A Qualitative Exploration of Pairs of Sisters: Understanding Risk and Protective Factors
Linked to Borderline Personality Disorder

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Table of Contents

Abstract ................................................................. 6
Résumé ............................................................... 9
Acknowledgements ......................................................... 12
Contributions of Authors ........................................ 15
Chapter 1: Introduction ........................................... 16
Chapter 2: Review of Literature ................................ 22
  Borderline Personality Disorder ................................ 22
  Empirical Findings on Abuse as a Predictor of BPD .............. 23
  Other Risk Factors in the Aetiology of BPD .................... 25
  Maltreatment and Resilience ..................................... 26
  Definitions of Resilience ......................................... 28
  Factors Linked to Resilience ..................................... 30
  Risk Factors .......................................................... 31
  Protective factors .................................................... 32
    Individual factors .................................................. 33
    Familial factors ................................................... 34
    External factors ................................................... 35
  Characteristics of the abuse experience ....................... 36
    Protective chains and ripple effects ......................... 36
  Critique of the Existing Research ............................. 37
  Rationale of the Study ............................................. 40
CHAPTER 3 ........................................................................ 42
Women with borderline personality disorder and their sisters: A qualitative analysis of experiences of childhood adversity ........................................ 42
Abstract ........................................................................ 43
  The Current Study .................................................... 49
Method .......................................................................... 49
  Researcher’s Background, Tasks, Experiences, and Biases .... 50
Research Team ...............................................................50
Participants ........................................................................51
Assessment Measures ..........................................................52
  Diagnostic assessment .......................................................52
  Childhood trauma assessment ............................................53
  Demographic form ............................................................54
  Interview Protocol ............................................................54
Procedures ..........................................................................54
Procedures for Analyzing Data ................................................55
  Familiarization with the data ..............................................56
  Generating initial codes ....................................................56
  Searching for themes ........................................................57
  Reviewing themes ............................................................57
  Defining and naming themes .............................................57
  Cross-analyses ...............................................................58
  Auditing .........................................................................58
Trustworthiness ....................................................................58
  Researcher’s reflexivity .....................................................58
  Dependability ....................................................................59
  Negative case analysis .....................................................59
Results ...............................................................................60
Shared Experiences of the Pairs of Sisters .................................60
The Meaning of Childhood Experiences ..................................60
  Emotions .........................................................................61
  Negative perceptions .......................................................62
Growing up with Parental Mental Illness and Substance Abuse ....64
Abuse and Conflict with Sibling(s) ..........................................66
Exclusive Experiences ..........................................................67
Divergent Experiences of Sexual Abuse ..................................68
Discussion ..........................................................................69
Limitations ............................................................................74
Exploring resilience and borderline personality disorder: A qualitative study of pairs of sisters...89
Abstract .................................................................90
Exploring resilience and borderline personality disorder: A qualitative study of pairs of sisters...91
Abuse as a Predictor of Borderline Personality Disorder ........................................91
Resilience and Childhood Abuse ............................................................................92
Protective Factors .................................................................................................93
The Present Study ................................................................................................96
Method ..................................................................................................................97
Researcher Profile ...............................................................................................97
Participants ..........................................................................................................98
Assessment Measures........................................................................................98
  Diagnostic assessment. ......................................................................................98
  Interview Protocol. ............................................................................................99
Procedures ..........................................................................................................99
Data Analysis .......................................................................................................100
Trustworthiness ....................................................................................................103
Results ................................................................................................................105
  Descriptive accounts. ......................................................................................105
    Themes..........................................................................................................105
  Individual protective factors.............................................................................106
  Family protective factors....................................................................................108
  External protective factors ..............................................................................109
  Novel protective factors ....................................................................................112
  Acceptance of the Past .....................................................................................112
  The Meaning of Children ................................................................................114
Abstract

Research on borderline personality disorder (BPD) is burgeoning because of its alarming prevalence, high rates of morbidity and mortality, emotional burdens to sufferers and their friends and families, and financial costs for society. The aetiology of BPD is thought to be multi-factorial involving several psychosocial risks. The risk factor most linked to the development of BPD is childhood abuse; however, 25-33% of individuals who have experienced childhood abuse do not develop any sign of psychopathology. Less attention has been paid to these individuals and to the protective factors that buffer individuals against risks. Hitherto, only a few studies have investigated protective factors that might moderate the damaging effects of childhood adversities and thereby protecting the “at risk” individual from developing BPD. This is regardless of the fact that individuals with BPD report higher incidences of abuse. The role of protective factors in buffering against the development of BPD is under-investigated and needs further research.

The current research examined risk and protective factors in the development of BPD. Pairs of sisters who were concordant on severe levels of exposure to significant risks were the focus of the study. Qualitative data analytic methods, thematic analysis (Braun & Clarke, 2006) and multiple case study (Stake, 2006) were employed to elaborate existing quantitative findings (Laporte, Paris, Guttman & Russell, 2011).

This dissertation comprises two manuscripts. The first manuscript investigates the risk factors linked to the development of BPD in 12 pairs of sisters. Findings suggest that in addition to the shared histories of experiences of parental emotional and physical abuse, these pairs of sisters had other important shared childhood experiences such as growing up with parental mental illness and substance abuse, and abuse and severe conflict with siblings. The findings also highlighted the meaning of these experiences
which had a profound and ubiquitous effect on them and included negative emotions and negative perceptions of life and relationships with others. In spite of the overlap in abuse experiences, there were subtle differences identified in sister pairs in their experiences of sexual abuse and thus they had different attributions and meaning of their experiences and their outcomes.

The second manuscript adds to this work and explores the protective factors in the 12 pairs of sisters. The findings highlight that the non-BPD sisters described having more individual and external protective factors. The finding also emphasizes the importance of increasing social support networks outside the family to decrease the risks of developing BPD. Two novel protective factors emerged from the qualitative analysis, acceptance of the past and the meaning of children, that might play a role in resilience and that need further investigation.

Taken together these two manuscripts provide an in depth qualitative investigation of risks and protective factors linked to the development of BPD. Manuscript 1 underscores the importance of examining not solely parents but multiple members in the family in order to develop a better understanding of the abuse-BPD link. Additionally, these findings contradict the viewpoint that individuals with BPD have been singled out by family members since the non-BPD sisters corroborated the woman with BPD history of abuse. These findings present a salient contribution to the field by suggesting attributions in trying to understand differential psychological outcome. In addition, the findings suggest a story of how BPD develops and the relationship about parental psychopathology leads to abuse and abuse leads to the development of BPD. While the findings for manuscript 2 are consistent with current research on protective factors, the data from this study suggest the meaning and purpose of children and acceptance of the
past are novel protective factors that need further elaboration. The findings also present a salient contribution to the field by suggesting that although individuals might have access to protective factors we need to develop a better understanding of specific ways to promote the use of these factors. These two manuscripts provide a solid rationale that more research on risk and protective factors linked to the development of this disorder is warranted. These manuscripts also have clinical implications that support a shift from the traditional deficit-focused treatments to a resilience approach that fosters personal strengths, resources, and competencies across multiple domains, knowledge of protective factors as well as risk factors, and what strengths also exist in the individuals’ family and environment.
Résumé

Beaucoup de recherches portent sur le trouble de personnalité limite (TPL) en raison d’une fréquence alarmante, d’un taux élevé de morbidité et de mortalité, du fardeau émotionnel important pour les personnes qui en sont touchées et leurs proches, et des coûts élevés pour la société. L’Étiole du TPL est considérée multifactorielle et comprend plusieurs facteurs de risque psychosociaux. Le facteur de risque le plus communément relié au développement du TPL est l’abus durant l’enfance; cependant, 25 à 33% des gens qui ont vécu des abus lorsqu’ils étaient jeunes ne développent aucun symptôme de psychopathologie. Peu d’attention a été accordé à ces individus et aux facteurs de protection qui atténuent les risques de développer un TPL. À date, seul un petit nombre d’études se sont penchées sur les facteurs de protection qui peuvent modérer les effets de traumatismes vécus durant l’enfance et l’adolescence et contrecarrer le développement d’un TPL chez des individus à risque. Cela ne tient pas compte du fait que les gens qui ont un TPL sont aussi ceux qui ont vécu un plus grave d’abus. Le rôle des facteurs de protection qui font obstacle au développement d’un TPL n’est pas suffisamment connu et nécessite d’autres recherches.

La présente recherche examine l’influence des facteurs de risque ainsi que des facteurs de protection dans le développement du TPL. Des paires de soeurs qui ont vécu des niveaux similaires de risques ont fait l’objet de l’étude. Des méthodes d’analyse qualitative, telles des analyses thématiques (Braun & Clarke, 2006) et analyses de cas multiples (Stake, 2006) ont été utilisées pour compléter les résultats d’une étude quantitative sur cette question (Laporte, Paris, Russell & Guttman, 2011).

Cette thèse de doctorat comporte deux articles. Le premier article porte sur les facteurs de risque liés au développement du TPL chez douze paires de sœurs. Les
résultats révèlent qu’en plus des expériences communes d’avoir subi de l’abus émotionnel et physique de la part de leurs parents, ces paires de sœurs ont également vécu d’autres expériences importantes communes, soit les problèmes de santé mentale et abus de drogues ou d’alcool chez leurs parents, de la violence et des conflits sévères avec leur fratrie. Les résultats soulignent également l’effet profond de ces expériences sur les victimes. Malgré la concordance des expériences d'abus, nos résultats démontrent la présence de différences subtiles dans leurs expériences d'abus sexuel et dans leurs attributions et signification donnée à leurs expériences.

Le deuxième article explore les facteurs de protection chez les douze paires de sœurs. Les résultats soulignent que les sœurs qui n’ont pas développées de problèmes de santé mentale décrivaient plus de facteurs de protection individuels et de facteurs externes liés à la résilience. Les résultats soulignent l’importance d’avoir des relations de soutien extérieures à la famille afin de promouvoir la résilience et diminuer les risques de développer un TPL. Deux facteurs de protection non encore identifié dans la littérature ressortent de l’analyse qualitative, soit l’acceptation du passé et l’importance des enfants. Ces facteurs de protection pourraient jouer un rôle important dans la résilience et auraient besoin d’être examinées dans des recherches futures.

Ces deux études qualitatives ont permises d’étudier plus en profondeur les facteurs de risques et de protection liés au développement d’un TPL. Le premier article souligne l’importance de ne pas seulement se pencher sur les comportements des parents mais également sur celui des autres membres de la famille afin de développer une meilleure compréhension du lien abus et TPL. De plus, ces résultats contredisent l’idée émise par certaines auteurs que les personnes présentant un TPL sont le mouton noir de la famille et sont donc celles qui ont été abusées durant leur enfance; leurs sœurs qui ne souffrent
d’aucune psychopathologue ont vécus des abus semblables. Cette thèse contribue à l’avancement des connaissances en suggérant des attributions en essayant de comprendre des résultats psychologiques différentiels. En outre, les résultats suggèrent une façon dont TPL se développe et le rapport au sujet de la psychopathologie parentale qui mène à la maltraitance ce que mène au développement TPL. Tandis que les résultats pour le deuxième article sont compatibles à la recherche courante sur des facteurs de protection, les données de cette étude suggèrent que soit l’acceptation du passé et l’importance des enfants soient de facteurs de protection qui auraient besoin d’être examiner dans des recherches futures. Les résultats contribuent à l’avancement des connaissances en suggérant que bien que les individus pourraient avoir accès aux facteurs de protection, nous devrions développer une meilleure façon dont un individu accède à ces facteurs et comment les utiliser. Les deux articles apportent un solide motif pour de futures recherches sur le rôle des risques et facteurs de protection liés au développement de TPL. Sur le plan clinique, ces articles soulignent la pertinence d’apporter des changements relativement aux traitements traditionnellement axés sur les déficits en faveur d’une approche sur la résilience qui encouragerait les forces, les ressources et les compétences à travers de multiples domaines, la connaissance des facteurs de protection aussi bien que des facteurs de risque, et quelles forces existent également dans la famille et l'environnement des individus.
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Contributions of Authors

The two manuscripts that comprise this dissertation are co-authored. I am the primary author of each, having completed the literature reviews, conceptualized each of the studies (generating overarching research questions and conducting data analyses), and written the dissertation document in its entirety. Both manuscripts are co-authored by Drs. Lise Laporte, Jack De Stefano and Marilyn Fitzpatrick who contributed substantive editorial comments and helped outline the structure the document. My doctoral co-supervisor, Dr. Lise Laporte, served in an advisory capacity during the conceptualization, formulation of research questions, and writing phase of manuscript preparation of both manuscripts. My second doctoral co-supervisor, Dr. Marilyn Fitzpatrick, served in an advisory capacity, contributing her knowledge and expertise in the writing phase of manuscript preparation for manuscripts 1 and 2 as well as editing both manuscripts. My committee member, Dr. Jack De Stefano served in an advisory capacity during the conceptualization, formulation of research questions, and writing phase of manuscript preparation of both manuscripts. As well, he verified the analysis results for accuracy, and discussed the interpretation of the results for both manuscripts.

The current study is part of a larger program of research at McGill University Health Center examining siblings (Laporte, Paris, Russell, & Guttman, 2011) growing up in a family with childhood adversities in which one woman develops BPD.
Chapter 1: Introduction

Among the personality disorders, borderline personality disorder (BPD) is one of the most severe, complex, and disabling. BPD affects approximately 1-2% of the general population (Gunderson & Links, 2008; Paris, 2003; Zanarini, 2000), 10-15% of psychiatric outpatients, and 20% of psychiatric inpatients (Lieb, Zanrini, Schmahl, Linehan, & Bohus, 2004; Widiger & Weissman, 1991). It is a major health concern since individuals with BPD are significant users of medical and social services (Grant et al., 2008), and their lifetime risk of suicide that is 10% (Ball & Links, 2009). Given the prevalence, morbidity, and the mortality associated with BPD developing an understanding into how risk and protective factors play a role in the development of this personality disorder is an important research objective.

An association between childhood abuse and BPD is consistently reported across the empirical studies indicating that a history of early abandonment (Paris, 2007) and sustained neglect (Zanarini, 2000), physical abuse (Bandelow et al., 2005), emotional abuse (Allen, 2008), and sexual abuse (Yen et al., 2002) are significant risk factors in the development of BPD. Thus, considerable research has provided the conclusion that no type of maltreatment is important on its own, but rather it is the complex combination of diatheses and stressors that lead to the emergence of BPD (Kessler & McLaughin, 2010). Given that maltreatment and BPD are linked it appears worthwhile to investigate the risks that might increase vulnerability to BPD as well as the protective factors that might mitigate the negative effects of maltreatment in the development of this personality disorder.
The interplay of risk and protective factors determines the outcome to a negative life circumstance such as childhood abuse and can be used to explain how an individual exposed to considerable risks might remain resilient (Rutter, 2007). Resilience involves the capacity to adapt and successfully cope with adversity, to deal with future stressful and traumatic events, and to provide protection from the development of psychopathology (Afifi & MacMillan, 2011). One of the central questions related to resilience concerns the mechanisms that facilitate positive adaptation to severe adversity and this implicates the concepts of risk and protective factors which are characteristics of the individuals, their families, and the external environment (i.e., community). Protective factors increase and risk factors decrease the probability the individual will be resilient to adversity (Werner, 1982). Thus, when examining the causes of maltreatment related to the development of psychopathology like BPD, findings from the resilience research suggest that other factors (e.g., interaction of risk and protective factors) should be taken into account.

The maltreatment research includes both retrospective and prospective studies that focus on the maladaptive outcomes of negative childhood experiences of maltreatment and in particular the manner in which this exposure increases the risk of psychopathology (Collishaw et al., 2007). Yet while we know about the adverse effects of maltreatment, many maltreated children actually show signs of positive adaptation as adults (Walsh, Dawson, & Mattingly, 2010). Research shows that there are individual differences in a child’s reactions to maltreatment in that around 25-33% of individuals who have experienced childhood maltreatment do not show any sign of adult psychopathology (Dumont, Widom, & Czaja, 2007). Thus, the emphasis on negative outcomes of maltreatment, while necessary, has overshadowed our understanding of an individual’s
ability to adapt and to manifest competence in the face of adversity (Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007). Broadening the focus of research to explore more positive adaptive responses and outcomes to maltreatment should lead to a more comprehensive understanding of the maltreatment-psychopathology link, and to advances in treatment and prevention.

Our current understanding of resilience has emerged primarily from the research on maltreatment (Herrman et al., 2011), which has focused extensively on individuals who develop Axis I disorders most notably depression, anxiety disorders, and post-trauma stress disorder linked to experiences of childhood abuse (Geritz & Medhanie, 2008; Trickett, Negriff, Juye & Peckins, 2011). To date, only a few studies have investigated factors that might alleviate the effects of maltreatment, protecting at risk individuals from developing personality disorders (e.g., Skodol et al., 2007) in spite of the fact that adults with Axis II diagnoses report higher incidences of childhood abuse and other psychosocial stressors (Zanarini, 2000). The role of protective factors that buffer these negative effects in individuals with personality disorders remains an understudied and critical area of research.

Most of the studies on maltreatment as a predictor of psychopathology tend to focus on individual differences where the person is compared to a matched control to explore the effects of maltreatment on one child in the family (O’Connor, 2001). The studies that have explored abuse within families have often found that in addition to the child reporting abuse at least one other child was also abused by their parents, thus suggesting that siblings are also the target of similar abuse (e.g., Lavergne & Tourigny 2000; Laporte, Paris, Guttman, & Russell, 2011). Given that research has demonstrated that abuse occurs in families, we might expect that all siblings share the experiences,
family environments, and thus the risks. Yet we know very little about the siblings of those individuals with a clear DSM diagnosis.

Since childhood maltreatment occurs in families, and given the fact that individuals with BPD grow up in dysfunctional families (Paris, 1997; Zanarini, 2000) and that the diagnosis of BPD is more likely in first-degree relatives of the individuals with BPD (Grim, 2000), it would be logical to study siblings who are living in the same situations (Laporte & Guttman, 2001; O’Connor, 2001). Up to now, there is little knowledge of the experiences of other siblings growing up in the same circumstances (Gunderson, et al., 2011).

Laporte et al. (2011) have developed a research program that addresses some of the methodological limitations of comparing individuals with BPD with matched controls in maltreatment research (Hines, Kaufman, Kantor, & Holt, 2006). They studied pairs of sisters to investigate within-family similarities and dissimilarities of risks to pathology in women with BPD and their sisters. Looking at similar experiences within families is an innovative approach to studying the risks in the aetiology of BPD. This approach can be used to study not only the risks associated with the development of BPD but also the protective factors that might mitigate the damaging effects of negative childhood experiences on susceptible individuals and prevent the development of BPD.

Much of the research in the fields of resilience, maltreatment, and personality disorders is quantitative. Few published qualitative studies provide an understanding of the “human” side of resilience, maltreatment, and BPD, that is, the experiences and perspectives of those who have lived the similar circumstances and experiences (Giffin, 2008; Nehls, 1999). Giving a voice to those women who have been victims of maltreatment and listening to their experiences and outcomes provides a layer of
knowledge and understanding that cannot be easily had when conducting quantitative studies. Qualitative research is thus a methodology that adds a unique perspective and a depth to the topics that cannot easily be achieved with quantitative methods.

