ДИ О ГЕН БИБЛИОТЕКА
Психология
2024

THE FLOW OF COMPASSION AND SELF-COMPASSION

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DOI: 10.54664/NMCL4556

Abstract: This article outlines the main trends in psychological research devoted to the flow of compassion for others and for the self. Attention is drawn to the fear of compassion for others, from others and for the self, with an emphasis on the beneficial effects of the healthy flow of compassion for the overall well-being. Different dispositions and motivations towards giving and receiving compassion will likely lead to a very different flow of compassion, resulting in different psychological outcomes. The paper also presents existing trends in research on the relations between the flow of compassion and attachment styles, goals and fear of compassion.

Keywords: compassion; self-compassion; fear of compassion; flow of compassion; well-being.

Flow refers to the "dynamic reciprocal processing nature of compassion" (Kirby et al. 2019). Even though self-compassion, compassion for others and from others may influence each other, it may also operate independently (Kirby et al. 2019). For example, high self-compassion may be combined with low compassion for others at the individual level (Lopez et al. 2018). Research also indicates that high compassion for others increases the likelihood of self-compassion (Breines & Chen 2013).

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Compassion and self-compassion have been mostly studied as separate constructs (Lopez et al. 2018), even though there has been growing interest in investigating their interaction as well. The above dualistic approach reflects a departure from the fundamental relevance of compassion as "breaking down barriers between self and other" (Quaglia, Soisson & Simmer-Brown 2020). This dualism is further reflected not only in studying each construct on its own merit, but also in terms of measurement scales. At the same time, some researchers have already highlighted the interdependent nature of the constructs (Longe et al. 2009; Gilbert et al. 2011), and strides are made to develop appropriate instruments to measure and approach compassion and self-compassion in an integrated way. According to Buddhist views, compassion is essential to both your own and others' happiness, since suffering inextricably brings pain to both the self and the others (Crosby & Skilton 1996, cited in Quaglia, Soisson & Simmer-Brown 2020). The division of research and measurement translates into a division of training such as a one-week compassion training and a one-week self-compassion training (Jazaieri et al. 2014). While analyzing the training, the scholars found that, among 94 studies devoted to the topic, only 5% put equal importance on both. No studies have blended both self-compassion and compassion into a single training. They have tended to stress either of the concepts in terms of outcomes (the self being privileged) or training (other-compassion training being privileged). We agree with Quaglia, Soisson and Simmer-Brown (2020) that while such dichotomy is beneficial for quantitative scientific inquiry, research and practical accessibility, it also runs the risk of undermining the power and true nature of the construct as reflecting the all-encompassing nature of compassion, in which the self is part of the whole. This could "diverge from the foundations," lead to inaccuracy, and undermine the true potential of the construct (Quaglia, Soisson & Simmer-Brown 2020).

As Gerber, Tolmacz and Doron (2015) point out, concern is not a "monolithic concept," but is shaped by various motives, fears, emotions, mental representations and behavioural inclinations. Two

forms of concern are distinguished: healthy concern and pathological concern.

Research has reported on the beneficial effects of self-compassion as a protective factor against depression, anxiety and stress (Macbeth & Gumley 2012). At the same time, concerns have been raised on the effectiveness of self-compassion in isolation (Kirby, Day & Sagar 2019), which is consistent with the concept of compulsive self-reliance (Bowlby 1969, cited in Kirby, Day & Sagar 2019). The mutual exchange of compassion between people enables regulation of suffering via "calming, soothing and connecting" (Kirby, Day & Sagar 2019). Thus, fears of giving and receiving compassion impede "affect regulation via social relating" and make people susceptible to various mental health problems such as depression, anxiety, self-criticism, shame, etc. (Kirby, Day & Sagar 2019). "Healthy concern" in which caring for others is balanced with self-care is considered an optimal from of concern unlike "pathological concern," where self-care is neglected at the expense of caring for others (Gerber, Tolmacz & Doron 2015). In a study including 187 participants, it was reported that self-compassion was inversely related to pathological concern, which is in line with self-compassionate people being able to provide self-care and nourish themselves in trying times and circumstances, whereas in the cases of pathological concern, self-care and self-interest are commonly denied. The same study reported no link between healthy concern and psychological concern, which may reflect the different motivation underlying both constructs: in the case of pathological concern, egocentric motivation prevails, whereas in healthy concern, altruistic motivation leads. Furthermore, both self-compassion and healthy concern were uniquely related to positive measures of well-being, whereas pathological concern was linked to higher depression, anxiety, stress, loneliness, and other variables. In both cases, well-being is derived via different mechanisms (Gerber, Tolmacz & Doron 2015). In the case of self-compassion, well-being is derived via self-care, and with healthy concern it is guided by the response to the concern for others by rising above the need for self-care.

