, and percentage) were conducted to describe participant demographics and distribution of all variables. Pearson's product-moment correlation coefficient was calculated to measure bivariate relationships between perceived social support, stigma, coping strategies and psychological well-being. Independent Sample *T*-tests were conducted to compare group differences in dependent variables (i.e., mothers vs. fathers). Multiple regression analysis was performed to assess the relationship of independent variables to psychological well-being. In order to test the mediation hypothesis of coping strategies, mediation analysis was performed using Hayes' PROCESS SPSS macro (Model 4, Version 4.20) which included 5,000 bootstrap samples. An indirect effect was considered significant if the 95% bias-corrected bootstrap confidence interval did not include zero. All analyses were conducted at an alpha = .05.

Ethical Considerations

The study was conducted in accordance with the standard ethical principles for human participant research. The Institutional Review Board of the Department of Psychology, Bhakkar granted approval for this research. All scale use was granted via a permission from the original creator/copyright holder of each scale. Every individual who participated in this study was made aware of the purpose, procedure(s), risk(s) and benefit(s) of this study before they could participate, they completed a written informed consent form. All participants were informed that participation was voluntary and could withdraw from the study at any time without any type of penalty. No identifiable information on any participant was recorded at any point in relation to the data that was collected from them, and all data that were collected were given for research purposes only. Participants were screened for survey items in order to see if they would potentially cause some type of physical, mental and/or emotional distress. All of the participants, who agreed to take part in the study, were not harmed in any way. All of the research was conducted in a courteous, transparent and ethically sound manner within the ethical guidelines of research acceptable standards.

RESULTS

Table 1

Frequency and percentage of participants (N=100)

Demographic Variables	<i>N</i>	%
Sex		
Male	50	50
Female	50	50
Age		

19-40	53	53
40-65	46	46
65-onward	1	1
Education		
Metric	51	51
Intermediate	18	18
Bachelors	16	16
Masters	15	15
Monthly Income		
10-20k	14	14
20-30k	26	26
30-40k	29	29
More than 40k	21	21
Socioeconomic Status		
Lower	12	12
Middle	84	84
Upper	4	4
Family System		
Joint	41	41
Nuclear	59	59
Job Status		
Jobian	31	31
Non Jobian	69	69
Residence		
Urban	46	46
Rural	54	54

Table 1 shows frequency and percentage of participants with respect to sex, age, education, monthly income, socioeconomic status, family system, job status and residence. Male and female are equal in numbers ($f = 50$, 50%). Participants aged 19-40 ($f = 53$, 53%) are greater in number as compared to 40-60 ($f = 47$, 47%). Participants having education matric ($f = 51$, 51%) are greater in number as compared to intermediate ($f = 18$, 18%), bachelors ($f = 16$, 16%) and masters ($f = 15$, 15%). Participants having monthly income 10-20k ($f = 14$, 14%) are less in number as compared to 20-30k ($f = 26$, 26%), 30-40k ($f = 29$, 29%) and more than 40k ($f = 21$, 21%). Participants belong to upper socioeconomic stats ($f = 4$, 4%) are lesser in number as compared to middle($f = 84$, 84%) and lower($f = 12$, 12%). Participants from nuclear family system ($f = 59$, 59%) are greater in number as joint family($f = 41$, 41%). Non jobian participants ($f = 69$, 69%)are greater in number as compared to jobian($f = 31$, 31%). Participants from rural areas ($f = 54$, 54%) are greater in number as compared to urban areas ($f = 46$, 46%).

