

## “Thou shalt love thy neighbor as thyself”?

### The relationship of self-care with empathy and altruistic behavior

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#### ABSTRACT

##### Aim

The aim of the study was to investigate whether self-care, understood as a set of functions ensuring one's own safety and personal development, promotes a tendency toward empathy and altruism.

##### Method

The study was conducted online on a group of 331 people, using the Self-Care Questionnaire, the Empathic Sensitiveness Scale, the Altruism Questionnaire, and the Social Desirability Questionnaire. The data was analyzed using both a variable-centered and a person-centered approach.

##### Results

Results obtained through path analysis revealed that the association between self-care capacity and engaging in altruistic behavior was mediated by tendencies toward empathic concern and perspective-taking. Self-care contributed to willingness to behave for the benefit of others, as it fostered other-oriented empathy. Cluster analysis results confirmed that properly developed abilities to protect and care for oneself were accompanied by empathic sensitivity to the welfare of others and willingness to engage in altruistic behavior. Notwithstanding, the results also indicated that self-care deficits do not preclude engaging in helping activities when they allow one to reduce one's own empathic suffering.

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**Conclusions**

Results obtained through correlation-regression and cluster analyses demonstrated that self-care promotes mature empathizing – associated with empathic concern and perspective-taking – and engaging in selfless actions for the benefit of others.

**Keywords:** self-care, altruism, empathic concern, personal distress, perspective-taking

**Introduction**

This paper is concerned with capacity for self-care, defined after the ego psychologists Khantzian and Mack (1983) as a set of functions ensuring personal development and safety. The authors relate this potential to Hartmann's synthesizing function of the ego (Hartmann, 1958) and, following A. Freud (1963), narcissistic cathexis of the self, conditioning its efficient functioning. The synthesizing/organizing function of the ego makes it possible to reconcile the goals of the various instances of the psychic apparatus with the demands of the environment, distant goals with current ones, and immediate gratification with the drive for self-preservation. Thus, it enables various types of activity, including such pro-developmental actions that require assessing and balancing the level of risk. Discussing these kinds of existential "growth or safety" dilemmas, Maslow (2009) argued that we face them from an early age – even as children we had to overcome the fear of falling in order to learn to walk. Constantly choosing safety would condemn us to stagnation, while ignoring it entails pain, ill health, or even death.

Representatives of mainstream developmental psychology generally agree that a child's early relationship with the mother is pivotally significant, satisfying the child's narcissistic need to be an object of love, allowing it to internalize the functions of gratification and soothing, and enabling it to consider signals of anxiety (e.g., A. Freud, 1963; Kernberg, 1976; Khantzian & Mack, 1983; Krystal, 1978). Disruptions in the attachment relationship and in the care provided to the child within its framework interfere with the development of capacity for self-protection. This issue has been discussed in more detail elsewhere (e.g., Stawicka, 2008; Suchańska, 1998). For the purposes of the current paper, however, it is worth noting that attachment theory links children's attitudes toward both themselves and others to the quality of their early relationships with their caregivers (e.g., Bartholomew & Horowitz, 1991). Meanwhile, self-care, defined as concern for one's own safety and development, does not necessarily imply sensitivity to the plight of others, which would undermine its postulated adaptive nature. The question whether self-care is socially adaptive in nature, i.e., whether it limits or promotes sensitivity to the safety of others, seems relevant to determine the theoretical and axiological status of this construct.

**Self-Care**

As suggested in the introduction, the idea of internalized self-care is based on the premises of ego psychology and object relations theory and is rooted in S. Freud's

(2004) concept of self-preservation drives of the ego. Its detailed treatment was presented by Krystal (1978) and Khantzian and Mack (1983). Based on analysis of individuals suffering from addictions and psychosomatic disorders, the said authors surmised that behaviors which are dangerous and manifest lack of concern for one's own well-being stem from functional deficits in capacity for self-protection and self-care, resulting from defective early childhood relationships with significant others.<sup>1</sup>

Krystal's (1978) concept of an intrapsychic block that prevents the use of natural vital functions emphasizes distortions in self- and object-representation and disturbances in the development of emotions. According to the author, "early mothering is experienced as permission to live" (Krystal, 1978, p. 177). Trauma resulting from maternal dysfunction makes it difficult to create an autoerotic substitute for the mother and internalize the caring functions she performs. At the intrapsychic level, the maternal object-representation is "walled off," which inhibits the integration of its functions and the exercise of self-help, self-soothing, or self-comforting. This leads to the perception of the mother as the sole source of satisfaction or to the sense that the protection of one's life remains within the purview of external objects: parents, doctors, or fate. The blocking of the potential for self-care is accompanied by a distortion of affective development, involving a blockage of the processes of affect differentiation, desomatization, and verbalization. Emotions then have no signaling function and cannot be used in self-regulation (Krystal, 1978).

