Self-compassion and forms of concern for others

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1. Introduction

Positive attitudes toward the welfare of others as expressed in feelings of joy with regard to their successes, and sorrow with regard to their distress, have in recent years drawn more attention in psychological research and discourse (Aspinwall & Staudinger, 2003; Tolmacz, 2013). Terms such as “compassion” or “concern” are used interchangeably to describe an individual’s awareness of another person’s pain, in a way that gives rise to the emergence of kind feelings and the desire to alleviate the other’s suffering (Wispe, 1991). In addition, as this attitude is based on an interest in others’ welfare, it does not arise only in the context of distress. It also finds expression in happiness for others’ accomplishments (Tolmacz, 2008). Alongside the interest in the subject of positive attitudes toward others, there has also been growing interest in the ways in which one can apply aspects of these attitudes toward oneself. In the present study, we wish to explore the nature of the relationship between positive attitudes toward the self and positive attitudes toward others.

1.1. Concern for others

This growing interest in different aspects of positive attitudes toward others has brought about a better understanding of these attitudes’ various components and unveiled a number of distinctions between them. These include the proposed distinction between empathy and sympathy (Wispe, 1986), the distinction among various kinds of caring (Boleyin-Fitzgerald, 2003), and the distinction between concern and empathy (Tolmacz, 2008). In addition, clinical evidence, theoretical perspectives and research all suggest that concern is not a monolithic concept and that its various forms are influenced by multiple and sometimes antagonistic motives, wishes, fears, mental representations of the self and others, emotions, and behavioral tendencies. In particular, a distinction was made between “healthy” concern, which involves the caring treatment of others alongside the maintenance of one’s self, and “pathological” concern, which seems to heavily favor the care of others over care of the self; individuals characterized by pathological concern seem to neglect their own needs entirely (Tolmacz, 2010).

In order to feel concern for others one must perceive the object of concern as having a subjective world of its own; therefore, one way to conceptualize concern is to take an intersubjective approach. Intersubjective approaches focus on the ways in which the self and the other are perceived as entities with subjective and objective aspects. Failing to recognize or denying the existence of the other’s subjective world (de-subjectivisation of the other) constitute the reasons for the absence of concern in a wide spectrum of situations. Ogden (1990) argued that only in the context of a sense of the other’s subjectivity is he or she perceived to be a three-dimensional subject warranting empathy, care, or guilt in the aftermath of injury. Holloway (2006) suggested that a theory of intersubjectivity “means that care is the psychological equivalent to our need to breathe unpolluted air” (p. 11).

If both the self and the other can be experienced as both subject and object, then there are four forms these relationships can take: self-subject and other-subject, self-subject and other-object, self-object and other-subject, and self-object and other-object (Tolmacz, 2013; Shavit & Tolmacz, 2014). Distinguishing among the four relationship patterns enables us to understand the distinction between healthy

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and pathological concern. One form – self-subject and other-subject, where regard for self as a subject accompanies a caring attitude toward the other – characterizes the healthy concern type. This concern makes itself apparent both in one’s sorrow over the other’s distress and in one’s sharing of the other’s joy. A scenario, however, in which there is a lack of regard for the self as a subject, accompanied by an over-caring attitude toward the other, characterizes a form of pathological concern.

The difference between HC and PC is manifested primarily in terms of well-being and spontaneous expression of self-needs. PC is characterized by two key features: (a) repression and denial of self-related needs, and (b) overinvestment in satisfying others’ needs. Berman (2012) regards this kind of concern as a case of self-negation or masochistic self-sacrifice. Similarly, Barbanel (2006) termed this kind of concern as caretaker personality disorder and applied it to individuals who devote themselves emotionally, physically, and psychologically to others while leaving their own needs unfulfilled. Research findings suggest that pathological concern is significantly positively associated with egocentric motivations, silencing of the self, attachment insecurities, imbalanced forms of relational entitlement, low self-esteem, low life satisfaction, negative emotionality and covert narcissism (Shavit & Tolmacz, 2014; Friedemann, Tolmacz & Doron, in press).

On the other hand, Winnicott (1963) and Bowlby (1979, 1988) suggested that to the extent a person has developed a capacity for healthy concern, he will be capable of expressing a caring attitude toward the other without compromising his sense of well-being. This understanding has been supported by research findings indicating that HC is significantly associated negatively with insecure attachment, silencing of the self and positively with self-esteem, life satisfaction, an assertive sense of entitlement and well-being (Helgeson, 1994, Shavit 2011).