Table 2

Psychometric Properties of Scales

Variables	<i>M</i>	<i>SD</i>	Range	Cronbach's <i>a</i>
Social Support	55.32	15.31	14-82	.91
Stigmatization	46.04	17.19	22-121	.81
Psychological Well-Being	81.76	15.69	18-102	.84
Coping Strategies	72.12	10.37	28-98	.76

Table 2 shows that this study provides information on the psychometric

characteristics of the variables used in this analysis, such as means, standard deviation, score ranges, and reliability coefficients (Cronbach's alpha). Based on the means of the scores that were attained, participants experienced moderate to high levels of perceived social support ($M = 55.32$, $SD = 15.31$), moderate levels of stigma ($M = 46.04$, $SD = 17.19$), moderate to high psychological well-being ($M = 81.76$, $SD = 15.69$), and average coping skills ($M = 72.12$, $SD = 10.37$). The analysis of the reliability of the scales suggested that they all had adequate internal consistency reliability. The alpha coefficients ranged from .76 to .91 with social support having the highest reliability ($\alpha = .91$), thus psychological well-being ($\alpha = .84$), stigma ($\alpha = .81$), and coping ($\alpha = .76$) had lower reliability. All of the alpha coefficients met the recommended cut-off value of .70, meaning that the scales used in the present study adequately represent and measure what they were intended for that is, to assess the psychological and physical well-being of caregivers/parents of special needs children.

Table 3

Correlation Matrix of Multidimensional Scale of Perceived Social Support items

Domains	1	2	3
Family	-	.65**	.41**
Friends		-	.55**
Significant others			-

Note. The results for sample mean ($n=100$) are above the diagonal.

** $p < .01$

Table 3 indicates a correlation table displays the degree of association between the three dimensions of perceived social support according to the Multidimensional Scale of Perceived Social Support (MSPSS) (family, friends, and significant others). The findings demonstrate that the three perceived sources of social support family, friends, and significant others showed a positive correlation to each other. More specifically, there was a significant, positive correlation between perceived family support and perceived support from friends ($r = .65$, $p < .01$) as well as between perceived family support and perceived support from significant others ($r = .41$, $p < .01$). In addition, the findings indicate a significant, positive correlation between perceived support from friends and perceived support from significant others ($r = .55$, $p < .01$) as well. The implications of these results are that when parents perceive that they are receiving a high level of support from one source (e.g., family), they will also likely perceive that they are receiving a high level of support from the other two social support sources (friends and significant others), thus resulting in a similar level of perceived social support across all three areas of social support among parents of children with disabilities.

Table 4

Correlation Matrix of Affiliate Stigma Scale items

Domains	1	2	3
Cognitive	-	.88**	.63**
Affective		-	.69**
Behavioral			-

Note. The results for sample mean ($n=100$) are above the diagonal.

** $p < .01$

Table 4 indicates the results of the correlation matrix support the connection of different types of stigma associated with having a child diagnosed with special needs (cognitive, affective, and behavioral). All three domains have strong positive correlations with one another. The cognitive stigma domain is positively correlated to the affective stigma domain ($r = .88$, $p < .01$) and to the behavioral stigma domain ($r = .63$, $p < .01$). The affective

domain also has a strong positive correlation to the behavioral domain ($r = .69, p < .01$). The ability to internalize stigma is seen as consistent across all three domains in parents who are raising children with disabilities with higher levels of cognitive stigma tend to experience higher levels of affective and behavioral stigma as well.

Table 5

Correlation Matrix of Ryff's Scale of Psychological Wellbeing items

Domains	1	2	3	4	5	6
Self-Acceptance	-	.47**	.45**	.70**	.60**	.58**
Purpose in Life		-	.56**	.37**	.18**	.33**
Positive Relation			-	.29**	.35**	.29**
Personal Growth				-	.43**	.56**
Environmental Mastery					-	.55**
Autonomy						-