This dissertation reports on work that examined risk and protective factors linked to the aetiology of BPD. Sister pairs, one with a BPD diagnosis and the other without any DSM diagnosis and who experienced comparable severity of parental physical and emotional abuse were studied because they represent atypical cases of exposure to significant risks and differential mental health outcomes. Manuscript 1 is a qualitative investigation of the experiences of childhood abuse and family dysfunction in pairs of sisters who experienced comparable parental physical and emotional abuse. Study 2 extends this work by exploring the protective factors that contributed to resilience outcomes in sister-pairs who experienced similar childhood abuse and family dysfunction. The dissertation converges on recommendations for practice and research.

This dissertation was prepared in accordance with the guidelines for a manuscript-based thesis put forward by the Faculty of Graduate Studies and Postdoctoral Studies at McGill University and includes a review of the literature and two manuscripts that, together, comprise a program of research exploring how pairs of sisters understand their adverse childhood experiences and risks and how protective factors are implicated in protecting at risk individuals from developing BPD. Each manuscript is presented as an independent chapter (Chapters 3 and 4), each containing its own introduction, methods, results, and discussion sections. While presented in separate manuscripts, the two studies were conceived of as complementary components of an overarching qualitative design.

The document includes a comprehensive review of the literature (Chapter 2) and ends with a discussion (Chapter 5) that summarizes and integrates the findings of the two
The reader will find some unavoidable redundancies in the introductions and methods of the two studies as each address the same general topics – BPD, maltreatment, and resilience, and investigates the same population, pairs of sisters - a woman with BPD and her unaffected first-degree biological sister.
Chapter 2: Review of Literature

Borderline personality disorder (BPD) is among the most common and damaging of DSM disorders (Nehls, 1999). Extensive research has focused on the harmful effects of negative childhood experiences, such as abuse, parental psychopathology, and dysfunctional family environments in the development of this disorder. Less consideration has been afforded to the factors that might moderate the adverse effects of negative life experiences and buffer individuals from developing this disorder. This review summarizes (1) an overview of BPD, (2) empirical findings on abuse as a predictor of BPD, (3) other risk factors in the aetiology of BPD, (4) maltreatment and resilience, (4) the current definitions of resilience, (5) factors contributing to resilience, (6) critique of the existing research, and (7) rationale of the current study.

Borderline Personality Disorder

Individuals with the diagnosis of BPD have been described as having, “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (Diagnostic Statistical Manual-IV-R, APA, 2000, p. 292). These individuals experience constant and persistent cognitive, emotional, and behavioural vulnerability (Crowell, Beauchaine, & Linehan, 2009). They demonstrate extreme emotional lability, make frantic efforts to avoid real or imagined abandonment, have chronic feelings of emptiness, periods of feeling removed from reality (i.e., dissociation), and difficulty controlling intense anger (Dziegielewski, 2002). Other characteristics of the disorder include recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour or both,
unremitting crises, and impulsivity (e.g., excessive spending, risky sex, substance abuse, reckless driving, binge eating, etc.) that is potentially self-harming (Hales & Hales, 1996).

The importance of developing a clearer understanding is underlined by its prevalence and the financial and emotional burden associated with it. On its own, this severe personality disorder affects 1-2 % of the general population (Gunderson & Links, 2008; Zanarini, 2000) and accounts for up to 20% of patients in psychiatric care who have been hospitalized (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Up to 10% of those who meet the criteria for BPD eventually commit suicide (Paris, 2008). Individuals with these diagnostic features are flooding health care services (Linehan, 1993). Clinicians often report that these individuals are difficult and challenging and whenever possible try to avoid treating them (Lewis & Appleby, 1988). Thus, this diagnosis also represents a tremendous toll not only on those with the diagnosis, but to the health care system (Crowell, et al., 2009). BPD also represents a tremendous emotional burden on the families and social networks of these individuals because of their unpredictable behaviour, pervasive instability, and their difficulty controlling impulses and regulating their emotions (Ball & Links, 2009).

**Empirical Findings on Abuse as a Predictor of BPD**

There is a growing body of evidence that suggests that all forms of childhood abuse are significant factors in the development of BPD (e.g., Ball & Links, 2009; Paris, 2008; Zanarini, 2000). A common feature of this research is the higher rates of childhood sexual abuse, physical abuse, witnessing serious domestic violence, and emotional and physical neglect among individuals with BPD (Bandelow et al., 2005). This evidence suggests that individuals with BPD who were abused grow up in an at-risk environment.
A study conducted by Guzder, Paris and Zelkowitz (1996) indicated that children with borderline pathology were more likely to experience several adversities, including sexual abuse, physical abuse, and extreme neglect compared to a control group who were also in day treatment.

In comparing psychiatric disorders, BPD has the most frequent association with sexual abuse (Brown & Anderson, 1991; Yen et al., 2002; Zanarini, 1997; Links, 1990); and this has been found to be one of the strongest predictors in the development of this personality disorder (Paris, 2008). For example, Bandelow et al. (2005) compared patients with BPD with healthy controls and found that among various types of traumatic childhood experiences, sexual abuse was significantly higher in the patients with BPD.

Other types of abuse are also salient in BPD. Laporte and Guttman (1996) evaluated 751 psychiatric records of discharged female psychiatric patients diagnosed with personality disorders and found that 93% of the patients with a BPD diagnosis had been exposed to at least one type of childhood abuse, in comparison with 74% of patients with other personality disorders. In another inpatient sample, Oldham, Skodol, Gallaher, and Kroll (1996) found an even larger discrepancy in childhood abuse patients with BPD (75%) and patients with other personality disorders (33%). Two studies of non-clinical subjects from representative surveys found that subjects who endorsed borderline features reported more childhood emotional, physical, and supervision neglect (Johnson, Smailes, Cohen, Brown, & Bernstein, 2000; Trull, 2001). An association between childhood abuse and BPD is consistently revealed across the research and the conclusion is that maltreatment is an important aetiological factor in BPD development (Kessler & McLaughin, 2010). Thus, abuse is a critical, central risk factor in the development of BPD. Given than maltreatment and BPD are linked, it appears worthwhile to further
investigate not only the risks linked to BPD but also the protective factors that might mitigate the negative effects of maltreatment on the development of this personality disorder.

Other Risk Factors in the Aetiology of BPD

The aetiology of BPD is complex and involves other risks factors besides childhood maltreatment including parental psychopathology and a dysfunctional family environment. There is strong evidence that many individuals with BPD have grown up with parental psychopathology including substance abuse (Paris, 2003; Zanarini 2000). White, Gunderson, Zanarini and Hudson (2003) reviewed the research and estimated that the incidence of psychopathology in the relatives of individuals with BPD is relatively high. They found that several disorders linked to the development of BPD in relatives including an association between BPD and major depressive disorders, impulse spectrum disorders, and BPD itself. The Guzder et al. (1996) study on borderline pathology in children supports this link in that these children were more likely to have parents with histories of substance abuse than a comparison group. Most recently, Bandelow et al. (2005) found that having a first degree relative with a psychiatric disorder from the neurotic spectrum was the most important familial risk factor for BPD in their study. White, Gunderson, Zanarini and Hudson (2003) also found that relatives of individuals with BPD had a 4-20 fold increase risk of a BPD diagnosis compared to the general population. Other studies have shown similar results in that the diagnosis of BPD is five times more frequent among close relatives of an individual with BPD than in the general population (Grim, 2000) and that there is a heightened risk of BPD in first–degree relatives (e.g., Zanarini, et al., 2004). Studies of relatives found BPD to be more common
in the first–degree relatives of people with this diagnosis than in the first–degree relatives of normal controls, or those with other Axis I and II disorders (Baron, Gruen, Asnis, & Lord, 1985; Links, Steiner, & Huxley, 1988; Loranger, Oldham, & Tulis, 1982; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988).

Another risk factor that has been explored in relation to the aetiology of BPD is a dysfunctional family environment. Practitioners have often noted that the family environment plays a significant role (e.g., Levy, Meechan, Weber, Reynoso, & Clarkin, 2005; Linehan, 1993; Young, Klosko, & Weishaar, 2003). For example, schema therapy for personality disorders is based on the premise that dysfunctional family environments play a role in the development of a BPD diagnosis (Young, et al., 2003). In this modality, four characteristics of the family environment interact and lead to BPD: (1) unsafe and unstable; (2) depriving; (3) harshly punitive and rejecting; and (4) subjugating. Although empirical research has yet to establish these four specific aspects of family environments, the Bandelow et al. (2005) study confirmed that family environments, characterized by separation from parents, growing up in foster homes, adoptions, criminality or violence in the family, and unstable and inappropriate parenting styles were associated with BPD. Whether from a clinical or empirical perspective, mental health disorders including BPD have consistently been linked to family dysfunction (Kessler & McLaughin, 2010).

**Maltreatment and Resilience**

The study of resilience was originally stimulated by research on maltreated children (Herrman et al., 2011). Herrman et al.’s literature review outlined that the majority of resilience research was on childhood adversities and that this research focused on the negative consequences and outcomes that occurred as a result of experiencing
Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS

childhood abuse. Subsequently, other researchers paid attention to the risk of psychopathology among children who experienced maltreatment and examined most notably Axis I disorders such as depression, anxiety disorders, post-traumatic stress disorder, somatization disorder, and suicide (Brown, Cohen, Johnson, & Smailes, 1999; Fergusson, Horwood, & Lynsky, 1996; Fergusson & Lynsky, 1996; Geritz & Medhanie, 2008; Lansford et al., 2002). Numerous studies have documented the impacts of childhood abuse on cognitive, behavioural, and interpersonal functioning (for a review see, Trickett, Negriff, Juye, & Peckins, 2011). The negative cognitive effects are seen in: (a) cognitive delays and lower IQ scores (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003), (b) neurobiological abnormalities (Glaser, 2000), and (c) school failure (McGolin & Widom, 2001). Within the behavioural domain there is evidence of (a) conduct problems, aggressivity, criminal behaviour, and substance abuse (Fergusson, Boden, Horwood, 2008; Schuck & Widom, 2001), (b) delinquency, and (c) truancy, (Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007; Collishaw, et al., 2007) related to maltreatment. Finally, interpersonal and social deficits have been reported in (a) peer-relationships, (b) intimate partner relationships, (c) and employment (Hill, Stafford, Seaman, Ross & Daniel, 2007; Widom, 1989; McGolin & Widom, 2001) for adults who were abused as children. Maltreated children are also at an increased risk for exposure to multiple forms of victimization (Coid, et al., 2003; Finkelhor, Ormond, & Turner, 2007).

While the research on child maltreatment has provided important data on the deleterious effects and adverse outcome of abuse it has tended to ignore the individual’s ability to adapt and successfully cope with childhood maltreatment (Rutter, 2006). Yet, research shows that there are notable individual variances in the response to adversity. Each year millions of children will be exposed to maltreatment (Butchart, Harvey, &
Furniss, 2006), yet 25-33% of these individuals will not develop psychopathology (Collishaw, et al., 2007; Daigneault, Hebert, & Tourigny, 2007; Dumont, Widom, & Czaja, 2007; Fergusson, et al., 2008; Fergusson & Lynsky, 1996; McGloin & Widom, 2001; Spaccarelli & Kim, 1995; Stevenson, 1999). These findings suggest that other factors, including the interaction of risk and protective factors must be taken into account when examining the link between childhood maltreatment and the development of psychiatric disorders like BPD. There is a growing acknowledgment that resilience plays a central role in how individuals adapt to adversities like childhood maltreatment (Afifi & MacMillian, 2011).

**Definitions of Resilience**

There has been a substantial debate on how best to define and investigate the construct of resilience (Collishaw et al., 2007; Luthar & Zigler, 1991; Rutter, 2006) and this might be partly due to the fact that researchers in the field come from very different disciplines (Herrman, et al., 2011; Heller, Larrieu, D’Imerio, & Boris, 1999). Definitions are constantly evolving as scientific information is developed and disseminated; nevertheless, there are several definitions that share some common features. In essence, these definitions link resilience, with adaptive coping, with tapping into strengths, positive outcomes following exposure to risk, and with protecting oneself from the development of mental disorders.

In a recent review of the scientific literature on resilience, Herrman et al. (2011) concluded that, “resilience refers to positive adaptations, or the ability to maintain or regain mental health, despite experiencing adversity” (p. 259). This definition suggests that resilience involves individual variations in response to risk such that positive
outcomes are achieved and negative outcomes are diminished. Individuals exhibit resilience if two key features are met: (a) significant threat, difficult circumstances, and/or stressful events; and (b) positive adaptations (Gilligan, 2001; Luthar, 2003).

Current definitions of resilience have been broadened to encompass multiple domains of functioning extending over time (Luther & Sexton, 2007; Rutter, 2007). The definition suggested by McGloin and Widon (2001, p.1023) focused on these multiple domains of functioning; psychiatric, emotional, and behavioural, and includes a sequential dimension. According to their definition, resilience can be assessed using these questions:

(a) Does the individual have a current or remitted diagnosis of psychiatric disorders and/or substance abuse problems? (psychiatric functioning); (b) Does the individual have a job? Are they able to hold a job for an extended time period? (employment and work history); (c) Has there ever been a period when you had no regular place to live, for at least a month or so? (homelessness); (d) Does the individual have an official arrest or self report of violence? Including a juvenile record? (criminal behaviour); (e) Does the individual participate in social activities? Are they able to maintain interpersonal relationships? (social activity); (f) What is their highest level of education obtained? (education)

Thus in the current definitions of resilience, an individual demonstrates resilience to adversity when there is a normal or above normal range of competence across several domains of functioning in the area of behavioural, emotional, social, and academic competence (Walsh, Dawson, & Matting, 2010).
Resilience has been used as a construct to explain the positive outcomes that occur in light of extreme stress and adversity. For example, when people do better than expected following some negative event we say that they are resilient. Luthar and Sexton (2007) suggest that resilience is usually shown by relative success compared to some norm, in other words, resilience is used to compare an individual to another on adaptive criteria. Because a psychiatric diagnosis is common when very severe trauma is the stressor, then the absence of diagnosis is an important marker or evidence of individual’s resilience. This has often been the outcome of choice in the investigation of the maltreatment and resilience (Herrman et al., 2011).

In this dissertation a resilient individual was identified as having: (1) experienced repeated, ongoing, severe physical and emotional abuse, and (2) reported no psychiatric disorders at the time of the study; and (3) achieved a normal range of competence across several domains of functioning (e.g., behavioural, emotional, social, and academic). This definition of resilience uses Luther’s (2003) definition and adds the notion of multiple domains (McGloin & Widon, 2001) to capture a more comprehensive understanding of resilience and the factors that contribute to it.

Factors Linked to Resilience

Pioneering research by developmental psychologists like Garmezy (1983, 1991), Rutter (1979, 1985), Werner (1982), and Werner and Smith (1992) have identified a number of factors thought to contribute to resilience in children and adolescents who experienced child maltreatment. These factors are characteristics of individuals, their families and their environments that either increase (protective factors) or decrease (risk factors) the chances that an individual will be resilient.
Risk Factors

Risk factors are elements or characteristics of the individual (such as the onset of a serious illness), the family (in which the parents are implicated such as child abuse), or the environment (such as residing in a high crime neighbourhood) which decrease the likelihood of positive adaptation (Rutter, 2007; Luthar, 2003). Initially researchers identified specific risks and childhood maltreatment was the most frequently identified risk factor (Herrman, et al., 2011). Over time, the types of risks examined have expanded to include: trauma, violence, separation, bereavement, loss, peer rejection, physical or mental health problems in self or key others, living with drug-or other substance-abusing parents, living in low income or in disadvantaged neighbourhoods, migration, natural disaster, war, poverty, etc. (Afifi & MacMillan, 2011; Hill et al., 2007; Rutter, 2007). Newman and Blackburn (2002) suggested that risk factors are cumulative and that the presence of one risk will increase the likelihood that more will emerge. He proposed that transition points in individuals’ lives can be both seen as threats or opportunities depending on the risk. Others have added and posited that risk cumulative impact is greater and is more salient of an issue than specific risks (e.g., Luthar & Brown, 2007). Given that risks are cumulative and that evidence has shown that risks are deleterious it is important to consider all risks and their interactions when examining a resilient outcome (Titterton, Hill, & Smart, 2002).

While resilience can only be observed after exposure to a risk little attention has been paid to the role risk played in developing that negative outcome. From the literature it is clear that risks are linked to negative outcomes but more attention needs to be given to how the negative outcomes develop. Perhaps risks and stress might act as inoculations
to negative events and thus strengthen an individual for further risks. Some evidence suggests that experiences of adversity sometimes strengthen resistance to later stress, the “steeling effect” (Rutter, 2006). In the steeling effect individuals exposed to risk actually appear to be strengthened after their exposure. Research on this phenomenon is sparse, mostly focusing on animals exposed to stress. For example, Amat, Paul, Zarza, Watkins, and Maier (2006) studied rats exposed to earlier stress and found an immunizing protection against later stress exposure. In humans, the steeling effect has been demonstrated in clinical interventions with phobias where the use of response prevention and behavioural desensitization techniques where exposure to a feared situation is used to increase mastery of the stressor (Rutter et al., 2008). Rutter (2006) proposed that successful psychological habituation to risk and stress may actually inoculate the individual and strengthen resistance to later risk similar to the therapeutic techniques used with phobias where exposure to risk and psychological habituation is necessary for a positive outcome. Evidence such as this suggests that risk factors can strengthen rather than weaken an individual’s response to stress. We therefore need to understand those mechanisms that allow steeling to happen and which could better explain how risk and resilience is protective for psychopathology.

**Protective factors**

Protective factors buffer individuals from the effects of negative life events that cannot be avoided. Over the past 30 years, a growing body of research has explored how these protective factors can actually be developed to help individuals function better and become more resilient (Luthar & Sexton, 2007). A protective factor may buffer the impact of the risk (Luthar & Cicchetti, & Becker, 2000), and influence how a person
responds to the adversity (McGee & Wolfe, 1991; Rutter, 1985). Based on Werner’s (1982) work, researchers have investigated protective factors linked to resilience and divided them into the broad categories of individual factors, familial factors, and external factors (Afifi & MacMillan, 2011; Herrman et al., 2011).

**Individual factors.** Individual protective factors may either be personal characteristics, personal traits, qualities, resources, or skills of the individual who is experiencing adversity or stressful life events (Afifi & MacMillan, 2011). Quantitative studies on individual protective factors have identified the following factors linked to resilience: (a) cognitive ability such as high IQ, cognitive flexibility, good intellectual functioning, (Fergusson & Lynskey, 1996; Gilligan, 2001); (b) personality traits of openness, extraversion, agreeableness, adaptability, flexibility attachment style, and positive temperament (Benard, 2004; Herrman et al., 2011); (c) personal characteristics and attributes such as internal locus of control or autonomy, self-efficacy, high self-esteem, positive self-concept, perceived competence, resourcefulness, optimism, hopefulness, external attributions of blame (Cicchetti, Rogosch, Lynch, & Holt, 1993; Morimoto & Sharma, 2004; Richardson, 2002); (d) resources such as sound problem-solving skills, coping styles (such as positive self-talk, positive social comparison, and selectively focusing on positive aspects), emotional regulation, mastery, being achievement oriented, positive future expectations, sense of purpose and future competence (having clear goals and an organized strategy for achieving them) (Dekovic, 1999; McGee, Wolfe, & Olson, 2001; Radvanovic, 1993); and (e) individual attributes such as physical health, exceptional talent, humour, creativity, and life satisfaction (Afifi & MacMillan, 2011; Gilligan, 2001). Researchers have identified several important individual factors linked to positive adaptation following child maltreatment which
include cognitive ability, cognitive styles, and personality style (e.g., Davidson et al., 2005). Studies of selected samples of children who experienced abuse suggest that high self-esteem, internal locus of control, external attributions of blame and the individuals’ coping strategies all predict more positive outcomes (Cicchetti, et al., 1993; McGee, et al., 2001).

