Experiences of Compassion in Adults with a Diagnosis of Borderline Personality Disorder: An Interpretative Phenomenological Analysis

Stephanie Fagan

Primary / Intermediate Mental Health Team, Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool, UK

Suzanne Hodge

Division of Health Research, Lancaster University, Lancaster, UK

Charlotte Morris

Recovery Team, North West Boroughs Healthcare NHS Trust, Warrington, UK

Corresponding author

Suzanne Hodge, Division of Health Research, Lancaster University, Health Innovation One, Sir John Fisher Drive, Lancaster LA1 4AT, UK

Email: s.hodge@lancaster.ac.uk

Abstract

The study explored experiences of compassion in adults with a diagnosis of Borderline Personality Disorder (BPD) to further the development of the construct of compassion in relation to BPD. Interpretative Phenomenological Analysis was used to develop themes from the narratives of six adults with a diagnosis of BPD. Five themes emerged: *Emotional Connection to Suffering, Empathic Understanding, Prioritisation of Needs, A Model of Genuine Compassion* and *Developing Acceptance and Worth*. Participants described the role of compassion in their difficulties, including the adverse impact of experiences of incompassion upon their sense of self. The themes were integrated into a model that highlighted a process of recovery through therapeutic encounters with others in which genuine compassion was modelled. In addition, barriers to compassion and factors facilitating the development of compassion emerged from the analysis and have implications for clinical practice.

Keywords: Borderline Personality Disorder, Compassion, Qualitative, Interpretative Phenomenological Analysis

Introduction

Borderline Personality Disorder (BPD) is a diagnostic category described in the Diagnostic and Statistical Manual for Mental Disorders (DSM) (American Psychiatric Association, 2013). BPD is characterised by difficulties with emotional regulation, impulse control and interpersonal relationships, including self-to-self relating (Fonagy & Luyten, 2009; Lieb et al., 2004). Common experiences associated with the diagnosis include rapidly fluctuating emotional states, a fear of abandonment, feelings of emptiness, an unstable sense of self, suicidal thinking and self-harming behaviour. Some individuals also experience transient psychotic episodes, including delusions and hallucinations (National Institute for Health and Care Excellence, 2009).

Childhood attachment experiences have been hypothesised as playing a key role in the development of these difficulties (Agrawal et al., 2004). Linehan's (1987, 1993) biosocial theory posits that emotional invalidation in childhood is a key factor in the development of difficulties associated with BPD. That is, individuals with a diagnosis of BPD have primarily experienced caregiving in which their emotions were either dismissed or went unrecognised (Gerhardt, 2014). There is a higher incidence of developmental trauma, such as abuse and neglect, in individuals with a diagnosis of BPD than among the general population (Martín-Blanco et al., 2015).

The Role of Shame and Stigma

Shame is proposed to be a core emotion experienced by people with a diagnosis of BPD and is thought to underlie specific difficulties including impulsivity, self-harm and suicidality (Rüsch et al., 2007). Shame is an intensely painful feeling related to a belief that we are flawed and unworthy of love and connection (Brown, 2006). It is an emotion which indicates a lack of self-compassion (Westphal et al., 2016) and self-criticism is its cognitive precursor (Warren, 2015). Negative early life experiences are proposed to underlie the development of shame and chronic self-criticism (Satici et al., 2015). Multiple studies have linked relational trauma such as abuse and neglect to low self-esteem and feelings of shame in people with a diagnosis of BPD (Finzi-Dottan, 2006; Holm et al., 2009; Horn et al., 2007; Krawitz, 2012a; Rüsch et al., 2007; Schanche et al., 2011; Warren, 2015).

The reductionist narrative associated with mental health diagnoses, in which difficulties are proposed to be the result of faulty biological or psychological processes within an individual (Moncrieff, 2014), can contribute to feelings of shame. In the case of BPD, not

only does this individualising tendency fail to account for the relational trauma that is the source of shame for many people given this diagnosis, it compounds their feelings of shame through stigmatisation (Bonnington & Rose, 2014) and pejorative labelling (Woollaston & Hixenbaugh, 2008). Aguirre (2016) argues that this stigmatisation of individuals with a diagnosis of BPD can be challenged through a compassionate understanding.