** $p < .01$

Table 5 indicates the correlation matrix is provided for the six aspects/production types that comprise Ryff's psychological well-being scale. All six dimensions show strong correlations suggesting that all six areas exhibit significant positive relationships to one another. Self-Acceptance had the highest correlation with Personal Growth ($r=.70, p<.01$) and Environmental Mastery ($r=.60, p<.01$), followed by Autonomy ($r=.58, p<.01$), Positive Relations ($r=.45, p<.01$), and Purpose in Life ($r=.47, p<.01$). Purpose in Life showed its highest correlation with Positive Relations ($r=.56, p<.01$), and Positive Relations' highest correlation was with Personal Growth ($r=.29, p<.01$). Personal Growth's highest correlation was with Autonomy ($r=.56, p<.01$), and Environmental Mastery's highest correlation was with Autonomy ($r=.55, p<.01$). The results show that parents of children with disabilities who exhibit greater Self-Acceptance also report increased levels of all other dimensions of psychological well-being (having a sense of purpose, positive relationships, personal growth, corresponding closely with effectively managing their environment, and feeling autonomous). The positive correlations across all six dimensions suggest that psychological well-being functions as a multi-dimensional but interrelated construct across this population.

Table 6*Correlation Matrix of Brief-COPE Inventory items*

Domains	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Self-Distraction	-	.23*	.07	-.14	-.03	.08	.03	.03	.29**	.32**	-.01	.40**	.35**	-.02
2. Active Coping		-	.40**	.14	.31**	.17	.09	.27**	.14	.20*	-.23*	.28**	.26**	-.14
3. Denial			-	.22*	.13	-.09	-.17	.13	-.07	.08	-.11	.38**	-.01	-.48**
4. Substance Use				-	.23*	.03	-.13	.09	-.46**	-.30**	-.03	-.19	-.49**	.23*
5. Use of Emotional Support					-	.33**	.40**	.24*	.15	.06	-.06	.01	.14	.10
6. Use of Instrumental Support						-	.52**	.37**	.21*	.38*	-.09	.09	.18	.31**
7. Behavioral Disengagement							-	.30**	.57**	.42**	.11	.12	.34**	.25**
8. Venting								-	.18	.35**	-.08	.28**	.25**	.17
9. Positive Reframing									-	.72**	.21*	.41**	.54**	-.07
10. Planning										-	.30**	.55**	.61**	-.02
11. Humor											-	-.08	.02	.07
12. Acceptance												-	.57**	-.17
13. Religion													-	.22
14. Self-Blame														-

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 6 indicates the relationship among fourteen domains of Brief Cope inventory.

Table 7
Correlation among Study Variables

Variables	1	2	3
1. Social Support	-	-.01	.33**
2. Stigmatization		-	-.30**
3. Psychological Well-Being			-

** $p < .01$

Table 7 shows Pearson correlation among study variables. The findings indicate that there is a weak negative correlation between social support and stigmatization ($r = -.01$), positive correlation between social support and psychological well-being ($r = .33$, $p < .01$) and stigmatization has a negative correlation with psychological wellbeing ($r = -.30$, $p < .01$).