**Familial factors.** Family protective factors are elements within the family environment that promote positive adaptive outcome to risks (Werner, 1990). These include positive relationships with caregivers characterized by warmth, responsiveness, stimulation, consistent guidelines and rules, structure, supportive good parenting, and acting as adequate role models (Hill, et al., 2007). Some studies emphasize that a warm, nurturing, and cohesive family environment, harmony between parents, family coherence, parents spending time with their children are seen to be key features in positive adaptation among children exposed to severe adversity (Afifi & MacMillan, 2001; Rutter, 2007). Rutter (2007) found that even the presence of one good parent-child relationship reduced the risk of conduct disorder among children with family discord who experienced abuse. Similarly, Herrman et al. (2011) suggested that a secure attachment to a mother, secure relationship with non-abusive parent, and absence of maternal depression or substance abuse, and an emotional bond to at least one parent were all associated with resilience. In addition, Heller, et al. (1999) suggested that the availability of emotional support from at least one parent or caregiver during the time when a child experienced abuse strengthened the ability of the child to draw support from other caring adults in their external environment thereby increasing their resilience. This was supported by Wind and Silvern’s (1994) study on mediators of the long-term effects of childhood sexual and/or physical abuse in a community sample of women. They found that a history of child
abuse and the lack of supportive parenting were predictive of negative adjustment in adulthood. In sum, most studies suggest that the more sensitive, supportive, accepting, caring, and safe the home environment, the more positive the outcome (Egeland, Carlson, & Sroufe, 1993; Spaccarelli & Kim, 1995).

**External factors.** External protective factors are elements that relate to the individual’s ability to draw support from others in their extended social system (Afifi & MacMillan, 2011; Herrman et al., 2001). Researchers have identified several possible external protective factors that may ameliorate the exposure to risk, including: (a) exposure to other nurturing adults; (b) developing extra-familial support (e.g., a connection to other competent adults outside the immediate family); (c) secure attachment with peers; (d) romantic partners; (e) spirituality and religion (e.g., Bandelow, et al., 2005; Collishaw, et. al, 2007; McGee & et al., 2001; Morimoto & Sharma, 2004). Herrman et al. (2011) also discussed examples of good schools, community services, and positive neighbourhood qualities, connections to pro-social organizations, sports, and artistic opportunities in fostering and nurturing resilience. If a supportive, nurturing external surrounding is present these external protective factors can help the individual who experienced adversity develop positive adaptation.

In sum, several protective factors that have been consistently reported in the maltreatment literature and seem to converge on the following as being consistently linked to positive outcomes such as connections with competent, caring adults in the family and community, good intellectual functioning, self-regulation skills, and positive self-views (Luthar & Cicchetti, 2000; Masten, 2001; Morimoto & Sharma, 2004; Rutter, 2006).
Characteristics of the abuse experience. Collishaw et al. (2007) suggest that when looking at predictors of resilience in maltreatment exposure, it is important to consider characteristics of the abuse experience. These include variability in the severity of the initial risk exposure, such as timing, duration, frequency, severity, degree of threat, and relationship to the perpetrator (Bulik, Prescott, & Kendler, 2001). Others have suggested (e.g., McGloin & Widom, 2001) exploring the different characteristics of the abuse experience such as (1) the type of abuse or neglect experienced; (2) the severity and chronicity of the maltreatment; (3) the child’s cognitive appraisal of the event; (4) the family response to the abuse; and (5) community response to the maltreatment when examining predictors of resilience to maltreatment. In addition, the age of onset has also been considered a variable in forecasting a positive outcome (Rutter, 2006).

Protective chains and ripple effects. There has been much debate concerning the importance of the sources of resilience, that is, whether protective factors are situated in the individual, the family, or the external environment (Herrman, et al., 2011). Given human complexity, it is unlikely that single or simple cause can explain why one person is resilient and another is not. Most researchers now agree that it is best to see resilience as an evolving, interactive process among individual, family, and environmental protective factors (Gilligan, 2001; Rutter, 2007; Schofield, 2001).

It is logical to think that risk or protective factors do not operate independent of each other. An individual’s resilience is determined by the interplay of personal characteristics, family characteristics, and the characteristics of the external environment (Werner, 1990). A strongly emerging point of view is that protective factors interact and work together to produce a resilience outcome. Investigators have referred to this cumulative effect as “pile up” of protective factors, “protective chains” or “ripple effects”
(Masten et al., 1999; Rutter, 1979; Waller, 2001). The more accumulation of protective factors the better the outcome. As Fergusson, Beautrais, and Horwood, (2001, p. 61) stated, “Vulnerability/resiliency is influenced by an accumulation of factors…positive configurations of these factors confer increased resiliency, whereas negative configurations increase vulnerability.” Thus, the more protective factors in an individual life, and the fewer risk factors, the greater the probability that the individual will be resilient. The reverse is also true. An increase of risks and the reduction of protective factors augment the individual’s likelihood of developing a range of problems (Masten et al., 1999; Rutter, 1999; Waller, 2001).

To summarize, BPD is a complex disorder with multiple risk factors. One of the risk factors most often linked to its development is childhood maltreatment. Considerable research has focused on the effects of negative life experiences and risks, including childhood maltreatment, in the development of BPD; however, few studies have focused their attention on the protective factors that might buffer the deleterious effects of maltreatment and shield a vulnerable individual from developing BPD. Given the centrality of both risk and protective factors to this personality disorder, more research on their important roles is needed.

**Critique of the Existing Research**

This section will focus on some of the obstacles associated in the three bodies of research: BPD, childhood maltreatment, and resilience. This is in no way a comprehensive review of all the limitations in the literature but rather pertain to the rationale for the current study. The first two limitations are common to all bodies of research; the last limitation suggests an area for further exploration.
A common feature of the three bodies of research- BPD, childhood maltreatment, and resilience- is that the majority of research utilized quantitative methods to drive their investigations. For example, several researchers have devised detailed coding schemes in order to capture the scope of child maltreatment (e.g., McGee & Wolfe, 1991) and the results overwhelmingly document the severity, prevalence, duration, of the psychosocial risks (e.g., Gunderson & Links, 2008; Paris, 2003; Zanarini, 1997). These quantitative data provide important evidence on prevalence rates, the relationships among variables and other important aspects of BPD. What is missing from this body of information is a closer description of the lived experiences and the multiple perspectives of these individuals. In short, we do not hear the voices of the participants who experienced maltreatment and their adaptive outcome to such experiences. Thus, there is a dearth of qualitative evidence that provides alternate understandings into the experiences of those who have experienced adverse risks in childhood and either develops BPD or were able to mitigate the deleterious effects and be resilient to the diagnosis (Nehls, 1999, Skodol et al., 2007).

Another common issue in the three bodies of literature is a design issue. Most of the empirical studies in these areas rely on designs that compare individuals with BPD with matched controls and usually limit the focus of interest to the individual with BPD under investigation. Rarely are other siblings within the family examined (Laporte & Guttman, 1998; Herrman et al., 2011). When the focus is exclusively on the individual with a diagnosis, it ignores the fact that BPD is more likely in first-degree relatives (Baron et al., 1985; Loranger et al., 1982; Links et al., 1988; Zanarini et al., 1988). Few studies have investigated family relatives of individuals with BPD despite the evidence that relatives are also at increased risks of developing BPD. Clearly, these relatives can
add additional perspectives on the phenomena of risks, psychopathology, family
dysfunction, and resilience and thus should receive more research attention (Grim, 2000;
Laporte et al., 2011).

In the field of maltreatment, the majority of the research designs compare
maltreated individual to matched controls. This design poses a concern because more
often than not, other siblings in the family have experienced abuse and this design does
not allow for an exploration on the extent to which the abuse is experienced by each
sibling and the differential effect on their health and psychological development
(O’Connor, 2001). This design does not give voice to the experiences of the siblings and
allow for a deeper understanding of the influences of traumatic events on family
members. This methodological issue is important to consider when exploring the impact
of risk and protective factors on mental health outcomes because siblings usually grow up
in the same family and thus are exposed to similar risks. If we were to look at the
experiences of siblings within the same family perhaps we can develop a clearer
understanding of participants and their experiences comparable risks (Luthar, 2003;

Although there is considerable research that has focused on the negative effects of
maltreatment in the development of personality disorders (e.g., Bandelow et al., 2005;
Pairs, 2008); thus far, only a few studies have investigated resilience to maltreatment and
the protective factors that might buffer against the risks of maltreatment and decrease an
individual’s likelihood of developing BPD (e.g., Skodol et al., 2007). This is despite the
fact that individuals with BPD report higher incidences of childhood maltreatment
(Zanarini, 2000). Moreover, most of the empirical studies on the maltreatment-resilience
focus on Axis I diagnosis (e.g., depression, anxiety, conduct disorder, post-traumatic
stress) and few studies on Axis II diagnosis (e.g., personality disorders) (Bandelow et al., 2005; Skodol et al., 2007). Less attention has been given to the role of resilience, the factors that might foster more positive outcomes and reduce the negative outcomes like developing a BPD and remains a critical area of research.

In sum, the foregoing suggest that our understanding of how BPD develops in the face of adversity might be increased by adding qualitative studies to quantitative ones and by paying greater attention to the role that resilience plays in positive outcomes.

Rationale of the Study

Although there is considerable empirical research on the negative effects of maltreatment in the development of personality disorders (e.g., Bandelow et al., 2005; Paris, 2008); thus far, few studies have investigated resilience in individuals who were maltreated and have developed personality disorders (e.g., Skodol et al., 2007). This is despite the fact that individuals with personality disorders such as BPD report higher incidences of childhood maltreatment. Less attention has been given to the role of resilience and the factors that might foster more positive outcomes and reduce the negative outcomes like developing a personality disorders. The role of resilience to personality disorders remains a critical area to research more extensively.

In reviewing the literature on BPD, the risk factors linked with its development, the relationship between risk and resilience and the role of protective factors in mitigating the deleterious effects of adversity, two important research objectives arise: developing a continued understanding into how risk plays a role in the development of BPD and how protective factors manage to buffer individuals from the negative effects of these risks. A recent quantitative study highlights this point. Skodol et al. (2007) found that for
individuals who have more positive experiences and positive interpersonal relationships in childhood had reduced vulnerability to adverse outcomes than those who had more negative experiences. While positive personal experiences as protective factors continue to be the focus of quantitative research, qualitative investigations have yet to be explored.

Qualitative investigations can capture the richness and fullness of an experience and can create a clearer understanding of the experience of risks factors associated with the development of BPD and their interplay with protective factors in buffering the development of this disorder. Qualitative methods give participants the opportunity to respond in their own words, rather than forcing them to choose among fixed responses, as in quantitative methods (Creswell & Plano Clark, 2007) and gathers more in-depth information versus quantitative methods of data gathering like Likert scales that only gather surface information (Polkinghorne, 2005). A qualitative approach would give different weight to the participants’ perception of risks and protective factors, attend to the voices of individuals with BPD and their siblings, describe and clarify the participants’ experience as it is lived and constructed in their awareness. Thus, qualitative research which is specifically constructed to take into account the particulars of human experience and to facilitate the investigation of such experience is necessary to add depth and breadth to the existing quantitative studies (Stake, 2006).
CHAPTER 3

Women with borderline personality disorder and their sisters: A qualitative analysis of experiences of childhood adversity

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Abstract

Research indicates that individuals with borderline personality disorder (BPD) have grown up in families characterized by a variety of risk factors. To date, little is known on the experiences of other children growing up in these families. This study qualitatively investigates the experiences of childhood abuse and family dysfunction in pairs of sisters who experienced comparable parental physical and emotional abuse. Four themes emerged from the analysis that were group into two overarching themes: the shared experiences and the exclusive experiences of pairs of sisters. The shared themes were the meaning their childhood experiences, growing up with parental mental illness and substance abuse, and abuse and conflict with sibling(s) and the exclusive theme was divergent experiences of sexual abuse in pairs of sisters. Major findings indicated that the pairs of sisters had more shared than unshared experiences of child maltreatment and family dysfunction while growing up. Implications for practice and research are also discussed.

KEYWORDS: borderline personality disorder, psychosocial risks, pairs of sisters, qualitative research
Women with borderline personality disorder and their sisters’ experiences of childhood adversity: A qualitative analysis

Borderline personality disorder (BPD) occurs at increasingly alarming rates. BPD is characterized by constant and persistent cognitive, emotional, and behavioural vulnerability (Crowell, Beauchaine, & Linehan, 2009). This serious mental disorder can develop in childhood or adolescence but often becomes apparent by young adulthood (Links, 1990) and has considerable health costs. BPD has a chronic, fluctuating course and individuals suffer significant functional impairments that affect their daily, occupational, and social functioning (Zanarini, 1997).

The Diagnostic Statistical Manual-IV-R (DSM-IV-R; APA, 2000) defines individuals with BPD as having “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (p. 292). Individuals with this disorder experience extreme emotional lability, make frantic efforts to avoid real or imagined abandonment, have chronic feelings of emptiness, periods of feeling removed from reality (i.e., dissociation), and difficulty controlling intense anger (Dziegielewski, 2002). Additional characteristics of BPD include recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour, unremitting crises, and impulsivity (e.g., excessive spending, risky sex, substance abuse, reckless driving, binge eating) that are potentially self-harming (Hales & Hales, 1996).

Statistics show that BPD affects between 1-2% of the general population (Gunderson & Links, 2008; Paris, 2005; Zanarini, 2000). Individuals who suffer from BPD often need extensive mental health services and make up 20% of psychiatric hospitalizations and 15% of psychiatric outpatients (Grant et al., 2008; Lieb, Zanrini,
Schmahl, Linehan, & Bohus 2004; Widiger & Weissman, 1991). Three-quarters of those who receive the diagnosis of BPD are female and the diagnosis is five times more common among close relatives than in the general population (Grim, 2000; Gunderson & Links, 2008; Nehls, 1999). Another devastating feature of this personality disorder is that up to 10% of those who meet the criteria for BPD eventually commit suicide; this rate is 50 times the general population (American Psychiatric Association, 2001). Given these high rates of morbidity and mortality, and the financial burdens, BPD is of serious concern to the mental health community (Crowell, et al., 2009).

Although the exact causes of BPD remain unknown, many researchers and practitioners believe that several psychosocial risk factors play a role in its development including childhood maltreatment, dysfunctional family environment, and family psychopathology. Researchers have described several types of childhood maltreatment as critical risk factors (Herman & van der Kolk, 1987; Soloff, Lynch, & Kelly, 2002; Johnson, Smailes, Cohen, Brown, & Bernstein, 2000). Investigators (e.g., Zanarini, 2000; Paris, 2003, Putman, 2003; Allen, 2008) have presented evidence that a high percentage of individuals with BPD report a history of neglect (92%), physical abuse (25-73%), and emotional abuse (75%). Recent empirical research on emotional abuse indicate that it frequently co-occurs with physical abuse (Allen, 2008; Higgins & McCabe, 2000; Morrimoto & Sharma, 2004) and that it is quite difficult to distinguish between these two types. The co-occurrence of different types of abuse makes it difficult to study the unique impact of any one form. Other evidence suggests that sexual abuse may be a more important predictor of BPD than other forms of maltreatment (Brown & Anderson, 1991; Paris, Zweig-Frank, & Guzder, 1994; Yen et al., 2002). Forty to 70 percent of individuals with BPD report a history of sexual abuse (Bandelow, et al., 2005; Paris, 2007; Zanarini,
More recently researchers are suggesting that it is a combination of diatheses and stressors of these experiences that may be the strongest predictor (Allen, 2008).

Dysfunctional family environments have long been considered another psychosocial risk factor linked to the development of BPD among clinicians who work with individuals with the diagnosis (e.g., Levy, Meechan, Weber, Reynoso, & Clarkin, 2005; Linehan, 1993; Young, Klosko, & Weishaar, 2003). For example, schema therapy for personality disorders (Young, et al., 2003) is based on clinical experiences with individuals with BPD and on the premise that dysfunctional family environments lead to the development of this diagnosis. They have highlighted four factors in the family environment that play a role in the aetiology of BPD. A family environment that is (1) unsafe and unstable which arises from abuse and abandonment; (2) depriving because of a lack of basic emotional needs; (3) harshly punitive and rejecting as modes of discipline; and (4) subjugating by suppressing the needs and feelings of the child, all interact in the aetiology of this disorder. Although there is little empirical research on these clinical hypotheses, accumulated clinical wisdom supports the idea that the aetiology of BPD is multi-factorial involving several risk factors.

In addition, family psychopathology including substance abuse has been described as a risk factor for the development of BPD (Bandelow et al., 2005; Gunderson, 1996; Linehan, 1993; Paris, 2008). A robust body of research on psychopathology among family members of individuals with BPD is available (for a review, see White, Gunderson, Zanarini, & Hudson, 2003). White, et al. (2003) found 15 empirical studies examining the incidence of psychiatric disorders in relatives of individuals with BPD. Their review concluded that a host of disorders including schizophrenia and schizotypal personality disorder (STPD) in the schizophrenia spectrum; major depressive disorder
(MDD) and bipolar disorder in the affective spectrum; and substance use disorders and antisocial personality disorder (ASPD) in the impulsive spectrum have been found in relatives of BPD. They also propose a heightened risk of 4-20 fold of a BPD diagnosis in relatives of individuals with BPD compared to the general population. They conclude that the diagnosis of BPD is a potential marker for other family members having a DSM disorder. The weight of this evidence makes a strong case for including relatives of individuals with BPD in studies looking at risk and vulnerabilities.

Despite the fact that the diagnosis of BPD is more probable in relatives of individuals with BPD (Grim, 2000), to date, little is known about the experiences of other children (i.e., siblings) growing up in these dysfunctional families and the role that shared risk factors play in their lives (Gunderson, et al., 2011). Studies of the impact of adversity on psychological development tend to focus on the individual and compares samples of individuals with BPD to a matched control. Comparing an individual with a matched control has been referred to a between-family design (Laporte, Paris, Guttman, & Russell, 2011) which focuses exclusively on the individual with the psychopathology and thus only examine the effects of adversity on one individual in the family. The extent of the risks experienced by each member of the family and the differential effect on her or his health and development is not known (O’Connor, 2001). The few studies that have explored childhood maltreatment within families have found that often at least one child in addition to the child reporting abuse was abused by their parents, thus suggesting that siblings experience similar abuse (e.g., Lavergne & Tourigny 2000; Laporte et al., 2011). Despite the empirical evidence that risks factors such as childhood maltreatment, family dysfunction, and psychopathology are linked to the development of BPD, research is only beginning to surface on the siblings’ experiences of living in these families,
especially with regard to their response to stressful events and their risks for developing psychopathology, and outcomes (Laporte, et al., 2011).