Compassion

Compassion is the act of engaging with suffering and taking action to alleviate and prevent suffering (Gilbert et al., 2017). It is both dynamic and relational and posited to *flow* in three directions: self-to-other, other-to-self and self-to-self (self-compassion; Kirby et al., 2019). Emotional invalidation, which is implicated in the development of difficulties associated with BPD (Linehan, 1993), describes an absence of compassion; an absence of engagement with suffering. Equally, emotional validation is a necessary component of compassionate caregiving. Indeed, Gillath et al. (2005) propose that compassion between caregiver and child is one of the mediating variables between attachment experiences in childhood and later personality development. Despite these conceptual linkages, the experience of receiving compassion from others has not been investigated in relation to the development and maintenance of difficulties associated with BPD. There has, however, been a growing body of research exploring the role of self-compassion.

Self-Compassion

People with a diagnosis of BPD report low levels of self-compassion (Pohl et al., 2020). Low self-compassion is correlated with shame in this group and predicted by low warmth, invalidation and abuse in childhood (Naismith et al., 2019). Indeed, self-compassion is thought to develop through the attachment relationship with a caregiver in early childhood (Neff & McGehee, 2010). In a study by Westphal et al. (2016) emotional invalidation in childhood was strongly associated with a lack of self-compassion in participants with diagnoses of BPD, depression and post-traumatic stress disorder.

Cultivating self-compassion has implications for recovery in individuals with a diagnosis of BPD (Donald et al., 2019). Pohl et al., (2020) identified that self-compassion buffers the negative consequences of developmental trauma in people with BPD diagnosis. However, individuals with personality disorder can experience a fear of self-compassion which can inhibit this process (Naismith et al., 2019).

Cultivating self-compassion is considered to be a promising intervention for feelings of shame (Warren, 2015), self-loathing and low self-esteem (Krawitz, 2012b). Two studies have been conducted to explore the effectiveness of compassion-focused approaches for people with a diagnosis of personality disorder. Lucre and Corten (2013) ran a 16-week compassion-focused therapy (CFT) group and found a beneficial impact on a range of outcome measures which were maintained at 1-year follow-up. Feliu-Soler et al. (2016) conducted a study investigating the effectiveness of a 3-week training programme in loving kindness meditation (LKM) and compassion meditation (CM) for people with a diagnosis of BPD. Moderate to large effect sizes were found in the LKM/CM group for reductions in 'BPD severity' and self-criticism as well as increases in mindfulness, self-kindness and acceptance.

The current research

No studies have investigated the construct of compassion in relation to BPD. One of the problems of focusing solely upon self-compassion is that it neglects wider systemic and relational factors. This promotes a narrative that individualises difficulties and so perpetuates shame and stigma.

The current study aims to explore experiences of compassion in people with a diagnosis of BPD. Due to there being no preconceived theory or framework on this topic, the current study uses an inductive, exploratory approach to determine whether compassion has implications for understanding the development and maintenance of difficulties associated with BPD. Moreover, by attending to both the intrapersonal and interpersonal flow of compassion, we can challenge the individualistic, stigmatising narrative and offer a wider, relational understanding of compassion in BPD.

Method

Design

Semi-structured interviews were conducted to generate rich, contextual information from participants. Interpretative Phenomenological Analysis (IPA) was chosen as its phenomenological, idiographic stance focuses attention on how individuals make meaning from their experiences, allowing the development of shared themes across participants whilst retaining the context and integrity of each participant's account (Smith et al., 2009). IPA also

explicitly acknowledges the interpretative role of the researcher throughout the research process.

Participants

Participants were recruited from non-National Health Service settings such as community groups and Twitter. Adults who reported that they had received a diagnosis of BPD were invited to participate. To be eligible for inclusion, participants were required to: 1) be willing and able to give informed consent for participation; 2) be 18 years old or above; 3) have received a diagnosis of BPD; 4) be resident in the United Kingdom; and 5) speak English. The decision was taken not to conduct a clinical assessment to confirm that participants met the diagnostic criteria. Instead potential participants were asked a set of screening questions to confirm the validity of their diagnosis which included asking about the circumstances in which the diagnosis was given.

The aim was to recruit a sample of 6-12 participants; a range in keeping with IPA guidelines which emphasise the importance of homogeneity within the sample, allowing for the development of theoretically generalisable, but contextually specific insights (Smith et al., 2009). Once the minimum number of six participants was reached, the data collected from these six individuals was reviewed by the first and second authors and the decision was taken to stop recruitment. There was a high degree of homogeneity across participants, both in terms of their demographic characteristics and the significance of the topic to them, and the data gathered was rich and detailed. For example, participants gave lengthy, insightful and reflective responses that were relevant to the constructs under investigation and which linked to their experiences. After six interviews, resonances between participants' accounts had become clear. Thus, the sample of six was deemed sufficient to enable in-depth analysis and for data adequacy to be reached (Vasilieiou et al., 2018). This is in line with guidelines on IPA (Moser & Korstjens, 2018) and other publications which have utilised IPA to explore lived experience in individuals with a diagnosis of BPD (Brooke & Horn, 2010; Gardner et al., 2019; Hodgetts et al., 2007).