Khantzian and Mack (1983) attempted to conceptualize the construct of the ego's self-care function and to identify its constituents, the proper internalization of which requires the integration of the caring and normative components as well as the affective and cognitive ones. The complex set of functions designated by the authors as self-care consists of seven elements, necessary to realize the drive for self-preservation and ensure safe development (Khantzian & Mack, 1983):

- a libidinal investment in caring about or valuing oneself and its psychological derivative – sufficient positive self-esteem to feel oneself to be worth protecting,
- the capacity to anticipate danger and respond to its anxiety cues,
- the ability to control impulses and renounce pleasures whose consequences are harmful,
- pleasure in mastering inevitable situations of risk, or in which dangers are appropriately measured,
- knowledge about the outside world and oneself sufficient for survival in it,

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<sup>1</sup> The concept closest in meaning to self-care in contemporary psychological theories other than the ones referred to in this text seems to be the construct of the Parent Self state proposed by Berne (1998) in transactional analysis. This is because it encompasses the cognitive and emotional components of both key aspects of caregiving: protecting one's own person as a value and supporting its development. In Baumeister's (2004) social-cognitive approach, the concept of the self's executive function includes the phenomenon of adaptive self-regulation, which undoubtedly supports self-care. However, this is only one aspect of self-care.

- sufficient self-assertiveness and aggressiveness to be capable of active protection,
- certain relational skills, especially the ability to recognize individuals and relationships that will enhance one's quality of life or at least will not jeopardize it.

This list, supplemented by the internalized soothing and gratification functions postulated by Krystal (1978), became the basis for subsequent attempts to operationalize the self-care construct, including the most recent one used in the present study (Kozłowska, 2005; Pilarska & Suchańska, 2021a, 2021b; Suchańska, 1998, 2001; Suchańska, Pilarska, & Brzeg, 2019).

### **Self-Care and Willingness to Act for Others**

As mentioned in the introduction, reflection on the adaptive significance of self-care leads to the following question: does self-care, defined as functioning oriented toward one's own development and safety, limit or promote sensitivity to the safety of others? Theoretical analyses and empirical data gathered in the search for determinants of self-care capacity point to the attachment relationship. Self-care is fundamentally grounded in the recognition of the self as valuable enough to be worth protecting, which is only possible in the context of a properly functioning early childhood relationship with a caregiver. The empirical data we collected (Pilarska & Suchańska, 2021a, 2021b; Suchańska et al., 2019) confirm that secure attachment significantly explains self-care capacity. Importantly, attachment that provides a sense of security is also an important factor for the socialization of empathic responsiveness and helping behavior. Already Bowlby (1982, 1988, as cited in Collins & Ford, 2010) suggested that only when a person's attachment needs have been satisfied will they be willing to engage in behaviors mediated by other behavioral systems, such as the caregiving system. Other authors point out further that "the ability to care for others is a reflection of how others have cared for us" (Karbowa, 2012, p. 131). A similar thought – embedded in the idea of mutual involvement or mutual actualization – can be found in Erikson's conception (2002). According to it, "a vitally involved infant is ready not only for the experience of being mothered but also for the development of the conditions basic for an identification with the mother – and the lifelong capacity to act 'maternally'" (Erikson, Erikson, & Kivnick, 1986, pp. 44–46). The impact of experiences formed in the context of attachment on willingness to help can be considered in terms of a modeling effect – affectionate caregiving behaviors of caregivers provide a model for children to adopt (Davis, 2001) – as well as by taking into account the internal operational models formed on the basis of attachment relationships – secure attachment bonds are characterized by positive emotional attitudes toward both oneself and others (Bartholomew & Horowitz, 1991). A study by Main and Weston (1981, as cited in Bowlby, 2007) showed that securely attached children exhibited concern at the distress of adults who had earlier attempted to engage the children in play. The persistence of such response patterns after two years from an initial attachment diagnosis was noted

in a study by Waters, Wippman, and Sroufe (1979, as cited in Bowlby, 2007). Children diagnosed as securely attached at 15 months were not only more socially proficient in preschool at the age of 3.5 years, but they also showed concern and understanding for the experiences of other children. Adult studies have also shown secure attachment to be associated with exhibiting compassion toward others and engaging in supportive and pro-social behaviors (Mikulincer & Shaver, 2017).

Since we attribute the same origins to self-care and helping others, it seems legitimate to inquire whether the concern for one's own safety and development expressed in self-care is self-centered, or whether it also pertains to others and co-occurs with capacity for empathy and altruism? Is it justified to postulate not only personal but also extra-personal adaptivity of self-care? Our research to date on the psychological correlates of self-care competence does not provide an unequivocal answer to this question (Pilarska & Suchańska, 2021a, 2021b). On the one hand, self-care remains strongly associated with self-esteem, which correlates with narcissism (Łaguna, Lachowicz-Tabaczek, & Dzwonkowska, 2007; Rhodewalt & Morf, 1995), but on the other it is also associated with extraversion and agreeableness, implying greater openness to others.

