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Subjective Predictors of Emotional Intelligence in People with Physical Disabilities and Their Significance for the Institutional Context

Subiektywne predyktory inteligencji emocjonalnej u osób z niepełnosprawnością fizyczną i ich znaczenie dla kontekstu instytucjonalnego

KEYWORDS
emotional intelligence, physical disability, biopsychosocial model, institutional support, adaptive responses

SŁOWA KLUCZOWE
inteligencja emocjonalna, niepełnosprawność fizyczna, model biopsychospołeczny, wsparcie instytucjonalne, reakcje przystosowawcze

ABSTRACT

Institutional support plays a crucial role in the social participation of individuals with physical disabilities. Emotional intelligence (EI) is a key personal resource that enhances adaptive responses, interpersonal relationships, and engagement in social roles.

The objective of this study is to examine the relationships between emotional intelligence and adaptive responses, self-esteem, a sense of coherence, and value preferences among people with physical disabilities. The study analyzed predictors of EI—adaptive reactions, self-esteem, a sense of coherence, and preferred values—in a sample of 204 participants aged 16–65 with physical disabilities living in southeastern Poland. Regression analysis and structural equation

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modeling indicated that shock negatively predicts EI, whereas moral–ethical self-concept, externalized hostility, and a sense of manageability are positive predictors. A preference for values such as personal security, family, social harmony, and order was also associated with higher EI. These findings demonstrate that the development of emotional intelligence depends on both individual characteristics and the institutional environment, which can provide support, inclusion, and targeted interventions. The results suggest that institutions can enhance EI by addressing early-stage adaptive reactions, strengthening personal and social resources, and promoting inclusive values.

ABSTRAKT

Wsparcie instytucjonalne odgrywa kluczową rolę w uczestnictwie społecznym osób z niepełnosprawnością fizyczną. Inteligencja emocjonalna (IE) jest kluczowym zasobem osobistym, który wzmacnia reakcje adaptacyjne, relacje interpersonalne i zaangażowanie w role społeczne.

Celem badawczym artykułu jest określenie związku między inteligencją emocjonalną a reakcjami przystosowawczymi, samooceną, poczuciem koherencji oraz wartościami preferowanymi przez osoby z niepełnosprawnościami fizycznymi. W niniejszym badaniu przeanalizowano predyktory IE – reakcje przystosowawcze, poczucie własnej wartości, poczucie koherencji i preferencje wartości – u 204 uczestników w wieku 16–65 lat z niepełnosprawnością fizyczną z południowo-wschodniej Polski. Modelowanie regresji i równań strukturalnych wykazało, że reakcja szoku osłabiała IE, podczas gdy moralno-etyczna samoocena, uzewnętrzniona wrogość i poczucie zaradności wiązały się z nią pozytywnie. Preferowanie takich wartości, jak bezpieczeństwo osobiste, rodzina, harmonia społeczna i porządek również wiązało się z wyższym IE. Wyniki te podkreślają, że rozwój IE zależy zarówno od cech indywidualnych, jak i od środowiska instytucjonalnego, które zapewnia wsparcie, integrację i ukierunkowane interwencje. Sugeruje to, że instytucje mogą wzmacniać IE poprzez reagowanie na wczesne reakcje adaptacyjne, wspieranie zasobów osobistych i społecznych oraz promowanie wartości inkluzyjnych.

Introduction

Individuals with physical disabilities, particularly those with motor impairments, often face challenges in accessing support groups

due to mobility limitations. Institutions play a critical role in their social functioning, not only by defining but also by reinforcing their belonging to the category of people with disabilities (Masłyk 2021). Promoting institutional practices based on the biopsychosocial model of disability is therefore essential, as it strengthens both the internal and external resources of individuals with disabilities (Petasis 2019). Research indicates that internal resources, such as self-esteem, self-efficacy, and a sense of coherence, alongside external resources like social support and environmental accessibility, play a significant role in self-assessment and overall adaptation (Peter et al. 2015; Post, van Leeuwen 2012; Kristofferzon, Engström, Nilsson 2018; Samsari, Soulis 2019). Institutional contexts can either enhance or constrain these resources.