Six individuals participated in the research: all were white, British women ranging in age from 28 to 57 years. All described themselves as currently well and none were accessing support from mental health services at the time of recruitment or throughout the duration of the research. All participants confirmed when recruited that they had previously accessed mental health services via the National Health Service (NHS) and had received their

diagnoses by an NHS psychiatrist. Participant summary information is provided in Table 1 and pseudonyms are used throughout to ensure anonymity.

Table 1

Summary of participants

Participant [a]		Gender	Ethnicity	Age
1	**Natalie**	Female	White	57
2	**Laylie**	Female	White	51
3	**Catherine**	Female	White	47
4	**Deborah**	Female	White	31
5	**Alice**	Female	White	28
6	**Sophie**	Female	White	32

[a] pseudonyms

Procedure

Ethical approval was obtained from Lancaster University Research Ethics Committee. All project materials were developed in collaboration with a service user expert and the terminology used in the study reflects their input.

The study was advertised online via Twitter and through advocacy groups and community support groups in Scotland and the North of England. Of the six participants recruited, five were interviewed face-to-face and one via telephone. Interviews lasted between 56 and 132 minutes and were conducted by the first author. Interviews were semi-structured and covered the following topics: 1) The concepts of compassion and BPD; 2) Experiences of receiving compassion from others; 3) Experiences of giving compassion to others; 4) Experiences of self-compassion; and 5) Overall impressions of the relationship between these aspects of compassion and BPD. Interviews were audio-recorded and subsequently transcribed by the first author.

Data Analysis

IPA was conducted in line with guidance provided by Smith et al. (2009). Each transcript was analysed individually, following steps 1-4 below, before developing a final set of themes for the whole sample in step 5. 1) The transcript was read and re-read and notes were recorded in a reflective field diary. This helped to make the researcher's interpretative

role explicit. 2) The transcript was copied to an Excel spreadsheet and adjacent columns used to record annotations. These included descriptive comments on the content of the transcript, notes on participants' use of language, and tentative interpretations of what was said. 3) Emergent themes were developed from these annotations. These themes were more explicitly interpretative, reducing the amount of detail contained in the annotations by conceptualising the core meaning conveyed in chunks of annotated text. 4) Superordinate themes were developed by searching for connections between emergent themes, developing clusters of themes which were reviewed and revised until a conceptually coherent set of superordinate themes was arrived at. These were checked against the participant's transcript and by consulting with the participant to ensure that the set of themes captured the key elements of their account in a meaningful way. The first four stages were repeated for each participant; 5) Overarching themes across participants were developed by integrating the sets of superordinate themes.

Results

Five overarching themes were identified: Emotional Connection to Suffering; Empathic Understanding; Prioritisation of Needs; A Model of Genuine Compassion; Developing Acceptance and Worth.

Theme 1: Emotional Connection to Suffering

Emotional connection to suffering appeared to lie at the heart of participants' descriptions of experiencing compassion for others: 'To be able to tolerate them if they're in pain and just accept the pain that they're in rather than trying to deflect it' (Sophie). This was described by Catherine when reflecting upon her work with children and encountering a young boy's distress: 'Compassion was hearing his pain…being there in that moment with him, in that pain, and holding him while he broke his heart…moving on that journey with him because he'd never experienced pain like that'.

Three participants described a process of vicarious reparation in which they made conscious attempts to heal themselves through being compassionate to others. Natalie described this experience in her work with young children who had experienced sexual abuse: 'By trying to do something for them, it was about the only way that I could relate to the young person, the child, who'd been so badly damaged back there' (Natalie). For Laylie and Deborah, this occurred within the context of friendship: 'I think one of the reasons I've

supported her for so long is that I see a lot of me in her at that age…I think I kind of want to give to people what was never given to me' (Laylie); 'Was I doing it because I really wanted to fix me and it was like making up for the things that were wrong with me if I could make it better in someone else?' (Deborah).