1.2. Self-compassion

One of the major contributions to the subject of positive attitude toward oneself was made by Neff, who introduced the concept of self-compassion (SC). Neff suggested that since compassion includes being open to the other’s suffering and generating the desire to heal the other through kindness, SC would entail applying these same qualities toward oneself. By conceptualizing SC as embodying one’s perception of one’s self as a subject, one could heal oneself through kindness.

According to Neff, SC is made up of three main components, which overlap and mutually interact: self-kindness, feelings of common humanity, and mindfulness. Self-kindness is the tendency to be caring and understanding toward ourselves rather than harshly critical or judgmental. When life circumstances are difficult, self-compassionate people soothe and comfort themselves, rather than taking a stoic “just grin and bear it” approach. The second component, the sense of common humanity, involves recognizing that all people fail, make mistakes, and experience pain. Difficult life circumstances and others’ failures are framed in the context of shared human experience, so that one feels proximity as opposed to distance from others when experiencing difficulty. Mindfulness, the third component of SC, involves being aware of the present moment’s experience in a clear and balanced manner that neither ignores nor ruminates on dissatisfaction aspects of oneself or one’s environment (Brown & Ryan, 2003). Mindfulness involves taking a meta-perspective on one’s own experience so that it can be considered within a greater perspective, thereby avoiding the temptation of becoming consumed by the story-line of one’s own pain, a process that has been termed “over-identification” (Neff, 2003b). People who over-identify tend to exaggerate and fixate on negative self-relevant thoughts and emotions, therefore preventing themselves from seeing options for overcoming their difficulties (for other approaches to self-compassion, see Gilbert, 2009).

Thus, SC involves observing one’s own experience in light of the common human condition. According to Neff (2003a,b), being self-compassionate does not mean being selfish or self-centered, and it also doesn’t mean that one prioritizes personal needs over those of others. Instead, an individual characterized by SC acknowledges that suffering, failure, and inadequacies are part of the human condition, and that all people – oneself included – are worthy of compassion.

Much research regarding SC has accumulated over the last decade, primarily by means of the self-compassion scale (SCS, Neff, 2009, 2011). A major focus of this research has been various aspects of the relationship between SC and one’s own well-being. Higher levels of SC have been associated with greater life satisfaction, emotional intelligence, social connectedness, and mastery goals, as well as less self-criticism, depression, anxiety, rumination, thought suppression, perfectionism, performance goals, and disordered eating behaviors (Adams & Leary, 2007; Neff, 2003a; Neff, Hsieh & Dejitterat, 2005; Neff, Rude & Kirkpatrick, 2007). Neff, Rude, and Kirkpatrick (2007) found that SC was associated with increased levels of curiosity and exploration, happiness, optimism, and positive affect. They also found that SC was associated with extraversion, agreeableness, conscientiousness, and negatively with neuroticism.

Empirical findings indicate that although SC is moderately correlated with global self-esteem (SE as measured by Rosenberg’s self-report measure, 1965), it independently predicts increased well-being and reduced psychopathology. More experimental research has indicated that when an individual is confronted with highly self-evaluative situations, SC has a buffering effect on his/her anxiety, an effect that SE, by contrast, was not found to have (Neff et al., 2007). In addition, Leary, Tate, Adams, Allen and Hancock (2007) found that SC predicted more optimal coping and less negative emotions in the wake of imagined negative scenarios, an effect, again, that was not found to be the case for global SE.

1.3. Self-compassion and concern for others

Since there is little differentiation between SC and the more general “compassion” one generates toward others (Neff, 2003a,b), Neff suggested that people who are highly compassionate toward themselves would be highly compassionate toward and/or concerned for others. In fact, Neff and Pommier (2013) found a substantial correlation between SC and concern for others, primarily among men engaged in Buddhist meditation, which incorporates SC components. Thus, according to Neff, in intersubjective terms SC embodies the self-subject and other-subject relationship form. Similarly, Bakan (1966) suggested that healthy concern for others is only possible when communion and agency can live together, so that a positive orientation toward others goes hand in hand with a positive orientation toward the self. On the other hand, Abele and Wojciszke (2007) showed that while agency is related to strivings to individuate and expand the self, communion arises from strivings to integrate the self in a larger social unit through caring for others. In fact, what we imply from this observation is that SC (characterized by a sense of agency) is a different construct from HC (characterized by a sense of communion). We suggest that these allegedly conflicting propositions may be incorporated in the following manner: both HC and SC share a common denominator of a positive sense of self and well-being. However, while SC reflects a primary orientation of autonomy, HC reflects a primary orientation of relatedness.

1.4. The current study

In keeping with this debate, the main purpose of the current study was to further explore the nature of the relationship between SC and different forms of concern for others as presented from a personal trait perspective.

