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Research Paper

Resilience, Self-Compassion, and Quality of Life Among Indian Parents of Children and Adolescents with Cerebral Palsy

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ABSTRACT

Background: Caring for children with cerebral palsy (CP) places heavy psychological, emotional, and physical demands on parents, particularly mothers, in India's resource-constrained settings. Despite this, little is known about how positive psychological resources like resilience and self-compassion influence caregivers' quality of life (QoL) in this context. **Aim:** This study aimed to assess the levels of resilience, self-compassion, and quality of life among parents of children and adolescents with CP in Karnataka, India, and examine how these psychological resources relate to caregivers' well-being. **Design:** A cross-sectional survey was conducted with 70 biological parents (51 mothers, 19 fathers) of children and adolescents diagnosed with CP, recruited from special education schools and rehabilitation centers across Karnataka. Standardized measures used included the Connor-Davidson Resilience Scale (CD-RISC-25), Neff's Self-Compassion Scale (SCS), and WHOQOL-BREF to assess resilience, self-compassion, and QoL, respectively. Chi-square analyses were applied to examine associations between these constructs. **Results and conclusion:** Results revealed moderate-to-high levels of resilience and self-compassion among caregivers, with significant associations between higher resilience and better psychological and environmental QoL. However, no significant associations were found between self-compassion and QoL domains or resilience levels. The findings suggest that while resilience appears to play a critical protective role in caregiver well-being, the impact of self-compassion may be influenced by contextual and cultural factors unique to the Indian caregiving environment. Study limitations include the cross-sectional design and reliance on self-report data. Policy and practice implications highlight the importance of developing culturally tailored interventions that enhance resilience and support caregivers' mental health to improve family outcomes.

Keywords: *Resilience, Self-Compassion, Quality of Life, Cerebral Palsy, Caregivers, India*

Cerebral palsy (CP), the most common motor disability in childhood, affects approximately 3 per 1,000 live births in India (Chauhan, 2019). Characterized by lifelong motor impairments and often accompanied by cognitive, sensory, and communicative challenges, CP places significant physical, emotional, and financial demands on families. In India, where caregiving unfolds against a backdrop of entrenched cultural

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expectations and constrained public health resources, parents—particularly mothers—encounter profound and enduring challenges. The daily demands of caring for a child with cerebral palsy (CP)—from assisting with mobility and personal care to managing therapy routines—often consume substantial time and energy, leading to chronic physical exhaustion and psychological strain (Vadivelan et al., 2020; Kondekar et al., 2024). Numerous studies highlight that these parents experience significantly higher levels of anxiety, depression, and stress compared to parents of typically developing children, with a marked decline in overall quality of life (QoL). Psychological health, in particular, emerges as one of the most vulnerable domains, reflecting the intense emotional toll of caregiving (Vadivelan et al., 2020; Kondekar et al., 2024). These challenges underscore an urgent imperative: to identify and strengthen protective factors—such as resilience, social support, and self-compassion—that can buffer the negative impacts of caregiver burden, especially within low-resource environments where formal support systems are limited.

Resilience and self-compassion have emerged as critical psychological resources for coping with caregiving stress. Resilience, defined as the ability to adapt positively to adversity, enables parents to navigate challenges through problem-solving, optimism, and social support (Dan et al., 2023). Self-compassion, which involves treating oneself with kindness during hardship, helps caregivers avoid self-criticism and emotional burnout (Ahmed & Raj, 2023). Internationally, studies demonstrate that parents of children with developmental disabilities who exhibit higher self-compassion report lower stress and depression, alongside better emotional well-being (Ahmed & Raj, 2023). Similarly, resilient caregivers maintain higher QoL by reframing stressors and accessing support networks. While these constructs are well-studied in Western contexts, their relevance in India—where stigma, gender inequities, and sparse disability services exacerbate caregiver strain—remains underexplored.