As Cassell (2004) points out, “No person exists without others; there is no consciousness without a consciousness of others, no speaker without a hearer.” Compassion involves the self and the other. By bonding with another person, compassion along with other self-transcendent emotions helps us benefit from the social side of our beings (Stellar et al. 2017). Compassion is not static but flows in a process of giving and receiving, unique for each individual. It can also vary according to the situation.

Germer & Neff (2019) indicate that some people first need to receive compassion from others before they can extend it. Also, it is possible for a person to be highly compassionate towards others but short on self-compassion, as well as to be high in self-compassion but low in compassion for others. “For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one’s own feelings and to care for one’s own welfare… Caring for others requires caring for oneself.” (14th Dalai Lama, cited in Mills & Chapman 2008). The above relationship has also been confirmed empirically. In a study among hospice workers, it was confirmed that better self-care was linked to higher compassion satisfaction, as well as to lower burnout and compassion fatigue (Alkema, Linton & Davies 2008). Compassion satisfaction was positively correlated with emotional and spiritual self-care, as well as with work-life balance. However, no relationship was reported for the physical, psychological, and workplace aspects of self-care. According to Radey and Figley (2007), encouraging compassion satisfaction can be a crucial protective element when dealing with suffering rather than avoiding compassion fatigue. At the same time, the presence of positive affect, adequate resources and self-care does not automatically guarantee compassion satisfaction.

When experiencing motivation to help, areas of the brain are activated that are associated with affiliation and reward (Lown 2016). Unfortunately, a gap exists between the perception of the suffering experienced by a person and an observer. This gap in perception has been estimated as 70% in a study at a teaching hospital (Lesho et al.

2009, cited in Lown 2016). This means that a great deal of patients does not perceive the care they receive as compassionate, and a large number of physicians do not perceive patients' suffering sufficiently.

Positive and Negative Attitudes Towards Compassion

Different dispositions towards giving and receiving compassion will likely lead to a very different flow of compassion, resulting in different psychological outcomes. Individual differences in attitudes towards compassion have a direct impact on emotions, expressions and behaviour outcomes (Kirby et al. 2019). A positive attitude towards compassion is compassion satisfaction, whereas a negative attitude is the fear of compassion. Thus, attitudes can either encourage or prevent compassion, which has important implications for both theory and practice.

In a study by Kirby et al. (2019), positive attitudes towards compassion among the general population were linked to a rise in explicit compassion experience, as measured by compassion for sad faces. In addition, positive attitudes also predicted compassionate behaviours, trait compassion and empathy (self-reported). Negative attitudes towards compassion were linked to decreased emotion and trait compassion, and this relationship was particularly significant for the fear of compassion for others.

The fear of receiving compassion is linked to anxious attachment, stress, depression, and self-criticism (Gilbert et al. 2011; Hermanto et al. 2016). A study conducted by Hermanto et al. confirmed the positive relationship between self-criticism and depression, with the link being stronger for individuals fearing to receive compassion. At the same time, being open to receiving compassion acts as a protective factor against depression (2016). Thus, people with high self-criticism but open to receiving compassion are less likely to suffer from depression.

Another study reported care-seeking as a predictor of self-compassion (Hermanto & Zuroff 2016). This relationship was stronger

when the care-seeking individuals were also caregiving, resulting in the highest levels of self-compassion. The lowest self-compassion level was linked to low care-seeking and high caregiving. At the same time, the fear of compassion can be broken down into three dimensions: fear of compassion from others, fear of compassion for others, and fear of compassion for the self (Gilbert et al. 2011).