Based on the understanding that concern is not a monolithic concept and is made up of a healthy form (self-subject and other-subject relationship) and a pathological form (self-object and other-subject relationship), we assumed that both HC and SC would be negatively associated with PC. Moreover, we assumed that these associations would also be reflected in their relationships with different aspects of...
the self, emotional well-being and interpersonal orientation. As for the relationship between SC and HC, while we assumed that they would be positively associated with each other, we also assumed that SC would be positively associated with measures of autonomy and that HC would be positively associated with measures of relatedness. It is important to note that the self-object and other-object form does not entail concern for self or others, and it was therefore not relevant to the current study.

2. Method

2.1. Study 1

The purpose of Study 1 was to explore the nature of the association between SC, PC and HC with aspects of well-being and interpersonal orientation.

2.2. Participants

The research included 156 participants (76 men and 80 women, ranging in age from 18 to 65, Mdn = 23) who volunteered to participate in the study without any monetary reward.

2.3. Measures

2.3.1. Self-compassion

The 26-item Self-Compassion Scale (SCS) assesses six different aspects of self-compassion (with negative aspects reverse-coded): self-kindness (e.g., “I try to be understanding and patient toward aspects of my personality I don't like”); self-judgment (e.g., “I'm disapproving and judgmental about my own flaws and inadequacies”); common humanity (e.g., “I try to see my failings as part of the human condition”); isolation (e.g., “When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world”); mindfulness (e.g., “When something painful happens I try to take a balanced view of the situation”); and over-identification (e.g., “When I'm feeling down I tend to obsess and fixate on everything that's wrong”)

Responses are given on a 5-point scale from almost never to almost always. Previous research indicates that the SCS has an appropriate factor structure, with a single overarching factor of self-compassion explaining the inter-correlations between subscales, and demonstrates predictive, convergent, and discriminant validity (Neff, 2003a). The questionnaire was translated into Hebrew using the “back translation” method (Brislin, 1980). In the current sample, Cronbach's alpha for the 26 items was high (.90).

2.3.2. Pathological concern

We utilized the Revised Pathological Concern Questionnaire (PCQ; Shavit & Tolmacz, 2014). The PCQ in its original version is an 18-item scale assessing thoughts, feelings and behavior related to two core components of pathological concern: (a) repression and denial of self-needs and (b) overinvestment in satisfying others' needs. Items were derived from psychoanalytic and intersubjective conceptualisations of pathological concern, and are in keeping with Barbanel's definition of caretaker personality disorder (Barbanel, 2006). Because three of the questionnaire items were long and measured two different components, in the present study they were divided into shorter, simpler ones (e.g., “I tend to establish relationships in which I dedicate my all to others”; “I tend to ignore the fulfillment of my own personal needs in a relationship”). Thus, the revised version of the scale includes 21 items. Participants were asked to rate the extent to which each item was descriptive of their feelings, beliefs, and reactions in a close relationship. Ratings were done on a 7-point scale ranging from not at all (1) to very much (7). In the current sample, Cronbach's alpha for the 21 items was high (.88). A total score was computed by averaging participants' answers to the 21 items. Higher scores reflected greater pathological concern traits.

2.3.3. Healthy concern

In order to assess healthy concern, the participants completed a questionnaire which was taken from the Interpersonal Reactivity Index (IRI; Davis, 1980). This questionnaire was designed to assess the cognitive and emotional aspects of empathy, and tapped 4 subscales. In the present study we used the Empathic Concern subscale, an 8-item scale, which evaluates the degree to which the respondent feels warmth, compassion and concern toward the other (e.g., “Seeing warm, emotional scenes melts my heart and makes me teary-eyed”). This subscale assesses healthy concern as an emotional component only. Participants rated the extent to which each item was descriptive of their feelings on a 5-point scale ranging from very not me (1) to very me (5). In the present sample, Cronbach's alpha was .85. A total score was computed by averaging the eight items. Higher scores reflected a stronger attitude of healthy concern toward the other.

2.3.4. True self-esteem

Our assessment of true self-esteem was based on Neff's understanding of it, which in turn was in keeping with Deci and Ryan's (1995) configuration of the concept. True self-esteem stems from autonomous, self-determined actions that reflect one's authentic self. True self-esteem is said to emerge from an “integrated sense of self [that] develops as one acts agentically within a context that allows satisfaction of the innate psychological nutrients that are essential for ongoing psychological growth, integrity, and well-being.” These nutrients include the three fundamental psychological needs for autonomy, competence, and relatedness (Deci & Ryan, 2000).