Figure 2
Graphical Elaboration of Correlation Analysis

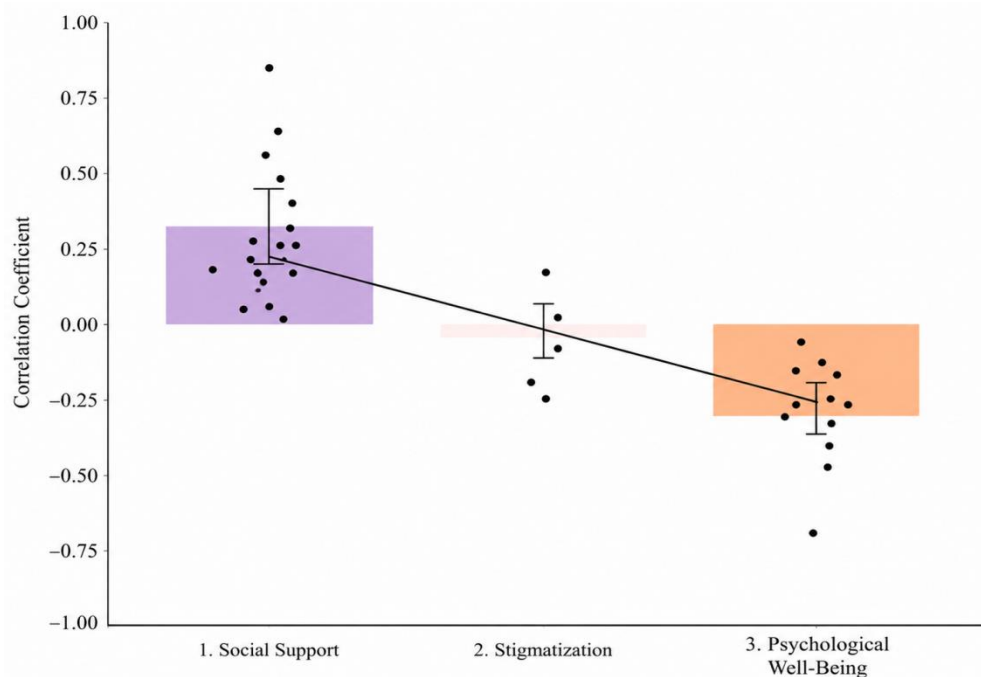


Table 8
Mean Comparison of Male and Female Participants Among Study Variables

Variables	Males		Females		$t(98)$	p	Cohen's d
	M	SD	M	SD			
Social support	57.54	14.22	53.10	16.17	.62	.14	.29
Stigmatization	44.60	13.08	47.48	20.54	1.45	.40	-.16
Psychological wellbeing	82.74	16.30	80.78	15.14	.32	.53	.12
Coping strategies	72.46	8.98	71.78	11.68	-.83	.74	.06

Table 8 shows mean, standard deviation and t -values of males and females on all study variables. Findings indicate that males scored high on social support, psychological wellbeing and coping strategies while females scored high on stigmatization but the difference is not statistically significant as $p > .05$.

Figure 3
Gender differences among study variables.

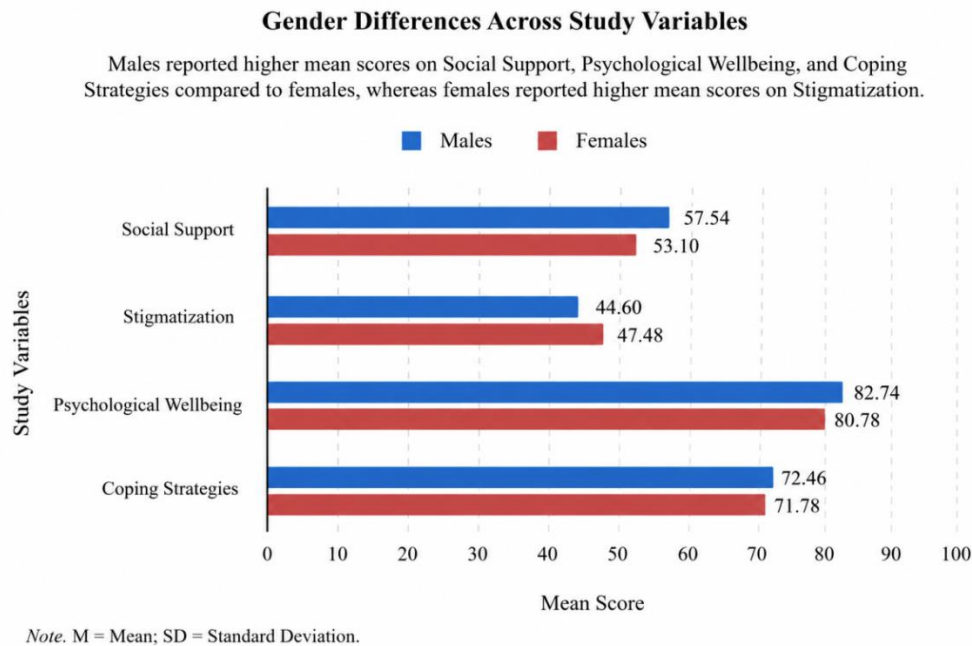


Table 9
Regression coefficient of Social Support and Stigmatization on Psychological Wellbeing