The following scenarios are possible:

1) High giving compassion, high receiving compassion

High giving compassion combined with high receiving compassion is the most optical flow in terms of healthy psychological functioning.

2) High giving compassion, low receiving compassion

It is possible to be open to giving compassion but not to receiving it. Difficulty in terms of the latter is linked to fear of compassion, which could be attributed to several reasons:

- receiving compassion or care is unfamiliar (Gilbert et al. 2011);
- "activate grief of wanting but not receiving compassion" (Gilbert et al. 2011); in this case, people may become acutely aware of their loneliness and may activate yearning for fulfilling relationships. In case the grief is very intense, it may cause distancing from the compassion of self-compassion (Gilbert et al. 2011);
- receiving kindness is perceived as weakness (Gilbert et al. 2011);
- receiving compassion is undeserved (Gilbert & Procter 2006);
- fear of letting others come close (Gilbert & Procter 2006);
- fear of losing one's identity (Gilbert & Procter 2006);
- egoistic motivation for anxiously attached individuals, ex. social desirability (Gilbert et al. 2011; Mikulincer et al. 2005).

3) Low giving compassion, high receiving compassion

It is also possible to be open to receiving compassion, but not to giving it, which denotes fear of expressing compassion for others. Some of the reasons for that are:

- deemed deservingness of the suffering (Gilbert et al. 2011);
- fear of being taken advantage of (Gilbert et al. 2011);

• distress of witnessing the suffering (Gilbert et al. 2011);

• self-preoccupation under anxious attachment styles (Mikulincer et al. 2005);

• avoidant attachment style (Mikulincer et al. 2005).

4) Low giving compassion, low receiving compassion

Low receiving compassion has been associated in research with fear or positive emotions and fear from compassion from others.

Gilbert et al. (2011) conducted a study among 222 students and 53 therapists. The scholars report that fear of self-compassion is positively linked to fear of compassion from others. Both types of compassion are related to self-criticism, self-coldness, insecure attachment, anxiety, stress, and depression (Gilbert et al. 2011).

The fear of positive and affiliative emotions and affect regulation could also be at the root of the dysfunctional receiving of compassion from others (Gilbert et al. 2011). Positive and affiliative emotions are born out of closeness and interaction with others. Children from abusive and neglectful family backgrounds could grow up with the idea that feeling happy is unusual, unacceptable, etc. In dysfunctional family environments, children start associating closeness with various negative outcomes (anger from a family member, loss, abuse, etc.). Thus, "positive emotions could be conditioned to, and associated with, aversive outcomes" (Gilbert et al. 2011). The fear of positive emotions signals and helps avoid a potentially negative outcome.

Gilbert et al. (2011) emphasize that the capacity for compassion is inextricably linked to the attachment system, which is comparable to a book. When closed as in the cases above to avoid "aversive outcomes," it will eventually reopen on the same page. Thus, the memories become deeply imprinted and need to be addressed via therapy in order to restore the capacity for compassion, positive and affiliative emotions. According to Gilbert et al. (2011), the fear of self-compassion and from others may be indicative of impaired capacity for generally experiencing affiliative emotions, with anxious attachment representing fear of affiliation.

In addition, in neglectful and abusive family environments, receiving care and compassion may have been so absent that the unfa-

miliarity of such emotion causes people to distance themselves from it (Gilbert et al. 2011). This may be further complicated by triggering memories of having wanted to experience interpersonal closeness and affiliation, but having been denied it, thus regressing to the more familiar state of loneliness and rejection even in cases when others are willingly extending compassion and care. This scenario is quite close to the avoidance attachment style described by Bowlby (1973).