In accordance with the concept of true self-esteem, two separate measures approximating true self-esteem were employed (Deci & Ryan, 1995). 1) The 10-item Self-Determination Scale measures individual differences in the extent to which people tend to function in a self-determined way, including increased self-awareness and sense of choice with respect to behavior, all of which reflects one's authentic self (e.g., “I feel like I am always completely myself” or “I do what I do because it interests me”). In the current sample, Cronbach's alpha for the 10 items was high (.83). 2) The 21-item Basic Psychological Needs Scale includes separate subscales measuring the satisfaction of needs for autonomy, competence, and relatedness (Deci & Ryan, 2000).

In order to assess healthy concern, the participants completed a questionnaire which was taken from the Interpersonal Reactivity Index (IRI; Davis, 1980). This questionnaire was designed to assess the cognitive and emotional aspects of empathy, and tapped 4 subscales. In the present study we used the Empathic Concern subscale, an 8-item scale, which evaluates the degree to which the respondent feels warmth, compassion and concern toward the other (e.g., “Seeing warm, emotional scenes melts my heart and makes me teary-eyed”). This subscale assesses healthy concern as an emotional component only. Participants rated the extent to which each item was descriptive of their feelings on a 5-point scale ranging from very not me (1) to very me (5). In the present sample, Cronbach's alpha was .85. A total score was computed by averaging the eight items. Higher scores reflected a stronger attitude of healthy concern toward the other.

2.3.5. Silencing the self

Participants completed a Hebrew version of the Silencing the Self scale (Jack & Dill, 1992). Participants rated their agreement with each item on a 5-point scale, ranging from (1) strongly disagree to (5) strongly agree. A total score was computed by averaging participants' answers to the 31 items. Higher scores reflected a stronger tendency to inhibit one's self-needs. In the current sample, Cronbach's alpha was high (.86). Finally, attachment orientations were measured with the Experiences in Close Relationships scale (ECR; Brennan et al., 1998; Mikulincer & Florian, 2000). The ECR is a 36-item measure assessing the two major dimensions of adult attachment style: attachment anxiety (e.g., “I worry a lot about my relationships”) and attachment avoidance (e.g., “I don't feel comfortable opening up to other people”). In order to reduce cognitive strain, due to the accumulating amount of the various scale items, we utilized the revised 18-item version of the scale. Participants rated the extent to which each item was descriptive of their feelings in close relationships on a 7-point scale ranging from not at all (1) to very much
(7). In the current sample, Cronbach’s alphas were high for both the nine anxiety items (.84) and the nine avoidance items (.86). Following the standard scoring procedure for the scale (Brennan et al., 1998), two scores were computed by averaging items on each subscale.

2.4. Procedure

Participants completed a battery of self-report scales which were administered in Hebrew on an individual basis. Participants were told that the study dealt with patterns of interpersonal relationships. In order to reduce the effects of common method variance (Podsakoff, MacKenzie, Lee & Podsakoff, 2003), participants were guaranteed anonymity and encouraged to respond freely, given the fact that there were no right or wrong answers. In addition, we counterbalanced the order of the study’s measurements and guaranteed personal feedback upon request.

2.5. Results and discussion, Study 1

To determine the associations between SC, HC, and PC, we conducted a series of Pearson correlations.

The analyses revealed that SC was significantly associated with lower PC, \( r(156) = -0.53, p < .001 \). No significant correlations were found between SC and HC, \( r(156) = .09, p = .246 \), or between HC and PC, \( r(156) = -0.04, p = .592 \).

To determine the contribution of SC, HC and PC to different aspects of the self, we conducted a series of multiple linear regression analyses with measures of SC, HC and PC as the predictors and different aspects of the self as the outcome measures. Regression coefficients are presented in Table 1.

The analyses revealed that SC was significantly associated with higher psychological needs, autonomy, competence, self-awareness, perceived choice, and self-determination. In contrast, PC was significantly associated with lower psychological needs, autonomy, competence, relatedness, self-awareness, perceived choice, and self-determination, and with higher silencing of the self, attachment avoidance and attachment anxiety. Finally, HC was significantly associated with higher psychological needs, competence, and relatedness, and with lower attachment avoidance and attachment anxiety.

Interestingly, while both SC and HC showed positive associations with the general measure of self-needs, they were not related. Moreover, in observing the associations of SC and HC with the different components comprising this measure, an important difference in terms of interpersonal orientation appeared. While individuals high in SC were characterized by a sense of autonomy, individuals high in HC were characterized by an orientation of relatedness. In addition, the negative association between HC and attachment avoidance further supports this linkage. Finally, individuals high in PC seemed to be lacking in both sense of autonomy and interpersonal orientation.