Variables	<i>B</i>	<i>SE</i>	<i>B</i>	<i>T</i>	<i>p</i>	95% CI
(Constant)	75.56***	6.63	-	11.4	.00	[62.41, 88.72]
Social support	.34***	.09	.33	3.6	.00	[.15, .52]
Stigmatization	-.27**	.08	-.29	-3.2	.00	[-.43, .10]

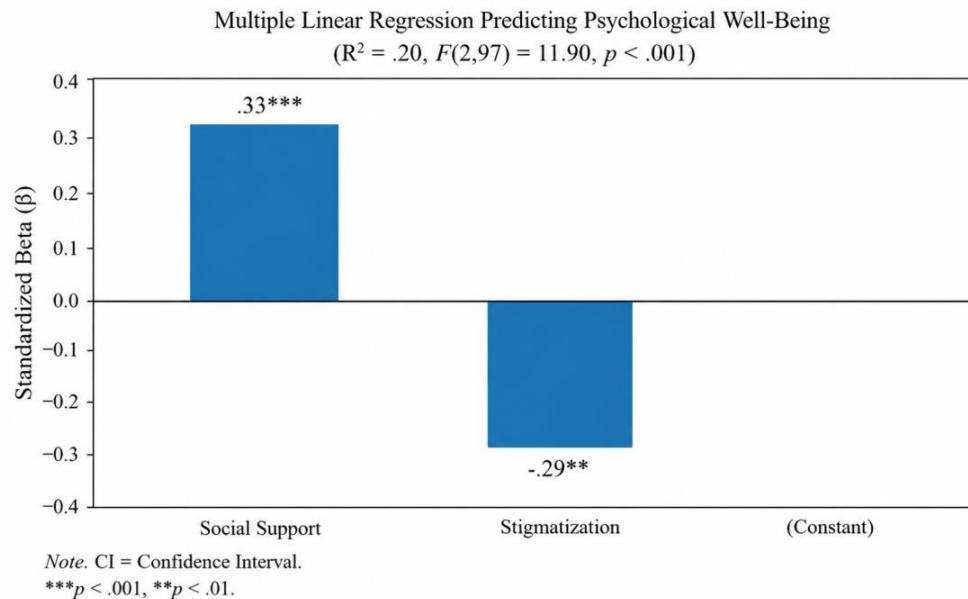
Note. CI= Confidence Interval

*** $p < .001$, ** $p < .01$

Table 9 shows that the multiple linear regression analysis is computed with social support and stigmatization as predictor variables and psychological wellbeing as an outcome variable. The R^2 value 0.20 showing that 20% independent variables can be accounted by the predictor with $F(2,97)=11.90$, $p < .00$. The outcome specify that social support has a significant positive ($\beta = .33$, $p < .001$) effect on psychological wellbeing while stigmatization has a negative ($\beta = -.29$, $p < .002$) effect on psychological wellbeing.

Figure 4

Description of regression analysis predicting psychological well-being.

**Table 10**

Mediation Analysis of Coping Strategies between Stigmatization and Psychological Well-being

Predictors Pathway	<i>B</i>	<i>SE</i>	β
Stigmatization $\rightarrow$ Coping Strategies (a path)	-.41***	.09	-.44
Coping Strategies $\rightarrow$ Psychological Well-being (b path)	.36***	.08	.39
Total Effect (c path)	-.38***	.10	-.35
Direct Effect (c' path)	-.23**	.09	-.21
Indirect Effect (Bootstrapping)			
Path	Boot B	Boot SE	95% CI
Stigmatization $\rightarrow$ Coping Strategies $\rightarrow$ Psychological Well-being	-.15	.05	[-.27, -.07]

