The concept of self-loathing has been identified as a core difficulty within borderline personality disorder (BPD) and a potential barrier to personal recovery. Individuals with BPD report largely negative self-concepts when compared with healthy controls. Further, individuals with BPD have reported that they see themselves as totally bad and deserving of punishment. Self-loathing in individuals with BPD has also been linked to deep-seated feelings of global shame.

‘Recovery’ is much broader than experiencing the remission of symptoms. Personal recovery is understood as living a subjectively meaningful and satisfying life, even when some symptoms of mental illness persist. The process of recovery from BPD is complex and includes recognizing the need for change, developing greater self-acceptance and a stronger sense of agency. Harsh self-criticism may impede this process by preventing individuals from taking action due to a harshly punitive self-concept.

Similar to self-loathing, self-criticism is defined as a pervasive pattern of self-directed negative emotion that includes anger, disgust and contempt for the self and is closely associated with expressions of shame which are global rather than context specific. In contrast, self-compassionate individuals respond to negative experience or failure with a kindly and compassionate attitude towards the self instead of harsh self-criticism.

Self-compassion interventions for BPD have generally used a group format with composite approaches influenced by Kristen Neff, Chris Germer or Paul Gilbert’s work utilizing psychoeducation and compassionate mind approaches such as self-soothing and guided
meditation for conditions including depression and BPD. The results of two published clinical trials suggest limited utility for these group approaches for BPD, with the first reporting no group differences on self-compassion scores and the second reporting significant increases in self-assurance but no differences in self-criticism. However, as highlighted by Roy Krawitz, interventions that ask clients with BPD to cultivate greater self-compassion often provoke negative reactions, and maybe perceived as invalidating to some BPD clients. Explicitly cultivating self-compassion in this context is fraught. Within the trauma literature, Pat Ogden and Janina Fisher suggest encouraging the client’s ‘wise adult self’ to empathize with their ‘child part’ with compassion towards the child’s suffering, with the expectation that self-compassion for the adult client will follow. This approach has the advantage of being specific to the client’s history rather than generic. This approach may also be compatible with modalities commonly used to treat BPD such as dialectical behaviour therapy (DBT) or mentalization-based therapy (MBT). However, to the best of our knowledge there are no clinical trials examining this approach in relation to BPD.

In the context of how little is known about self-compassion in relation to BPD, we assessed the importance of the relationship between personal recovery and the degree to which self-compassion and self-criticism were experienced in participants diagnosed with BPD. We hypothesized that (a) self-reported recovery from BPD would be positively associated with self-rated self-compassion and (b) self-reported recovery would be negatively associated with self-criticism.

Method

Procedure

Participants were recruited from a specialist, publicly funded clinic and from the DBT program at a private clinic, both located in a metropolitan Australian city. The study received Human Research Ethics Committee approval in accordance with Australian and international guidelines on participation in research. The recruitment process at the public clinic began by asking clinicians (by emailed letter) to identify prospective participants who were not in crisis and were able to give informed consent to participate in the project. The treating clinician then approached suitable potential participants and asked if they were willing to receive a letter and follow-up telephone call from the researcher. Advertising flyers were also displayed at the clinic. Potential participants were then recruited via invitation letter and a follow-up telephone call.

Potential participants recruited from the private clinic were initially identified by their DBT clinician. Their capacity to consent was determined by their treating psychiatrist. The DBT clinician then asked the potential participant if they wished to participate. If this was the case, the person consented to a phone call from the researcher to seek verbal consent to participate. All questionnaires were completed onsite at the two clinics, with a researcher available to answer questions. Formal written consent to participate was obtained prior to the completion of the questionnaires. The Borderline Personality section of the Structured Interview for Clinical Diagnosis DSM-IV TR was administered to confirm the diagnosis of BPD.

Participants

Nineteen clients took part in the study. Of these, 17 participants were recruited from the public clinic and two from the private clinic. Participants were aged 19 to 59 years (33.47 average age); 17 participants were female.

Questionnaires

Structured Clinical Interview for DSM-IV: Borderline Personality Scale (SCID-IV-TR-BPD). The SCID-IV-TR BPD scale is a structured clinical interview with 9 items. Responses are rated from 1 to 3. A score of 1 indicates the absence of the criterion, 2 indicates the presence but sub-threshold level of the criterion and 3 indicates a clinically significant presence of the criterion. The SCID-IV-TR BPD has good inter-rater reliability on the BPD scale with a reported Kappa value of 0.91.