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>SC</th>
<th>PC</th>
<th>HC</th>
<th>( R^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>0.24***</td>
<td>-0.28**</td>
<td>0.12</td>
<td>0.24</td>
</tr>
<tr>
<td>Competence</td>
<td>0.34***</td>
<td>-0.21**</td>
<td>0.25**</td>
<td>0.32</td>
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<td>Relatedness</td>
<td>0.14</td>
<td>-0.28**</td>
<td>0.35**</td>
<td>0.28</td>
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<tr>
<td>Psychological needs</td>
<td>0.28**</td>
<td>-0.30**</td>
<td>0.29**</td>
<td>0.37</td>
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<tr>
<td>Self-awareness</td>
<td>0.17</td>
<td>-0.32**</td>
<td>0.13</td>
<td>0.21</td>
</tr>
<tr>
<td>Perceived choice</td>
<td>0.18</td>
<td>-0.34**</td>
<td>0.09</td>
<td>0.22</td>
</tr>
<tr>
<td>Self determination</td>
<td>0.20</td>
<td>-0.37**</td>
<td>0.13</td>
<td>0.29</td>
</tr>
<tr>
<td>Silencing the self</td>
<td>-0.05</td>
<td>0.39**</td>
<td>-0.10</td>
<td>0.36</td>
</tr>
<tr>
<td>Attachment avoidance</td>
<td>-0.11</td>
<td>0.37**</td>
<td>-0.38**</td>
<td>0.36</td>
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<tr>
<td>Attachment anxiety</td>
<td>-0.19</td>
<td>0.30**</td>
<td>-0.10</td>
<td>0.40</td>
</tr>
</tbody>
</table>

* \( p < .05 \)

** \( p < .01 \)

2.6. Study 2

The purpose of Study 2 was to further explore the nature of the association between SC, PC and HC within a context of emotional well-being.

2.7. Participants

The research included 187 participants (87 men and 100 women, ranging in age from 21 to 38, \( Mdn = 25 \)) who volunteered to participate in the study without any monetary reward.

2.8. Measures

Measures of SC, PC and HC were as described in Study 1 and demonstrated high Cronbach’s alpha reliability measures (0.92, 0.91 and 0.84, respectively).

2.8.1. Negative emotionality

We utilized the 42-item Depression, Anxiety, and Stress Scale (DASS; Lovibond & Lovibond, 1995). This scale is composed of 14 items assessing depression (e.g., dysphoria, hopelessness, devaluation of life), 14 items assessing anxiety (e.g., autonomic arousal, situational anxiety, subjective experience of anxious affect), and 14 items assessing stress (difficulty relaxing, nervous arousal, being easily upset/agitated, being irritable/over-reactive, being impatient). Participants were asked to rate the extent to which they experienced each state over the past week on a 4-point scale, ranging from 1 (not at all) to 4 (very frequently). Scores for depression, anxiety and stress were calculated by summing the scores for the relevant items. In the current study, Cronbach’s alpha across the three scales was 0.86.

2.8.2. Mood

We utilized a Hebrew version of the Positive and Negative Affect Schedule (PANAS; Watson, Clark & Tellegen, 1988). This is a 20-item measure describing different moods, and participants rated the extent to which each item accurately described them on a 5-point scale, ranging from 1 (not at all) to 5 (very much). Ten items describe negative moods (e.g., worried, troubled, angry) and 10 items describe positive moods (e.g., excited, proud, interested). In the current sample, Cronbach’s alpha was .87 for positive mood and .89 for negative mood. On this basis, responses to each subscale were averaged to form two global indexes.

2.8.3. Rejection Sensitivity Questionnaire

We utilized the Hebrew version of the Rejection Sensitivity Questionnaire (RSQ; Downey & Feldman, 1996). The RSQ describes 17 hypothetical situations in which participants are asked to imagine requesting something from a significant other. Participants rated their degree of concern about the outcome of each situation (Rejection Sensitivity) on a 6-point scale, ranging from very unconcerned (1) to very concerned (6), and the likelihood that the other person(s) would respond in an accepting fashion (Rejection Sensitivity 2) on a 6-point scale, ranging from very unlikely (1) to very likely (6). Downey and Feldman (1996) recommended computing a rejection sensitivity score for each situation by multiplying the expected likelihood of rejection (reversing the acceptability ratings) by the degree of anxiety about the outcome. The RSQ has been shown to be reliable and valid (Downey & Feldman, 1996). In the current sample, Cronbach’s alpha for Rejection Sensitivity was 0.88 and for Rejection Sensitivity 2 was 0.80.