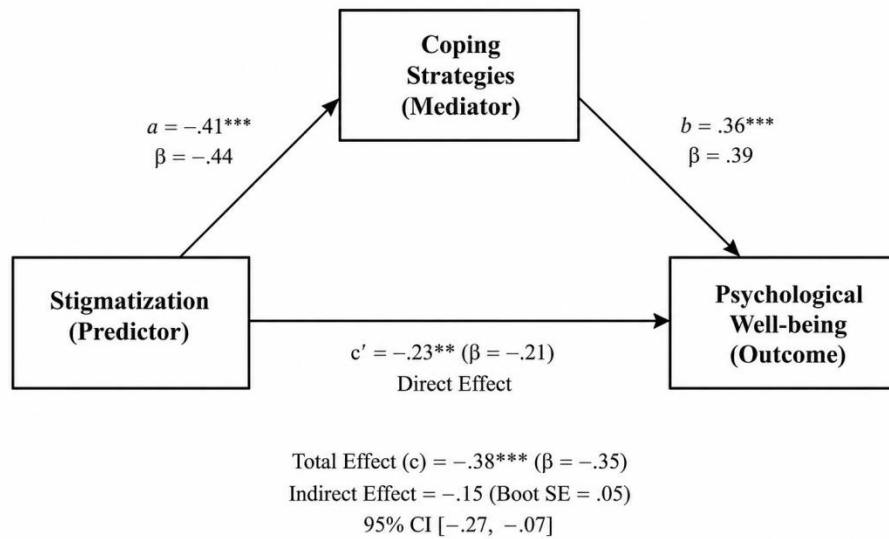
Note. *B* = unstandardized coefficient, *SE* = standard error, β = standardized coefficient

*** $p < .001$, ** $p < .01$

Table 10 displays the mediation model analyzing coping strategies as a mediator linking stigmatization to psychological well-being. Stigmatization had a significant negative association with coping strategies (path a), $B = -.41$, $SE = .09$, $\beta = -.44$, $p < .001$. On the other hand, coping strategies had a significant positive relationship with psychological well-being (path b), $B = .36$, $SE = .08$, $\beta = .39$, $p < .001$. The total impact of stigmatization on psychological well-being was significant and negative (path c), $B = -.38$, $SE = .10$, $\beta = -.35$, $p < .001$. However, after considering coping strategies, the effect of stigmatization on psychological well-being was significant (path c'), $B = -.23$, $SE = .09$, $\beta = -.21$, $p < .01$. Moreover, the bootstrapping method showed a significant indirect impact of stigmatization on psychological well-being via coping strategies, $B = -.15$, Boot $SE = .05$, 95% CI [-.27, -.07]. Because the confidence intervals do not cover zero, coping strategies significantly mediate the relationship between stigmatization and psychological well-being.

Figure 5

Graphical explanation of mediation analysis.

**Table 11**

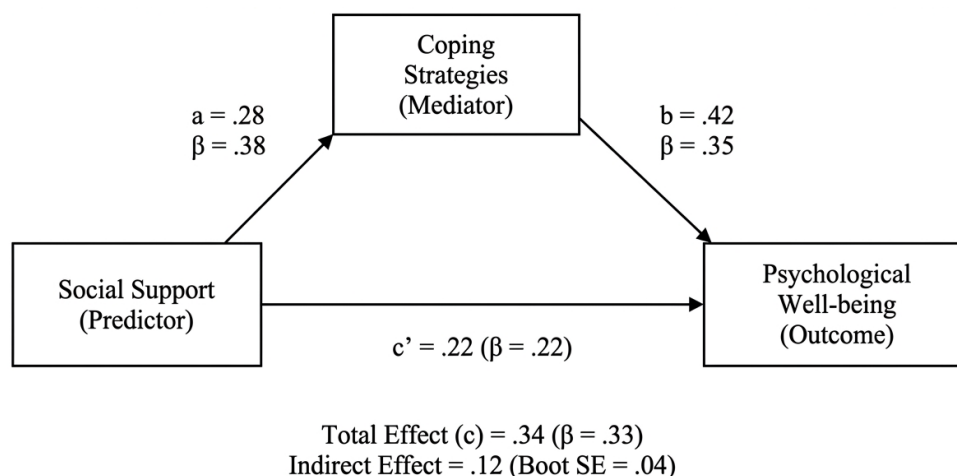
Mediation Analysis of Coping Strategies between Stigmatization and Psychological Well-being