Emotional intelligence represents a key internal resource that enables individuals to understand and regulate their own emotions, facilitating problem-solving and influencing the emotions of others (Salovey, Mayer 1990; Reis et al. 2007). Higher emotional intelligence is associated with greater social competence and improved academic and professional outcomes (Bar-On 2007; 2010). Accordingly, institutions play a pivotal role in fostering emotional intelligence, as the implementation of equality measures alone does not automatically change stereotypical perceptions of individuals with disabilities (Masłyk 2021). Strengthening emotional intelligence contributes to improved functioning across multiple areas of social life, promoting long-term benefits for both individuals and society. Every person is in a constant relationship with their environment, which shapes their functioning and can contribute to its modification.

The role of emotional intelligence in the social participation of individuals with disabilities

As society evolves, the situation of individuals with disabilities also changes, as reflected in legal instruments guaranteeing social participation, such as the UN Convention on the Rights of Persons with Disabilities, as well as in indicators such as higher levels of education, increased employment rates, and improved quality of life. The experience of coping with disability is not solely an individual one

but also a social process, as a person with a disability must navigate a range of complex social tasks and, in doing so, may receive cognitive, emotional, and physical support from family members, friends, and co-workers (Kosciulek 2007; Nario-Redmond, Noel, Fern 2012). According to Kosciulek (2007), the most important social tasks include maintaining a sense of normalcy, adapting to changing social relationships and social roles, coping with stigma, and preserving a sense of control. Every person remains in a constant relationship with their environment, which both shapes their functioning and can contribute to its modification.

These tasks, however, are being reshaped in contemporary contexts—not only by expanding the understanding of normality to include the concept of diversity (Davis 2013; Andrews 2020), but also through self-advocacy efforts aimed at improving the situation of people with disabilities, leading to lower levels of disability-related stress (Bogart 2015) and the development of a positive self-image (Dunn, Burcaw 2013; Bogart 2014). In parallel, the concept of stigma has expanded to include the need to cope with microaggressions experienced by people with disabilities, even in communities characterized by high levels of inclusivity (Jammaers, Fleischmann 2024).

However, it is important to note that the experience of disability continues to be associated with an elevated risk of loneliness, isolation, exclusion, discrimination, distorted social perceptions, and exposure to microaggressions (Rokach, Lechcier-Kimel, Safarov 2006; Sim, Hugenberg 2022). Individuals experiencing loneliness may appear to have poorer social skills than they actually possess (McDonald et al. 2018). These negative experiences contribute to reduced self-esteem and negative emotional states and may also lead to health problems (Rokach, Lechcier-Kimel, Safarov 2006; MacDonald et al. 2018). Emotional intelligence integrates multiple dimensions of the disability experience—social, psychological, and biological. Empirical research supports this by examining the relationships between emotional intelligence and various aspects of functioning in individuals with disabilities:

(1) biological dimension: research on emotional intelligence and its impact on health (Bar-On 2007; Fernández-Abascal, Martín-Díaz 2015), as well as on chronic pain in disability (Costa et al. 2017; Doherty et al. 2017);

(2) psychological dimension: studies examining perceived psychological well-being (Gallagher, Vella-Brodrick 2008; Fernández-Berrocal, Extremera 2016) and depressive symptoms (Downey et al. 2008; Ahmadpanah et al. 2016; Sergi et al. 2021), including the protective role of emotional intelligence in the process of self-stigmatization (Trigueros et al. 2020);
(3) social dimension: research studying functioning in education (Parker et al. 2009; Mushtaq, Asghar, Bakhtawar 2019), employment (Desti, Shanthi 2015; Miao, Humphrey, Qian 2017), as well as in the contexts of entrepreneurship (Bar-On 2007) and leadership (Gómez-Leal et al. 2021).

Thus, the research objective of this article is to identify predictors of emotional intelligence in the following areas: adaptive responses, self-esteem, sense of coherence, and value preferences among people with physical disabilities.