The Indian sociocultural context uniquely shapes caregiving experiences. Mothers, often primary caregivers, face social isolation and blame for their child's condition, compounded by familial and community stigma (Vadivelan et al., 2020). Limited access to healthcare, therapy, and financial assistance forces families to rely on informal support, deepening stress (Vadivelan et al., 2020). Structural barriers, such as inadequate public transportation and workplace inflexibility, further restrict parents' ability to balance caregiving with employment or self-care. Despite these challenges, preliminary evidence suggests that resilience and self-compassion may buffer against cultural and systemic adversities. For example, a pilot study of Indian parents found that brief self-compassion interventions improved well-being and reduced depressive symptoms (Ahmed & Raj, 2023), highlighting their potential applicability in low-resource settings.

However, research on positive coping mechanisms among Indian CP caregivers remains scarce. Most studies focus on burden and mental health deficits, neglecting strengths-based approaches. This gap limits the development of culturally tailored interventions that leverage resilience and self-compassion to enhance QoL. By examining these constructs within India's unique context, this study aims to clarify their role in mitigating caregiver strain and informing policies that support families. Such insights are vital for fostering parental well-being and, by extension, improving outcomes for children with CP in a setting where systemic support is often lacking.

METHODOLOGY

A cross-sectional survey design was employed to examine resilience, self-compassion, and quality of life (QoL) among parents of children and adolescents with cerebral palsy (CP) in Karnataka, India. The study aimed to assess the levels of these variables and their interrelationships. Participants were recruited from special education schools and rehabilitation centers in the three Karnataka districts of Mysore, Bengaluru, and Shimogga using purposive sampling. The final sample consisted of 70 biological parents (51 mothers, 19 fathers) of children/adolescents diagnosed with CP. Inclusion criteria required that participants be a biological parent of a child or adolescent with CP; any parent who declined to participate was excluded. The sample demographics were recorded using a semi-structured Socio-Demographic Data Sheet.

Instruments

The study utilized standardized self-report measures.

1. **The Connor–Davidson Resilience Scale (CD-RISC-25):** The Connor-Davidson Resilience Scale (CD-RISC-25) is a widely used self-report instrument designed to assess resilience, defined as the ability to cope with adversity and bounce back from challenges. In this study, the 25-item version was used to measure resilience among parents of children with cerebral palsy. The scale evaluates multiple dimensions of resilience including adaptability, stress coping, emotional regulation, and self-efficacy. Respondents rate each item on a 5-point Likert scale ranging from 0 (not true at all) to 4 (true nearly all the time), based on their experiences over the past month. The total score ranges from 0 to 100, with higher scores indicating greater resilience. The scale demonstrates high internal consistency with a Cronbach's alpha of 0.93, indicating strong reliability. It encompasses key components such as hardiness, coping skills, adaptability, purpose, optimism, emotional regulation, and self-efficacy.
2. **Neff's Self-Compassion Scale (SCS):** This scale has six subscales where three are positive such as "self-kindness" (5 items), "common-humanity" (4 items) and "mindfulness" (4 items) and three are negative such as "self-judgment" (5 items), "isolation" (4 items) and over-identification (4 items), thereby consisting of 26 items in total. Each item has to be responded on 5 point scale ranging from "almost never to almost always". The scoring of positive subscale goes by 1-5 and in case of negative subscale it goes by 5-1. Each subscale scores are computed by calculating the mean of item responses of each subscale. The total self-compassion 71 scale score has to be computed by a grand mean of all six subscales means. Thus, the possible range of scores is 1-5. The higher the scores the higher the level of self-compassion. The test-retest reliability is 0.93 and Cronbach's alpha is 0.94.
3. **The WHOQOL-BREF (26 items):** is a shortened version of the WHOQOL-100, developed by the World Health Organization to assess individuals' perceptions of their quality of life across various domains. It consists of 26 items covering four key domains: Physical Health, Psychological Health, Social Relationships, and Environment. Each item is rated on a 5-point Likert scale, assessing the extent to which an individual experiences various aspects of well-being. The WHOQOL-BREF provides a valid and reliable assessment of quality of life in both clinical and general populations. It has been widely used in cross-cultural research and is suitable for evaluating health outcomes and quality of life in diverse settings, including caregivers and parents of children with chronic conditions like cerebral palsy.