Affiliative emotions have a beneficial impact on well-being through an increase in endorphin and oxytocin, which have calming effects (Gilbert et al. 2011). Individual differences exist in this effect of affiliative emotions on well-being. A study by Rockliff et al. (2008) found that a crucial distinguishing element was self-criticism. Respondents who reacted to compassion-inducing imagery with an increase in heart rate variability, accompanied by a decrease in cortisol levels, were also low in self-criticism and had secure attachments, whereas those who reacted with a decrease in heart rate variability had high self-criticism, anxious attachment, and various psychopathologies. Higher heart rate variability indicates safety and self-soothing abilities, whereas lower heart rate variability indicated increased threat (Porges 2007, cited in Rockliff et al. 2008).

Secure attachment, on the other hand, promotes both giving compassion to and receiving it from others (Mikulincer & Shaver 2007). People who are securely attached perceive compassion and kindness as sources of support and are open to them, whereas people with insecure attachment styles usually either avoid or stick to attachment anxiously, since they are not sure whether support is available.

The low giving of compassion has been linked to various underlying factors. For example, Mikulincer et al. (2005) confirm that seeking help is perceived as a weakness by avoidantly attached individuals. They find that distress caused by another's suffering also leads to distancing and withholding compassion. In addition, if the person is deemed to have caused his/her own suffering or done an injustice (Batson et al. 1995), compassion may be withheld. The low giving of compassion to others can stem from self-interest or from an

avoidant attachment style. Anxious attachment, on the other hand, has been linked to high giving of compassion (Gilbert et al. 2011).

Fear of Self-Compassion

When incorporating the direction of compassion into the flow, more combinations of the four options above are possible by adding self-compassion (fearing or extending self-compassion). Studies confirm that fear of self-compassion is in high correlation with fear of compassion from others (Gilbert et al. 2011). The fear of self-compassion could be attributed to the following:

- a hard time expressing compassion to oneself (Gilbert et al. 2011);
- self-criticism (Gilbert et al. 2011);
- environments featured by a lack of affection/abuse (Mikulincer & Shaver 2007);
- social desirability to report compassion for others more so than for oneself (Lopez et al. 2018). Research by Gilbert & Procter (2006) confirms that people high in self-criticism may experience a hard time being self-compassionate, while at the same time being willing to extend compassion to others.

Self-compassion has been negatively connected with depression, anxiety, self-criticism and rumination (Neff 2003a), and positively with optimism and happiness (Neff 2003b).

In an interpretive phenomenological study, Pauley and McPherson (2010) concluded that depressed individuals experienced the opposite of self-compassion. Being self-compassionate was difficult for respondents either because they did not believe they have the skills to be self-compassionate, or because depression and anxiety interfered with self-compassion. In the first scenario, participants reported that they had not experienced self-compassion, or it was very limited due to "long-standing" negative attitudes towards oneself (Pauley & McPherson 2009). In the second scenario, participants reported that self-criticism increased when they felt anxious or depressed. In addition, they tended to focus on the negative aspects of events, as well as to feel isolated from others by losing desire for self-care and for be-

ing self-judgmental. Thus, self-compassion marks healthy emotional functioning, denoting a normal flow. The lack of self-compassion is associated with an unhealthy flow and can be the result of either losing the ability to be self-compassionate or of never having experienced it. The study also shed light on the experience of compassion, which was perceived by the participants as involving action beyond sentiment (Pauley & McPherson 2009).

A meta-study of the association between fear of compassion scales and mental health reported indicators of 0.40 (for self-compassion), 0.30 (for compassion for others), and 0.48 (for compassion from others) (Kirby, Day & Sagar 2019).

In a study to validate scales for measuring the above three types of fears related to compassion, Gilbert et al. (2011) report a very high correlation between fear of self-compassion and fear of compassion for others in both groups of respondents (0.51 and 0.67). According to the same scholars, these high correlations reflect "difficulty in experiencing affiliative emotions in general."

Self-criticism is found to be strongly correlated with the fear of compassion for the self and from others (Gilbert et al. 2011). Self-critical people can perceive happiness and compassion from others as "unpleasant and mocking" (Strnadelova, Halamova & Mentel 2019). An eye-tracking study confirms that people with different levels of self-criticism vs. self-assurance display different eye fixation patterns towards happy faces (Strnadelova, Halamova & Mentel 2019). Self-criticism is further broken down into inadequate self and hated self. People with the more pathological form of hated self tend to avoid direct eye contact with happy faces, whereas those with inadequate self tend to focus on all areas of the face. People with self-reassurance focus more on the areas around the eyes. The findings above have direct implications for receiving compassion. By not focusing on the areas of the eyes which reveal true happiness, people high in self-criticism may be missing or misinterpreting important opportunities for receiving compassion when needed.