The present study is an attempt to answer the question outlined above. In order to more fully capture self-care's relationship with empathic tendencies and altruism, the investigation involved both a variable-centered and a person-centered approach. Based on the theoretical considerations above and the results of previous research, we hypothesized that the former approach would reveal a positive relationship between self-care and altruism (hypothesis 1), with a mediating role played by the tendency to show empathic concern and take the perspective of others (hypothesis 2). In turn, we expected the latter approach to enable the identification of clusters representing specific configurations of self-care, empathic tendencies, and altruism (hypothesis 3); in particular, we expected the emergence of a cluster of individuals who would simultaneously exhibit high levels of self-care, be inclined to show compassion toward others and attempt to understand their experiences, and be willing to help others in difficult situations (hypothesis 4).

## Method

### Participants

Data was collected from 359 individuals in total, but analysis was limited to a group of 331 participants because 28 individuals (7.8%) were excluded due to apparently random or careless responding. Two indicators sensitive to different aspects of such responding were used (Curran, 2016; Meade & Craig, 2012). The data was first cleaned using long string analysis (assessing the frequency of marking the same answer in a row), and then Mahalanobis distance was used; the cutoff point for both was  $Z > 2.5$ . The analyzed sample included 167 women

and 164 men. Their age ranged from 35 to 55 years ( $M = 44.53$ ,  $SD = 5.39$ ). Among the participants, 24.5% had primary education, 23.6% had vocational education, 25.7% had secondary education, and 26.3% had higher education. Their places of residence included rural areas (19.9%), small cities up to 20,000 inhabitants (18.7%), medium-sized cities with populations between 20,000 and 99,000 (20.2%), large cities with populations between 100,000 and 500,000 (20.2%), and the largest cities with populations exceeding 500,000 (20.8%).

## Measures

The study used the Self-Care Questionnaire, the Empathic Sensitiveness Scale, the Altruism Questionnaire, and a demographic form containing questions about gender, age, education, and place of residence. Considering that the area of altruistic behavior is saturated with the need for social approval, the Social Desirability Questionnaire was also used to eliminate the influence of this variable on the results.

The Self-Care Questionnaire (SCQ; Pilarska & Suchańska, 2021a) contains 34 items relating to manifestations of self-care functions and divided into following categories: valuing oneself and one's life (6 items), resisting harmful temptations (3 items), readiness and initiative to face life's challenges (5 items), assertiveness and defense of one's rights (5 items), belief in the availability and accessibility of social support (3 items), interpersonal trust and relational failures (5 items), mindful awareness of internal states (3 items), and self-soothing ability (4 items). All the questionnaire's statements are rated on a five-point scale with defined extremes (1 – *does not describe me at all* and 5 – *describes me very well*). It is justified to interpret the results with regard to both the individual dimensions and the overall construct of self-care. The higher the score, the higher the level of self-care. The tool has good psychometric properties. Its internal consistency, determined using Cronbach's alpha, amounts to .89 for the entire questionnaire and ranges from .67 to .86 for the individual scales (Pilarska & Suchańska, 2021a). Reliability coefficients calculated from our data confirm the tool's reliability ( $\alpha = .90$ ,  $\omega = .88$ ; see Table 2).

The Empathic Sensitiveness Scale (ESS; Kaźmierczak et al., 2007) is based on the Interpersonal Reactivity Index (IRI; Davis, 1980) and enables the measurement of three dimensions of empathy: the tendency to feel sympathy and compassion toward people affected by distress (Empathic Concern scale), the tendency to experience fear, distress, annoyance, or discomfort in response to the suffering of others (Personal Distress scale), the tendency to spontaneously adopt the point of view of others in everyday life situations (Perspective-Taking scale). The scale includes a total of 28 statements, which are rated on a five-point scale, with higher scores indicating higher empathic tendencies in a given area. Satisfactory Cronbach's  $\alpha$  reliability coefficients have been demonstrated for each scale (.78, .78, and .74, respectively; Kaźmierczak et al., 2007). In the present study, the values of Cronbach's  $\alpha$  reliability coefficients ranged from .77 to .83, while McDonald's  $\omega$  coefficients ranged from .76 to .81 (see Table 2).