2.8.4. Social anxiety

We utilized the Hebrew version of the LSAS 24-item scale (Liebowitz, 1987) which measures fear and avoidance of social situations over the previous week. It consists of 11 items relating to social interaction and 13 items related to public performance. Each item is rated on two 4-point Likert-type scales. The first rating is a measure
of fear/anxiety and ranges from 0 (none) to 3 (severe) for which Cronbach's alpha was 0.93. The second rating is a measure of avoidance and ranges from 0 (never) to 3 (usually) for which Cronbach's alpha was 0.92. A total score was calculated by summing all of the fear and avoidance ratings.

### 2.8.5. Loneliness

We utilized a Hebrew version of the 20-item R-UCLA scale (Russell et al., 1980): a measure of loneliness and satisfaction with one's social connections. Participants rated the extent to which each item was self-descriptive on a 4-point scale from 1 (not at all) to 4 (very much). In the current study, Cronbach's alpha for the 20 items was high (.92). We therefore averaged the items, with higher scores indicating higher levels of loneliness.

### 2.8.6. Caregiving

To measure participants' caregiving orientation we utilized the Caregiving System Scale (CSS; Shaver, Mikulincer & Shemesh-Iron, 2010) which measures individual differences in hyperactivation and deactivation of the caregiving strategies, based on an attachment theory understanding (Bowlby, 1982). Participants rated the extent to which each item was descriptive of their feelings regarding their caregiving on a 7-point scale ranging from not at all (1) to very much (7). In the current sample, Cronbach's alpha was .85 for both the 12-caregiving avoidance items and the 12-caregiving anxiety items. On this basis, responses to each subscale were averaged to form two global scores.

### 2.9. Procedure

Participants completed a battery of self-report scales, which were administered in Hebrew on an individual basis. Participants were told that the study dealt with patterns of interpersonal relationships. Participants were guaranteed anonymity, encouraged to respond freely, and told that there were no right or wrong answers. In addition, we counterbalanced the order of the study's measurements and guaranteed personal feedback upon request. We also measured the participants' current mood, enabling us to control for their current mood and further reduce the effects of common method variance (Podsakoff et al., 2003).

### 2.10. Results and discussion, Study 2

To determine the associations between SC, HC, and PC, we conducted a series of Pearson correlations.

The analyses revealed that SC was significantly associated with lower PC, \( r(187) = -.61, p < .001 \), and HC was significantly associated with higher PC, \( r(187) = .16, p = .033 \). No significant correlations were found between SC and HC, \( r(187) = .03, p = .730 \).

To determine the contribution of SC, HC, and PC to well-being and interpersonal difficulties, we conducted ten two-step hierarchical regression analyses using HS, SC, and PC as predictors of measures which reflect well-being and interpersonal difficulties. PANAS scores were included in the first step of each analysis. In the second step, we added the scores of SC, HC, and PC as predictors to determine their unique contribution to the dependent variables. Regression coefficients are presented in Table 2.

As shown in Table 2, after controlling for the PANAS scores (positive and negative mood), a statistically significant change in explained variance still remained in all ten analyses. The analyses revealed that SC was significantly associated with lower avoidance of social situations, lower rejection sensitivity and higher caregiving avoidance. In contrast, PC was significantly associated with higher depression, anxiety, stress, loneliness, and social anxiety, and with avoidance of social situations, rejection sensitivity, caregiving avoidance, and caregiving anxiety. Finally, HC was significantly associated with lower loneliness, lower rejection sensitivity, lower caregiving avoidance, and with higher anxiety.

Overall, the findings suggest that SC, HC, and PC are three constructs uniquely associated with measures of well-being and interpersonal orientation. Well-being was negatively associated with PC. Interestingly, no substantial associations were found between SC, HC and well-being, the exception being a positive association between HC and anxiety. Regarding the aspect of interpersonal orientation, and further to the findings that emerged from Study 1, the results from Study 2 suggest that while SC is not uniquely related to measures of interpersonal orientation, HC and PC displayed substantial and contrasting associations. HC was indicative of positive expectations and sense of competence in relating to others, while PC showed the opposite tendencies.

### 3. Discussion

The subject of positive attitudes toward oneself and others has drawn an increasing amount of attention in recent years. Intuitively, the constructs of SC and concern for others seem to have much in common: i.e., one would think that people who are highly compassionate toward themselves would also be highly compassionate toward others (Bakan 1966; Neff & Pommier 2012). On the other hand, Abele and Wojciszke (2007) indicated that agency and communion, representing SC and HC respectively, are in fact independent of each other.