This issue was partly addressed by Laporte et al. (2011) who specifically designed a methodology- the sibling design- to study women with BPD and compare them to their sisters in the context of the family. With this design siblings are also included and the sources of within-family similarities and dissimilarities, their shared family environment, and their joint traumatic events are studied. The expectation is that this will be useful in understanding the extent to which familial risk factors such as parental psychopathology are shared by siblings. In addition, within-family research can allow sisters to be matched on comparable levels of abuse and other abuse variables such as severity, chronicity, and frequency of maltreatment.

The Laporte et al. (2011) results indicated that the sisters of the women with BPD did not have any psychopathology even though they reported similar histories of adversities. Findings like this one run counter to the pervasive belief that severe adversity and specifically abuse is a robust marker of borderline pathology. However, the reliance upon quantitative self- report measures may limit our understanding of the lived experiences of these sisters growing up in families with numerous adversities because these measures only gather surface information and do not adequately capture the richness of an experience (Polkinghorne, 2005). A qualitative research investigation could nuance the meaning of the sisters’ similar experiences, illuminating the complex interactions between the risk factors as predictors of BPD, and explain the quantitative findings. Giving voice to the sisters who have experienced similar childhood adversities can broaden our understanding and provide an informative picture of the sisters without a diagnosis experiences who have been ignored and not well represented in the research.
This type of investigation could shed light on how these sisters make sense of their experiences and how they perceive their different mental health outcomes.

The Current Study

The purpose of this case study was to qualitatively investigate the experiences of childhood abuse and family dysfunction in pairs of sisters who experienced comparable severe parental physical and emotional abuse. Its aim was to understand these experiences and to explore the similarities and differences between them in their exposure to risks. The overarching questions that guided the research were: “How do these sisters construe their experiences growing up in the same families and with numerous adversities?” and “How do these sisters perceive the influence of their childhood experiences?” and “How do they derive meaning from their experiences?”

Method

The case study was selected as a method to allow the researcher to answer the study’s fundamental research questions and to utilize multiple sources of data of pairs of sisters to make sense of their risk experiences (Creswell, Hanson, Plano Clark, & Morales, 2007; Hancock & Algozzine, 2006). The data were analyzed using a process of thematic analysis, a mode of investigation employed for identifying, analysing and reporting themes within data (Braun & Clarke, 2006; Ezzy, 2002). This method enabled the actual, reported experiences of the sisters to direct the analysis and the themes (Creswell, 2007; Lincoln & Guba, 1985; Merriam, 2009; Stake, 2010) and gives weight to their own version of events, their personal experiences, and their meaning (Merriam,
2009; Polkinghorne, 2005). The literature was used as a vehicle to guide the analysis and to facilitate an understanding of the pairs of sisters' experiences without it dictating how the data were interpreted (Yin, 2009).

**Researcher’s Background, Tasks, Experiences, and Biases**

The first author is a Canadian female counselling psychology PhD candidate. She had clinical, counselling, and research experience with abuse and trauma, psychopathology, and BPD. In addition, she was familiar with the literature in the area of psychosocial risks and the aetiology of BPD. Her primary tasks involved interviewing participants, generating initial codes, searching, reviewing, defining and naming the themes that emerged from the data. Her primary bias was her belief that severe and cumulative experiences of childhood abuse have substantial impact on the development of BPD. The researcher expected that the participants, who reported having more psychosocial adversities (e.g. childhood abuse) would be more likely to develop BPD in adulthood than their sisters, and that women who developed BPD would have suffered more sexual abuse than their sisters. Throughout the research process, she noted her biases regarding the potential findings of the study in order to minimize their impact on the data coding process (Flyvberg, 2006).

**Research Team**

The research team assisting the primary researcher included an expert methodologist, auditor, and co-interviewer. The expert methodologist was a tenured university professor in Educational and Counselling Psychology, who has expertise with qualitative methods, teaches the courses on this methodology at the graduate level, and
who has published qualitative studies. The auditor is a doctoral candidate with knowledge and skill in working with individuals diagnosed with DSM disorders, and has experience in conducting and analyzing qualitative research. The co-interviewer was a senior psychiatrist in the department of psychiatry who had expertise conducting interviews and working with individuals BPD. It is noteworthy to add that the research team tried to retain neutral beliefs and views regarding BPD to allow for the participant to have a voice.

Participants

The participants were 12 pairs of sisters. They were part of a larger sample of 56 sibling-pairs recruited to study siblings growing up in a family in which one individual developed BPD (Laporte, et al., 2011). The sample consisted of females with BPD and their unaffected first-degree biological sisters who were full siblings and who had lived with at least one of the same biological parents until the age of 16. All the sisters were within five years of age from each other. The women with BPD were drawn from psychiatric clinics across a large urban area. Detailed sampling procedures have been reported previously (Laporte, et al., 2011).

A purposive selection of the participants was made in order to ensure that the sample represented the phenomenon under investigation (Eisenhardt, 2002; Polkinghorne, 2005; Wertz, 2005). Since childhood physical and emotional abuse frequently co-occurs, it difficult is to nuance the unique impact of each type of abuse (Allen, 2008). Thus, for the purpose of this study, the 12 pairs of sisters that matched and reported concordance on their similar experiences of severity of parental physical and emotional abuse on the Childhood Trauma Interview (CTI; Fink, Bernstien, Handelsman, Foote, & Lovejoy,
and were discordant for psychopathology were selected; one sister had BPD and the other did not have any DSM diagnoses at the time of the study. Therefore, matching pairs of sisters on concordant reports of severity of parental physical and emotional abuse would ensure they were exposed to similar significant risk (i.e. comparative childhood experiences of physical and emotional abuse). This sample is a unique subset of the large 56 pair sample because the previous quantitative study by Laporte et al. (2011) indicated that women with BPD reported more severe levels of parental physical and emotional abuse. However, this purposive selected subsample represents atypical cases because both sisters are matched on concordant severe experiences of parental physical and emotional abuse. For the purpose of this study, emotional abuse was defined using the *Childhood Trauma Interview* (CTI; Fink, et al., 1995) as insulting, threatening, rejecting, scolding, demeaning, blaming, belittling, degradation, and ignoring acts and physical abuse was defined as experiences of being beaten, kicked, punched, burned, suffocated, locked up, or cut. Table 1 summarizes the characteristics of the participants in the study.

![Table 1 about here](image)

**Assessment Measures**

*Diagnostic assessment.* Self-report scales and clinical interviews were administered to establish the presence of Axis I and Axis II disorders and general psychological symptoms. Detailed diagnostic procedures including information on the validity and reliability of the measures have been reported previously (Laporte, et al., 2011). In order to receive a diagnosis of BPD, participants were required to meet DSM-IV (First, Spitzer, Gibbon, & Williams, 2002) criteria by scoring 8 out of a possible 10 on the Diagnostic Interview for Borderline Personality Disorder–Revised (DIB-R) (Zanarini,
Gunderson, & Frankenburg, 1989). The DIB-R has been widely used in many studies and has been well validated (Zanarini et al., 1989). Axis I diagnoses were assessed with the Hamilton Depression Scale (HAM-D, Hamilton, 1960), the Hamilton Anxiety Scale (HAM-D, Hamilton, 1959), parts of the Clinical Interview for DSM-IV (SCID-I, First, Spitzer, Gibbon, & Williams, 2002) and the Symptom Checklist-90, revised (SCL-90-R, Derogatis, 1975). An experienced psychiatrist with previously established inter-rater reliability on these instruments (Paris et al., 1994) conducted these diagnostic interviews. Sisters of the women with BPD completed the same instruments to determine their clinical status. The sample of 12 pairs of sisters comprised 12 women with BPD and 12 sisters with no current diagnosis.

**Childhood trauma assessment.** The Childhood Trauma Interview (CTI; Fink, et al., 1995) is a detailed clinician-administered interview that examines six types of childhood interpersonal trauma (separation or loss, physical neglect, emotional abuse, physical abuse, witnessing violence, and sexual abuse). This instrument quantifies the age range, type of perpetrator, frequency, severity, and duration of a wide range of all events up to age of 18. Duration is scored in years, while severity and frequency are scored on a scale of 0-6 as described in the scoring manual. The CTI has demonstrated high reliability and validity, good inter-rater reliability, and strong construct validity (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Fink et al., 1995).

The CTI was used to select and match sister pairs on childhood experiences of severe levels of parental emotional and physical abuse. Participants were selected if they scored 4 or higher out of 6 indicating the severity of physical and emotional abuse ranging from severe to very extreme.
Demographic form. Basic socio-demographic information was collected in the early part of the interview in order to encourage the participants to talk openly and feel comfortable with the process. The demographic form asked for basic information about the participants’ age, ethnicity, education, family composition, who they lived with growing up, their current functioning, if they had children and how their children were functioning, current relationships and the mental health history of family members.

Interview Protocol. The protocol included questions designed to obtain the richest narratives possible from each participant in the topic areas of their perceptions of the similarities and differences between them, parental treatment, and the impact of their childhood experiences, and their ability to reach out and form social support networks. Initially each participant was asked to respond to the following question: “Do you feel different from your sister? How do you explain it?” (see appendix A for interview protocol). This question was intended to begin a conversation about experiences that were meaningful to persons who lived with childhood abuse and trauma and to explain their different perceptions. If personal examples about similarities and differences between the pair were not forthcoming the interviewer prompted, “Tell me more about that,” or “Can you give me an example?” to extend the narrative. The initial open-ended questions allowed participants to elaborate fully on their childhood experiences, and to comment at length on whatever aspects of the interview questions were of most interest to them.

Procedures

Institutional review boards at all hospitals from which patients were recruited, as well as the Research Ethics Board at McGill University, approved the study. Informed consent was obtained from each participant after the purpose of the study and procedures
were fully explained. Upon completion of the interview, all participants received an honorarium for their participation. Each participant of the pair was interviewed independently on their history of childhood abuse and on their recollection of their and their sibling’s childhood experiences using the CTI. Following the administration of the CTI, the open-ended interview protocol was administered. Participants were randomly assigned to interviewers, however, the same interviewer never spoke to both sisters. The interviewers were unaware of the diagnosis of the participant they were interviewing unless told by the participant. The two interviewers completed a pilot interview with a pair of sisters who fit the study criteria but were not included as participants to become comfortable with the protocol and address any concerns regarding the contents or process of the interview. During the interviews, the interviewers made verbatim notes on the participants’ answers and transcribed them after the meetings. Stake (2006) proposes because of time constraints, audio- and videotapes should be used and transcribed only when they are vital to the final report (p. 34). French segments of the verbatim notes were translated by the bilingual interviewers at the time of the interview, and reviewed for accuracy by a bilingual Francophone colleague. Thus, the transcribed verbatim notes of the CTI and interview are the main source of data for this analysis. The interviews ranged between maximum 60 to 180 minutes and were terminated when the participant indicated that there was nothing more to discuss. None of the participants reported adverse reactions to the interview. After the interviews, the participants names were deleted from the data and participants were assigned a code number.

Procedures for Analyzing Data
The data were analyzed with thematic analysis methods (Braun & Clarke, 2006; Ezzy, 2002). The following 6 phases of thematic analysis were utilized: (1) familiarization with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; (6) cross-case analyses to analysis the case, the pairs of sisters (Stake, 2006; Creswell, 1998). For the first five cases, data analysis was done jointly by the researcher and the expert methodologist where they would discuss their individual conceptualizations regarding the meaning, categorization of the data, themes and patterns and then arrive at an agreement on a final understanding of the data. The remaining seven cases data was analyzed by the primary investigator. Once the data for the 12 pairs of sisters were analyzed the researcher and the expert methodologist met to discuss the final themes and cross case comparisons.

**Familiarization with the data.** The first phase involved immersion in the data and consisted of repeated reading of the material, in an active way, searching for meanings, patterns and themes (Yin, 2003). This phase began with a reading of the entire data set before coding began. Analytic memos were generated; the notes and marking of ideas for coding that were revisited in the subsequent phases (Creswell, 2007).

**Generating initial codes.** The second phase involved the generation and production of initial codes (Braun & Clarke, 2006; Ezzy, 2002). “These codes identify a feature of the data of interest, and refer to ‘the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). In this way, the data were organized into significant groups (Huberman & Miles, 2002; Tuckett, 2005; Stake, 1995) to form the basis of repeated patterns (themes) across the data set.
Searching for themes. The third phase involved sorting the different codes into potential themes, and collating all the relevant coded data extracts within each theme (Braun & Clarke, 2006; Ezzy, 2002). A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun & Clarke, 2006). Essentially, this involved considering how different codes combine to form an overarching theme. At this phase, the researcher started to develop her thinking about the relationship among codes, among themes, and among different levels of themes (e.g., main overarching themes and sub-themes within them). At the end of this phase all data were coded and a collection of potential themes and sub-themes has been produced.

Reviewing themes. The fourth phase entailed the refinement of themes where the researcher decided if themes need to be collapsed, separated, or discarded by pair (Thomas, 2006). Here the researcher read all the assembled extracts for each theme, and considered whether they appeared to form a coherent pattern. If themes were not coherent, the researcher reworked them, which involved, creating a new theme, finding a place for extracts that did not fit, or discarding them from the analysis (Gillham, 2000). At the end of this phase, the researcher developed a solid idea of the different themes, how they fit together, and the overall account they tell about the data (Yin, 2003).

Defining and naming themes. At this phase, themes were defined and named. The researcher explored whether any themes contained sub-themes. Sub-themes are essentially themes-within-a-theme (Braun & Clarke, 2006, p.16). The names of themes were chosen “in ways which preserve the participants’ own words” (Strauss & Corbin, 1998).
Cross-analyses. The purpose of cross-analysis is to identify similarities across cases (Creswell, 2007; Stake, 1995; Yin, 2003). To achieve this goal, the researcher repeated the five phases mentioned above across all the pairs of sisters in the data set.

Auditing. Auditing is a process where an external auditor examines both the process and the product of the narratives assessing for accuracy (Creswell, 1998; Lincoln & Guba, 1985; Miles & Huberman, 1994). The audit process entailed checking all the data to ensure that raw data were appropriately sorted into codes and abstracted into accurate and complete themes (Creswell, 2007; Stiles, 1993; Yin, 2009). Consensus meetings were held by the first author and the external auditor for the initial open codes, which were adapted and refined accordingly. When divergent coding themes arose during auditing results were discussed until consensus was achieved (Creswell, 1998). The auditor made several written suggestions and these were incorporated.

Trustworthiness

Trustworthiness and credibility of the findings were established using various steps including auditing (described above), researcher’s reflexivity, dependability, and negative case analysis (Morrow, 2005).

Researcher’s reflexivity. The researcher’s reflexivity is process by which the researcher identifies their biases relative to the research study (Stake, 1995). The primary researcher’s identity may have potentially influenced data analysis. Creswell (1998) suggests the use of “bracketing”, in which the researcher clearly clarifies her potential biases and assumptions relative to the phenomena being explored. For the purpose of this study, bracketing included reflections of the researcher’s own biases that she brought to the study, her own personal experiences as a participant in the research, and the benefits
and challenges which she encountered in this process. To reduce redundancies refer to
the section above researcher’s background, tasks, experiences, and biases. Reflexive
memos tracked the researcher’s assumptions and reflections from the onset of the data
analysis and immersion in the literature. In the case study analysis the reflexive memos
become a source of data used in triangulation within cases (Stake, 2006, p.32)

**Dependability.** Dependability, which involved compiling a clear and detailed
trail of all the data, is a way to verify the steps of the research process and demonstrate
consistency of the data (Creswell, 2007). The researcher produced an audit trail and was
transparent about the research steps taken and decisions made from the start of the
research project including how she handled the data, by recording how she analyzed the
data, and reporting quotes and examples from the data to support the results so that the
study can be audited (Merrick, 1999). These are records that are kept regarding what was
done in an investigation so that the reader has clear understanding of all the steps that
were involved in the research, can follow what she has done and may perform any checks
required to ensure the quality of the results. The audit trail is beneficial to the analysis as
it provides and ongoing cross-indexing between notes and data (Robinson, 2003).

**Negative case analysis.** Another way the researcher ensured the trustworthiness
of the study was the employment of negative case analysis, a process by which she
refined her working hypotheses as the inquiry advanced in light of negative or
disconfirming evidence (Creswell, 1998; Lincoln & Guba, 1985). Here, using case study
analysis techniques the initial hypotheses were revised until all cases could be included.
For example, when the sisters were reflecting on their exposure to sexual abuse, there
were two pairs who did not experience this form of maltreatment. Their situations were
considered negative cases and were used to develop alternative hypotheses. This
procedure allowed for the consideration of new explanations and elaborations of the similarities and the disparities among the pairs of sisters exposed to childhood adversities and dysfunctional families.

Results

The qualitative analyses of the interviews yielded four themes that were grouped into two overarching themes: the *shared experiences* and the *exclusive experiences* within the pairs of sisters. The shared themes were the meaning of childhood experiences, growing up with parental mental illness and substance abuse, and abuse and conflict with sibling(s). The exclusive theme was divergent experiences of sexual abuse in pairs of sisters. The four themes presented are the strongest, most relevant and important for understanding the phenomenon under investigation (Stake, 2006). Table 2 summarizes these overarching themes, themes, and subthemes expressed by the participants in the study. Since the participants’ own words powerfully convey their experiences, representative excerpts from the interviews, organized by the themes, are presented here.

[Table 2 about here]

**Shared Experiences of the Pairs of Sisters**

All the sisters described their experiences of growing up in their family as characterized by abuse, parental psychopathology, and dysfunction. Their narratives reflected more similarities than differences in their histories of abuse and experiences of family dysfunction. The following themes capture their shared experiences.

**The Meaning of Childhood Experiences**

All of the sisters were asked to reflect on the impact of their childhood experiences on their present life. Unanimously, they recounted how their childhood
experiences had a huge impact on them both then and now. Two themes emerged from the narratives of the sisters: emotions and negative perceptions.

**Emotions.** The sisters described five emotions - anger, sadness, loneliness, self-blame, and shame - that were a direct result of being abused and living in dysfunctional family environments. The women indicated that the majority of these feelings continued to surface and have affected them throughout their lives.

All participants described feeling a great deal of anger about childhood abuse. Some felt anger toward the perpetrators, an ongoing feeling that they continue to experience whenever they think of what happened to them. A non-BPD sister described her anger, “I am angry with my father. I remember hiding from him when he would get in his rages and would beat us. I am angry he made us victims” (Pair 3). A woman with BPD explained, “I feel angry. I was only eleven. I did not want to have sex with my brother. Why couldn’t he find someone his own age? Why did he pick me and not someone else?” (Pair 12). Although the sisters described anger with the perpetrators, most described a more general anger about the situation or other people in their lives. A woman with BPD explained that, before entering therapy and dealing with her abuse, “I used to be very angry with myself and every single person. The anger follows me everywhere. I would think why did this have to happen to me?” (Pair 10). A non-BPD sister shared, “I am angry about what happened in my childhood. I feel I would have more emotions and compassion if my childhood was different. I would have had a better life with more opportunities. That makes me angry” (Pair 1).

Many of the participants also described sadness about their childhood experiences. “My childhood is full of painful memories. I am very sad when I think about my youth” (Pair 3, non-BPD sister). Several participants described that when they feel sad they also
feel very isolated, lonely and helpless as a result of the abuse. This feeling was particularly present for the sisters who felt they had no one to talk to about the abuse. “I felt very empty and alone. I had no one. I still feel empty and alone today.” (Pair 1, woman with BPD).