Procedure

Data collection was carried out in person. Ethical clearance was obtained from the Institutional Ethics Committee of the affiliated institute prior to the study. The researcher visited each selected school/center and invited eligible parents to participate. After explaining the study purpose, written informed consent was obtained from each participant. Questionnaires were administered individually in a private setting. All instruments were available in Kannada (the local language); English versions were translated into Kannada by bilingual experts and back-translated to ensure linguistic accuracy. Participants completed the surveys independently, with the researcher present to clarify any queries. On average, questionnaires took approximately 20–30 minutes to complete. To maintain confidentiality, completed questionnaires were coded and stored securely. Participation was voluntary, and parents who were unwilling or unable to participate were excluded from the study.

Data Analysis

After data collection, responses were coded and entered into statistical software (SPSS). Descriptive statistics (means, standard deviations) were calculated for all measures. Chi Square test was used to examine the association among resilience, self-compassion, and quality of life scores. All analyses focused on the study objectives and the three primary outcome constructs (resilience, self-compassion, QoL), in line with the research aims.

RESULTS

The sample comprised 70 biological parents of children and adolescents with cerebral palsy (CP), with 41 parents of children and 29 parents of adolescents. Most of the respondents were female (72.9%), with 27.1% being male. Most participants were married (97.1%), and the predominant type of marriage was arranged (91.4%). A majority of parents had been married for 10–19 years (61.4%), while 27.1% had been married for less than 10 years, and 11.4% for over 20 years.

Family structures were mostly nuclear (52.9%), followed by joint families (25.7%) and nuclear-extended (21.4%). Educational attainment varied, with higher secondary education (32.9%) being the most common, followed by graduate (18.6%) and secondary education (18.6%). About 8.6% were postgraduates, and only a small fraction (4.3%) reported no formal education.

Most parents were homemakers (64.3%), with 28.6% employed full-time and 5.7% part-time. Regarding socio-economic status (SES), 45.7% were classified as upper-middle class, 32.9% lower-middle, and 21.4% upper-lower.

Regarding family size and child position, 45.7% of parents had two children, and 22.9% had three. Notably, 35.7% reported their child with CP was first-born, 28.6% were only youngest children, and 7.1% were middle children. About two-thirds (65.7%) of the children with CP were male.

In terms of living conditions, 61.4% of families lived in rented houses, while 38.6% owned their homes. Most families resided in urban areas (61.4%), followed by suburban (22.9%) and rural (15.7%) areas. Regarding support services, 67.1% of parents said services were “somewhat” available, 24.3% said they were “readily” available, and only 10% reported poor availability. Over half rated the quality of available services as “good” (51.4%), while 31.4% rated it “fair.”

Table 1 Sociodemographic and Family Characteristics of Parents of Children and Adolescents with Cerebral Palsy (N = 70)