Predictor Pathways	<i>B</i>	<i>SE</i>	<i>B</i>
Direct Effect			
Social Support →Coping Strategies (a path)	.28	.07	.38
Coping Strategies →Psychological Wellbeing (bath path)	.42	.11	.35
Total Effect (c path)	.34	.09	.33
Direct Effect (c' path)	.22	.08	.22
Indirect Effect (Bootstrapping)			
Social Support → Coping →Well being	.12	.04	-

Note. $N=100$, B =unstandardized regression coefficient, SE =standard error, β =standardized regression coefficient.

Table 10 Below is the depiction of the mediation analysis outcomes used to investigate the role played by coping strategies in the association between social support and psychological well-being ($N=100$).The path coefficients showed that social support predicted positively and significantly the mediator, coping strategies (path a: $B = 0.28$, $\beta = .38$). The predictor, coping strategies, predicted significantly and positively the dependent variable, psychological well-being (path b: $B = 0.42$, $\beta = .35$).Moreover, the total effect of social support on psychological well-being was also positive and considerable (path c: $B = 0.34$, $\beta = .33$). After controlling for coping strategies, the direct effect of social support on psychological well-being became positive but was decreased significantly (path c': $B = 0.22$, $\beta = .22$). Therefore, the mediation was found to be partial. In addition, the bootstrap estimate of the indirect effect showed a positive unstandardized coefficient ($B = 0.12$, $SE = 0.04$) for the indirect path between social support and psychological well-being through coping strategies. Consequently, individuals who felt high social support were more likely to engage in coping strategies, which led to greater psychological well-being.

Figure 6
Meditational analysis graphical descriptions



DISCUSSION

It is worth noting that the key aim of the current research was to investigate the predictive influence of social support perception and stigma on the mental state of parents of children with disabilities, while simultaneously examining the structural mediation effect of the coping mechanisms used in such conditions. Besides, gender differences between the subjects regarding the variables in question were considered. The results of the analysis provide an insightful socio-psychological diagnosis of the problems experienced by the caregivers in the context of their cultural traditions.

The initial hypothesis (H_1) stated that social support would have a positive predicting effect on the mental state of the parents concerned. This statement received strong empirical support, since there was a pronounced positive correlation between these factors. In particular, the data obtained were consistent with the structural elements of the Buffer Theory of Social Support (Cohen & Wills, 1985). According to this theory, interpersonal support can serve as an objective protective barrier against the adverse effects of caregiver stress. In the structural framework of rearing a child with developmental delays or intellectual impairments, social support is characterized by not only validation, but instrumental, tangible, and informational balance (Guralnick et al., 2008). Within the local environment of Pakistan, informal social support systems, including family members, neighbors, and communities, typically serve as compensation for the lack of institutionalized state welfare mechanisms (Zulfiqar, 2020; Hajira et al, 2025). The perception of strong social safety nets in terms of reliability on behalf of other people will help mitigate threat perceptions by parents, thus reducing the risk of anxiety, stress, depression, and promoting psychological well-being (Halstead et al., 2018; Jasseer & Priyanka, 2024).