In keeping with this debate, and incorporating the distinction we described between “healthy” and “pathological” concern for others, we assumed that the relationship between SC and concern for others would depend upon the kind of concern under discussion. Specifically, we

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<table>
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<tr>
<th>Variable</th>
<th>Dass_Depression</th>
<th>Dass_Anxity</th>
<th>Dass_Stress</th>
<th>Loneliness</th>
<th>Social anxiety</th>
<th>Social avoidance</th>
<th>Rejection sensitivity 1</th>
<th>Rejection sensitivity 2</th>
<th>Caregiving avoidance</th>
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<tr>
<td>PANAS_Positive</td>
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<td>-0.16</td>
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<td>-0.31**</td>
<td>-0.12</td>
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<td>PANAS_Positive</td>
<td>-0.37**</td>
<td>-0.14</td>
<td>0.27**</td>
<td>-0.15</td>
<td>0.05</td>
<td>0.05</td>
<td>-0.13</td>
<td>0.04</td>
<td>-0.21**</td>
<td>-0.12</td>
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<td>PANAS_Negative</td>
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<td>0.29**</td>
<td>0.26**</td>
<td>0.23**</td>
<td>0.09</td>
<td>-0.20**</td>
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<tr>
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<td>0.19**</td>
<td>0.04</td>
<td>-0.21**</td>
<td>0.10</td>
<td>-0.02</td>
<td>0.05</td>
<td>0.24**</td>
<td>-0.30**</td>
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<td>SC</td>
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<td>0.15</td>
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<td>0.05</td>
<td>0.08</td>
<td>-0.22**</td>
<td>-0.25</td>
<td>-0.05</td>
<td>0.21**</td>
<td>0.02</td>
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<tr>
<td>PC</td>
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<td>0.28**</td>
<td>0.18**</td>
<td>0.52**</td>
<td>0.33**</td>
<td>0.25**</td>
<td>0.33**</td>
<td>-0.08</td>
<td>0.22**</td>
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<td>F(2,176)</td>
<td>75.68</td>
<td>18.71**</td>
<td>61.55**</td>
<td>63.58**</td>
<td>7.20**</td>
<td>38.29**</td>
<td>5.63**</td>
<td>33.11**</td>
<td>9.45**</td>
<td>17.53**</td>
</tr>
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<td>R²</td>
<td>.46**</td>
<td>.17</td>
<td>.41</td>
<td>.42</td>
<td>.08</td>
<td>.30</td>
<td>.06</td>
<td>.28</td>
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<tr>
<td>ΔR²</td>
<td>.62**</td>
<td>8.07**</td>
<td>3.78**</td>
<td>18.89**</td>
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<td>8.44**</td>
<td>4.33**</td>
<td>7.33**</td>
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* \( p < .05 \)

** \( p < .01 \)
hypothesized that SC would be positively related to healthy concern, where both share a regard for self as a subject. By contrast we assumed that SC would be negatively related to pathological concern, where regard for self as an object accompanies a caring attitude toward the other. Moreover, we assumed that these different associations would be reflected in their relationships with different aspects of the self, emotional well-being and interpersonal orientation.

Our findings supported our hypothesis regarding the negative association between SC and PC. Indeed, while one’s self compassion is reflected in the tendency to be caring and understanding toward oneself, rather than harshly critical or judgmental, one of the core characteristics of pathological concern is a tendency to repress and deny one’s own self-interests.

Interestingly, no relationship was found between HC and PC. This finding converges with a previous study (Shavit & Tolmacz, 2014) which indicated that pathological concern may evolve from an egocentric motivation for caregiving (as a means of obtaining a sense of control, receiving help, or gaining some reward in the future); healthy concern, by contrast, seems to express more altruistic motives.

Surprisingly, we did not find any relationship between SC and HC. Therefore our assumption that SC and HC would be positively associated was not confirmed. Furthermore, regarding the dispute presented above, our results support the distinction between agency and communion made by Abele and Wojciszke (2007). In other words, the understanding of depression, if attained, would simultaneously reveal itself in one’s attitude toward oneself and also toward another was not confirmed. This finding suggests that at the core of each of the three constructs, there are essential characteristics that distinguish one from the other. The fact that each of these constructs was uniquely related to different aspects of well-being, emotional difficulties and interpersonal orientation enables us to further explore and conceptualize their unique qualities.