Another negative emotion some of the women described was self-blame. A woman with BPD said, “I thought it was my fault, that I was a bad person and that I did not deserve to be loved” (Pair 5). Another sister explained that she continued to question why she was abused and sometimes still wonders if she was to blame. “Why did this have to happen to me? I don’t know I still don’t know if it was something about me” (Pair 6, non-BPD sister).

Finally, a few of the women have experienced feelings of shame since childhood. For some, the shame has stopped them from talking about the abuse and family dysfunction with people: “I feel ashamed; I don’t want my family to look bad. They are well respected and I don’t think anyone would believe me” (Pair 8, woman with BPD). A few of the non-BPD sisters explained that they are no longer ashamed about what happened to them. One non-BPD sister indicated that, “The experiences of abuse are part of my past. I don’t feel ashamed about it; I have turned the page over. I see it now as just something that happened to me” (Pair 6).

**Negative perceptions.** In addition to describing negative emotions associated with the abuse and dysfunction, all the women also discussed negative perceptions of life and relationships with others. A woman with BPD (Pair 8) stated,

I think my childhood experiences, the family situation, the abuse and beating had an impact. I think my illness is a consequence of my past. I
started burning myself and cutting at ten. I am still very affected and my memories haunt me.

A non-BPD sister (Pair 1) described the strong impact of the sexual abuse she experienced, “I have trouble to love. The abuse made my emotionless, I cannot show affection, even to my children”. The sisters attributed their negative perceptions of life to their deleterious childhood experiences and these experiences influenced who they are today and are a part of them.

Several women also described their distrust and fear of men ranging from having a difficult time getting close and entering intimate relationships to fearing physical harm from them. The women of Pair 11 talked about how their childhood experiences informed their perceptions of relationships. The woman with BPD stated,

I think the type of father I had, the first man I had in my life skewed my perception of relationships, my expectations of how men and women behave with each other. I think not having an abusive father would have made my childhood better.

Her non-BPD sister reflected, “Because of my experiences, I don’t trust people. It takes me awhile before I let people in, especially men.” A different pair (7) spoke of how they wished their mother had left their father. The woman with BPD maintained,

I feel that I have had horrible role models for couple and parent relationships. Once again, I have returned to my violent partner and it has taken me a long time to realize that the abuse is not normal. I think that witnessing my parents’ violent relationship has affected my relationship
into adulthood. I have difficulty to trust and I have feared I will be abandoned.

These sisters reflected that their childhood experiences informed their choices of intimate partners and they admitted to engaging in abusive romantic relationships in adulthood and repeating the abuse and dysfunction in these relationships.

**Growing up with Parental Mental Illness and Substance Abuse**

Participants described a childhood where not only parental maltreatment but also parental psychiatric problems were commonplace. All participants spontaneously described childhood experiences of living with parents with psychiatric illnesses, explaining that the abuse they experienced was due to family members’ mental illnesses.

On a regular basis, my mom would abuse me because she was not well. I had multiple fractures, marks, and bruises and missed a lot of school for a good amount of time because of things like that. I remember my mother was not really happy and had a very short temper. I think she suffers from depression and aggression (Pair 10, woman with BPD).

Participants also spoke of feeling isolated and confused about their parents’ mental status. Some recounted that their parent’s mental illness was not discussed in any real way with them when they were children.

Everybody pretended like nothing was going on. My mother would go off and be hospitalized, and nobody would tell us where she was, nobody would tell us when she’d be back or what was going on. I recall this very vividly. Nobody ever said anything they pretended that it was normal (Pair 3, non-BPD sister).
A different pair (7) spoke of their concerns that their mother suffered from depression. The woman with BPD stated, “I was aware that my mother was more vulnerable and sad and I felt I had to protect her and my sister against the verbal and physical abuse of my father.” The non-BPD sister agreed with this, “There was a lot of tension on our house because of my father’s temper and anger and I remember my mother was very sad.”

Another non-BPD sister described her confusion, “I saw that she (mother) was disinterested, when we talked she didn’t listen. She never wanted to do activities with us but no one told me why” (Pair 10). Silence and confusion was a common experience among the sisters; family members rarely acknowledged or explained anything relating to the parents’ illnesses.

Some sisters talked about negative feelings associated with having parents with psychiatric disorders and described the chronic stress associated with fears of their parents committing suicide. Pair 3 talked about how they remembered when their mother attempted to commit suicide and as a result had a psychiatric hospitalization. They worried continually and both sisters expressed feeling sad about their mother’s problems and suicide attempts. The woman with BPD maintained that, “I did well in school to make my mother happy. I would try to conform so that she would not get angry or sad and then end up in the hospital.” Other sisters recounted their feelings on providing care to their parents with mental illness that were often full of mixed feelings of love and anger. One pair (9) described how they wanted to help their mother, but there were times when they had also been very angry because they felt that they had given up so much, but got so little in return.

These women also saw parental alcohol abuse as an important factor in their experiences. Pair 9 stated that the climate in their house was tense when their father
drank and they often felt they had to walk on egg shells. The non-BPD sister recalled that when “my father was drunk there was a lot of tension and fear”. The woman with BPD recounted, “My father was an alcoholic. He would beat us. My memories of him haunt me.” Pair 3 spoke about their recollections of their father returning drunk from the pool hall and yelling rude and offensive comments. The woman with BPD described being afraid and hiding in the closet from her violent alcoholic father. Pair 6 shared that their father was a violent and volatile alcoholic. The woman with BPD recounted a painful memory that she could not have any friend over because of her father’s drinking and his unpredictable temper. “We lived in constant fear of him.” The non-BPD sister stated, “My father was a crazy violent addict.” The narratives of the pairs of sisters described the constant terror they were exposed to on a regular basis because of the atmosphere in their homes. Pair 5 discussed the effects of alcohol abuse on their family income. They revealed that while they were growing up there was a major flux in family income because their father gambled and would drink away the family income. There were times when the family lived on welfare. The sisters talked about how their parents’ alcohol abuse had a profound effect on their ability to provide consistently for their basic needs.

**Abuse and Conflict with Sibling(s)**

Most of the pairs of sisters shared their experiences of abuse and conflict with each other. Three pairs of sisters discussed their experiences of abuse and conflict with other siblings in the family in addition to the abuse and conflict experienced between the pair. These experiences included emotional abuse and repeated patterns of aggressiveness with the intent to inflict harm. Their narratives are filled with how the siblings would scream at each other, threaten to hurt each other, and order each other
around and how they were fearful when their sibling would become aggressive. These sisters would describe emotional abuse as the most common and frequent type of abuse among the siblings. All participants remembered continuous arguments and daily negative interactions between the children in the family. A non-BPD sister (Pair 4) described the interactions between her and her siblings as, “Everybody yelled, insulted, and said very mean things to each other, it was just the way our family was.” The sisters also recounted that the emotional abuse and aggressiveness would go hand in hand. “We would verbally insult each other, say really means things and when my sister couldn’t handle the insults she would slap me and we would get into physical fight and say even more insult and hurtful things” (Pair 11, non-BPD sister). Some of the sisters recounted that the emotional abuse preceded the physical abuse and often there was an escalation and intensification of abuse. “We would start off bickering, calling each other all sort of names, then we would start fighting very aggressively with knives or hit each other until we would bleed, it was terrifying (Pair 11, non-BPD sister).” A different pair (8) spoke of their brother’s aggression and harm, “He would hit me; beat me until I could not speak. Sometimes he would whip me with a skipping rope or place my hand in the fireplace (woman with BPD).” Her non-BPD sister narrated, “One time he tried to use a saw to cut my leg off.” From the accounts of these pairs of sisters, we can see that the abuse was not confined to their parents but was a common feature of their entire childhoods.

**Exclusive Experiences**

Even though the majority of the sisters’ narratives reflect very similar histories of abuse and family dysfunction, there was one area where the sisters differed in their
experiences of childhood abuse which emerged as the theme of divergent experiences of sexual abuse.

**Divergent Experiences of Sexual Abuse**

Women with BPD and non-BPD sisters (16 women) both experienced sexual abuse and they recounted that these experiences of sexual abuse affected them profoundly. Sexual abuse consisted of both non-contact and contact childhood sexual experiences, including touching of breasts or genitals, performing oral sex, and penetration. However, the women with BPD differed from their non-BPD sisters in that they all reported being exposed to more perpetrators, had more occurrences of sexual abuse outside the family, and were exposed to more severe forms of sexual abuse than their non-BPD sisters.

The women with BPD attributed the differences between them and their sister to having experienced more perpetrators and having more sexual abuse outside the family. A woman with BPD (Pair 6) recalled,

> We were both sexually abused by our father and I had no one to tell. Also every weekend I would visit my grandfather and he also sexually abused me until I was 12 years old. I think that is why I am more affected than my sister.

Her non-BPD sister recounted a similar account to her sister, “My sister claims that our grandfather abused her too and that is why she has her problems”. The women with BPD also recalled more experiences of sexual abuse outside the family. A woman with BPD (Pair 2) shared that both sisters were sexually abused by their babysitter. In addition to that incident, she described herself as a victim of gang rape by several older boys who
lived in her hometown. The second incident affected her greatly and she stated in the interview, “I can’t trust people and I prefer to be on my own, and have difficulty getting attached. I see myself as a victim and am afraid it will happen again. The idea of sex does not appeal to me.”

On the other hand, the non-BPD sisters attributed their sisters’ difficulties to the nature and severity of the sexual abuse, abuse involving penetration. The non-BPD sister (Pair 2) said, “I think the sexual intercourse - the sex, not just touching - with my sister and the babysitter was a watershed that influenced my sister”. Another non-BPD sister tried to explain the differences between her and her sister as, “Although we have both been abuse by others and grew up in an abusive climate, I think it was the sexual intercourse that my sister experienced at the hands of our father that was the trigger to all her problems” (Pair 10). According to the non-BPD sisters’ own accounts the nature of sexual abuse (e.g. sexual intercourse, rape) was seen more significant risk factors in BPD.

Discussion

The intent of this qualitative study was to investigate the experiences of childhood abuse and family dysfunction in pairs of sisters who were matched on concordant reports of parental physical and emotional abuse. An analysis of the data resulted in four themes that highlighted the pairs of sisters shared and exclusive experiences of childhood abuse and family dysfunction. A major finding in their narratives illustrated how similar these experiences of childhood abuse from multiple family members, parental psychopathology, and dysfunctional family environments were for both. The pairs of sisters discussed their shared histories of abuse that took place in the context of difficult family environments. These shared risk factors were a part of these women’s day-to-day
existence. They talked about how the effects were profound, continuous, and ubiquitous, and how their past traumas were very much a part of their present life.

These women identified more shared risk factors than unshared which included emotional and physical abuse from multiple family members, parental psychopathology, and dysfunctional family environments. These shared risks could suggest an increased likelihood of poor adaptation and negative consequences which is the case for the women with BPD. The fact that psychopathology is an outcome of only one sister in spite of their acknowledgment that adversity was there for both challenges the widely held notion that adversity has a direct implication for psychopathology. Rutter (2006), however, has proposed that experiences of adversities can strengthen the individual’s response to later stresses, a phenomenon he named, the steeling effect. If this notion proves to be correct, childhood adversities and negative experiences may be a kind of protection which could explain the outcome for the non-BPD sister. The steeling effect suggests that the non-BPD sisters could have achieved successful psychological habituation to their predicaments of childhood abuse, parental psychopathology, and dysfunctional family and this may have strengthened rather than weakened them and may have lead to the absence of psychopathology. Nonetheless, the steeling effect does not provide an explanation as to why the women with BPD developed psychopathology. We may find with continued research that the adversity-steeling connection has a point where too much adversity no longer contributes to steeling but actually erodes it.

Most of the sisters’ narratives reflected their shared histories of child maltreatment; however, their histories of sexual abuse differed on one aspect. While all participants who experienced sexual abuse recounted how it affected them very deeply and echoed throughout their lives, the non-BPD sisters managed to avoid the stigma and
suffering reported by individuals with a BPD diagnosis. The women with BPD described a quantitatively different experience in that the abuse was with more perpetrators, occurred with both family and non-family members, and appeared more severe experiences of sexual abuse. Although nuanced, the non-BPD sisters attributed the different mental health outcomes to more severe sexual abuse (e.g., sexual abuse involving intercourse). These sisters seemed to have an intuitive understanding of the trajectory of more severe abuse in that these descriptions are supported by quantitative studies indicating that penetration is the single most influential predictor of psychopathology in adults with childhood experiences of sexual abuse (Bandelow, et al., 2005; Finkelhor & Brown, 1985; Kaehler, & Freyd, 2009; Paris, et al., 1994). In contrast, the women with BPD attributed their mental health outcomes to having experienced multiple perpetrators. Again, the research seems to support this perception in that multiple perpetrators and re-victimization (Finkelhor, Ormond, & Turner, 2007; Greenfield & Marks, 2010; Paris, 2008; Zanarini, 2000) is consistently seen in BPD symptomology and psychopathology. In essence, both sisters seem to have a deep understanding that both quality and quantity of abuse experience and especially in combination can be used to make sense of why only one suffered from the diagnosis of BPD. Both of the sisters’ attributions of reason for the BPD diagnosis are reflected in the research literature. Further research might be targeted at the attributional processes that are made after experiencing this adversity.

A contribution of this study to the literature is that it provided a narrative of these women’s perspective of their experience growing up and living with parents with mental illness and/or substance abuse problems. In spite of the robust literature on BPD, little is known about the perspective of adults who have had these experiences as children
Both groups of sisters’ stories shared the distress of living with parents struggling with a mental illness and/or substance abuse and how that contributed to a developmental climate filled with tension and constant fear and dysfunction. All the women attributed the abuse they experienced to the mental illness and substance abuse of their parents perhaps as a way to make sense of their experiences. The pervasiveness of the abuse described by these women is an indication of the devastating effect of the parental mental illness and substance abuse on children. These narratives suggest that parental psychopathology led to parental failure and to a disruption of what might normal developmental sequences like making friends and a social network, feeling safe to take advantage of school.

The sisters’ narratives suggest a story of how BPD develops and the relationships among parental psychopathology, abuse, and BPD. Their narratives suggest that experiences of parental psychopathology can lead to an increase in abuse and the experiences of abuse can then lead to the development of BPD which was the case for the women with BPD. This chain of events is supported by studies that have established links between sexual abuse and BPD (Yen et al., 2002; Zanarini, 2000). The meditational role of parental mental illness and the strength of these effects remain empirical questions. Quantitative studies using a meditational analysis might help us unravel the relationship among these variables. Studies that seek to establish the contributions (in statistical terms) of the story of how BPD developed for these sisters seem indicted. In addition, the source of the abuse report seems to be an important factor in further elucidating for its moderating effects. In this research, in commenting on the link between sexual abuse and BPD, there was general agreement about the negative effects of the abuse experience but considerable discrepancy about the importance of the causes that
are linked to BPD (i.e., the women with BPD emphasized multiple perpetrators and re-victimization and the non-BPD sisters emphasize severity of the type of abuse). Thus, empirical studies that seek to untangle the mediating and moderating effects seem warranted.

The sisters’ stories support Young et al.’s (2003) hypotheses that the family environment plays a significant role in the development of BPD. The pairs of sisters described their family environments as unsafe and unstable as a result of ongoing abuse, as depriving, harshly punitive critical, and rejecting, and subjugating. Empirical research on family environments associated with the development of BPD has validated several family correlates which used standardized measures. Families with BPD have been described in the literature as being significantly more conflictual, controlling, less cohesive, less expressive, and invalidating (Gunderson & Singer, 1975; Linehan, 1993; Paris, 1998; Zanarini, 2000). What is important to note here is when investigations have been conducted on families with BPD researchers have mainly looked at the parental unit and the individual with BPD and they have not reported separately on siblings’ abuse. However, from the narratives of these women, we can see that the abuse was not confined to their parents but rather to multiple members of the family were abusive to one another. The accounts of these sisters revealed not only parental physical abuse, lack of warmth, rejection and suppressing of their needs but also conflict with their siblings that added another layer to the dysfunction of the family environment. While progress has been made in detecting, preventing, and treating family violence, sibling violence is largely unrecognized and generally underreported by parents, siblings, teachers, mental health professionals, and the community and has lagged behind receiving relatively little attention in the child maltreatment literature (Caffaro, & Conn-Caffaro, 2005; Shaw,
Understanding the extent of its contribution to the abuse-BPD link suggested by these data seems a fruitful area for further enquiry.

Despite shared experiences of abuse, parental psychopathology, and dysfunction, only one sister from the pair received a diagnosis of BPD; the other sister remained unaffected. This is suggestive that the outcomes found in those who have been exposed to abuse, parental psychopathology, and family dysfunction may not be adequately explained or predicted by the risks factors alone (Luthar, 2003). Previous research has hypothesized that protective factors may help to explain why not all children who have experienced risks and adversity develop psychopathology. Risk, adversity, and trauma are an aspect of resilience research where there is a great interest in understanding how children cope and adapt to the risk (Rutter, 2007). Individuals who demonstrate the ability to overcome the negative effects associated with experiences of childhood abuse and dysfunctional family environments are considered resilient. Protective factors associated with resilience are assumed to assist with adaptive functioning when facing adversity and deserve further study (Collishaw et al., 2007).

**Limitations**

Although this study presents new findings about the experiences of risk for sisters, it should be considered in light of several potential limitations relative to sampling, researcher bias, sources of data, and translation of data. Even though the sample size is consistent with other qualitative investigations, the findings have limited transferability because of the nature of the sample. The women with BPD were recruited from psychiatric institutions and thus represent a group of women with a more serious prognosis and perhaps more severe abuse (Laporte et al., 2011). Moreover, the findings
of this study could have a sampling bias in that only one pair of sibling were interviewed and perhaps there was variability in the experiences of childhood risks and mental health outcomes in other siblings in the family. The participants in this study were self-selected and motivated to participate and perhaps other siblings in the family who suffered from psychopathology may have chosen not to participate.

Another limitation of the study concerns the issue that the principal investigator served as one of the primary interviewers. While this provided the investigator with a rich perspective on the participants’ experiences, it is also possible that the researcher’s biases may have had an impact on the content of the interview, as well as data analysis. In terms of data analysis, this study is based on one set of researcher’s understandings of the data related to childhood maltreatment and family dysfunction among sisters with different mental health outcomes. Although the primary author attempted to account for her biases in the context of analyzing the data, it is possible that her perceptions uniquely influenced aspects of the investigations in ways that cannot be discerned. To this end, it is important that other investigators replicate and extend the study.

The findings may also be limited because of the main source of data (i.e. transcribed verbatim notes on the interviews). The researcher attempted to correct this potential error through triangulation of the data (Stake, 2006) (i.e., multiple interviewers, interviewers, and researchers), peer debriefing (auditors and consultants), stability checks, and multiple sources of data. Another potential issue relative to this study surrounds language translation. Efforts were made to translate transcriptions accurately; however, translated text is always an approximation of the original text.
Conclusion

This research study was directed toward understanding the experiences of childhood abuse and family dysfunction in women with BPD and their non-BPD sisters. The current qualitative analysis shows that pairs of sisters matched on severity of parental emotional and physical abuse recounted concordance with regards to experiences of abuse from multiple family members, parental psychopathology, and family dysfunction, they were however different on their experiences of sexual abuse. The results underscore the importance of giving more attention to all children who grow up with maltreatment, parental psychopathology, and family dysfunction. Clinicians treating adults with psychopathology might need to include other family members, offering periodic assessment of children to determine their needs and concerns (Johnson, Cohen, Kasen, & Brook, 2006). Services for these children such as psycho-education programs on mental illness for all family members might address the negative feelings of isolation, confusion, anxiety, sadness, anger, fear that these sisters experienced. Support groups, individual or group therapy, for children could also aid them as they struggle with their parents' mental illness (Mordoch, & Hall, 2002).