The Altruism Questionnaire (A–N; Śliwak, 2005, 2014) is a two-part tool for measuring altruism. In the abbreviated version, the first part includes 5 stories, accompanied by a set of 6 responses expressing different intensities of altruistic (or non-altruistic) attitudes. The second part includes 5 stories, and the participants express opinions on the decisions made by the stories' protagonists using a six-point scale (from *strongly agree* to *strongly disagree*). The overall score is the total sum of points obtained in both parts. The tool's full version has satisfactory reliability ( $\alpha = .81$ ; Śliwak, 2005). The reliability coefficients for the abbreviated version calculated in our own study were lower ( $\alpha = .67$ ,  $\omega = .65$ ; see Table 2), which can be partly explained by the reduced number of items (by 42%).

The Social Desirability Questionnaire (SDQ; Drwal & Wilczyńska, 1995) is an instrument modeled on the scale by Marlowe and Crowne (1964). It consists of 29 items saturated with social desirability, rated on a dichotomous (*true–false*) scale. The final score is the sum of the points from diagnostic responses, and raw scores can also be converted into sten scores. The questionnaire's reliability is high ( $KR-20 = .81$ ,  $r_{S-B} = .83$ ; Drwal & Wilczyńska, 1995); using Cronbach's  $\alpha$  and McDonald's  $\omega$  coefficients, the present study estimated it at .79 and .76, respectively (see Table 2).

## Research Procedure

The survey was conducted online using the Nationwide Research Panel Ariadna. A similar number of women and men were invited to participate, and care was taken to balance the participants' age, education, and place of residence. The questionnaires included in the survey were arranged in the order in which they are described above. The survey was anonymous and voluntary. For taking part in the survey, the participants received points in the research panel's loyalty program, which could then be exchanged for in-kind prizes.

## Data Analysis Methods

For the purposes of descriptive analysis, means and standard deviations were calculated for all variables in the entire study group, and associations between them and the sociodemographic variables such as gender, age, education, and place of residence were examined. To evaluate the differences between the groups, parametric (Student's *t*, ANOVA) or non-parametric (Mann-Whitney *U*, Kruskal-Wallis) tests were used, depending on whether appropriate assumptions were met. A multiple comparisons procedure was additionally applied to comparisons involving more than two groups.

The collected data were further analyzed in three stages; the first two remained within the framework of a variable-centered approach and the third involved a person-centered approach. In the first stage, correlation analysis was used to determine the interrelationships between the measured variables. In addition to zero-order correlations, partial correlations were calculated, controlling

for the need for social approval. Since the distributions of the analyzed variables deviated from normality, Spearman's rank correlation coefficient was used in the calculations. In the second stage, path analysis was used to assess the direct and indirect effects of self-care on altruism. As the data's distribution did not meet the assumption of multivariate normality, the analysis used a maximum likelihood estimator with the correction proposed by Satorra and Bentler (1994). Estimation of the model's fit to the data was based on CFI, RMSEA, and SRMR, with the assumption that RMSEA and SRMR below .08 and CFI above .90 indicated an acceptable fit (e.g., Marsh, Hau, & Grayson, 2005). In order to deepen the analysis, a cluster analysis was carried out in the next step to empirically identify natural groups with specific constellations of the investigated variables. It was carried out with a two-stage clustering method, using Schwartz's Bayesian Information Criterion (BIC).

## Results

The results of the descriptive analysis, including intergroup comparisons, are shown in Table 1.

Table 1

*Descriptive statistics and associations of the study variables with the sociodemographic variables*

	SC <i>M (SD)</i>	EC <i>M (SD)</i>	PD <i>M (SD)</i>	PT <i>M (SD)</i>	AL <i>M (SD)</i>	NSA <i>M (SD)</i>
Total	114.82 (16.03)	38.27 (6.22)	24.79 (5.06)	31.52 (4.59)	38.05 (6.48)	15.98 (5.01)
Gender						
Women	114.55 (15.95)	39.66 (6.45)	25.89 (4.68)	32.07 (4.55)	38.19 (6.64)	16.17 (4.82)
Men	115.10 (16.16)	36.85 (5.66)	23.68 (5.20)	3.97 (4.57)	37.91 (6.32)	15.78 (5.19)
<i>r (p)</i>	.02 (.772)	.21 ( $< .001$ )	.22 ( $< .001$ )	.12 (.033)	.03 (.582)	.06 (.298)
Age						
Early middle age	114.55 (15.22)	37.87 (6.37)	25.12 (4.98)	31.32 (4.67)	37.02 (6.38)	15.43 (5.22)
Late middle age	115.09 (16.84)	38.66 (6.07)	24.46 (5.14)	31.73 (4.51)	39.07 (6.43)	16.52 (4.74)
<i>r (p)</i>	.04 (.475)	.08 (.165)	.06 (.252)	.03 (.635)	.16 (.004)	.13 (.022)