Variable	Category	Parents of Children (n = 41)	Parents of Adolescents (n = 29)	Total (N = 70)
Gender	Male	29.3% (12)	24.1% (7)	27.1% (19)
	Female	70.7% (29)	75.9% (22)	72.9% (51)
Marital Status	Married	100.0% (41)	93.1% (27)	97.1% (68)
	Widowed	0.0% (0)	6.9% (2)	2.9% (2)
Type of Marriage	Arranged	90.2% (37)	93.1% (27)	91.4% (64)
	Love	9.8% (4)	3.4% (1)	7.1% (5)
	Both	0.0% (0)	3.4% (1)	1.4% (1)
Years of Marriage	<10 Years	46.3% (19)	0.0% (0)	27.1% (19)
	10–19 Years	53.7% (22)	72.4% (21)	61.4% (43)
	20+ Years	0.0% (0)	27.6% (8)	11.4% (8)
Family Type	Nuclear	51.2% (21)	55.2% (16)	52.9% (37)
	Nuclear-Extended	22.0% (9)	20.7% (6)	21.4% (15)
	Joint	26.8% (11)	24.1% (7)	25.7% (18)
Education Level	No Formal Education	2.4% (1)	6.9% (2)	4.3% (3)
	Primary	12.2% (5)	24.1% (7)	17.1% (12)
	Secondary	22.0% (9)	13.8% (4)	18.6% (13)
	Higher Secondary	29.3% (12)	37.9% (11)	32.9% (23)
	Graduate	22.0% (9)	13.8% (4)	18.6% (13)
	Postgraduate	12.2% (5)	3.4% (1)	8.6% (6)
Employment Status	Full-Time	29.3% (12)	27.6% (8)	28.6% (20)
	Part-Time	2.4% (1)	10.3% (3)	5.7% (4)
	Homemaker	68.3% (28)	58.6% (17)	64.3% (45)
	Retired	0.0% (0)	3.4% (1)	1.4% (1)
Socioeconomic Status (SES)	Upper Middle	39.0% (16)	55.2% (16)	45.7% (32)
	Lower Middle	36.6% (15)	27.6% (8)	32.9% (23)
	Upper Lower	24.4% (10)	17.2% (5)	21.4% (15)
Birth Order of CP Child	Only Child	36.6% (15)	17.2% (5)	28.6% (20)
	First Born	14.6% (6)	65.5% (19)	35.7% (25)
	Middle Child	4.9% (2)	10.3% (3)	7.1% (5)
	Youngest Child	43.9% (18)	6.9% (2)	28.6% (20)

Variable	Category	Parents of Children (n = 41)	Parents of Adolescents (n = 29)	Total (N = 70)
Number of Children	1	36.6% (15)	17.2% (5)	28.6% (20)
	2	48.8% (20)	41.4% (12)	45.7% (32)
	3	9.8% (4)	41.4% (12)	22.9% (16)
	4	4.9% (2)	0.0% (0)	2.9% (2)
Gender of CP Child	Male	65.9% (27)	65.5% (19)	65.7% (46)
	Female	34.1% (14)	34.5% (10)	34.3% (24)
Housing Status	Own	29.3% (12)	51.7% (15)	38.6% (27)
	Rented	70.7% (29)	48.3% (14)	61.4% (43)
Area of Residence	Urban	53.7% (22)	72.4% (21)	61.4% (43)
	Suburban	24.4% (10)	20.7% (6)	22.9% (16)
	Rural	22.0% (9)	6.9% (2)	15.7% (11)
Support Services Availability	Readily	19.5% (8)	31.0% (9)	24.3% (17)
	Somewhat	65.9% (27)	69.0% (20)	67.1% (47)
Support Services Quality	Good	51.2% (21)	51.7% (15)	51.4% (36)
	Fair	29.3% (12)	34.5% (10)	31.4% (22)
	Poor	9.8% (4)	10.3% (3)	10.0% (7)

The socio-demographic characteristics of the sample (N = 70), comprising parents of children (n = 41) and adolescents (n = 29) with cerebral palsy, are detailed as follows and represented in Table 1. A majority of the participants were female (*n* = 51, *72.9%*), while males accounted for (*n* = 19, *27.1%*). Most parents were married (*n* = 68, *97.1%*), with a small proportion widowed (*n* = 2, *2.9%*). The predominant marriage type was arranged (*n* = 64, *91.4%*), followed by love (*n* = 5, *7.1%*) and both types (*n* = 1, *1.4%*). Regarding years of marriage, the largest group reported being married for 10–19 years (*n* = 43, *61.4%*), followed by less than 10 years (*n* = 19, *27.1%*), and more than 20 years (*n* = 8, *11.4%*). Most families were nuclear (*n* = 37, *52.9%*), with nuclear-extended (*n* = 15, *21.4%*) and joint families (*n* = 18, *25.7%*) also represented. Educationally, a plurality had completed higher secondary education (*n* = 23, *32.9%*), followed by graduate (*n* = 13, *18.6%*), secondary (*n* = 13, *18.6%*), primary (*n* = 12, *17.1%*), postgraduate (*n* = 6, *8.6%*), and no formal education (*n* = 3, *4.3%*). In terms of employment, most were homemakers (*n* = 45, *64.3%*), with others employed full-time (*n* = 20, *28.6%*), part-time (*n* = 4, *5.7%*), or retired (*n* = 1, *1.4%*). Socioeconomically, the sample was distributed across upper middle (*n* = 32, *45.7%*), lower middle (*n* = 23, *32.9%*), and upper lower classes (*n* = 15, *21.4%*). The birth order of the child with CP was most often first born (*n* = 25, *35.7%*), followed equally by only and youngest children (*n* = 20 each, *28.6%*), and middle children (*n* = 5, *7.1%*). The number of children per family most commonly was two (*n* = 32, *45.7%*), followed by one (*n* = 20, *28.6%*), three (*n* = 16, *22.9%*), and four (*n* = 2, *2.9%*). The children with CP were predominantly male (*n* = 46, *65.7%*), with females comprising (*n* = 24, *34.3%*). In terms of housing, most lived in rented accommodations (*n* = 43, *61.4%*), while others owned their homes (*n* = 27, *38.6%*). Residence was primarily urban (*n* = 43, *61.4%*), followed by