Further research is needed to investigate the protective factors that might buffer the adverse effect of childhood maltreatment, family psychopathology and dysfunction. Studies addressing the question of how non-BPD sisters became resilient would illuminate this question. Research investigating coping responses to these risks could increase the potency and efficiency of interventions targeted at reducing the effects of the childhood adversities on the development of BPD.
References


Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS


Connecting Text: Principal Aims of Study 2

In manuscript 1, the depth and breadth of sisters’ narratives highlighted how similar were their experiences of risks. However, these findings suggest that shared risks are not sufficient in determining the link between risks and BPD since the sisters experienced more shared risks than unshared risks and yet only one sister of the pair had a diagnosis of BPD. Thus, we can reason that the absence of a diagnosis is a marker of the non-BPD sister’s resilience (Luther & Sexton, 2007). However, the mechanisms through which one sibling withstands these risks have yet to be fully elaborated. A growing body of literature has focused on enhancing our understanding of resilience through the examination of protective factors (Collishaw, et al., 2007). Research focusing on protective factors can provide insight into how to promote resilience and overall mental health and well-being among individuals who experienced childhood adversities and cumulative risks such as abuse, exposure to substance abuse, and mental health problems of parents.

Study 2 builds on study 1 by examining the phenomena of protective factors and resilience for those who have experienced childhood maltreatment and dysfunctional family environments. The work is a qualitative multiple case study that explores the protective factors that contribute to resilience in sister-pairs who experienced comparable parental emotional and physical abuse and family dysfunction. Both studies are situated within a larger program of research examining siblings one of whom develops BPD. The program includes quantitative investigations of pairs of sisters in order to explain when and how shared childhood adversities lead to BPD (Laporte, Paris, Guttman, & Russell, 2011). The second article aims to elaborate how siblings without BDP withstand the risks and to nuance and explain the quantitative findings of the larger program. The reader will
find some unavoidable redundancies in the reporting of the methods and limitations of the
two studies; the data are drawn from the same population of sister-pairs and have
addressed different research questions (APA, 2010; Rennie, 1994; Stake, personal
communication, August 11, 2011).
CHAPTER 4

Exploring resilience and borderline personality disorder: A qualitative study of pairs of sisters.

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Abstract

Research indicates that a large proportion of children exposed to childhood abuse experience psychological, cognitive, behavioural, social, and physical problems. These maladaptive outcomes can have important long-term implications. Childhood abuse has been found to be a predictor of psychopathology, including the diagnosis of borderline personality disorder (BPD). However, not all maltreated children develop BPD as adults. This qualitative study explores the protective factors that contribute to adaptive outcomes of pairs of sisters who experienced childhood abuse and family dysfunction. Eight themes emerged and were organized into individual, family, external, and novel factors. Implications for practice include a shift to resilience focused interventions and early interventions with treatments approaches such as Dialectal Behavioural Therapy (Linehan, 1993) and Schema Focused Therapy (Young, Klosko, Weishaar, 2003). Research implications include searching for ways to promote the use of protective factors in vulnerable individuals.

Keywords: protective factors, borderline personality disorder, exposure to childhood abuse, pairs of sisters, qualitative research
Exploring resilience and borderline personality disorder: A qualitative study of pairs of sisters.

Worldwide estimates of child abuse indicate that every year millions of children are abused and neglected (Butchart, Harvey, & Furniss, 2006). Child abuse is a significant public health concern associated with short- and long-term negative consequences, maladaptive outcomes, and psychological impairments (for a review see Trickett, Negriff, Juye, & Peckins, 2011). The adverse effects of childhood abuse include cognitive delays and lower IQ scores (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003), neurobiological abnormalities (Glaser, 2000), dysfunctional behaviours such as conduct problems, criminal behaviour, aggression, and substance abuse (Fergusson, Horwood, & Lynsky, 1996; Schuck & Widom, 2001), peer-related problems, school failure, delinquency (Collishaw, et al., 2007; Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007). Experiences of abuse are also linked to an increased risk of adolescent and adult psychiatric disorders including depression, suicide, anxiety disorder, post-traumatic stress disorder, and somatization disorder (Brown, Cohen, Johnson, & Smailes, 1999; Fergusson, Lynsky, & Horwood, 1996; Lansford et al., 2002), and over a broad range of social and interpersonal functioning, including intimate partner relationships, friendships, and employment problems (Hill, Stafford, Seaman, Ross & Daniel, 2007; Widom, 1989; McGolin & Widom, 2001). Adults who have been abused as children also appear at increased risk of serious negative life events such as poly-victimization (Coid, et al., 2003; Finkelhor, Ormond, & Turner, 2007). In sum, abuse has been associated with many deleterious effects.

Abuse as a Predictor of Borderline Personality Disorder
The literature on borderline personality disorder (BPD) has provided evidence that childhood abuse is a significant risk factor linked to the development of BPD (Bandelow, et al., 2005; Gunderson & Links, 2008; Paris, 2005; Zanarini, 2000). BPD is a serious mental disorder characterized by pervasive and persistent cognitive, emotional, and behavioural instability (Zanarini, 2000; Paris, 2008; Gunderson & Singer, 1975). This instability often disrupts the individual’s daily, social, occupational, family life, long-term planning, and sense of self. In comparison with various other psychiatric disorders, BPD is the diagnosis most frequently associated with childhood abuse (Paris, 2003; Yen et al., 2002; Zanarini, 1997). Researchers have found that individual with BPD have reported histories of neglect (92%), physical abuse (25-73%), emotional abuse (75%), and sexual abuse (40-70%) (Crowell, Beauchaine, & Linehan, 2009; Gunderson, 1996; Gunderson & Lyoo, 1997; Paris, 2007; Zanarini, 2000). BPD is among the most common and poorly understood of the personality disorders. There is value in making it a focus of research because people with this diagnosis suffer greatly and the interpersonal complexities of the disorder challenge many clinicians whose task is to help them.

Resilience and Childhood Abuse

Most research focusing on the effects of childhood abuse has investigated the negative outcomes and pathways that occurred as a result of experiencing the abuse (Gerirtz & Medhanie, 2008; Paris, 1998). Despite evidence supporting the increased risk of psychological and psychiatric problems, not all abused children develop mental health problems as adults. In fact, a number of studies have demonstrated that individuals vary considerably in their response to significant adversities and risks. Researchers have estimated that around 25-33% of individuals who have experienced childhood abuse appear relatively unaffected and do not develop adult psychiatric problems (Collishaw, et
al, 2007; Daigneault, Hebert, & Tourigny, 2007; Dumont, Widom, & Czaja, 2007; Fergusson, Boden, & Horwood, 2008). An abused child who does not develop psychiatric problems as an adult would be considered resilient to the abuse (Lutthar, 2003; Rutter, 2007).

The study of resilience is multidisciplinary and as a result there is no single definition of this construct (Herrman, et al., 2011; Heller, Larrieu, D’Imerio, & Boris, 1999). Definitions of resilience are constantly adjusted as scientific information evolves; nevertheless, there are several existing definitions that share a number of features. Herrman et al. (2011) suggest that, “Resilience refers to positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity” (p.259). An absence of a psychiatric diagnosis is sufficient to label an individual who has significant risk factors as resilient (Luthar & Sexton, 2007). McGloin and Widon (2001, p.1023) proposed to expand the definition of resilience to include multiple domains of functioning and a sequential dimension. According to their definition, resilience can be assessed along the domains of psychiatric functioning, employment history, homelessness, criminal behaviour, social activity, and education in the present as well as lifetime occurrence or non-occurrence of problems. Thus, abused individuals are resilient if they do not have a psychiatric diagnosis and demonstrate a normal range of competence across several domains of functioning over their lifespan (McGloin & Widon, 2001; Walsh, Dawson, & Matting, 2010).

**Protective Factors**

A burgeoning literature has focused on resilience in people with a history of childhood abuse and has highlighted a variety of protective factors (Afifi & MacMillan, 2011; Luther & Cicchetti, 2000; Werner, 1990). The research suggests that the absence
or presence of protective factors may help explain why some children who are abused show positive psychological adjustment in adulthood while others demonstrate poor outcomes (Luther & Brown, 2007; Morimoto & Sharma, 2004). Protective factors are characteristics of individuals, their families, and their external environments that mediate the risks and increase the chances that an individual will be resilient. Based on Werner’s (1982) work, the protective factors linked to resilience have been divided into the broad categories of individual factors, familial factors, and external factors (Afifi & MacMillan, 2011; Herrman et al., 2011).

The individual protective factors have been described as personal characteristics, personal traits, qualities, resources, or skills of the individual who is experiencing adversity or stressful life events (Afifi & MacMillan, 2011; Werner & Smith, 1992). The factors most often identified in empirical studies of maltreatment include cognitive ability, personality style, high self-esteem, internal locus on control, external attribution of blame, and coping strategies (e.g., Davidson et al., 2005).

Family protective factors include the quality of one’s relationship within the family (Werner, 1990). Family coherence, stable care giving, warm, nurturing, and cohesive family environment, and some supportive parenting of abused children are all important (Afifi & MacMillan, 2001; Hill, et al., 2007; Rutter, 1987). Most studies suggest that the more sensitive, supportive, caring, and safe the home environment, the more adaptive the outcome (Egeland, Carlson, & Sroufe, 1993; Spaccarelli & Kim, 1995; Wind & Silvern, 1994). In addition, Heller et al. (1999) suggests that the availability of emotional support at the time of the abuse can strengthen the ability of an individual to draw support from others in adulthood. Herrman et al. (2011) also proposes that a secure attachment to mother, a secure relationship with the non-abusive parent, and an absence
of maternal depression or substance abuse are associated with resilience. Protective factors within the family underline the importance of positive relationships with a primary caregiver and an emotional bond to at least one parent.

External protective factors are related to the individual’s ability to form, maintain, and benefit from good interpersonal relationships and social support (Afifi & MacMillan, 2011; Herrman et al., 2001). These include peer relationships, extra-familial relationships, intimate partners, spirituality and religion (Collishaw, et. al, 2007; Bandelow, et al., 2005). Herrman et al. (2011) also suggest that good schools, community services, neighbourhood qualities, connection to pro-social organizations, sports, and artistic opportunities play a part in developing resilience. Overall, the protective factors that have consistently drawn the most attention are connections with competent, caring adults in the family and community, good intellectual functioning, self-regulation skills, and positive self-views (Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Morimoto & Sharma, 2004; Rutter, 2006).

While there is much research that highlights a range of possible protective factors that may account for resilience following child abuse, there are areas that warrant further exploration. Afifi and MacMillian (2011) conducted a review of resilience literature and found only a few qualitative studies on this topic. They concluded that this type of methodology could elaborate the meaning of the individuals’ experiences of resilience, generate hypotheses, and identify new protective factors for future research. Despite, the substantial research that has systematically documented the negative effects of maltreatment in the development of personality disorders (e.g. Bandelow et al., 2005; Pairs, 2008); a few studies have investigated resiliency in individuals with personality disorders and their recovery from these disorders (e.g. Skodol, 2007). Another limitation
in the study of childhood abuse and resilience is that participants are often not matched on exposure to comparable risks (Luthar, 2003). In order for an individual to be considered resilient, they must have been exposed to significant risks. However, it is difficult to determine if resilient participants experience the same levels of risk as non-resilient participants (Collishaw et al., 2007); participants have seldom been matched on exposure to comparable maltreatment risks (Luthar, 2003).

The Present Study

Laporte, Paris, Guttman and Russell (2011) have designed a program of research to investigate pairs of sisters and the within-family similarities and disparities in risk factors. This design has the potential to address exposure to shared risk factors such as parental psychopathology and substance abuse, dysfunctional family relationships, financial burdens, and childhood maltreatment. The current study is part of a program that has found that the sisters of the women with BPD who themselves have no psychiatric illness had similar childhood maltreatment and histories of adversities (Laporte, et al., 2011).

The current investigation is a qualitative case study of pairs of sisters that explores the protective factors that mitigate the negative effects of childhood abuse and family dysfunction. The overarching questions that guided the research were: “How do these sisters construct their experiences of resilience?” and “How do these sisters describe their awareness of their resilient and non-resilient outcomes?” and “How do they understand their experiences of protective factors?

For this study, the resilient sisters were identified as those who: (1) experienced repeated, ongoing, severe parental physical and emotional abuse, and (2) reported no psychiatric disorders at the time of the study; and (3) achieved a normal range of
competence across several domains of functioning (e.g. behavioural, emotional, social, and academic). Relatively little is known about these asymptomatic individuals and how they achieved relatively good outcomes despite suffering risk experiences that for many have serious negative consequences.

**Method**

This study employed a multiple case study analysis approach (Stake, 2006). This methodology was selected for its suitability for closely examining several cases linked together by the fact that all cases are pairs- one woman with BPD and one non-BPD sister. The emphasis in this approach on cross case analysis (Stake, 2006) is to gain an understanding of the commonalities and disparities that characterizes the phenomenon under investigation- the experience of protective factors. This approach also encompasses descriptions of the multiple realities of sisters’ experiences. It uses the existing knowledge base in the literature to guide the analysis without stipulating how it is construed (Creswell, Hanson, Plano Clark, & Morales, 2007; Hancock & Algozzine, 2006; Lincoln & Guba, 1985; Merriam, 2009; Polkinghorne, 2005).

**Researcher Profile**

For the researcher’s background, tasks and experience refer to Perlin, Laporte, De Stefano, & Fitzpatrick (unpublished doctoral dissertation). Relative to the present study, the primary researcher believed that sisters with more protective factors would have better adjustment and would present as more resilient. She also speculated that sisters who were more resilient would attain that resilience through individual and external protective factor, as they came from the same families as the women with BPD. During the research process, she noted these biases in order to diminish their impact on the data analysis process (Flyvberg, 2006).
Participants

This study included twelve pairs of sisters who were purposively chosen (Eisenhardt, 2002; Polkinghorne, 2005; Wertz, 2005) because they were discordant for psychopathology and matched on their reported concordance of similar risk experiences of severity of parental physical and emotional abuse on the *Childhood Trauma Interview* (CTI; Fink, Bernstein, Handelsman, Foote, & Lovejoy, 1995) thus ensuring they were exposed to similar significant risk. The sisters were full siblings, within five years of age, and who had lived together with at least one of their biological parents. The women with BPD were recruited from psychiatric clinics in a large urban area and then their non-BPD sisters were contacted for the study participation. Additional details about sampling, procedures and diagnostic information have been reported previously (Laporte, et al., 2011). Table 1 summarizes the characteristics of the participants in the study.

|Table 1 about here|

Assessment Measures

**Diagnostic assessment.** Diagnostic procedures were conducted in order to establish the diagnostic status of each sister. Women who were designated as women with BPD, met DSM-IV-TR (First, Spitzer, Gibbon, & Williams, 2002) criteria and scored 8/10 on the Diagnostic Interview for Borderline Personality Disorder–Revised (DIB-R) (Zanarini, Gunderson, & Frankenburg, 1989). Their siblings completed the same diagnostic procedures to determine their clinical status and were designated as non-BPD sisters if they did not meet the diagnostic criteria. The *Childhood Trauma Interview* (CTI; Fink, et al., 1995) was administered to both sisters in each pair to collect data on their history of trauma and childhood abuse up to the age of eighteen.
Interview Protocol. The interview protocol was designed to obtain full narratives and opened with inquiring about socio-demographic information in order to encourage a relaxed interview procedure. The interview was developed to explore the sisters’ experiences growing up. It was a semi-structured interview and consisted of ten questions, asking the sisters about their perceptions of the similarities and differences between them in relation to their clinical status, individual characteristics, experiences of parental treatment, experiences of parental psychopathology and experiences of family members psychopathology, experiences of family dysfunction, the meaning of their childhood experiences on their present functioning, and their social supports. Each participant was asked to respond to this question initially: “Do you feel different from your sister? How do you explain it?” (see appendix A for interview questions). This question was intended to engage in conversation about experiences that were meaningful to the participant. If personal examples about similarities and differences between the pair were not forthcoming the interviewer prompted, “Tell me more about that,” or “Can you give me an example?” to extend the narrative. Participants were given the opportunity to elaborate fully on their experiences, and to comment at length on whatever aspects of the interview questions were of most interest to them.

Procedures

The study was approved by institutional review boards at all hospitals from which patients were recruited, as well as the Research Ethics Board at McGill University. After the purpose and procedures of the study were clearly explained to each participant, the participant signed an informed consent. Following the administration of the CTI, an open-ended interview was conducted individually with each sister. One sister of each pair was randomly assigned to interviewers to ensure the interviewers did not meet sisters
from the same family. In addition, the interviewers were blind to the mental health status of the sisters unless informed by the participant. During the interviews, the interviewers wrote verbatim notes on the participants’ responses and transcribed them after the interviews. Stake (2006) proposed that transcribed notes are sufficient source of data as long as the process of triangulation in used in the case study analysis. The multiple sources of data were used for the qualitative analysis such as the transcribed verbatim notes of the CTI and interview protocol. The interviews ranged between maximum 60 to 180 minutes and concluded when the participant indicated that they had nothing else to discuss. Upon completion of the interview protocol an honorarium was provided to all participants for their involvement in the study. None of the participants reported negative reactions to the interview. Some interviews were conducted in French to accommodate participants whose mother tongue was French. French segments of the verbatim notes were translated by the bilingual interviewers at the time of the interview, and reviewed for accuracy by a bilingual Francophone colleague.

Data Analysis

The data were analyzed using cross case analysis (Stake, 2006). For this analysis, a case was considered to be a sister pair. The analysis was done in two phases: first reading the individual cases and producing collected case reports, then phase two, conducting the cross case analysis. For six pairs, the researcher and the expert methodologist discussed their individual conceptualizations regarding the uniqueness and the similarities in the case reports, categorization of the data by protective factors, themes and patterns, and arrived at an agreement on a final understanding of the data. The first author then analyzed the next six pairs and once the data for the 12 pairs of sisters were
fully analyzed the primary researcher and the expert methodologist met to discuss the final themes and cross case comparisons.

The main emphasis of the first phase, the reading of the interviews, was on becoming deeply familiar with each case pair. Initially, preliminary notes in the margins of the verbatim case notes were created with the goal of producing systemic notes (Stake, 2006), that would synthesize the researcher’s impressions and highlight themes related to the research questions (Creswell, 2002). Concurrent with the study of the cases, the researcher consulted related literature in order to perform a content analysis (Stake, 2006, p.42) and to guide the study in an explanatory way (Creswell, 1998, p.87). Subsequently the researcher wrote a synopsis of the story told of each pair- the collected case reports-which identified key information about the case and highlighted the uniqueness and similarities from the cases for the next phase (Creswell & Plano Clark, 2007; Wolcott, 2009).

In phase two, the cross-case analysis, the participants’ experiences as represented in the case reports were examined in light of the research questions (Stake, 2006, p. 47) in order to examine what is common and what is unique across the case. The research literature guided the cross case analysis via a content analysis of Werner’s (1990) resilience framework.