Psychosocial responses to functional loss and chronic illness are characterized by temporality and can therefore be classified as short-term, intermediate-term, or long-term. They may be adaptive or maladaptive (Livneh 2001; 2022). The psychosocial reactions to the acquisition of a disability or chronic illness most frequently cited in the literature include shock, anxiety, denial, depression, hostility, and adaptation. The final stage involves cognitive, emotional, and behavioral components (Livneh et al. 2004). Successful adaptation reflects the integration of physical and sensory changes into a transformed body image and enhanced self-esteem. In contrast, unsuccessful adaptation is associated with the persistence of physical and psychological symptoms, including chronic anxiety and depression, psychogenic pain, chronic fatigue, and cognitive distortions.

The importance of changes in the hierarchy of values during the adjustment process to acquired disability was already noted by Wright (1983). She linked the mechanism of compensation to emotional involvement, combined with a shift in value orientation and a transformation of self-image in which aspects of humanity not directly tied to physical functioning are emphasized. Similar conclusions have been confirmed in subsequent studies (Keany, Glueckauf 1993; Smedema, Bakken-Gillen, Dalton 2009; Barclay-Goddard et al. 2012; Dunn, Burcaw 2013). Ongoing research on the internal resources of people with disabilities indicates that these resources

may be diminished due to the specific challenges associated with the disability experience (Moein, Houshyar 2015).

The development of self-esteem in people with physical disabilities proceeds differently depending on whether the disability is congenital or acquired. In the case of congenital disabilities, self-esteem is closely linked to body image, as demonstrated by research on the development of children and adolescents with disabilities. Schmidt et al. (2015) emphasize that, regardless of developmental stage or the country in which the studies were conducted, physical self-concept is strongly correlated with global self-esteem in both boys and girls. This relationship is not determined only by the level of physical activity, although it is associated with physical appearance and motor skills.

Acquired motor disability, by contrast, is associated with adaptive responses to disability, among other factors. The lost ability is gradually integrated into the individual's self-image and is accompanied by emotional acceptance of the functional consequences of the impairment, along with behavioral adaptation and social reintegration (Livneh, Antonak 1990). Additionally, it is worth noting that factors positively influencing the self-esteem of people with disabilities include social activism, which fosters social identification with one's own disability as well as with others in similar life situations (Nario-Redmond, Noel, Fern 2012).

Sense of coherence, in turn, is defined as a sense of comprehensibility, manageability, and meaningfulness (Antonovsky 1987). It typically develops around the age of 33 and remains relatively stable throughout adulthood, although it may change when a person is confronted with difficult experiences. A high level of this resource facilitates better coping with unpredictable stressors, especially in situations involving severe stress. Disability can be viewed as a chronic stressor that individuals may face throughout their lives (Livneh 2001). On the one hand, disability and its consequences may weaken a person's sense of coherence; on the other hand, as a psychological resource, sense of coherence can buffer against the harmful effects of disability (Jahnsen et al. 2002; Dymecka et al. 2022). A strong sense of coherence is associated with higher quality of life, as demonstrated by reviews conducted within the salutogenic model of health (Eriksson, Lindström 2007), as well as by other studies on the relationship

between sense of coherence and disability (Chumbler et al. 2013; Broersma et al. 2018; Moen et al. 2019).

Emotional intelligence, when examined in the context of adaptation to disability and chronic illness, is a dynamic phenomenon; it develops gradually through a person's efforts to cope with an experience (Livneh 2022). It is also shaped by internal resources which, according to the biopsychosocial model of disability, encompass adaptive responses, self-esteem, sense of coherence, and values. Accordingly, the research hypothesis assumes that adaptive reactions in the form of shock and hostility (so-called short-term reactions) are associated with lower emotional intelligence, whereas higher levels of internal resources—manifested as elevated self-esteem and sense of coherence, along with a preference for values not tied to physical condition—are conducive to higher emotional intelligence.