Self-criticism, on the other hand, can differ in form and function. It can either be targeted at punishing or destroying the self, or

at improving the self and preventing past mistakes (Hermanto et al. 2016). Several theories in psychology share the notion that self-criticism is linked to strict and controlling family environments (Hermanto et al. 2016). The fear of receiving compassion may be seen as a sign of weakness and confirms a negative self-image (Gilbert et al. 2011); people may feel undeserving of compassion or unfamiliar with the experience, or it may awaken painful childhood memories (Gilbert et al. 2011). Studies have reported that people high in self-criticism have the tendency to fear receiving compassion (Gilbert et al. 2011; Gilbert et al. 2014). Self-criticism is confirmed as positively correlated to depression and to fear of receiving compassion across four samples varying in age, geographical and cultural context (Hermanto et al. 2016). According to Hermanto et al. (2016), this is due to an "overdeveloped and chronically activated threat system" and to an "underactivated soothing system," displaying problems with brain maturation (Gilbert & Procter 2006). This is likely linked to their motivation to achieve and maintain their positive self-image and to underestimate the interpersonal domain (Mongrain & Zuroff 1995, cited in Hermanto et al. 2016). The avoidant attachment style, typical of self-critical individuals, also contributes to perception of low social support and to fewer requests for support, exacerbating negative affect and promoting depressogenic attitudes (Hermanto et al. 2016).

Some people who are unfamiliar with the experience of compassion due to rigid family environments lack the ability to be compassionate and accepting towards themselves. Children who have been exposed to abuse, neglect, criticism, rejection, withdrawal of love when seeking care or expressing anger may learn to internalize those experiences in their self-concept (Gilbert & Procter 2006). They claim that self-blame is a "learned defensive response in conflicts with others."

Depression is positively linked to fear of compassion for the self and from others, which in turn is positively linked to anxious attachment styles for both groups of respondents (Gilbert et al. 2011). The authors conclude that these styles may go beyond fear of rejec-

tion and abandonment but may represent fear of affiliation. Such conclusion is in line with other research (Mikulincer & Shaver 2007).

In addition, the fear of compassion for the self and from others is highly correlated to the fear of extending compassion to others in one of the samples (Gilbert et al. 2011). Further analysis confirmed that the fear of compassion for others in this group was also linked to insecure attachment styles. A similar finding is also attested by Mikulincer et al. (2005) through five experiments in different countries. All of them consistently concluded that increasing attachment security led to an increase in compassion and to real altruistic behaviour. Attachment avoidance was connected with lower compassion and willingness to help, whereas attachment anxiety was linked to personal distress and did not lead to actual helping behaviour (Mikulincer et al, 2005). According to the authors, the sense of attachment security frees energy that is redirected to the caregiving system, allowing for a more compassionate attitude in case of distress. In the third study, the increase in security led to an increase in compassion and to willingness to help a person in distress, with the best effects in the absence of expectations of empathic joy. The latter as a motive for helping has been linked to the desire to help the other for the purpose of enjoying the dissolution of their distress, which was reported to be connected with insecurely attached individuals (Mikulincer et al. 2005). In this way, the scholars place compassion and helping within the framework of the attachment personality theory.

Thus, the flow of compassion is impacted by the above fears of compassion. Compassion may be present in a given context, but due to internal affect regulation, there may be a blockage in giving or receiving it (Gilbert et al. 2011). The same scholars suggest two possible ways to address this via therapy: either working within the emotional system or the attachment system.

Thus, in order to extend compassion, one needs to be able to "tolerate distress" caused by the suffering of the other (Gilbert 2010). If one gets consumed by distress, one may not be able to help if we get consumed by our discomfort (Strauss et al. 2016).