For the content analysis, the researcher considered the uniqueness and the similarities of the case reports according to the Werner’s (1990) resilience framework and utilized the three categories of protective factors - individual, familial, and external protective factors - to guide the generation of initial codes. Here the researcher also explored any atypical information in the case report data that might extend the findings.

In the case where the atypical findings were contrary to existing literature or were
unaccounted for in the literature a fourth level was created to account for the unexplained data- a “novel” category. This process involved the simultaneous coding of data and the construction of categories that capture the voices of these women’s narratives about their potential protective factors.

Subsequently as the researcher searched for themes, she considered the “expected utility” (Stake, 2006, p.48), in other words, the value of the data in adding to the understanding of the theme. Stake (2006) suggests that the researcher then rates the utility or value of the cases as high (H), middle (M), low (L). High utility means that the case appears to be one of the most useful for developing a theme. When all cases were rated, the researcher scanned the ratings noting the highly relevant cases for each theme (Stake, 2006). The expected utility phase involved the refinement of themes and at this point the researcher needed to decide if themes needed to be collapsed, separated, or discarded (Thomas, 2006). The end product of this phase should include a solid idea of the different themes, how they fit together, and the overall report of the data (Stake, 2006).

Once the expected utility phase is completed, assertions about the phenomena are made which involved defining and naming the themes. Here, themes are defined and named (Stake, 2006). The researcher explored whether any themes contained sub-themes and modified the themes or re-grouped themes in order to most accurately capture what appeared to be occurring.

The final phase included interpreting the findings as a whole which involved synthesis and triangulation (Creswell, 2007; Stake, 2010) to describe as clear a picture of the sisters’ experiences. The researcher conducted triangulation with the existing literature to evaluate and/or expand the emerging themes as a form of validation to see
whether new viewpoints were consistent with what is already known about the case and the phenomenon. Stake (2006) advocates that each central finding requires at least three or more confirmations and assurances. This convention was followed from the narratives of the sister pairs so that key meanings were accounted for and nothing was disregarded.

The auditing process consists of enlisting two external consultants, the auditor, to examine both the procedure and the findings of the case study methodology (Creswell, 1998; Lincoln & Guba, 1985; Miles & Huberman, 1984). For the purpose of this study, an auditor was selected that had no prior knowledge of the data to ensure objectivity. The auditor was a doctoral level student in clinical psychology, with clinical knowledge and experience of individuals with DSM diagnosis, and research experience in conducting and analyzing qualitative research. The auditor was sent a document of the participants’ quotations and asked to match quotations to Werner’s (1990) categories. Once she completed the matching, she and the investigator held consensus meetings to compare their findings. In the auditing results, when there was disagreement about the findings, these were discussed until consensus was reached (Creswell, 1998; Stiles, 1993). In addition to this auditing process, the third author served as an inquiry auditor (Fassinger, 2005) who monitored the overall process and final theme selection. He provided on-going feedback on the emerging themes and on their clarity in understanding the sisters’ experiences. Thus, the research team assisting the primary researcher included an expert methodologist, two external consultants, an auditor and inquiry auditor, and a co-interviewer.

**Trustworthiness**
Several steps were taken to ensure the credibility and trustworthiness of data at each phase of the research (Merrick, 1999; Morrow, 2005). The authenticity and credibility of the findings were demonstrated through reconstructing and re-contextualizing the data by using triangulations (multiple interviewees and interviewers), peer debriefing (auditors, a peer reviewer). Triangulation (Stake, 1995) was done in several ways in this study. The cross-case analysis is a form of triangulation as it consults multiple participants’ perspectives relative to the same questions. The use of two interviewers also triangulates the data collection; different interviewers pose questions and elicit information in ways that allow alternative data to emerge. The use of auditors provided an alternative perspective at the data analytic stage. The second author served as a peer reviewer and offered clarifications about methods and possible interpretation of the data. The reviewer and the first author met and kept written accounts of the sessions (peer briefing sessions) (Lincoln & Guba, 1985). Research reflexivity and dependability were attended to by keeping an “audit trail” (memos and reflexive journal) and by “bracketing” (i.e., setting aside the researcher’s assumptions and the information from the literature so that the data were allowed to “speak for themselves”).

Negative case analysis allowed the researcher to refine her working hypotheses as the inquiry advanced in light of negative or disconfirming evidence to increase the trustworthiness (Creswell, 2007; Lincoln & Guba, 1985). Initial hypotheses were revised until all cases fit. For example, two women with BPD recalled that they had social supports whereas the other ten women with BPD could not recall having any social supports. Since the women with BPD are not considered resilient, and the ability to form and maintain relationships is a protective factor, these two pairs were considered a negative case for the social support factor. This procedure allowed for the consideration
of alternative explanations of similarities and disparities among the pairs of sisters in the experience of protective factors.

**Results**

**Descriptive accounts.** Looking at the pairs of sisters’ relative to the ways in which they were resilient the non-BPD sisters demonstrated resilience across multiple domains (psychiatric, behavioural, academic, familial, and social) compared to the women with BPD demonstrating more breadth of protective experiences. On the psychiatric domain, all non-BPD sisters had no psychiatric diagnose despite their shared experiences of risks. In terms of behavioural competence, two of the non-BPD sisters were unemployed compared to seven of the women with BPD. Another aspect of the behavioural domain is criminal behaviour; none of the non-BPD sisters had been in prison whereas three of the women with BPD had. In relation to the academic achievement domain, the non-BPD sisters obtained on average 2 additional years of schooling compared to their sisters. Five women with BPD dropped out of high school where only one non-BPD sister dropped out of high school. In the familial domain, nine non-BPD sisters have children, whereas six of the women with BPD have children. As for stable relationships, all the non-BPD sisters were able to identify someone in whom they can confide; several identified more than one confidant. On the other hand, the women with BPD were able to recall fewer people in whom they could confide; five had no one and half mentioned the primary person they confide is their therapist.

**Themes.** The results of the qualitative analyses of the interview data yielded eight themes that were grouped into four overarching themes. The four overarching themes were individual protective factors, family protective factors, external protective factors, and “novel factors”. The eight themes are individual characteristics, emotional regulatory
Individual protective factors

In the category of individual protective factors, three themes emerged, individual characteristics, emotional regulatory skills, and future time orientation, when the sisters were asked to explain how they perceive the differences between them. On individual characteristics, the pairs of sisters described themselves as completely different from one another, as polar opposites in the personality realm. The women with BPD portrayed their healthy sister with more positive personality traits and used descriptors such as caring, sensitive to others, intelligent, popular, easy going, good humoured, optimistic, and having a strong sense of self. For example, a woman with BPD characterized her sister as follows, “My sister and I are so different. She is very social, likes being with people, everyone likes her and she likes everyone, she is intelligent, and likes helping others” (Pair 6). On the other hand, the non-BPD sisters described the women with BPD with more negative personality traits and individual characteristics: full of negative emotions, very sensitive, having a weak sense of self, feistier, dramatic, needing lots of attention, and intense.

My sister, since the day she was born, was headstrong. She would talk back to our parents. She was a real tornado full of energy. She could scream like no other kid could. She is very different than me. She needs so much attention. She needs to know she is loved. She is very dramatic, sensitive, and very extremist. She cannot control her temper (Pair 5).
When they were asked to reflect on the differences between them and their sisters, participants talked about their ability or lack of ability to regulate or manage emotions. In particular, the non-BPD sisters believed that it was easier from them to control their feelings in relation to the experiences of abuse when comparing themselves to the women with BPD.

Our father abused both of us but it seems to have affected my sister more. She reacts to everything and is so sensitive and believes our father scapegoated her. She also claims that our grandfather abused her and that is why she has her problems. She is so emotional (Pair 7).

The narratives of the women with BPD were dense with descriptions of feeling engulfed by their emotions. For example, women with BPD found it difficult to manage their anger.

I am extremely different from my sister. She is calmer and nicer, while I am like a bomb and can get angry very fast. The anger follows me everywhere. I am extroverted and opened and my sister is more introverted and talks less about her feelings about the abuse (Pair 11).

The women with BPD described their childhood as an emotionally loaded experience. They avoided their negative feelings associated with the abuse and reported feeling frozen in their emotions (e.g. anger, rage, violent emotions). The non-BPD sisters recalled that they were more able to focus on regulating and managing their emotions.

We are completing different. My sister doesn’t think she just reacts. She can’t stand stresses or insults and gets very upset. Her feelings are so intense. I am more easy-going and mellow. I can let things go and
not get worked up; I try not to let my emotions take over. I am the responsible one and I take care of her (Pair 12).

Half of the non-BPD sisters viewed themselves as future oriented; in childhood they were able to imagine themselves in the future and fantasize about how life will be when the difficult times were over. They were optimistic and hopeful for the future, had positive attitudes and expectations, and planned to achieve their goals and objectives. One non-BPD sister indicated that planning for the future, doing well in school, and focusing on her goals was her way of creating structure in her unstable, chaotic home environment (Pair 5). Another non-BPD sister recalled that she was an avid reader and would escape into her novels and fantasize playing the role of the characters in order to imagine a life without abuse (Pair 9). This was in contrast to most of the women with BPD who indicated that they had experienced difficulties thinking beyond the present, had limited thoughts about their future, and believed they would relive and repeat the abusive and dysfunctional home environment forever. The women with BPD lacked positive expectations for themselves and the future and expressed hopelessness about getting better. One woman with BPD reflected,

The BPD is a consequence of my past. I have been cutting myself since I was ten years old and I haven’t stopped and don’t think I will. I am still very affected and my memories haunt me, I can’t move past them or think about a future (Pair 9).

**Family protective factors**
In spite of childhood exposure to abuse and neglect by family members, non-BPD sisters were able to identify one family protective factor—setting limits with family members.

Most of the non-BPD sisters revealed that setting limits and boundaries from their abusive environments was important to a positive adaptation. For example, “We all suffered from my father’s rages and his beatings. These memories are painful and I try to distance myself from them and remove myself from the horrible things that happened to me growing up” (Pair 4). This is in contrast to the women with BPD who were unable to remove themselves from their abusive and dysfunctional pasts. “For as long as I can remember I wanted to change my family dynamics. I wanted to have a normal happy life. I am still working on changing the dynamics and the fact that my mother is so negative and really gets me down” (Pair 11). Some of the sisters indicated that removing themselves from their abusive families was a way to create and maintain manageable boundaries from their abusive environments. One non-BPD sister recalled that because the emotional abuse from her extended family members made her feel humiliated and devalued, she decided at the age of 14 to not see them anymore (Pair 10). The non-BPD sisters discussed that they were able to separate by setting limits, developing a strong sense of self and leaving their family of origin. This finding suggests that the decision and action of separating from family members appears to be an important skill in the resilience process.

**External protective factors**

Participants were asked to reflect on their experiences and the ability to form social supports during childhood and adolescents. Within pairs, sisters differed on their ability to identify people whom they saw as supportive, compassionate, and empathic
whom they could turn to for general support during their childhood. Eleven non-BPD sisters identified one or more people whom they saw as supportive and caring when they were children. These women discussed the importance of having supportive, stable, and nurturing relationships. They reflected on their ability to form, maintain, and benefit from relationships with others outside their family. Some women reported that they searched for support outside their homes to help them deal with their unstable and volatile family. This external protective factor included two types of social networks: central adults and peer friendships.

Within the social support system theme, a protective factor was the presence of a positive adult outside the home, who acted as a role model, providing support, protection, and encouragement. Participants described extended family members (i.e., grandparents), teachers, or a person in the mental health profession, or family friends as important adults in their lives. These people were available to them on a fairly regular basis. The women described these adults as safe and saw their homes or places of work as havens where they were welcome. A non-BPD sister (Pair 1) recalled speaking to her teacher about the sexual abuse she was exposed to at home. She said, “I connected with a teacher I had. She was always there to listen to me and give me good advice on what to do about my home life.” In retrospect, these supportive others were viewed as links to the world outside their chaotic, unreliable, and unpredictable family situation providing them with care, attention, and stability. Some viewed the adult in their lives as role models for parenting and stability. Additionally, the adults present during their childhoods also modeled nurturing positive relational exchanges. One non-BPD sister recounted,

I was able to confide in my grandmother when I was a child. My grandmother took care of me. She paid attention to me, just loved me. I
was also able to confide in a nun while I was at boarding school. By confiding in the nun I was able to pass my adolescence as peacefully as possible whereas my sister felt she had no one (Pair 6).

Many of the women credited these adults as major influences in their lives; these supportive relationships were necessary and essential to their development.

Included in these external protective factors were also secure friendships women formed with their peers. Three non-BPD sister recognized that their friends were the supports that they created outside her family to help them cope (Pair 2, Pair 9, & Pair 12). One of them said, “When my mother kicked me out and left me on the street I was able to turn to my friend, he took me in and took care of me” (Pair 9). Some sisters reported that their friends allowed them to express their feelings non-judgementally. For instance, one non-BPD sister reported that her friends gave her permission to express her feelings without restraint. She characterized her friends as honest, amenable, and receptive (Pair 9). According to these women, peer relationships provided a secure and stable environment for them. Central adult and peer-relationships helped foster positive adaptation for these women as a supportive, nurturing environment was present.

In contrast, ten of the women with BPD recounted that they had difficulty identifying anyone whom they saw as compassionate and caring with whom they could share their problems when they were children. They indicated that they had found it difficult to trust people and often did not dare let anyone get close. A woman with BPD said, “As children we did not have anyone to confide in when things were not going well at home. I could not trust my mother because of the alcohol and her depression. I realized from a young age that life was lousy and negative” (Pair 11). Another woman with BPD revealed that, “When I was young I had no one to share with but I took pills
and I found they helped” (Pair 1). Another stated, “I started cutting myself when I was ten. I did not want to be a burden on anybody. Because my family was well respected, even when my mother did bad things to us no one protected and believed me” (Pair 9). The accounts of the women with BPD revealed how isolated, helpless, and vulnerable they felt because they could not find anyone to rely on, confide in, depend on, and trust.

**Novel protective factors**

In the novel category of protective factors two factors were identified that were not previously described in the literature: acceptance of the past and meaning of children. These themes present potentially new information about resilience among individuals who experienced childhood abuse and the development of BPD.

**Acceptance of the Past**

Four non-BPD sisters specifically described their ability to turn the page over, to let go of the past, detach themselves from their abusive histories, move on, and work through their negative emotions associated with the abuse. For example, one non-BPD sister reported, “Despite what happened in my childhood, I do not let it affect me now because I turned the page over, I worked through my anger and other negative emotions associated with it” (Pair 7). This theme presents potentially new information about resilience among pairs of sisters exposed to childhood abuse and the development of BPD. In comparison to the women with BPD, non-BPD sister reflected,

I think we are very different in the way we see and describe events. My sister pays attention to every detail and she retains everything. I do not remember everything from our childhood, our past. My sister remembers everything as if it is important and recounts events I do not find important. I do not let these experiences affect me anymore. I
decided that I can no longer be unhappy and stuck in the past. I moved forward and I do not look back (Pair 11).

In addition, several of non-BPD sisters were able to accept flaws in their families of origin and not let these imperfections define them. These women recognized that their parents had deficits and limitations and were able to evaluate and accept the shortcomings in their families of origin while developing an independent sense of self. For example, a non-BPD sister revealed,

I don’t let what happened in my childhood phase me anymore. My father is not perfect; he is violent, mean, and aggressive. I just have to accept it. You have to deal with your family imperfections and inadequacies and recognize that no one is perfect (Pair 12).

The non-BPD sisters wanted to let go and move on from their past while the majority of the narratives of the women with BPD focused on them being stuck in the past, trying to repair the past, and hanging on to their identities as a victim of the abuse in their past. One woman with BPD recounted, “I am always looking to understand my problems and think if I understand my family issues and the reasons why I was abused then maybe I can get better” (Pair 10). Some women with BPD indicated that the flaws in their families of origin and poor and neglectful parenting was something that they focused on and worked to improve. “Since adolescence, I have been in therapy because I do not want to be like my parents and harm my children like they hurt me. I want to fix them and I am focusing on and need to fix it” (Pair 1). Another woman with BPD reflected,

Whenever I think of my childhood I get sad. I am not close with my mother; she never calls me and tells me I cannot talk to her about my
problems. I want to fix that. I have always wanted a better relationship with my mother (Pair 3).

The Meaning of Children

Most of the women (14 participants) had children; both the non-BPD sisters and the women with BPD discussed how their children helped them cope with the impact of their childhood experiences. The non-BPD sister of Pair 11 stated, “My children helped me overcome my past and I work hard to be open to my children and get their respect.” Her sister with BPD recalled, “I want to get healthier for my children. They give me reason to deal with my past and help me cope.” Those with BPD noted that their children were a reason to get better and motivation to recover from the diagnosis. The women described how their children provide them with unconditional love, gave them a reason to be healthy and do well in life, provided them with purpose, helped them get their life in order and set goals, and gave them motivation to be a better parent than the ones they had.

I want to make sure that my two daughters will never have to go through anything like I went through. My illness is a consequence of my past and my upbringing and my cutting. I am still very affected and my memories haunt me. My children have helped me cope, set clear goals for myself and for them and they are the reason I go after these goals, and want to be healthier (woman with BPD, Pair 8).

These participants described how they made a strong commitment not to reproduce the abusive environment in which they grew up. A woman with BPD (Pair 1) stated, “I do not want to be like my parents. I work hard to not harm my children like my parents harmed us. They teach me how to love and be loved.” They identified their children as
influential in providing them with direction in their lives. A non-BPD sister (Pair 4) said, “I have purpose now and a reason to move forward because of my child.”

**Discussion**

The present study adds to our understanding of differential resilient outcomes among pairs of sisters who experienced childhood abuse and dysfunctional family environments. Using Werner’s resilience framework (1990) of individual, familial, and external protective factors provided an early structure for the data, elaborating the protective factors that can mitigate the negative effects of these experiences. As expected, the non-BPD sisters recounted having more individual protective factors and external protective factors than their sisters with BPD. This finding might speak to the fact that despite the pairs of sisters strikingly similar shared childhood histories of abuse and family dysfunction, they differed in those protective factors that promoted resilience and decreased the risks of developing BPD. In addition to providing support and elaboration for the three categories identified in the literature, the data revealed how two novel factors—acceptance of the past and the meaning of children—might contribute to resilience.

The non-BPD sisters endorsed several individual factors (individual characteristics, emotional regulatory skills, and future time orientation) that have been identified as important protective factors related to resilience (Afifi & MacMillan, 2011; Herrman et al., 2011; Werner, 1990). In examining their narratives, the non-BPD sisters seemed to have less difficulty with their emotional reactions, to have a capacity to manage these emotional experiences, especially the negative ones that could be essential to resilience. The ability to regulate the experience and expression of emotions was mirrored in the non-BPD sisters as they were able to prevent their emotions from
interfering with developing goal-directed, future oriented behaviour, and other pro-social behaviour like forming social supports. This feature, emotion dysregulation, is a core characteristic of BPD (Linehan, 1993). Linehan proposes that emotional dysregulation, a very intense sensitivity to emotional stimuli and a very slow recovery once the emotional response has occurred is at the core of maladaptive emotional regulatory skills in BPD. The details of the women with BPD experiences seem to fit this frame. That the non-BPD sisters did not demonstrate this emotional vulnerability in spite of their experiences of dysfunctional environments suggests that they were able to develop these emotional regulatory skills that are protective to psychopathology. Certainly when one is not burdened in the present by negative debilitating emotions, there is room for more intentional and future oriented behaviours. The non-BPD sisters were able to be optimistic, hopeful, and positive about the future; they could fantasize about the future which gave them an escape from the chaos and unpredictability they endured in childhood. It is also possible however that they were characteristically more hopeful and optimistic which made them more resilient. Optimism and hope has been found to protect against negativism and depression (Mrazek & Mrazek, 1987). Seligman (1990) studied positive interpretations of negative events in his work on learned optimism where he looked at explanatory styles, the manner in which an individual habitually explain to themselves why events happen (p.15). An optimist explanatory style is at the core of positive thinking. A positive concept of the future, the self, and the world stems from seeing the causes of bad events as temporary, limited, and outside oneself which is how the non-BPD sisters attributed their experiences. A pessimistic explanatory style is seeing the causes of bad events in the opposite way which is more like how the women with BPD described and understood their experiences. Perhaps hope, optimism, and a
positive explanatory style helped the non-BPD sisters form attitudes that moderated the negative effects of their childhoods and pulled them through difficult situations.