Method

The study employed a diagnostic survey method using the following research instruments: the Emotional Intelligence Questionnaire (INTE) by N.S. Schutte, J.M. Malouff, L.E. Hall, D.J. Haggerty, J.T. Cooper, Ch.J. Golden, and L. Dornheim (Polish adaptation: Ciechanowicz, Jaworowska, Matczak 2000); the Questionnaire of Adaptive Reactions (RIDI) by H. Livneh and R.F. Antonak (Polish adaptation: Byra, Kirenko 2016); the Self-Esteem Scale (TSCS) by W.H. Fitts (Polish initial adaptation: Kirenko 1998); the Life Orientation Questionnaire (SOC-29) by A. Antonovsky (Polish adaptation: Koniarek, Dudek, Makowska 1993); the Portrait Values Questionnaire (PVQ-R2) by S. Schwartz (Polish adaptation: Cieciuch 2013); and an interview questionnaire. The reliability and validity of the instruments were supported by the results of the present study, justifying their use in this research.

Participants

The study included 204 individuals with mobility disabilities, comprising 86 women (42.16%) and 118 men (57.84%). Participants were recruited in southeastern Poland using a snowball sampling

method (Babbie 2004). All applicable ethical standards for conducting scientific research were observed. Participants ranged in age from 16 to 65 years, with a mean age of 36.22 years. The sample included individuals with upper or lower limb amputations (44; 21.57%), spinal cord injuries (41; 20.10%), cerebral palsy (41; 20.10%), multiple sclerosis (37; 18.14%), and motor disabilities of other etiologies (41; 20.10%). The majority of participants were classified as having Group I disability, which was the most frequently diagnosed category (126 individuals; 61.77%). The duration of disability ranged from birth to 54 years, with a mean duration of 31.68 years. Most participants were unmarried (92; 45.10%), followed by those who were married (79; 38.72%), separated or divorced (23; 11.27%), and widowed (10; 4.90%). Most participants lived in urban areas (117 individuals; 57.35%). Regarding self-rated health status, 144 participants (70.59%) described it as good, 43 (21.10%) as very good, and the remaining 17 individuals (8.33%) as poor or unsatisfactory.

Results

To identify predictors of emotional intelligence among participants with physical disabilities, stepwise multiple regression was initially applied to the global emotional intelligence score. Subsequently, to determine more precisely which predictors from the groups of independent variables—adaptive reactions, self-esteem, sense of coherence, and values—had explanatory power for the dependent variable, structural equation modeling techniques were used. Because the distributions of the variables deviated significantly from normal distribution, analyses were conducted using the asymptotically distribution-free method. High indices of model fit were obtained, including a χ^2/df ratio below 2, GFI and AGFI values above 0.9, and RMSEA values of 0.8 or lower. Detailed results are presented in Table 2 and Figure 1. However, prior to this analysis, a correlation matrix of the study variables was constructed using Pearson's *r* (Table 1).

Table 1. Correlation matrix of variables from the data of people with disabilities studied

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
1 Inte	–																											
2 S	–.34	–																										
3 N	–.28	.81	–																									
4 W	–.11	.41	.48	–																								
5 D	–.30	.82	.76	.35	–																							
6 According to	–.33	.78	.74	.31	.76	–																						
7 Wr	–.18	.79	.72	.31	.68	.70	–																					
8 A	–.02	.20	.12	.41	.15	.11	.14	–																				
9 P	.09	–.26	–.22	.12	–.30	–.24	–.23	.50	–																			
10 pzr	.21	–.39	–.42	–.20	–.37	–.36	–.35	.02	.29	–																		
11 pz	.28	–.49	–.47	–.14	–.44	–.42	–.41	.05	.31	.75	–																	
12 ps	.28	–.43	–.44	–.04	–.46	–.41	–.35	.15	.46	.67	.79	–																
13 koh s.	.28	–.48	–.49	–.14	–.46	–.43	–.41	.08	.39	.90	.93	.89	–															
14 Ks	.02	–.08	–.09	.10	–.06	–.13	–.05	.13	.11	.12	.23	.24	.22	–														