When exploring self-compassion, all participants described difficulty in connecting with their own emotions: 'I tend to shut my emotions down, I'm scared of uncomfortable feelings so I tend to just turn them off as soon as I feel them' (Laylie). Some participants related this to their experiences of emotional learning in childhood: 'I was constantly having to rein in my own emotions and not have them justified or validated to kind of care for others' (Alice). Participants discussed finding self-care (i.e. practical ways of caring for themselves) easier than self-compassion due to the absence of emotional connection: 'I can do practical things, have a bath, lie down for an hour or read a book for an hour, because I can just dissociate from it and get on with it and do it' (Catherine).

Similarly, the emotional connection that is elicited with another when receiving compassion resulted in uncomfortable feelings of vulnerability for some participants: 'You don't want people in your guts, it feels like a million hands in your guts' (Alice). These feelings of discomfort in relation to vulnerability were a barrier for sharing emotional distress with others and so inhibited the potential of receiving compassion: 'If I'm at all vulnerable, then all the shutters come down, and padlocks go on' (Catherine).

Theme 2: Empathic Understanding

This theme reflects the importance of understanding another's emotions as a consequence of their life experiences. Participants suggested that understanding was necessary for compassion: 'I would struggle to give someone compassion if I didn't understand' (Deborah). This was achieved through genuine connectedness, by making a conscious effort to understand the mind of another: 'It all comes back to listening, you know, that active listening, not just listening, but really hearing' (Alice). Participants described the way in which stereotypes and labels can hinder this process of genuine connectedness and understanding. For example, Sophie described the impact of her diagnosis upon understanding: 'I think it maybe comes back to judgement as well because he [professional] had clearly judged me based on the diagnosis rather than as a person'. Similarly, having 'expectations about how others should act in a given situation' (Deborah) and 'making assumptions' (Alice) obstructed genuine connectedness and understanding.

The development of self-understanding facilitated compassion from others through enabling the sharing of this understanding: 'I know what's wrong with me, I know what's going on, so I can turn round to someone and say actually that's made me really paranoid because of this, this and this' (Alice). For some participants, this related specifically to understanding the impact of trauma upon them: 'My mum really is probably compassionate in the true sense in that she's using empathy because she knows my history and she knows the things that I have been through' (Deborah). Catherine described how having knowledge of the impact of trauma can facilitate understanding in the moment and so facilitate a compassionate response:

> They can hear the bigger picture so it's not just oh that's happening in the here and now, they can hear the whole big picture attached to that…I can hear the abuse and I can empathise and I can feel and I get it, that's compassion: 'I get it'.

Empathic understanding further facilitated compassion as this knowledge could be utilised to offer compassion in a person-centred way. As described by Deborah: 'Compassion is so different for everyone, what works for one person is not going to work for another person'. Therefore, in order to provide compassion in a way that is helpful, it is important to understand the needs of another. Alice described the distinction between compassionate engagement with suffering and the compassionate action elicited: 'It might be a display of very well meant, very deeply felt compassion, but the act itself might not be compassionate'.

Theme 3: Prioritisation of Needs

This theme reflects the selflessness involved in giving compassion to others and the necessity to prioritise one's own needs to offer compassion to oneself. All participants described the selflessness involved in compassion: 'I think it is very much on the scales towards being an act that is all about giving' (Deborah). Alice described the genuine nature of compassion and the way in which it is given freely: 'I think it's compassion that just comes from very genuine love and it's, there's not anything else driving it, there's not a kind of self-serving nature behind it'. When participants described receiving genuine compassion from others, they alluded to their needs coming first and the potential cost to the other: 'he [my psychiatrist] was able to, first of all make a decision in my interest, which felt like he was putting himself, like, he was taking a risk but, you know, trying to do things that he felt were right for me' (Natalie).

A pattern evident within the participants' accounts of compassion was that of putting others' needs before their own: 'I'm really good at giving compassion to other people, but I'm shit at giving it to myself' (Laylie). They described this as being 'overly compassionate' (Alice) or providing 'over the top compassion' (Deborah) and questioned whether this was genuine compassion: 'I thought what I was doing was being kind and caring, however what I've realised is that I'm just repeating patterns from childhood where I try and fix everybody' (Laylie). According to three participants (Alice, Laylie and Natalie), this arose from having been a young carer and so learning, and being expected, to prioritise the needs of others above themselves.

Participants described the feelings elicited by continually putting the needs of others before themselves. Laylie described her compassion towards others as leading to 'anger, resentment and frustration…then feeling bad for feeling resentful and angry'. In the same way, Deborah described compassion as being finite: 'People are like a bottle of water you've only got so much to give and then you are empty'. She suggested that a lack of compassion arises due to people 'becom[ing] toughened to a point where [they] stop caring and stop showing compassion because compassion can be incredibly draining'.