Recovery Assessment Scale (RAS). The RAS is a 41-item self-report instrument designed to assess personal recovery. Participants rate themselves on a 5-point Likert scale with 5 = strongly agree and 1 = strongly disagree. Sample items include ‘I can handle it if I get sick again’ and ‘I have a desire to succeed’. The RAS has good reliability and validity with acceptable test-retest reliability (r = 0.88) and good internal consistency (α = 0.93).

In contrast to self-loathing, a validated measure of self-criticism is available which may serve as a reasonable proxy for measuring self-loathing in this clinical group.

Neff Self-Compassion Scale (SCS). The Neff SCS is a 26-item self-report instrument designed to assess whether individuals show acceptance and a kind attitude towards themselves. Participants describe themselves on a 5-point Likert scale (1 = almost never and 5 = almost always). The Neff SCS has good internal consistency (α = 0.92) and good test–retest reliability (α = 0.93).

Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS). The FSCRS is a 22-item self-report instrument designed to assess how individuals think about themselves when they encounter difficulties in their lives. Participants respond on a 5-point Likert scale (0 = not at
all like me and 4 = extremely like me). The FSCRS has been shown to have a three-factor structure: inadequate self, hated self and reassure self. Cronbach’s alpha for the three factors are good ($\alpha = 0.85$ to 0.90).10

Statistical analysis

All statistical analyses were performed using IBM SPSS (version 21, Armonk, NY). Descriptive statistics for the RAS, Neff SCS and the FSCRS included mean scores, kurtosis and skew for each of the score distributions. Assumptions of normality (Kolmogorov–Smirnov test), were tested. Normality of the data distribution was upheld on the RAS and the Neff SCS; the relationship between these two variables was evaluated using Pearson’s $r$. In the case of the FSCRS the assumption of normality was violated and Spearman’s $\rho$ was calculated for evaluation of the relationship between the FSCRS and the RAS.

Results

Descriptive statistics for all variables are presented in Table 1. Correlations were calculated to examine relationships between personal recovery and self-compassion and personal recovery and self-criticism. There was a statistically significant positive correlation between personal recovery (as indicated on the RAS) and self-compassion (as indicated on the Neff SCS), $r = 0.75$, $n = 19$, $p < 0.01$. There was a statistically significant negative correlation between personal recovery (as indicated on the RAS) and self-criticism (as indicated on the FSCRS), $\rho = -0.67$, $n = 19$, $p < 0.01$.

Discussion

The intent of this study was to examine how personal recovery correlates with self-compassion and self-criticism in participants with BPD. It was hypothesized that higher self-compassion scores would be positively associated with personal recovery and therefore that higher self-criticism scores would be negatively associated with personal recovery. Both of these hypotheses were supported by the study results. These correlations were substantial: $r = 0.75$ for self-compassion and personal recovery, accounting for 56% of the variance; and $\rho = 0.67$ for self-criticism and personal recovery, accounting for 45% of the variance.

The strength of these relationships suggests that a focus on recovery accompanied by interventions to enhance self-compassion and diminish self-criticism may be important in supporting positive change in BPD. It is therefore possible that interventions designed to cultivate a more self-compassionate attitude will directly support attaining personal recovery. Conversely, interventions focused on personal recovery may support positive changes in self-compassion. It is, of course, not possible within a correlational study such as this one to determine the causality of this relationship.

Despite the very small cross-sectional sample used in this study, the results suggest very strong interactions between self-reported personal recovery and self-compassion or self-criticism. Future studies would benefit from a larger sample size that explicitly includes participants who differ in the severity of their BPD.

Clearly, self-compassion needs to be specifically targeted within BPD treatment. Future research may constructively focus on integrating trauma-based approaches to self-compassion within the key modalities used to treat BPD, individualizing them to the client’s history. A randomized controlled trial of interventions inclusive of self-compassion within the context of DBT or MBT would clarify the efficacy of this in relation to BPD.

Conclusions

The present study provides a preliminary examination of a cross-section of clients in treatment for BPD. Despite the small sample size, the strong positive correlation between personal recovery and self-compassion, complemented by the robust negative correlation between personal recovery and self-criticism, highlights the importance of broadening treatment to focus on personal recovery and to explicitly include interventions to enhance self-compassion.

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<td><strong>Mean</strong></td>
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RAS: Recovery Assessment Scale; Neff SCS: Neff Self-Compassion Scale; FSCRS: Forms of Self-Criticising/Attacking and Self-Reassuring Scale.
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