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
15 St	–.11	–.05	.05	.10	–.04	–.04	–.02	–.11	.03	–.04	–.03	–.06	–.05	.62	–													
16 H	–.16	.00	.10	.08	.02	.03	.10	–.08	–.02	–.12	–.05	–.11	–.10	.55	.71	–												
17 O	–.07	.03	.06	.17	–.01	–.07	.01	.06	.14	–.01	.02	.14	.05	.69	.59	.51	–											
18 Wł	–.16	.13	.23	.24	.14	.07	.10	.04	–.02	–.12	–.12	–.10	–.13	.51	.57	.57	.58	–										
19 U	.01	–.17	–.16	.15	–.10	–.14	–.26	.15	.15	.25	.32	.40	.35	.45	.17	–.00	.32	.17	–									
20 Ż	.14	–.26	–.27	.12	–.23	–.29	–.32	.20	.26	.28	.37	.47	.40	.48	.10	.01	.38	.08	.69	–								
21 Pr	.02	–.14	–.13	.13	–.06	–.08	–.23	.14	.19	.25	.38	.36	.36	.40	.08	–.01	.32	.12	.78	.78	–							
22 T	–.04	–.06	–.07	.27	–.00	–.05	–.20	.16	.10	.25	.21	.23	.25	.21	.01	–.19	.08	.09	.68	.56	.63	–						
23 B	.13	–.08	–.07	.11	–.02	–.03	–.13	.03	.04	.07	.18	.24	.18	.49	.23	.13	.39	.24	.71	.57	.70	.51	–					
24 KA	.11	.26	.26	.04	.25	.26	.23	.11	–.16	–.30	–.23	–.18	–.26	–.05	–.04	–.10	–.02	.06	.02	–.13	.02	–.12	.22	–				
25 KB	.27	.03	–.03	.04	.06	.01	.00	.16	.07	.08	.11	.11	.11	–.09	–.22	–.26	–.13	–.16	.12	.13	.13	.22	.11	.30	–			
26 KC	.08	.07	.04	–.06	–.00	.08	.15	.02	–.08	.05	.04	.08	.06	.05	.09	.02	.02	–.03	.04	.06	.03	–.08	.12	.31	.30	–		
27 KD	.24	.04	–.03	–.10	–.02	–.01	.06	.02	–.06	.06	.02	.11	.07	–.01	–.10	–.18	.01	–.16	.05	.17	.11	.06	.22	.33	.33	.35	–	
28 KE	.12	.15	.10	–.02	.17	.11	.21	.07	–.07	–.08	–.12	–.11	–.11	–.05	–.07	–.07	–.04	–.01	.06	.03	.05	.05	.13	.47	.63	.43	.46	–

Source: Own study.

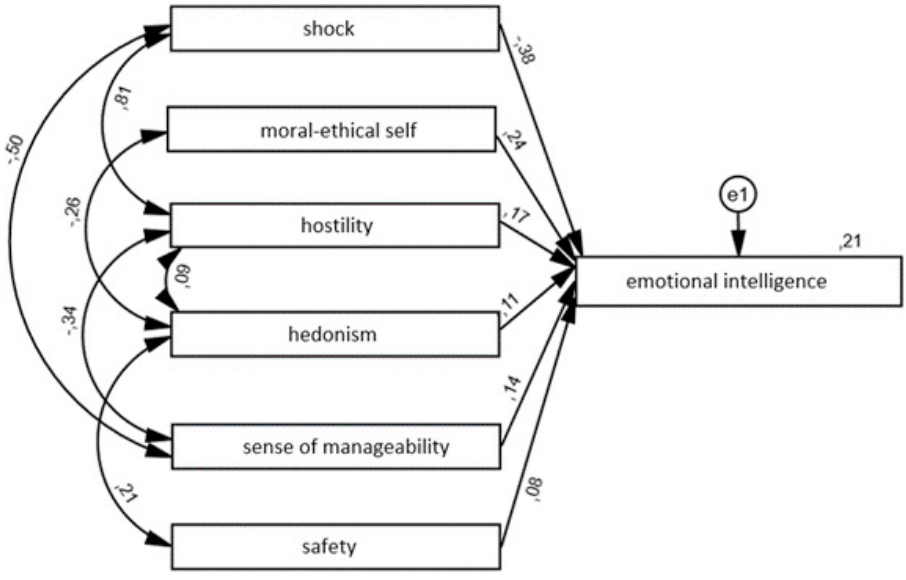
Among the independent variables reaching statistical significance, the regression model explaining 31% of the variance in the dependent variable—emotional intelligence (Table 2)—shows that the strongest influence comes from preferences for values related to personal security, family, friends, and nation, as well as harmony and social order. Emotional intelligence is also shaped by an indirect adaptive response referred to as externalized hostility, which is expressed by individuals with physical disabilities or chronic illnesses toward other people, objects, or situations. This response emerges when individuals begin to resist the physical limitations that they experience, obstacles encountered during treatment or therapy, and their perceptions of themselves in relation to moral values, attitudes toward God, a sense of being a "good" or "bad" person, and the extent to which they perceive available resources as sufficient to meet the demands posed by stressful stimuli.