Going back to the positive and negative aspects of compassion, Radey and Figley (2007) raise the important question of how much positivity is needed to balance the negativity associated with the suffering. In that aspect, it is useful to consider the positivity ratio, or the ratio of positive to negative affect. According to the authors, a positive ratio (3:1 and more) can translate in caregivers being able to transform the distress into compassion satisfaction by using the power of positive affect, resources, and self-care.

Compassionate and Self-Image Goals

The flow of compassion can also be investigated within the framework of support giving and receiving. It is confirmed that the provider, the receiver and the situation have weight in the effectiveness of support (Sarason, Pierce & Sarason 1990). For example, personality and attachment styles of both the giver and the receiver can influence how the support is being perceived and interpreted.

Excellent research on giving and receiving support as a function of types of goals has been carried out by Crocker and Canevello (2008). They focus on goals because they are a very clear expression of intentions, which in turn have direct bearing on the effectiveness of the support (Sarason, Pierce & Sarason 1990). Two major types of goals are relevant: compassionate and self-image goals. When people have compassionate goals, the focus is on increasing the well-being and on reducing the harm for another person. Such people have a transcendental perception of universal connectedness (Crocker & Canevello 2008). They also see relationships as a non-zero sum in a sense that gains by another person are not viewed as taking away from another. When people have self-image goals, the focus shifts to their own self-image and self-interest. They view relationships as instruments to obtain and to improve their own well-being. Success achieved by one person is perceived as failure for another (zero sum).

In the first case, when people have compassionate goals, they are very likely to receive support in response through projection of the warmth and compassionate caring that they elicit towards others (Crocker & Canevello 2008) without having had such an intention in

the first place. Since people with compassionate goals would be more likely to extend help, the recipients of support would feel warmth and compassion; they will connect to the provider and will be more likely to extend help in turn. All the above leads to an increased perception of available support for the provider as well, which would instigate an "upward spiral" of further willingness to help.

Crocker and Canevello (2008) suggest that goals in relationships are the critical ingredient for the flow and "upward spiral" of support. Consistent with their idea above, they predicted that people high in compassionate goals combined with low self-image goals were associated with a substantial increase in perception of available social support among university students over the trimester. In addition, they had higher self-compassion, higher agreeableness and extraversion. They also reported more trust, less loneliness and conflict. On the other hand, students with high self-image goals reported loneliness, conflicts, individualistic caregiving and a lower perception of available support.

What is more interesting is that people who had high compassionate goals combined with high self-image goals reported very different results, with no substantial increase in perceived availability of support over the trimester. This finding leads to the conclusion that self-image goals erode the positive effects of compassionate goals on trust and support. A possible explanation for this is that self-image goals may dilute the effect of compassionate goals and send mixed signals to the receiver. Thus, mistrust in the intentions of the provider of support may lead to the behaviour not being perceived as supportive, but as self-interested by the receiver.

In a subsequent study to delve deeper into the mechanism of the above interaction between goals, Crocker and Canevello (2008) examined intrapersonal and interpersonal perceptions of support and actual support between roommates over 21 days. The results confirm that changes in actual experience of support occur that go beyond intrapersonal perceptions. Thus, high compassionate goals also lead to an increase in the support given, the support perceived by the receiver, and the actual social support received by the giver in turn.

Conclusion

In light of the above research, the question of the optimal flow of compassion and self-compassion becomes even more significant. The lack of empathy has been linked to various types of psychopathologies like aggression, antisocial behaviours, self-absorption, narcissism, inability to build emotional bonds, etc. (APA 1987, cited in Zahn-Waxler & Radke-Yarrow 1990). On the other hand, excessive empathy has been linked to blurred boundaries with others, approaching their problems as one's own, thus precluding self-actualization, autonomy and mature social connections, mixing empathy with guilt, etc. The lack of empathy or overinvolvement have been linked with marital discord, parental depression, parental maltreatment, and other risk factors (Zahn-Waxler & Radke-Yarrow 1990). This has important implications for theory and practice, as incorporating the optimal flow of compassion may be more effective than focusing on raising either compassion for others or self-compassion.

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