Moreover, by placing their own needs second to others', some participants became unwell. For Natalie, this led to a 'hospital admission' while Laylie described becoming 'burnt out, because all I was doing was caring about these other people and listening to their traumas and not having dealt with mine' (Laylie).

All participants described difficulty with self-compassion due to difficulties in attending to their own needs. Some participants related this to their early life experiences of their needs being overlooked: 'I was never taught kindness…basic human rights and basic human needs were never taught to me' (Catherine). Some participants described difficulty with self-compassion due to a learned pattern of placing others' needs before their own: 'Perhaps that sense of put other people before yourself stops self-compassion' (Alice). Many participants felt uncomfortable about practising self-compassion and prioritising their own needs: 'If I'm compassionate to myself, I feel like I'm being selfish' (Laylie); 'I know with me it's very like a feeling of being self-indulgent or weak that will stop me' (Alice).

Theme 4: A Model of Genuine Compassion

The previous three themes described participants' views of the elements that constitute compassion, including emotional connection to suffering, empathic understanding

and the prioritisation of needs. Theme four reflects the way in which participants' experiences of care from others contributed to the development of their internal frames of understanding compassion.

Participants discussed that they had either 'never had any model for compassion' (Sophie) or had unhealthy experiences of 'false compassion' (Alice). This resulted in 'the wires [of what compassion is] becoming very, very crossed' (Alice). For example, Alice described having seen compassion 'used as quite a manipulative thing, where people are giving the air of being compassionate very much for self-validation or to control other people'. Laylie described a similar experience: 'I've been through a lot of domestic violence and, you know, these guys, they can be compassionate, you know, couldn't have been nicer until it turned'. These experiences led to a reluctance to receive compassion from others: 'At first you do bat it [compassion] off' (Alice). This was related to feelings of distrust and suspicion: 'If somebody is kinda nice to me, I automatically think what are you after…because I don't trust their motives' (Laylie); 'it always comes with a bit of a why, why, what do you want, what are you asking for, what's the ulterior motive' (Catherine).

In order to enable the development of a healthy model of compassion and allow compassion into their lives, participants described the importance of the relationship between themselves and the person offering them compassion as well as their life context at the time. For example, Laylie described the importance of safety and stability in allowing others to be compassionate towards her: 'I feel safe, I feel safe, and I had never felt safe in my life until I went into treatment, that helped'.

The development of a healthy model of compassion was described by Catherine: 'She [social worker] gave me compassion, she boxed it up and provided me with it, if it wasn't for her, I wouldn't know what compassion is'. Similarly, Alice described the lasting effects of receiving compassion: 'It's a very powerful thing that I've really been able to take and carry with me…it really gives you something to keep a hold of'. This learning had an impact on participants' ability to provide compassion to others as well as practise self-compassion: 'As I started to develop self-compassion, the compassion for other people has developed alongside it' (Sophie).

Theme 5: Developing Acceptance and Worth

Theme five reflects the impact that receiving compassion had upon participants' sense of self. All participants described a sense of feeling inadequate, flawed and unworthy.

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Although relational trauma was not explicitly explored within the interviews, everyone in the study alluded to traumatic experiences that impacted negatively on their sense of self. Across the six interviews, participants recalled instances of sexual abuse, emotional abuse, emotional neglect and domestic abuse. The inherent lack of compassion in these experiences was described by some participants as the absence of emotional connection to their suffering: 'I wasn't shown compassion by either of my parents at all…if I was upset, she [my mother] would lock me in a room and just walk away' (Sophie).

For some participants, these feelings were consolidated through receiving a diagnosis. Natalie described the impact of the diagnosis on her sense of self:

> It was about telling me I was some sort of misfit, and it wasn't that I was ill so much, it was just that I was a bad person or, you know, there was something wrong with me as a person and who I was: your personality is wrong, who you are is wrong.

Participants' deep sense of unworthiness impacted upon their ability to allow compassion into their lives as they felt 'undeserving': 'I really struggled to look after anyone or care for anyone because I was hell-bent on destroying me' (Laylie);

> I had just given up because I felt I was so unimportant…once you're in a place where you hate yourself compassion does completely go out the window, you won't let it in for yourself, you won't let it in from anyone else (Deborah).