suburban (*n* = 16, *22.9%*) and rural (*n* = 11, *15.7%*). Regarding support services, most rated availability as somewhat available (*n* = 47, *67.1%*), with a smaller portion finding them readily available (*n* = 17, *24.3%*). Service quality was described as good (*n* = 36, *51.4%*), fair (*n* = 22, *31.4%*), and poor (*n* = 7, *10.0%*).

Table 2 Distribution and Chi-Square Analysis of Quality of Life, Self-Compassion, and Resilience Among Parents of Children and Adolescents with Cerebral Palsy (N = 70)

Variables	Groups	Frequency	Percentage	χ^2	df	p
	Low	6	8.6			
	Moderate	27	38.6			
Quality of Life (Physical)	High	37	52.9	21.457	2	0.000
	Low	15	21.4			
	Moderate	28	40			
Quality of Life (Psychological)	High	27	38.6	4.486	2	0.106
	Moderate	23	32.9			
Quality of Life (Social)	High	47	67.1	8.229	1	0.004
	Low	2	2.9			
	Moderate	35	50			
Quality of Life (Environmental)	High	33	47.1	29.343	2	0.000
	Moderate	54	77.1			
Self Compassion	High	16	22.9	20.629	1	0.000
	Moderate	44	62.9			
Resilience	High	26	37.1	4.629	1	0.031

The distribution of psychological attributes among parents of children and adolescents with cerebral palsy revealed significant variation across domains of quality of life, self-compassion, and resilience are detailed as follows and represented in Table 2. In the physical domain of quality of life, the majority of participants reported high quality of life (*n* = 37, *52.9%*), followed by moderate (*n* = 27, *38.6%*) and low (*n* = 6, *8.6%*), with a statistically significant difference, $\chi^2(2) = 21.457$, $p < .001$. In the psychological domain, 27 participants (*38.6%*) reported high, 28 (*40.0%*) moderate, and 15 (*21.4%*) low psychological well-being, though this distribution was not statistically significant, $\chi^2(2) = 4.486$, $p = .106$. For social quality of life, most parents experienced a high level (*n* = 47, *67.1%*), compared to moderate (*n* = 23, *32.9%*), and the difference was statistically significant, $\chi^2(1) = 8.229$, $p = .004$. In the environmental domain, scores were again predominantly moderate (*n* = 35, *50.0%*) or high (*n* = 33, *47.1%*), with only two participants reporting low quality (*2.9%*); the difference was highly significant, $\chi^2(2) = 29.343$, $p < .001$. Regarding self-compassion, the majority of parents reported a moderate level (*n* = 54, *77.1%*), and a smaller group reported high (*n* = 16, *22.9%*), with a significant difference observed, $\chi^2(1) = 20.629$, $p < .001$. Similarly, in terms of resilience, 44 participants (*62.9%*) were categorized as having moderate resilience and 26 (*37.1%*) as high, with the difference statistically significant, $\chi^2(1) = 4.629$, $p = .031$. These findings underscore significant differences in physical, social, and environmental

domains of quality of life, as well as in self-compassion and resilience levels among caregivers.