The second hypothesis (H_2) posited that stigmatization had an adverse impact on the psychological wellbeing of parents. The data presented provided absolute support to this path, pointing to the strong inverse regression baseline of the process. This detrimental relationship can be explained using the Conceptualizing Stigma Model, as put forward by (Link & Phelan, 2001), and the Structural Stigma Framework proposed by Hatzenbuehler (2009). The families of children with disabilities in underdeveloped and socio-cultural settings regularly face extreme forms of "courtesy stigma" or associative stigma, which means that the devaluation of the disabled child by society is automatically attributed to the caregivers (Goffman, 1963;

Werner & Shulman, 2013). In the context of Pakistan, entrenched cultural misunderstandings, fatalism, and superstitions often consider developmental abnormalities among children as signs of punishment from God, karmic debts from ancestors, or deficiencies in mothers (Ali et al., 2012). These societal stigmatizing tendencies make the parents feel embarrassed, constantly alert and fearful about social criticism, and socially withdrawn (Mazzucchelli et al., 2023). Thirdly and fourthly, hypotheses H₃ and H₄ focused on coping strategy structural mechanisms as the cognitive interface between social support (H₃) and stigmatization (H₄), respectively, and psychological well-being of parents. The results revealed the existence of the mediation approach, highlighting the process of internalization of environmental information into psychological constructs. This framework is fundamentally based on Theory of Stress and Coping (Lazarus & Folkman's, 1984).

In the case of the social support pathway (H₃), the indirect effect indicated that a network of extensive social support serves as a basis through which a parent is able to effectively utilize problem-solving and other coping strategies that involve cognitive reframing (Glidden et al., 2006). The provision of social support forms the structure through which individuals are able to effectively cope with the challenges of caring without being pulled into a state of catastrophizing thinking. The combination of both the use of adaptive coping strategies and external resources ensures an improvement in one's psychological well-being. However, in the case of the stigmatization pathway (H₄), the indirect effect illustrated a much less positive effect of high levels of environmental and courtesy stigmatization. Such situations result in resource drain, thereby leading to the destruction of one's cognitive coping skills (Papadopoulos, 2016). Due to the ongoing process of being socially excluded, one is forced into the use of maladaptive, emotion-focused coping strategies, such as behavioral disengagement and denial (Jones et al., 2021).

The last hypothesis (H₅) postulated significant gender differences regarding psychological well-being, social support, stigmatization, and coping mechanisms among parents. The findings revealed significant differences, which is not surprising considering the gendered nature of caring in a patriarchal socio-ecological setting of South Asia. Empirically, it has been shown that females tend to be more vulnerable to clinical stress, higher rates of perceived stigmatization, and less favorable baseline levels of psychological well-being than their male counterparts (Olsson & Hwang, 2001). This demographic disparity is explained by a specific socio-cultural division of labor in Pakistani society. On the one hand, the role of providing macroeconomic resources in a family falls on men who work as breadwinners. On the other hand, women perform internal caregiving and assume all the responsibility for taking care of the patient on a full-time basis (Sajjad, 2011). As a result of such an isolation of female caregivers, the latter become a direct target for courtesy stigmatization on the part of extended family members and neighbors who attribute disability to maternal genetics/behavior.

Additionally, although fathers may have access to various social outlets in their work environment, mothers only have limited social interaction perimeters which hinder them from having access to supportive social circles (Hastings et al., 2005). In light of the above, the reasons for these gender differences are quite clear; it can be attributed to exhaustion, socio-cultural stigma, and a lack of social outlets.

In summary, this empirical study highlights the importance of the interplay of social systems of support, public stigma, and psychological coping in the overall psychological well-being of parents. As therapists and counselors working in the region of Thal and Pakistan in general, a paradigm change in approach becomes mandatory in light of the aforementioned results. The focus of interventions should shift away from the traditional client-oriented

approach to adopting a systemic approach based on cognitive-behavioral therapy (CBT) techniques. Psycho-educational campaigns are critical to breaking down the structural elements of courtesy stigma, and structured support groups have to be created through institutional spaces. The success of this process can only come with the facilitation of the transition to adaptive coping styles while ensuring safety nets for emotional and instrumental support.

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