Participants described the way in which receiving compassion from others had a transformative impact on their sense of self. For many participants this was as a result of their interactions with mental health professionals. Catherine described the impact of receiving compassion from a social worker when she was a teenager: 'It taught me to believe in who I am'. Laylie described the impact of bonding with mental health professionals in a therapeutic community: 'It made me feel like I mattered and it made me feel like I'm not this horrible, bad, evil person…if other people are kind to me then I must be ok'. This development of a more positive sense of self had implications for recovery. Natalie and Alice spoke about receiving compassion from a psychiatrist and friendship group, respectively:

> The fact that somebody was really showing that, well, actually I was somebody who mattered, I was somebody who had value and I think that that was a real important thing, an important first step for me to start to see myself as somebody who had some value and somebody who was worth fighting for (Natalie);

That's what got me through, that is the reason that I'm still alive today, had it not been, and I am not over exaggerating this at all, were it not for that lot [friendship group], I would be dead, simple as (Alice).

Similar to the difficulty in allowing compassion from others due to a deep sense of being unworthy and undeserving, participants described how a lack of self-acceptance was a barrier to self-compassion: 'I think showing self-compassion is the hardest because you know every little thing about yourself, warts and all' (Deborah). However, by embracing common humanity (i.e. the notion that we are all connected, flawed beings), participants developed an acceptance of themselves and others which assisted in the cultivation of compassion: 'As I'm more able to accept my own faults, well not necessarily faults, but I'm more able to accept how other people are…it's probably the same, similar techniques to developing compassion to myself' (Sophie). Deborah described how the development of this perspective contributed to her recovery:

> If you know everything [about yourself] and can still say 'I'm worth a second chance, I'm worth a bit of self-care, I'm a human being and I make mistakes and I deserve to still have some nice things', then I think you can pretty much get better and move forward.

Discussion

These findings suggest that participants understood genuine compassion as containing three main components: emotional connection to suffering, empathic understanding and the prioritisation of needs. Participants discussed the impact of incompassion (a lack of compassionate connection) and the presence of relational and/or developmental trauma (e.g. abuse and neglect) upon their sense of self. All participants described viewing themselves as flawed and undeserving of compassion. Participants experienced difficulty in receiving compassion from others and being compassionate to themselves. Nevertheless, by experiencing genuine compassion, participants alluded to a process of developing greater ability to offer genuine compassion to themselves and others. This also contributed to a process of recovery underpinned by self-acceptance and the development of self-worth. A diagrammatic representation of this recovery process is illustrated in Figure 1.
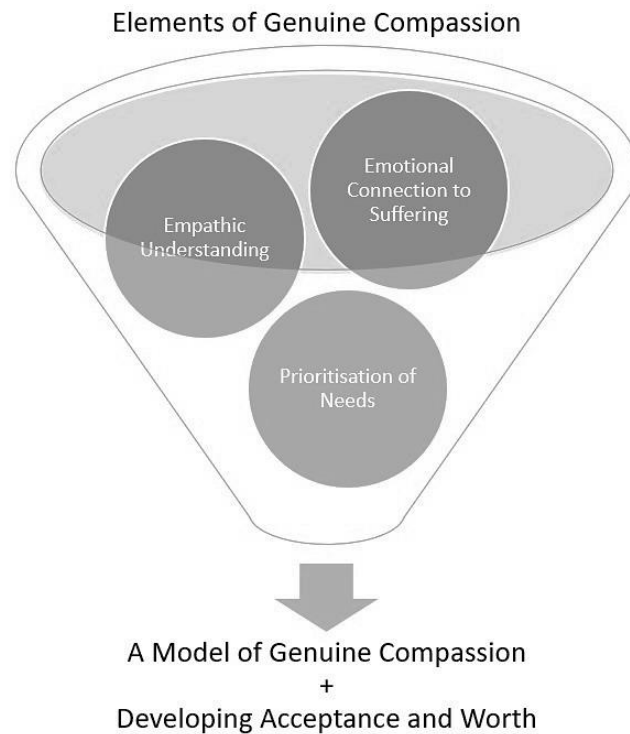
Elements of Genuine Compassion

Emotional Connection to Suffering

Empathic Understanding

Prioritisation of Needs

A Model of Genuine Compassion
+
Developing Acceptance and Worth

Figure. 1. of compassion in diagnosis of BPD: process. Experiences adults with a A recovery

The Three Elements of Compassion

Compassion contained three elements in relation to self or other: emotional connection to suffering, empathic understanding and prioritisation of needs. This is in line with Harrington's (2002) definition that compassion 'brings us into a felt relationship with the pain and needs of some other' (p. 21). The elements of emotional connection to suffering and empathic understanding resemble the concept of emotional validation, mirroring Linehan's (1993) biosocial model of BPD which highlights the developmental impact of an invalidating environment in childhood.