continuation of Table 1

	SC <i>M (SD)</i>	EC <i>M (SD)</i>	PD <i>M (SD)</i>	PT <i>M (SD)</i>	AL <i>M (SD)</i>	NSA <i>M (SD)</i>
Education						
Primary	114.26 (15.26)	38.62 (5.78)	25.04 (5.14)	31.78 (4.69)	38.21 (5.81)	16.04 (5.48)
Vocational	113.22 (14.44)	37.62 (5.73)	25.49 (4.37)	31.06 (4.54)	37.59 (6.98)	16.44 (4.39)
Secondary	116.42 (18.03)	38.12 (5.94)	23.87 (5.59)	3.99 (4.89)	37.98 (6.10)	16.26 (4.89)
Higher	115.22 (16.12)	38.67 (7.28)	24.84 (4.97)	32.22 (4.17)	38.38 (7.02)	15.24 (5.17)
<i>r (p)</i>	.06 (.773)	.09 (.420)	.12 (.215)	.14 (.086)	.06 (.781)	.12 (.211)
Place of residence						
Rural	109.68 (16.26)	38.67 (6.02)	25.94 (4.90)	32.05 (4.86)	38.30 (6.44)	15.86 (5.37)
Small city	115.44 (16.96)	38.15 (6.20)	25.65 (4.44)	3.89 (4.18)	38.31 (6.69)	16.92 <sup>a</sup> (3.96)
Medium city	116.12 (14.85)	37.91 (4.76)	24.01 (5.16)	31.58 (4.65)	38.78 (6.00)	16.45 (5.33)
Large city	115.87 (16.13)	37.96 (7.02)	23.97 (5.47)	31.88 (4.61)	37.42 (7.11)	16.57 (4.99)
Largest city	116.91 (15.39)	38.64 (6.96)	24.48 (5.04)	31.19 (4.62)	37.48 (6.19)	14.22 <sup>b</sup> (4.87)
<i>r (p)</i>	.14 (.141)	.04 (.968)	.15 (.098)	.07 (.773)	.10 (.476)	.19 (.015)

Note. SC – self-care, EC – empathic concern, PD – personal distress, PT – perspective-taking, AL – altruism, NSA – need for social approval; *r* – effect size indicator.

<sup>a, b</sup> Different superscripts in multiple comparisons indicate significant differences.

Comparisons of mean scores among men and women showed significant differences between the groups with regard to empathic tendencies. Women were characterized by higher levels of empathic concern, personal distress, and perspective-taking in comparison to men. A significant difference was also observed in the intensity of altruism and the need for social approval between respondents entering middle age (i.e., between the ages of 35 and 44) and those in later middle age. Individuals in early middle age manifested lower levels of altruism and need for social approval. In addition, the need for social approval was found to vary significantly by place of residence. Participants living in small cities exhibited stronger need for social approval than those living in the largest cities. Measures of effect size indicated that all significant differences were weak ( $r < .30$ ).

The results of the first stage of analysis (i.e., correlation analysis) are presented in Table 2. As can be surmised from the data presented therein, self-care capacity shows a moderate negative correlation with personal distress, moderate positive correlations with perspective-taking and empathic concern, and a weak positive correlation with altruism. Empathic concern and perspective-taking show a moderate positive association with altruism, while personal distress shows no significant association with altruism. When the need for social approval was taken into account, the aforementioned significant relationships remained significant, although they weakened slightly.

Table 2

*Correlation coefficients between the variables: zero-order (above diagonal) and partial controlled for need for social approval*

	SC	EC	PD	PT	AL	NSA
SO	.90 (.88)	.30***	-.37***	.36***	.18***	.31***
ET	.24***	.83 (.81)	.17**	.62***	.45***	.22***
OP	-.35***	.21***	.80 (.81)	.08	-.03	-.13*
PP	.32***	.60***	.11*	.77 (.76)	.36***	.20***
AL	.11*	.41***	.00	.33***	.67 (.65)	.25***
PAS	-	-	-	-	-	.79 (.76)

Note. SC – self-care, EC – empathic concern, PD – personal distress, PT – perspective-taking, AL – altruism, NSA – need for social approval.

Cronbach's  $\alpha$  and McDonald's  $\omega$  (in parentheses) reliability coefficients are shown along the diagonal of the table.

\*  $p < .05$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$ .

Subsequently path analysis was carried out to verify a mediation model in which the relationship between self-care and altruism was explained by empathic tendencies (empathic concern, personal distress, and perspective-taking). To control for the influence of the need for social approval, the latter variable was introduced into the analysis as a covariate. Given the differences in the analyzed variables between men and women and between individuals at different stages of adulthood, the impact of gender and age was also included in the model. Starting with the full model, we tested successive nested models created by removing paths to obtain a simplified model in which all paths would be significant at least at the  $p < .05$  level. Goodness of fit measures showed that the final parsimonious model had a good fit to the data ( $\chi^2 = 8.85$ ,  $df = 9$ ,  $p > .05$ , CFI = 1.00, RMSEA = .00, SRMR = .03). The model is presented in Figure 1.