Table 2. Results of multiple regression analysis for the explained variable *Emotional Intelligence* (Inte) and independent variables

Predictors	b*	Std. dev. with b*	B	Std. dev. with b	t(187)	P
Absolute term			61.11	17.53	3.49	.001**
Shock	–.39	.12	–1.35	.42	–3.23	.001**
Moral-ethical self	.26	.08	.87	.27	3.20	.002**
Hostility	.28	.11	1.02	.39	2.63	.009**
Hedonism	–.17	.07	–.68	.28	–2.46	.015*
Pz	.18	.07	.31	.13	2.41	.017*
Security	.33	.10	1.09	.33	3.26	.001**
R = .60; R2 = .31; F(16.187) = 6.69; p < .000***.						

Source: Own study.
* p < .05; ** p < .001; *** p < .000.

Diagram 1. Path model for the predictors of Emotional Intelligence of the people with disabilities studied



Source: Own study.
chi2 /df = 1.47; GFI = .98; AGFI = .93; RMSEA = .05

In contrast, the presence of a panic shock reaction—particularly one that emphasizes the significance of physical damage, setbacks, and events, as well as the perceived magnitude of their future consequences—together with a lack of reflection and a focus on experienced loss or the pursuit of pleasure and the satisfaction of basic needs, significantly inhibits the development of emotional intelligence. The path model further refines this set of predictors of emotional intelligence in individuals with physical disabilities by excluding indicators of hedonism and security due to their lack of statistical significance. This confirms the predictive importance of the remaining factors, with shock emerging as the strongest indicator; its high negative value markedly weakens emotional intelligence. By contrast, positive indicators—moral-ethical self-concept, externalized hostility, and a sense of manageability—significantly strengthen the analyzed variable.

Discussion of results

Emotional intelligence is a resource that aligns with the phenomenological assumptions of the model of adaptation to life with disability and chronic illness. It creates an interactive relationship between subjective elements (the individual's self-awareness) and indicators of adaptation to disability across intrapersonal, interpersonal, and non-personal dimensions—that is, those related to the living environment of a person with a disability (Livneh 2022). This perspective assumes that the process of adapting to life with a disability may be initiated by a sudden experience or diagnosis and is therefore associated with efforts to cope with that experience. The process has a certain structure which, despite its heterogeneity, contains shared and recurring features.

In the multivariate stepwise path models constructed on the basis of regression analysis, the identified predictors were statistically significant, although their predictive configurations differed in meaningful ways. This was primarily due to the nature of intragroup correlations. Among respondents with motor disabilities, the strongest and most consistently negative predictors of emotional intelligence were adaptive reactions in the form of shock. These reactions are interpreted as "raw" responses following a traumatic event and are viewed as reactions to life-threatening injury or the diagnosis of a chronic condition that disrupts prior life patterns. Such reactions, unlike clinically diagnosed symptoms, are considered normative responses (Livneh 2022). Failure to adapt is associated with persistent symptoms such as anxiety and depression, psychogenic pain, chronic fatigue, social withdrawal, and cognitive distortions (Livneh et al. 2019).