Our findings indicate that, in general, individuals high in SC enjoy a high level of well-being. It is evident that they feel competent, autonomous, well-aware and motivated by their own choices and preferences. Individuals high in healthy concern also share a sense of competence; they do not, however, display a similar sense of agency, and the satisfaction of their psychological needs is based on aspects of relatedness. When it comes to individuals high in PC, our findings paint a completely different picture. These individuals are profoundly lacking in their senses of autonomy, competence and relatedness. Moreover, in contrast to individuals high in SC, individuals high in PC experience a deficiency in their capacity to attend to and follow through with their own self-needs and wishes.

Turning to aspects of interpersonal orientation, our findings reveal significant differences between the three constructs. While individuals high in SC are fairly confident in interpersonal situations, they are primarily oriented toward their own need for autonomy. Individuals high in HC, by comparison, seem to be profoundly oriented toward the other, and their lack of fear of being rejected suggests that they have a healthy sense of relatedness and that they strive for communion. But the findings regarding individuals high in PC again tell a very different story. These individuals are extremely anxious within interpersonal settings. They are intimidated by the mere possibility of being rejected, a fear which may explain their preference to be avoidant within interpersonal encounters.

The aspect of emotional difficulties clearly distinguishes between the three constructs. It seems that one can graphically posit SC and PC at two ends of the spectrum of emotional difficulties. People high in SC are characterized by availability of positive affect and lowered vulnerability to emotional pain. In contrast, people high in PC appear to be extremely vulnerable to experiencing emotional difficulties and pain. This consistent pattern suggests that SC serves as a defense strategy from emotional pain through self-nourishment. On the other hand, PC reflects a severe deficiency in maintaining emotional resilience due to denial of self-needs. Notably, the association between HC and anxiety suggests that HC does not essentially serve as a strategy to avoid emotional pain. In order to better comprehend the nature of HC, as well as SC and PC, we will now turn to an integration of our findings across the three aspects described.

The current study was initiated under an assumption that SC and HC were complimentary constructs and similarly distinguished from PC. Our findings, however, indicate the existence of a more complex relationship between the three constructs. Individuals high in PC may appear to be deeply interested in the other and in interpersonal relationships; our findings, as well as previous ones (Shavit & Tolmacz, 2014), suggest that this display is nevertheless better understood as a strategy to cope with their fragile sense of self and an attempt to establish a sense of competence through satisfying others’ needs at the expense of their own self-needs. In other words, they allegedly employ a self-as-object and other-as-subject form of relationship. Thus by its very nature PC contradicts both SC and HC, and pathologically concerned individuals are in fact likely to experience great difficulty and pain in daily living.

Additionally, while individuals high in SC and HC experience greater well-being, satisfaction and competence in their daily lives, we suggest that their sense of competence is linked to different dispositions. Self-compassionate individuals are focused primarily upon self-nourishment, and when struggling, are able to cope in a mindful manner (Germer, 2009). In contrast, healthy concerned individuals’ primary satisfaction derives from their ability to rise above their own self-nourishment needs and recruit their finest human capabilities to fulfill their deep concern for others. In order to illustrate the difference between these two attitudes, we draw upon extracts from two notable commencement speeches:

“…Your time is limited, so don’t waste it living someone else’s life. Don’t be trapped by dogma — which is living with the results of other people’s thinking. Don’t let the noise of others’ opinions drown out your own inner voice. And most important, have the courage to follow your heart and intuition. They somehow already know what you truly want to become. Everything else is secondary…”  
[Steve Jobs]

“…”What I regret most in my life are failures of kindness. Those moments when another human being was there, in front of me, suffering, and I responded … sensibly. Reservedly. Mildly. And so, a prediction, and my heartfelt wish for you: as you get older, your self will diminish and you will grow in love. YOU will gradually be replaced by LOVE. If you have kids, that will be a huge moment in your process of self-diminishment.”  
[George Saunders]

3.1. Limitations and future directions

Before ending this discussion, it is important to make clear that the studies reported here represent only an initial examination of the relationship between these three constructs and their affinity with different aspects of the self, emotional well-being and interpersonal orientation. The constructs were initially examined as concurrent traits when in fact, as mentioned, the attainment of the capacity for concern entails a developmental perspective. In addition, the current studies were conducted with Israeli young adults. Further studies should attempt to examine the replicability and generalizability of the findings to other age, cultural, ethnic, and religious groups, as well as their applicability to a developmental perspective. Future research should also examine the contribution of these constructs within the realm of intimate relationships. For example, it might be interesting to explore relational satisfaction among couples bearing different variations of the three constructs across different phases of their shared lives (e.g., during pregnancy,
prolonged illness, etc.). This line of research could also be relevant to other interpersonal settings such as occupational and communal fields.

References


References