Self-care was significantly associated with empathic tendencies – positively with empathic concern and perspective-taking ( $\beta = .21$ ,  $p = .001$  and  $\beta = .31$ ,

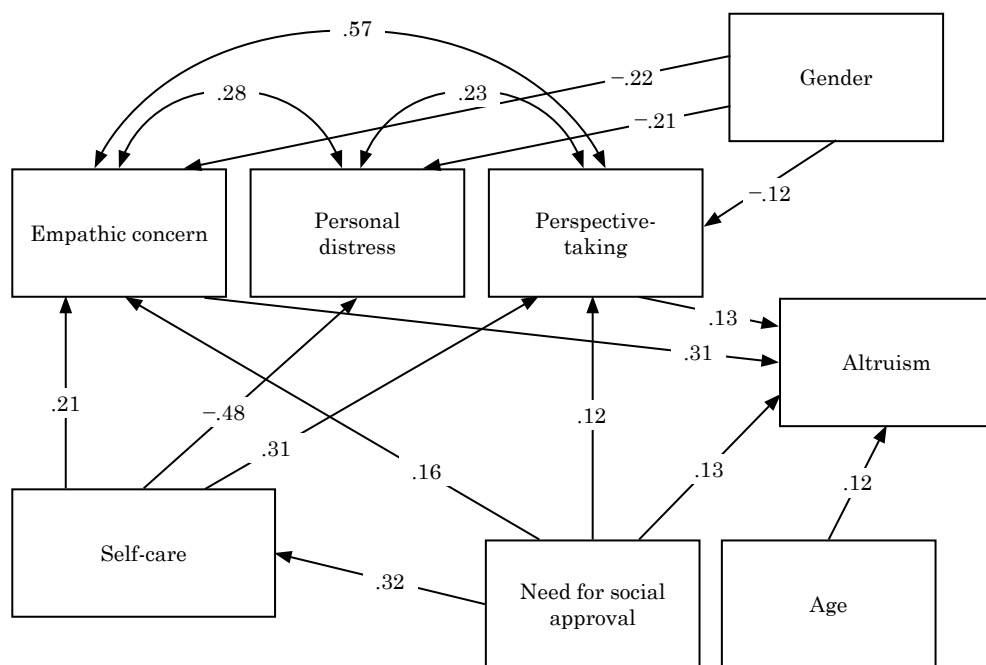


Figure 1. Model of the relationship between self-care and altruism (statistically insignificant paths were omitted).

$p < .001$ , respectively) and negatively with personal distress ( $\beta = -.48, p < .001$ ). Two components of empathy – empathic concern and perspective-taking – were positively related to willingness to engage in altruistic behavior ( $\beta = .31, p < .001$  and  $\beta = .13, p = .034$ , respectively). Testing the effects of self-care on altruism showed that these effects were only indirect ( $IE = .11, p = .001$ ) – it was the part of self-care capacity variance represented by empathic concern ( $IE = .07, p = .001$ ) and, to a lesser extent, perspective-taking ( $IE = .04, p = .064$ ) that showed significance in terms of predicting willingness to engage in altruistic behavior. Both effects of self-care for altruism were positive, and so capacity for self-care was expressed in the tendency to be compassionate and sympathetic, and to spontaneously adopt the perspective of others; in consequence, these effects were conducive to altruistic behavior. Overall, the model explained nearly 23% of altruism variance.

The variable-focused analysis of results presented above confirmed the expectations expressed in hypotheses 1 and 2. It was supplemented by a person-centered analysis to investigate typical configurations of self-care, empathic tendencies, and altruism. A positive, albeit weak, correlation suggested that self-care capacity is linked to willingness to engage in altruistic behavior. Cluster analysis allowed us to test whether the individuals with high levels of self-care constituted a homogeneous or heterogeneous group in terms of altruistic activity. Three clusters were distinguished based on the BIC criterion, as shown on the

graph of means in Figure 2. The adopted solution confirms the predictions from hypotheses 3 and 4.