One aspect that was identified in the current study which has not been described in compassion literature is that of the prioritisation of needs. That is, offering compassion to others involves selflessness while being self-compassionate involves prioritising one's own needs. Findings suggest that there is a cost involved in providing compassion unilaterally due to the prolonged subjugation of one's own needs. Participants described becoming burnt-out, resentful and experiencing a deterioration in their own mental wellbeing. This may be reflective of 'submissive compassion', in which compassion is expressed in order to enhance acceptance while avoiding rejection (Catarino et al., 2014).

Participants in the current study described difficulty in emotionally connecting to their own suffering while over-identifying with the suffering of others. This may explain why participants had difficulty practising self-compassion, yet experienced 'over the top compassion' for others. This difference between compassion for others and self-compassion is not unexpected. Previous research has indicated that they are not significantly related (López et al., 2018). The discrepancy between these areas in the current study may account for participants vicariously attempting to 'repair' themselves through wishing to intervene in the suffering of others. Some participants described a reluctance to express their suffering to others due to unsafe feelings of vulnerability. This may have inhibited the opportunity for others to emotionally connect to their suffering and so obstructed the receipt of compassion. According to Ryle (1997), common relational templates in individuals with a diagnosis of BPD include: 1) Perfectly cared for in relation to providing perfect care; and 2) Emotionally blunted in relation to critical, rejecting or threatening. These relational templates may explain why the participants in the current study had difficulty connecting to their own suffering. For example, they may have related to themselves in a critical, rejecting or threatening way which resulted in emotional blunting. Similarly, they may have related to others in a perfectly caring way at times, resulting in high levels of compassion for others.

Compassion was facilitated in the participants by an empathic understanding from others and towards themselves. In particular, this related to understanding the impact that emotionally abusive and neglectful experiences had had upon the development of their difficulties. For some participants, empathic understanding was impeded by the diagnostic label as it detracted from a trauma-informed understanding. This aligns with increasing evidence suggesting that the BPD label can have a detrimental impact upon people due to individualising difficulties and neglecting the wider relational context (Horn et al., 2007).

Shame: The Absence of Compassion

Participants perceived themselves as unworthy, inadequate and undeserving of compassion. This reflects Brown's (2006) definition of shame: an intensely painful feeling related to a belief that one is flawed and unworthy of love and connection. This supports findings from previous studies regarding the negative perception that people with a diagnosis of BPD have of themselves as a result of adverse relational experiences (Finzi-Dottan, 2006; Horn et al., 2007; Holm et al., 2009; Krawitz, 2012a; Schanche et al., 2011; Warren, 2015). Some research indicates that it is the presence of abuse that results in the development of

difficulties associated with the diagnosis of BPD (Holm & Severinsson, 2008). Although a high percentage of individuals with a diagnosis of BPD report having experienced abuse in childhood, this does not apply to everyone. The current study may account for this by making a distinction between the absence of compassion and the presence of abuse. Perhaps it is not abusive experiences per se that lead to difficulties associated with BPD, but the absence of compassion that is associated with such experiences. Some of the experiences described by participants, such as emotional invalidation and the subjugation of needs involved in being a young carer, align with this view. It may also explain why not everyone who experiences abuse develops difficulties associated with BPD. Indeed, a compassionate caregiver is an oft-cited protective factor in resilience to trauma.

Developing a Model of Genuine Compassion: Self-worth and Recovery

The current study suggests that participants' experiences of compassion, particularly in childhood, impacted upon their ability to develop a model of genuine compassion. This relates to the assertion that self-compassion and empathy are developed through the attachment relationship with a caregiver in early childhood (Neff & McGehee, 2010). Similarly, difficulties with self-compassion are associated with high levels of parental rejection (Pepping et al., 2015) and emotional invalidation in childhood (Westphal et al., 2016); findings supported by the current research. These findings align with Linehan's biosocial model of BPD which posits that the invalidation of emotions during childhood can impact upon an individual's ability to recognise, understand and regulate their own emotions in adulthood (Linehan, 1987, 1993).

The current study supports findings which suggest that barriers to self-compassion include feelings of shame, a belief that the self is unworthy and concerns that self-compassion is selfish or indulgent (Gilbert et al., 2011). However, if barriers are addressed, compassion can play an important role in recovery. Through receiving compassion from others, participants described a process of internalising compassion and developing a model of genuine compassion. This assisted them in being more compassionate to others and to themselves. Moreover, it enabled them to develop a sense of worthiness. This aligns with literature in which recovery from BPD involves reducing shame, developing a sense of worth and self-acceptance alongside feelings of belonging and connectedness with others (Kverme et al., 2019; Ng et al., 2019). Moreover, participants suggested that self-compassion was facilitated by learning to forgive themselves, accept themselves and allow themselves to be

human. This is the same process of change that is described in the compassion-focused intervention literature (Krawitz, 2012b; Warren, 2015).