Table 3 Cross-tabulation of Resilience Levels and Quality of Life Domains among Parents of Children and Adolescents with Cerebral Palsy

Quality of Life	Moderate level of Resilience				High level of Resilience				χ^2	df	p
	Low (%)	Moderate (%)	High (%)	Total (%)	Low (%)	Moderate (%)	High (%)	Total (%)			
QoL Physical	66.7% (4)	66.7% (18)	59.5% (22)	62.9% (44)	33.3% (2)	33.3% (9)	40.5% (15)	37.1% (26)	0.388	2	0.824
QoL Psychological	86.7% (13)	64.3% (18)	48.1% (13)	62.9% (44)	13.3% (2)	35.7% (10)	51.9% (14)	37.1% (26)	6.169	2	0.046
QoL Social	--	73.9% (17)	--	62.9% (44)	--	26.1% (6)	--	37.1% (26)	1.793	1	0.181
QoL Environmental	100.0% (2)	82.9% (29)	39.4% (13)	62.9% (44)	0.0% (0)	17.1% (6)	60.6% (20)	37.1% (26)	14.96	2	0.001

The cross-tabulation of resilience levels with various quality of life (QoL) domains among parents of children and adolescents with cerebral palsy revealed several notable associations and are represented in Table 3. In the physical QoL domain, among parents with moderate resilience, 4 (*66.7%*) had low, 18 (*66.7%*) moderate, and 22 (*59.5%*) high QoL, totaling 44 (*62.9%*); for those with high resilience, 2 (*33.3%*) had low, 9 (*33.3%*) moderate, and 15 (*40.5%*) high QoL, totaling 26 (*37.1%*), with the association being non-significant, $\chi^2(2) = 0.388$, $p = .824$. In the psychological QoL domain, a significant association was found, $\chi^2(2) = 6.169$, $p = .046$, where among those with moderate resilience, 13 (*86.7%*) had low, 18 (*64.3%*) moderate, and 13 (*48.1%*) high QoL, while among those with high resilience, 2 (*13.3%*) had low, 10 (*35.7%*) moderate, and 14 (*51.9%*) high QoL. In the social QoL domain, the majority with moderate resilience reported moderate QoL ($n = 17$, *73.9%*), while those with high resilience reported a lower percentage in this category ($n = 6$, *26.1%*), though this difference was not statistically significant, $\chi^2(1) = 1.793$, $p = .181$. In contrast, a highly significant association was observed in the environmental QoL domain, $\chi^2(2) = 14.960$, $p = .001$, where all parents with low environmental QoL ($n = 2$, *100.0%*) and a majority with moderate environmental QoL ($n = 29$, *82.9%*) were in the moderate resilience group, whereas the majority of those with high environmental QoL ($n = 20$, *60.6%*) belonged to the high resilience group. These findings suggest that higher resilience is significantly associated with better psychological and environmental quality of life among caregivers.

Table 4 Cross-tabulation of Self-Compassion Levels and Quality of Life Domains among Parents of Children and Adolescents with Cerebral Palsy

Variables	Moderate level of Self Compassion				High level of Self Compassion				χ^2	df	p
	Low (%)	Moderate (%)	High (%)	Total (%)	Low (%) 2	Moderate (%) 2	High (%) 2	Total (%) 2			
Quality of Life											
QoL Physical	83.3% (5)	74.1% (20)	78.4% (29)	77.1% (54)	16.7% (1)	25.9% (7)	21.6% (8)	22.9% (16)	0.307	2	0.858
QoL Psychological	86.7% (13)	67.9% (19)	81.5% (22)	77.1% (54)	13.3% (2)	32.1% (9)	18.5% (5)	22.9% (16)	2.429	2	0.297
QoL Social	--	82.6% (19)	74.5% (35)	77.1% (54)	17.4% (4)	25.5% (12)	22.9% (16)	22.9% (16)	0.58	1	0.446
QoL Environmental	100.0% (2)	80.0% (28)	72.7% (24)	77.1% (54)	0.0% (0)	20.0% (7)	27.3% (9)	22.9% (16)	1.12	2	0.571
Resilience	--	81.8% (36)	69.2% (18)	77.1% (54)	18.2% (8)	--	30.8% (8)	22.9% (16)	1.469	1	0.226