Another statistically significant variable was the hostility stage of adjustment, indicating that people at this stage of adaptation to disability exhibit higher levels of emotional intelligence. This finding is also related to the time required to process difficult experiences (Livneh, Antonak 1990; Antonak, Livneh 1991; Livneh et al. 2019). The configuration of variables explaining higher levels of emotional intelligence supports the assumption that emotional intelligence is related to the duration and stage of living with disability or chronic illness experience. These results also partially confirm the hierarchical nature of responses to disability acquisition—partial in the sense that

they confirm only the first two stages, showing that individuals who have reached the stage of hostility demonstrate a higher emotional intelligence quotient (Antonak, Livneh 1991).

A critical perspective on the adaptation process points to its dual nature. On the one hand, successful adaptation reflects the integration of physical and sensory changes associated with transformations in body image and self-esteem. On the other hand, empirical findings emphasize the role of temporality, suggesting that the duality of the adaptation experience stems from the need to process traumatic consequences, with more realistic and constructive interpretations of experience emerging over time (Livneh et al. 2019).

Self-esteem is also related to the process of adapting to disability, as an individual's self-concept and identity are closely linked to body image. Visible disability can affect the value component of self-image, which may erode its positive dimension and result in a negative self-perception (Livneh 2001). High self-esteem has beneficial effects across many domains of human functioning, including relationships, education, work, and mental and physical health. These benefits are largely independent of age, gender, and race. People with higher self-esteem tend to have better social relationships because, being confident in their own competence and attractiveness, they are better able to initiate and manage social interactions (Orth, Robins 2022). Self-esteem also serves as a protective buffer against anxiety (Pyszczynski et al. 2005; Extremera, Fernández-Berrocal 2006; Hulme, Hirsch, Foot 2012; Cejudo et al. 2018), which is particularly important for people with disabilities.

With regard to the relationship between emotional intelligence and self-esteem, positive correlations have been identified, as self-esteem is associated with positive emotional states. Studies conducted among individuals without disabilities have demonstrated this relationship (Schutte et al. 2002, 2010; Cheung, Cheung, Hue 2014). Despite strong theoretical support in the literature, the hypothesis that higher levels of internal resources in the form of self-esteem would predict emotional intelligence was not confirmed in the present study, as other variables proved to be more statistically significant. Similar findings—showing adequate levels of emotional intelligence alongside lowered self-esteem due to a reduced sense of control—were reported by Gómez-Díaz and Jiménez-García (2018)

in a study of people with physical disabilities. In contrast, research conducted among students with physical disabilities found that higher self-esteem was associated with higher emotional intelligence (Suriá-Martínez et al. 2019).

Another internal resource influencing adaptation is sense of coherence, which may be weakened by the experience of disability. At the same time, the present findings indicate that higher levels of this resource are associated with lower levels of disability in mental domains (Vegard et al. 2019). Similar conclusions emerge from studies on individuals with spinal cord injury, which show that a stronger sense of coherence is linked to better mental health and greater long-term well-being (Kennedy et al. 2010). By contrast, research examining the quality of life of people who acquired a disability as a result of severe brain injury found that their levels of sense of coherence were comparable to those of people without disabilities; however, these outcomes were also influenced by emotional factors and levels of social participation (Jacobson et al. 2011). Moreover, studies have shown that individuals who acquired a disability and reported higher levels of sense of coherence twelve weeks after spinal cord injury experienced significantly better psychological well-being one year later (Kennedy et al. 2010). Thus, the hypothesis that higher levels of sense of coherence are associated with a higher emotional intelligence quotient was confirmed.

People with disabilities often need to develop their own hierarchy of values, one that is not concentrated around physicality. Wright (1983) notes that individuals with disabilities tend to extend the perceived effects of disability beyond its actual consequences, resulting from the sense of loss associated with the experience of disability. Changes in the value systems of people with physical disabilities participating in logotherapy groups, in which discussions focused on values such as meaning in life and responsibility—have been shown to produce positive effects in all spheres of functioning (Moein, Houshyar 2015). Working on a sense of life purpose has also been linked to improved quality of life after injury and to better adjustment to living with a disability (Thompson et al. 2003). The hypothesis was confirmed, as participants' preference for hedonistic values was associated with a lower emotional intelligence quotient.