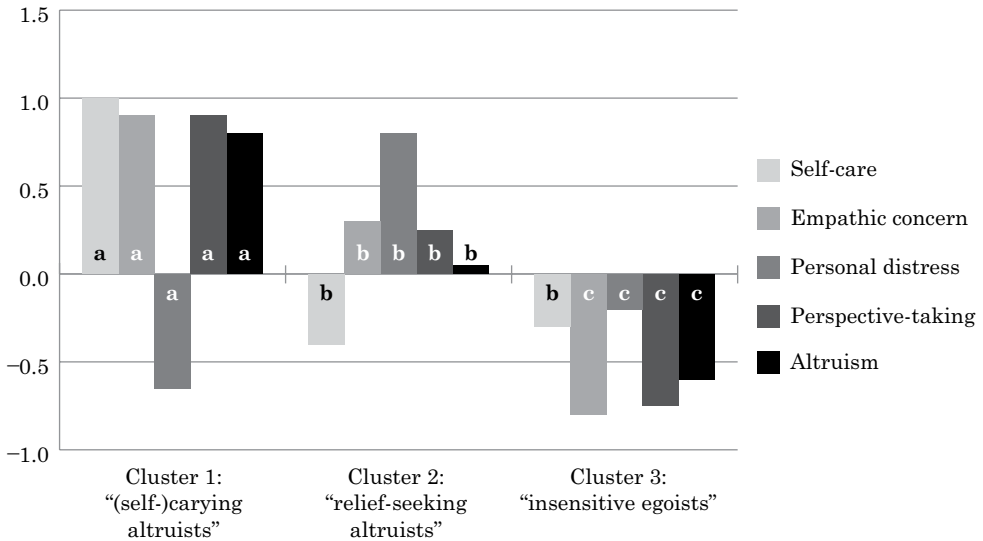


Figure 2. Graph of standardized means for the clusters obtained (different letters on the bars indicate differences significant at the  $p < .05$  level).

Cluster 1 ( $n = 89$ ; 26.9%) included individuals with high levels of self-care, high levels of other-oriented empathy (empathic concern and perspective-taking), and high willingness to engage in altruistic behavior. These individuals can be described as “(self-)caring altruists.” Cluster 2 ( $n = 109$ ; 32.9%) and cluster 3 ( $n = 133$ ; 40.2%) included individuals who exhibited similarly low levels of self-care but differed in terms of the other analyzed dimensions. Individuals from cluster 2 manifested high levels of personal distress and average levels of other-oriented empathy along with average levels of altruism. Individuals from this cluster can be described as “relief-seeking altruists.” Individuals in cluster 3 were characterized by low responsiveness to the experiences of other people and little willingness to act selflessly on their behalf. These individuals can be conventionally described as “insensitive egoists.”

## Discussion

The present study aimed to answer the question whether self-care, defined as functioning oriented toward one’s own safety and development, determines sensitivity to the well-being of others. From the theoretical side, an affirmative answer is suggested by reports that describe both self-care capacity and empathic sensitivity as shaped by social experiences from relationships with attachment

objects. The association of attachment trust with self-care, empathic responsiveness, and providing support to others is also supported by empirical data (Joireman, Needham, & Cummings, 2002; Kestenbaum, Farber, & Sroufe, 1989; Pilarska & Suchańska, 2021a, 2021b; Suchańska et al., 2019). Based on this theoretical and empirical foundation, we constructed the model tested in this study, assuming that self-care promotes empathizing with other people, which in turn translates into a willingness to act selflessly for the benefit of others.

The resulting picture of the relationships between the model's various elements largely confirms previous theoretical and empirical findings. The analysis of the links between self-care and empathic tendencies shows that higher levels of self-care predict higher intensities of other-oriented dimensions of empathy (i.e., perspective-taking and empathic concern) and lower intensities of personal distress, a component of empathy that is linked to difficulties in controlling and regulating experienced emotions and focus on one's own emotions (Każmierczak et al., 2007). In light of the results, individuals with high levels of self-care can be characterized, in the broadest of terms, as both emotionally and socially well-functioning. The relatively strongest association was revealed between self-care and personal distress, which is in line with the thesis that "the preservation of the ability to recognize and signal one's own internal states, the internalization of self-soothing and self-gratification actions, the reproduction of control actions, and the development of control and tension-coping functions play a fundamental role in the formation of self-care competence" (Suchańska, 2001, p. 72). The obtained result pattern reflects well the common social roots of self-care and empathy – a close and secure relationship with a caregiver is a prerequisite for internalizing caregiving functions and promotes emotional responsiveness to the experiences of others (Davis, 2001; Krystal, 1978).

Our investigation of the interrelationships between empathic tendencies and altruism verifies the role of empathic concern and perspective-taking as predictors of altruistic attitudes. The beneficial significance of these two components of empathy for social behavior, including the willingness to support and help others, was also indicated by the results of previous studies (Batson, 1991; Davis, 2001). It is worth noting that willingness to engage in altruistic behavior was more strongly associated with empathic concern than with perspective-taking. This observation is consistent with suggestions by Batson (1991) and Davis (2001) that empathic concern is the source of truly altruistic motivations.