The cross-tabulation of self-compassion levels with various quality of life (QoL) domains and resilience among parents of children and adolescents with cerebral palsy are represented in Table 4. In the physical QoL domain, among those with moderate self-compassion, 5 (*83.3%*) had low, 20 (*74.1%*) moderate, and 29 (*78.4%*) high QoL, while those with high self-compassion showed 1 (*16.7%*) low, 7 (*25.9%*) moderate, and 8 (*21.6%*) high QoL scores; the association was not significant, $\chi^2(2) = 0.307$, $p = .858$. For psychological QoL, 13 (*86.7%*) in the moderate self-compassion group had low, 19 (*67.9%*) moderate, and 22 (*81.5%*) high QoL, while in the high self-compassion group, 2 (*13.3%*) had low, 9 (*32.1%*) moderate, and 5 (*18.5%*) high QoL, with no significant association observed, $\chi^2(2) = 2.429$, $p = .297$. In the social QoL domain, 19 (*82.6%*) of those with moderate self-compassion and 35 (*74.5%*) of those with high self-compassion reported high social QoL, while 4 (*17.4%*) and 12 (*25.5%*) respectively reported moderate social QoL; again, the association was not significant, $\chi^2(1) = 0.580$, $p = .446$. Regarding environmental QoL, participants with moderate self-compassion reported 2 (*100.0%*) low, 28 (*80.0%*) moderate, and 24 (*72.7%*) high QoL, while those with high self-compassion reported 0 (*0.0%*) low, 7 (*20.0%*) moderate, and 9 (*27.3%*) high QoL, with no significant difference found, $\chi^2(2) = 1.120$, $p = .571$.

Lastly, the distribution of resilience across self-compassion levels showed 36 (*81.8%*) of those with moderate self-compassion and 18 (*69.2%*) of those with high self-compassion classified as having moderate resilience, while 8 (*18.2%*) and 8 (*30.8%*), respectively, were categorized as having high resilience; the association was also not statistically significant, $\chi^2(1) = 1.469$, $p = .226$. These findings suggest that while moderate levels of self-compassion were more prevalent, they were not significantly associated with variations in QoL or resilience.

DISCUSSION

The present study examined the association between resilience levels and various domains of quality of life (QoL) among parents of children and adolescents with cerebral palsy. The findings indicate that resilience plays a differential role across QoL domains, with statistically significant associations observed in psychological and environmental domains, but not in the physical or social domains.

Resilience and Quality of Life

A significant association was found between resilience and psychological quality of life (QoL), with higher resilience corresponding to higher psychological well-being ($\chi^2(2) = 6.169$, $p = .046$). This aligns with previous research indicating that resilience serves as a protective factor against psychological distress in caregivers of children with disabilities (Bekhet et al.,2012; McConnell et al., 2015). Resilient parents are more likely to employ adaptive coping strategies, maintain a positive outlook, and experience lower levels of depression and anxiety, which in turn enhances their psychological QoL (McConnell et al., 2015). Moreover, studies have shown that resilience can mediate the relationship between caregiving stress and psychological well-being, meaning that higher resilience reduces the negative impact of caregiving stress on caregivers' mental health (Bekhet et al.,2012; Peer & Hillman, 2014).

The association between resilience and environmental QoL was highly significant ($\chi^2(2) = 14.960$, $p = .001$), with parents exhibiting higher resilience more likely to report better environmental QoL. This may be attributed to the fact that resilient individuals are better able to navigate and utilize available resources, access support services, and adapt to environmental challenges (Raina et al., 2005; Peer & Hillman, 2014). Raina et al. (2005) highlighted that family functioning and caregiver adaptation are influenced by both internal (resilience) and external (environmental) resources, which together contribute to improved QoL outcomes.