Clinical Implications

Findings from the current study suggest that compassion may provide a unifying, relational and accessible framework for understanding the development and maintenance of difficulties in individuals with a diagnosis of BPD. Compassion also has implications for recovery for individuals with a diagnosis of BPD. Although compassion-focused approaches are primarily offered as direct or group therapies to strengthen self-compassion in individuals, the current study suggests that receiving compassion from others directly facilitates the development of self-compassion and self-worth. Therefore, focusing on providing the conditions necessary for compassion to flourish in relationships with mental health professionals could be expanded as an intervention in its own right. This is particularly relevant given the high levels compassion fatigue reported by mental health professionals working with people with a diagnosis of BPD (Woollaston & Hixenbaugh, 2008) and the documented need for culture changes in healthcare systems to provide more compassionate care (Francis, 2013).

Although not explicitly compassion-focused, Dialectical Behaviour Therapy (DBT), developed by Linehan as an evidence-based intervention for people with a diagnosis of BPD (Linehan, 1987, 1993), can be understood as representing a therapeutic approach in which compassion is embedded. In DBT, therapists are specially supported in their roles in order to maintain a compassionate, non-judgemental stance (Chapman, 2006, Dimeff & Linehan, 2001). Moreover, one of the key aspects of DBT is to support clients to develop skills in regulating their emotions. Emotional regulation has been identified as a mediating factor in the relationship between self-compassion and mental health (Inwood & Ferrari, 2018).

Strengths and Limitations

The current research demonstrated novel and promising initial findings regarding the role of compassion in BPD in relation to both the development of difficulties and recovery. As such, these findings may serve as an opportunity to generate future hypotheses to further our understanding of the construct of compassion in relation to the diagnosis of BPD and generate a unified theoretical framework.

Accessing a population who considered themselves to be in recovery was both a strength and limitation of the study. It enabled exploration of the facilitative nature of compassion towards recovery which may not have been otherwise acknowledged. However, an exploration of the life experiences of individuals who would not consider themselves to be 'in recovery' might provide further insight into experiences of compassion at different stages in people's lives.

Using IPA to analyse people's experiences related to having a diagnosis of BPD could be seen as problematic due to the importance of homogeneity in IPA and the heterogeneity of BPD as a diagnostic category. Not only is there a high degree of diagnostic overlap and comorbidity (Andión et al., 2013), but the life experiences and difficulties associated with a BPD diagnosis can be diverse. However, the small sample recruited to this study proved to have a high degree of homogeneity in terms of gender, ethnicity and identification with the topic of compassion. Of course, using IPA constricted the option for a larger and more diverse sample which may have increased the theoretical generalisability of the findings and their applicability beyond the context of White British women. Furthermore, although we determined that the analysis had reached a sufficient level of data adequacy to be robust, further data may have resulted in differently configured themes or more nuanced explanations.

Future Research

Findings from the current study reinforce the notion that the reductionist, individualising narrative that accompanies BPD can impact upon individuals' sense of self. In addition, diagnosis can detract from relational explanations which link incompassion and the development of the difficulties associated with BPD. Therefore, it is essential to incorporate a relational, trauma-focused understanding into the BPD narrative in order to circumvent the self-blame that it perpetuates within some individuals. In developing this, research is needed into the role played by an absence of compassion in difficulties experienced by individuals with a diagnosis of BPD.

To further the theoretical development of compassion as a clinical construct, it would be useful to ascertain the role of the prioritisation and subjugation of needs in compassion and how this relates to early experiences such as being a young carer, as described by the study participants. It would also be of great value to explore the relationship between compassion, emotional validation and attachment theory given the links identified in the

current study and the weight of evidence gathering in these areas in regards to the diagnosis of BPD. Finally, given the potential for the involvement of compassion in recovery, it is important that future research investigates how to overcome the barriers to receiving compassion from others and practising self-compassion which were outlined in the current study.

Conclusion

Compassion has a significant role in the development of difficulties associated with BPD and has implications for recovery. This reinforces the fundamental importance of a relational understanding and approach. Barriers to compassion and factors which facilitate the development of compassion emerged from the analysis and have notable implications for clinical practice.

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