Verified through mediation analysis, the relationship between self-care and altruism proved to be entirely mediated by empathic tendencies. Self-care, therefore, promotes willingness to engage in behaviors for the benefit of others because it is associated with other-oriented empathy; it promotes this willingness only to the extent that it contributes to empathic responses to the experiences of others. The obtained results indicate a good fit between the model and the empirical data and explain the link between self-care and altruism. At the same time, they revealed no significant direct effect of self-care (one not mediated by the variables present in the model), which prompts the question of what might account for its absence. Perhaps the lack of a direct association between self-care and altruism is only apparent and a significant link would emerge if the

analysis encompassed links between self-care and variables related to focus on oneself and one's own goals, which have been associated with a reduced tendency to empathize and act for the benefit of others (Karyłowski, 1982). We would then be dealing with a suppression effect (Cichocka & Bilewicz, 2010). It is worth recalling that self-care is a complex construct – its different dimensions can affect willingness to engage in altruistic behavior in opposing ways (Suchańska, 1998).

The cluster analysis performed in this study made it possible to distinguish three clusters with specific configurations of self-care, empathic tendencies, and altruism. Interpretation of these connections again suggests that individuals capable of caring for themselves also retain the abilities to sympathize and empathically perceive reality from the perspective of others, which co-occur with a strong altruistic attitude. When facing someone in need, these individuals tend to be willing to help and act selflessly on their behalf.

With a deficit in self-care, empathic tendencies and readiness for altruistic behavior can vary to a certain extent. Some individuals whose ability to care for themselves has been impaired remain sensitive to others, with personal distress being their primary response to other people's suffering – they become empathically infected and overwhelmed by the negative emotions of others. In the presence of others in distress and in need, they may attempt to provide help in order to alleviate the intensity of their own aversive experiences. They may also disengage from the situation causing their discomfort, and the easier it is to get away without helping, the more inclined they are to do so. The primary motivation of these individuals is to remove the unpleasant tension, and the help provided along the way is, according to Batson (1991) and Davis (2001), selfish in nature. In turn, other individuals with functional deficits in self-care capacity can exhibit low interpersonal reactivity and remain indifferent to other people's states. Such people show little willingness to act for the benefit of others. It can be assumed that the self-care deficit of the first type is particularly associated with defective formation of self/not-self boundaries and with difficulties in regulating emotions. In the second case, the low responsiveness to the observed emotional experiences of others is likely linked to a low overall susceptibility to experiencing emotional reactions under the influence of external factors, including danger-signaling stimuli, which are crucial for safe functioning. Important in this context are the results of brain neuroimaging research demonstrating shared networks of pain and empathy (Xiang et al., 2018). It is also worth emphasizing that, from a developmental perspective, the cause of insufficient mobilization of emotional and cognitive competence in both cases of impaired self-care described above should be sought in negative affective investment in the self.

The results presented in this paper are an important refinement of the results of correlation-regression analyses and suggest that the relationship between self-care and altruism may not be linear.<sup>2</sup> Although the ability to protect

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<sup>2</sup> To explore this possibility, a curvilinear (quadratic) relationship between self-care and altruism was tested. The results of curve estimation and hierarchical regression analysis, in which self-care and self-care squared were introduced into the equation as predictors in the first and second block, respectively, showed that both the first and second

and care for oneself, properly developed under conditions of a secure relationship, predicts concern for the well-being of others and willingness to engage in altruistic behavior, individuals whose self-care functions have weakened may also engage in helping activities, motivated by the desire to reduce the unpleasant tension caused by the suffering of others that they cannot otherwise manage.

The present study has its limitations. These include its cross-sectional nature, which does not allow clear conclusions to be drawn about cause-and-effect relationships. The study was also limited by the online method of data collection, which does not provide control over external factors accompanying the survey, and the use of self-report measurement methods, which are prone to distortion. The use of techniques to identify distorting scores and controlling for the influence of the social approval variable was meant to guarantee high quality of the obtained data but did not neutralize all possible threats to the results' accuracy. One should also keep in mind that effective self-care requires the interaction of various resources, not all of which need to be realized or taken into account in the process of conceptualizing and operationalizing this notion. The search for and study of the nature of the complex relationship between self-care and pro-social behavior deserves theoretical reflection and empirical exploration. We hope that the doubts not dispelled by the analyses presented herein will be resolved in further research.

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blocks were statistically significant ( $p < .001$ ). Adding a predictor in the form of self-care squared significantly increased the percentage of explained variance – by  $\Delta R^2 = .02$  ( $p = .003$ ) – and decreased the standard error of estimation – by  $\Delta SEE = .07$ . These results suggest that the quadratic model is a better fit to the data and allows for more accurate prediction of altruism. However, it should be noted that a comparison of the absolute values of the unstandardized residuals of the two models (linear and quadratic), using the Wilcoxon test, yielded a statistically insignificant result ( $Z = -.98, p = .326$ ) and, therefore, did not confirm the advantage of the curvilinear model over the linear model.

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