No significant association was found between resilience and physical or social QoL domains. This contrasts with some studies suggesting that resilience can buffer the negative impact of caregiving on physical health (Peer & Hillman, 2014). However, it is possible that physical QoL in this population is more directly influenced by the physical demands of caregiving and the health status of the child, rather than by psychological resilience alone (Raina et al., 2005). Similarly, social QoL may be affected by societal attitudes, stigma, and availability of social support, factors that may not be fully mitigated by individual resilience (Kuster & Orth, 2013).

Self-Compassion and Quality of Life

The present study investigated the association between self-compassion levels and various domains of quality of life (QoL) and resilience among parents of children and adolescents with cerebral palsy. The results indicated no statistically significant associations between self-compassion and any QoL domain (physical, psychological, social, or environmental) or with resilience. While moderate self-compassion was more prevalent, higher self-compassion did not translate into significantly better outcomes in these domains.

These findings diverge from much of the existing literature, which generally reports positive associations between self-compassion and caregiver well-being. Prior studies have shown that self-compassion is linked to greater life satisfaction, hope, and goal reengagement, and

is negatively related to symptoms of depression and stress in parents of children with developmental disabilities (Neff & Faso, 2014). Self-compassion has also been identified as a protective resource, reducing the risk of psychological distress and helping caregivers recover more quickly from stressors (Hlabangana & Hearn, 2020; Murfield et al., 2024). Furthermore, self-compassionate caregivers are more likely to balance caregiving with self-care, maintain optimism, and pursue personal goals, even under stress (Neff & Faso, 2014; Bohadana et al., 2019).

Recent interventions targeting self-compassion, such as self-compassion-based resilience programs and mindfulness-based stress reduction, have demonstrated improvements in mental health, resilience, and coping among caregivers (Allen & Leary, 2010; Raina et al., 2004). These programs appear particularly effective in addressing caregiver isolation, self-criticism, and burnout, all of which are common in parents of children with cerebral palsy (Allen & Leary, 2010; Hlabangana & Hearn, 2020).

However, it is important to note that some studies have found the relationship between self-compassion and well-being to be complex and potentially influenced by other factors, such as mindfulness, social support, and the severity of the child's condition (Gouveia et al., 2016; Moreira et al., 2015). In the current study, the lack of significant associations may be due to the relatively high prevalence of moderate self-compassion, limited variability in self-compassion scores, or contextual factors unique to this sample.

Overall, while the literature supports the role of self-compassion as a coping resource and predictor of well-being in caregivers, the present findings suggest that its impact may not be uniform across all domains of quality of life or resilience for parents of children with cerebral palsy. Future research should explore potential moderating variables—such as social support, mindfulness, or caregiving context—that may influence the relationship between self-compassion and well-being in this population.

Limitations and Future Suggestions

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design restricts the ability to draw causal inferences between self-compassion, resilience, and quality of life among caregivers. The reliance on self-report measures may introduce response bias, and the relatively small sample size may limit the generalizability of the results to the broader population of parents of children with cerebral palsy. Additionally, important variables such as the severity of the child's behavioral problems, socio-economic status, and family functioning were not extensively explored. The study also did not account for the potential moderating effects of social support.

Future research should address these limitations by employing longitudinal designs to clarify the directionality of relationships among self-compassion, resilience, and quality of life. Expanding the sample size and including more diverse caregiver populations would enhance generalizability. It is also recommended that future studies incorporate multidimensional assessments, including objective measures of child disability, behavioral challenges, and family resources. Exploring the roles of social support, dispositional mindfulness, and self-efficacy as moderating or mediating variables could provide deeper insights into the mechanisms underlying caregiver adaptation. Intervention studies targeting these factors—such as stress management, self-compassion training, and peer support—are warranted to determine their effectiveness in improving caregiver well-being and reducing burden.

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Conflict of Interest

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