Limitations of the study

The study's findings have several limitations, which may also provide guidelines for future research. First, the study relied on self-report measures; therefore, emotional intelligence and the other variables were assessed based on participants' subjective evaluations (Schutte, Malouff 1998). Another limitation concerns the composition of the research sample, which was internally heterogeneous in terms of age as well as the presence of congenital versus acquired disabilities. While the study identified predictors of emotional intelligence among individuals with physical disabilities, the lack of differentiation between congenital and acquired disabilities limits the ability to capture differences between these groups. Moreover, the Polish adaptation of the questionnaire did not yield fully consistent results when applied separately to people with congenital and acquired disabilities (Byra, Kirenko 2016). It should be noted, however, that the questionnaire was originally designed for use with both congenital and acquired disability populations (Livneh, Antonak 1990).

Theoretical and practical implications

Previous research has extensively emphasized the importance of social support and internal resources in the functioning of people with disabilities (Gómez-Zúñiga et al. 2023; Livneh 2022). Existing studies have demonstrated that emotional intelligence is a crucial internal resource that enhances social skills, adaptation, and overall well-being among individuals with disabilities (Bar-On 2007; Hodzic et al. 2017; Livneh 2022). Prior research also reveals that social support, environmental accessibility, and targeted training (e.g., in social skills or emotional regulation) play a significant role in reducing marginalization and promoting inclusion (Gómez-Zúñiga et al. 2023; Jensen et al. 2014). Neuroscientific evidence further indicates that individuals with higher levels of emotional intelligence activate brain regions associated with interpersonal relations, suggesting distinct adaptive benefits (Reis et al. 2007). Taken together, this body of literature provides a solid foundation for understanding how emotional intelligence and contextual resources shape the biopsychosocial experience of disability.

Based on the findings of the present study, several practical implications can be proposed. Particular attention should be paid to the shock stage of adaptation, as this phase is associated with the lowest levels of emotional intelligence. Individuals at this stage require systematic and personalized institutional support. Institutional interventions should not be limited to structural accessibility but should also incorporate programs aimed at strengthening internal resources. These may include individual-level activities (such as therapy, coaching, and mentoring), as well as group-based initiatives (support groups, peer mentoring, and workshops). Emotional intelligence training, as suggested by previous research, should be complemented by interventions identified in the present study, particularly at the early stages of adaptation. This integrated approach may enhance both intrapersonal and interpersonal functioning. Complementary activities, such as art therapy (Năstasă 2016) or design-thinking workshops (Menon et al. 2023), may serve as innovative ways of building emotional intelligence and entrepreneurial competences, thereby expanding opportunities for social participation.

Therefore, social skills training supplemented by activities aimed at enhancing emotional intelligence may be crucial, given the need to effectively utilize social support (Jensen et al. 2014). Social support is an element of the social networks in which individuals are embedded, influencing their actions, beliefs, and attitudes (Kirke 2007). Individuals with disabilities, due to their health situation, require multiple forms of support, both instrumental and emotional. This constitutes one of the key conditions for increasing the independence of people with disabilities, thereby enabling them to make their unique contributions to social life (Kowalik 2018). Such contributions may be particularly significant in an era of liquid modernity, in which belonging to social groups is increasingly threatened and often replaced by substitute forms of participation. Belonging itself becomes a privilege that is not equally accessible to all individuals (Bauman 2006).

In addition to therapeutic and educational implications, it is important to emphasize the need for changes in the environments of people with disabilities, as these environments are not merely physical constructs but also encompass sociocultural influences (Dunn 2015). The promotion of values that support the inclusion of people with disabilities in the community is particularly important (Wright

1983; Brown 2003), as it enables them to fulfill meaningful social roles and to establish and sustain significant social relationships. Ultimately, strengthening internal resources should be recognized as a key institutional responsibility. Promoting inclusive values and facilitating meaningful social roles is consistent with the biopsychosocial model of disability and enables individuals to make distinctive and valuable contributions to social life.

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