A theme within the family protective factors was setting limits with family members. The non-BPD sisters disclosed that distancing themselves from their abusive childhood was important to their positive outcome and resilience. It appears logical that these sisters needed to separate and individuate from their dysfunctional families if they were to create structure and stability in their lives. The importance of setting boundaries and limits with individuals with BPD is highlighted in the therapy models that help individuals establish a strong identify and sense of self by working on autonomy and realistic limit settings (Young, Klosko, and Weishaar, 2003). Many clinicians believe that an individual with BPD has an enmeshed/underdeveloped self (a DSM diagnostic criterion) and that the individual feels an extreme emotional involvement and closeness with the parental figure, at the expense of full individuation and normal social and psychological development. This underdeveloped self in women with BPD may be reflected in a failure to develop an appropriate future orientation. Young et al. propose that individual with an underdeveloped self feel as though they are drifting without any direction. Gunderson and Berkowitz (2006) developed the multiple family group program which incorporates guidelines for treating individuals with BPD and their family. One of the guidelines discusses setting limits and is taught to family members of individuals with BPD. The fact that the non-BPD sisters understood the importance of setting limits when they were young facilitated their positive outcome. Thus, as revealed by the non-BPD sisters the task of setting limits and developing a sense of self (Mrazek & Mrazek, 1987) appears to be an important feature to developing resilience to risk and adversity.
External support networks (central adult and peer relationships) appeared to be an important feature for the non-BPD sisters’ positive outcomes. Most non-BPD sisters were able to identify one of more people whom they saw as concerned, supportive, caring, and nurturing when they were children. This is in stark contrast to the majority of women with BPD who recalled having difficulty finding support. The protective factor of social supports is an established component of resilience and has been identified in multiple studies in the area of childhood abuse and other traumas (Afifi & MacMillan, 2011; Collishaw, et al, 2007; Herrman et al., 2011; Rutter, 2007; Werner, 1990). This protective factor is among the most frequently cited factors with the main emphasis on connections with competent, caring adults in the family and community (Luthar, Cicchetti, & Becker, 2000; Rutter, 2006). The non-BPD sisters noted that they perceived these relationships as critical to their development.

Since both sisters presumably had access to these protective factors, it is interesting to note that the non-BPD sisters were able to benefit from this access to this protective factor. Perhaps the difference is one of initiative; the non-BPD sisters recalled seeking and reaching out to people who they believed would welcome them and with whom they would feel safe. However, they did not discuss why they actively sought out others, or how they were able to draw others to them. This perhaps suggests that the non-BPD sisters were more interpersonally sensitive and able to identify adults who were seen as supportive. This also implies that they took the interpersonal risks to approach and engage these individuals. Perhaps it is not enough to have external protective factor available to you but it also important to have the personal resources, skills, and abilities to use it in a proactive way. This is an interesting and important question for further research. Studies that examine the ways in which children and older individuals can
recognize and create opportunity for social support within external networks such as in schools, community, and clinical settings are needed.

Two novel factors emerged from the sisters’ narratives that have not been previously elaborated on in the resilience-maltreatment literature: acceptance of the past and the meaning of children. Acceptance of the past was discussed by the non-BPD sisters as they described their ability to let go, detach themselves from their abusive and dysfunctional past, move forward, work through their adversities, and accept the deleterious effects of their childhood. The non-BPD sisters also demonstrated an ability to accept flaws with their families of origin. These women recognized, evaluated, and accepted the imperfections, deficits, limitations, and shortcoming of their families and choose to accept their family reality as is. This is in notable comparison to the woman with BPD who was stuck in the past and unable to accept its reality which has been described in the BPD literature as ruminating about the past. Ruminating can lead to emotional reasoning and dysregulation. Mindfulness, acceptance and distress tolerance, components of dialectical behavior therapy (DBT), have been utilized to stop ruminating because the point of mindfulness is to be “in the moment” and not consider past or future events (Linehan, 1993). The non-BPD sisters’ narratives support this empirically supported treatment model for BPD and provide evidence for the importance of distress tolerance skills that highlight the importance of acceptance. Linehan proposes that the ability to tolerate and accept distress is an essential mental health goal since distress is part of life and cannot be avoided or removed. Distress tolerance involves the ability to accept oneself and the current situation and accepting life as it is in the here and now. Moreover, in DBT there are core mindfulness skills which involve helping individuals to not evade their feelings. The women with BPD emphasized that they had
difficulty evading their negative feelings and had unsuccessful attempts at controlling their feelings. It would be interesting to explore how the non-BPD sisters develop this ability and were able to tap into these resources despite living in at risk situations. What these findings offer is one of the potential mechanisms that may make DBT effective. Less attention in research has been paid to acceptance and mindfulness as factors that might protect individuals with abusive histories from BPD.

The meaning of children, a protective factor described by both groups of sisters, occurred later in life and can be related to recovery and remission from personality disorders. The notion of recovery from personality disorders is in its infancy, even though empirical studies of the course of personality disorders have demonstrated that only half of the individuals with a personality diagnosis maintain these diagnoses over the lifespan (Shea, et al., 2002; Zanarini, Frankenburg, Hennen, & Silk, 2003). Skodol et al. (2007) studied resilience and recovery from personality disorders and explored positive life experiences that help people to cope with adversity and make them more able to cope with stress in the future. They suggest that researchers should look for factors that help people with personality disorders improve. Both women with BPD and their non-BPD sisters discussed how having children made them want to get better and improve and thus may promote recovery from BPD and adult resilience. Their children provided them with purpose and meaning, motivation, hopefulness, a reason to want to be healthy and do well in life, and to create stability and set goals. Viktor Frankl a humanistic psychologist describes how finding meaning in the face of great adversity- for him the experience of a concentration camp- creates the will to continue living and to make meaning of suffering (Frankl, 2006). These women in their search for meaning of their experiences found purpose in their own children. Children helped them to recognize the imperfections and
shortcoming in their own parents and incited them to want to be better parent. This could be seen as a form of rewriting the past by being the parent they wanted to have. Thus, this positive life experience is about having a higher purpose that extends beyond meeting one’s own personal needs. The role of purpose and intentions beyond oneself might promote adult resilience and a move toward improved health.

From the non-BPD sisters’ narratives it appeared that the protective factors interacted and worked together to produce adjustment and positive adaptation. For example, the non-BPD sisters made the deliberate choice to distance themselves from their abusive environments and set limits with their family members in the hope that they would be less affected by the trauma. However, their decision to do so may have been buttressed by their positive individual characteristic (i.e. relationship skills) that allowed them to seek out people as social support. This finding is consistent with the research on protective chains and ripple effects (Rutter, 2007; Walker, 2001) that refers to the cumulative effect of protective factors that mitigate the negative effects of risks, protecting the vulnerable individual from developing a psychopathology. We could reason that the women with BPD did not have or could not use these protective factors.

**Limitations**

Even though a case study of sister pairs illuminated some important and new factors relative to resilience, there are several limitations to this study. First is the issue of transferability of findings in that, the factors identified as supporting resilience to childhood maltreatment cannot be generalized to other personality disorders. A second limitation of this study is that the primary researcher acted as one of the main interviewers and analyzed the data. While this approach provided a wealth of experience and a rich perspective from which to interpret the data and conduct the analysis, it may
have also biased the interpretation of the data. By triangulating the data and conducting the analysis using multiple sources (multiple interviewees, interviewers, and content analysis - basing the interpretations on the literature, and multiple authors), there has been an attempt to decrease the impact of the primary researcher’s bias. However, the credibility of the results could have been enhanced through, for instance, member checking (Creswell, 2007). Member checking was not possible due to practical considerations, but sharing the narratives with the sister pairs and inviting their feedback would certainly have helped to authenticate the accuracy of the findings. The findings may also be limited because of the main source of data are transcribed verbatim notes on the interviews. The researcher attempted to correct this through triangulation of the data (Stake, 2006), peer debriefing, and conducting a content analysis but there is still potential for missing subtle meanings of the sisters’ narratives. One finale issue relative to this study surrounds language translation. Efforts were made to translate transcriptions accurately; however, translated text is always an approximation of the original text and hence subtle meaning may have been missed.

Conclusion

This research study has identified protective factors that relate to reducing risk for developing BPD and increasing the likelihood of positive mental health outcomes. These findings have significance for clinical practice and research. Clinical interventions that support a shift to resilience and are designed to foster personal strengths, resources, and competencies across multiple domains (behavioural, social, emotional, and cognitive) and that incorporate acceptance, distress tolerance skills, interpersonal skills, and core mindfulness skills could be helpful for individuals recently diagnosed with BPD. The findings offer a potential mechanism that may make empirically support treatment for
BPD, like DBT (Linehan, 1993) effective. DBT, with its focus on mindfulness skills, acceptance, distress tolerance skills, interpersonal effectiveness skills, and emotional regulation skills seems to echo the non-BPD sisters’ narratives related to their resilience. Schema focused therapy (Young et al., 2003) reflects some of the current findings in the manner in which they address clinical intervention designed to set limits and boundaries with clients which were highlighted in the non-BPD sisters’ accounts. These findings suggest that early interventions with treatments such as DBT and Schema Focused Therapy could have beneficial effects on recently diagnosed individuals with BPD. Furthermore, since several of the women with BPD reported that they currently rely on their therapist for support, psychotherapy, especially since it works at developing and sustaining a trusting and trustful relationship with these women and this might help increase their capacity to trust, receive help, and seek out assistance from others.

Several research directions can be developed from these findings. This qualitative study demonstrate that it is not enough to have the protective factor available to the individual but it is also necessary for the individual to recognize salient sources of protective factors and to know how and when to use them. The protective factor of social supports was endorsed by the non-BPD sisters in this study and is a well established component of resilience. The pairs of sisters described significant risks within their family system and environment and not surprisingly the protective factors they identified were derived their external support network such as from their school, their community, and their neighbourhood environments. However, specific ways to endorse the use of this protective factor have yet to be explored. It would be helpful to determine ways to promote social support for individuals exposed to abuse in schools, communities, and in
clinical settings. Further research into how children seek out supports and how they are able use these relationships to deal with adversity may be useful.

Another direction for future research is to explore positive life experiences that might promote recovery from BPD. The role of purpose, especially in one’s value to another human as seen in the meaning of children could be an important factor in coping with adversity and helping the person shift from maladaptive outcome to more adaptive ones.
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Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS


CHAPTER 5

Conclusion

Summary of Findings and Original Contribution to Research

The aetiology of BPD is complex involving several psychosocial risks.
Considerable research has focused on the risk factors linked to the development of this disorder; however, less attention has been given to the protective factors that buffer against the risks and can moderate the development of BPD. Thus far, only a few quantitative studies have investigated protective factors evolved in the prognosis of BPD (Skodol et al., 2007). Moreover, few studies have investigated the risks within families (Laporte et al., 2011; Laporte et al., in press) as well as the protective factors within families that are at risk for psychopathology and family dysfunction.

The present program of research sought to add to existing research by investigating the risk factors involved in the development of BPD and the protective factors that buffer against the risks of maltreatment and protecting individuals from developing this disorder. First, a focused literature review was presented, summarizing existing research in BPD, maltreatment, and resilience. This review drew attention to the paucity of qualitative research in this area of study, as well as to the relative lack of studies on resilience and BPD. Manuscripts 1 and 2 reported results of two qualitative studies. Study 1 employed a thematic analysis (Braun & Clarke, 2006) to examine the experience of risk factors linked to the development of BPD in 12 pairs of sisters where one sister has the BPD and the other does not have any DSM diagnosis at the time of the study. In study 2, a multiple case study design (Stake, 2006) was employed to investigate the protective factors that contribute to adaptive outcomes of 12 sister pairs who experienced similar childhood abuse, parental psychopathology, and family dysfunction.
The two manuscripts which comprise this document provide a cumulative contribution to the overall picture of the experiences of risk that increase the likelihood, and protective factors that decrease, the probably of developing BPD.

Results for study 1 supported previous quantitative study suggesting that women with BPD and their sisters grow up with similar childhood adversities (Laporte et al., 2011). However, the study extends these previous findings by looking at not only emotional and physical abuse from their parents but also abuse and conflict between the siblings and thus suggesting that multiple members of the family were abusive to each other. These findings underscore the importance of looking at all members of the family environment, including siblings, in order to develop a better understanding the abuse-BPD link. In addition, these findings contradict previous findings that suggest that women with BPD have been singled out (Paris, 2008; Zanarini & Frankenberg, 1997) since the non-BPD sisters recalled similar risks experiences of childhood abuse, parental psychopathology and family dysfunction. The non-BPD sister also reported that these experiences impacted them the same way and that the effects were profound and continuous. These findings present a salient contribution to the field by highlighting that how in spite of similar experiences there were differences in the sister pairs attributions and perceptions of the abuse experience. For example, the women with BPD saw their mental health outcomes as products of their more severe experiences of sexual abuse and the multiple perpetrators. The sister pairs also suggested a story of how BPD develops and the relationship of how parental psychopathology leads to increase abuse experiences and that these abuse experiences can leads to BPD. These links represent new contributions to the field. A unique feature of this study is that by looking at pairs of sisters we get a broader perspective on the abuse experiences. This study is the first of its
kind to qualitatively compare pairs of sisters where one has the diagnosis of BPD and the other is discordant despite their shared childhood risks. Looking at both sisters and their experiences provided an understanding of the “human” side of risk linked to BPD and thereby giving a voice to those women who have been victims of maltreatment. Exploring their experiences and outcomes provided an added layer of knowledge and understanding to the majority of quantitative studies in this area of study. Moreover, giving voice to the sisters without a diagnosis but who have experienced similar childhood adversities can broaden our understanding of maltreatment and psychopathology since they are not well represented in the research.

As the first study examined the depth and breadth of experiences of risks factors linked to the development of BPD in pairs of sisters, the women indicated more shared risks experiences including similar experiences of severity of abuse and abusers within the same family, experiences of parental psychopathology, and family dysfunction. These shared experiences of risks could suggest an increased likelihood of poor adaptation which is the case for the women with BPD. The fact that developing a personality disorder is an outcome of only one sister in the pair in spite of their acknowledgment that adversity was present for both challenges the widely held notion that adversity has a direct implication for psychopathology. However, the mechanisms through which one sister withstood these risks experiences have yet to be fully elaborated. This underscores the necessity of expanding the research to enhance our understanding of resilience through the exploration of protective factors (Collishaw, et al., 2007).

Results for study 2 support previous research findings suggesting that individual, familial, and external protective factors (Werner, 1990) are important in buffering the negative effects of risk factors and moderating the development of psychopathology.
These findings agreed with previous quantitative results on protective chains and ripple effects (Rutter, 1993; Walker, 2001) and that the cumulative effects of protective factors are more effective in mitigating the negative effects of risks. The findings also support the importance of a social support network external to the family that is an established feature of resilience and supported in numerous empirical studies (Afifi & MacMillan, 2011). Additionally, the findings from this study suggest two factors that did not easily fit with the currently accepted resilience framework (individual, family, external protective factors). The sisters described how acceptance of the past and purpose through the meaning of children were related to positive mental health outcomes. Acceptance of the past was described by the non-BPD sisters as their ability to let go, detach themselves from their abusive and dysfunctional past, move forward, work through their adversities, and accept the deleterious effects of their childhood, and the flaw within their families of origin. The non-BPD sisters’ narratives are reflected in components of dialectical behavioural therapy (DBT) that highlights the importance of acceptance and mindfulness skills that underscore the important of being “in the moment”. These findings from this study bolster the conceptual underpinning of DBT and may point to potential mechanisms that may make DBT effective. Another contribution is the novel factor of the meaning of children described by both of sisters. The fact that parenthood occurred later in these sisters’ lives can be related to the notion of looking at positive life experiences that occur later in life to promote recovery from psychopathology. A new concept in the resilience research, recovery from psychopathology (Skodol, et al., 2007) explores positive life experiences that can help people to cope and overcome their adversities and improve their mental health. Women with BPD discussed how having children made them want to get better and improve and thus having purpose linked to other people may promote recovery
from BPD and adult resilience. These findings illustrated the need not only to study the factors that protect against developing psychopathology but also understand those factors be related to recovery and health promotion.

**Implications for Clinical Practice**

There are a number of clinical implications that stem from these findings for vulnerable individuals who are at risk for developing psychopathology. Clinical interventions with a resilience focus (i.e., listening to clients’ narratives for evidence of strengths, interests, hopes) that are designed to develop personal strengths, resources, and competencies across multiple domains could be helpful for vulnerable individuals at risk of developing psychopathology. Clinicians should be knowledgeable of risk and protective factors linked to resilience so that assessment not only have a deficit focus but also one where they are able to identify protective factors specific to coping with the risk and developing resilience to the risk. The current findings also suggest that assessment and treatment should take into account aspects of the individual’s risk and protective factors in the family and outside the family.

Clinical interventions with treatment approaches that specifically target interpersonal effectiveness, mindfulness skills, emotional regulation, and limit setting such as DBT (Linehan, 1993), schema focused therapy (Young, Klosko, & Weishaar, 2003), and multiple family group program (Gunderson & Berkowitz, 2006) are needed for recently diagnosed individuals with BPD. When we take the content of the non-BPD sisters’ narratives, they suggest that skills like boundary setting, acceptance, distress tolerance, interpersonal effectiveness, mindfulness, and emotional regulation must be the focus of intervention. Indeed, clinicians need to listen more carefully to their clients’ narratives.
Specifically, clinical interventions that help women with BPD to develop interpersonal skills and access social support networks seem logical. Probably one of the most salient findings is that the majority of the non-BPD sisters identified the importance of an external social support network as key to their positive outcome. Psychosocial programs and clinical interventions should explore specific ways to promote the use of social supports as a protective factor. Expanding the social network of women with BPD might be facilitated by relationship based therapies where clinicians develop trusting relationship with these vulnerable individuals as a way to increase their capacity to trust and seek out assistance from others.

Furthermore, youth programs that provide psycho-education on mental illness, that promote social, emotional, cognitive, behavioural competencies may be helpful in buffering the effects of at risk family environments. Programs that provide psycho-education and promote competencies can identify and target key factors that can reduce stress and vulnerability in high-risk situations, foster coping and healing of at risk situations, and empower individuals to overcome prolonged adversity.

**Directions for Future Research**

The combined results from study 1 and study 2 indicate that continued research on the experiences of risk and protective factors linked to the development of BPD is warranted. Additional research is needed to understand not only the protective factors that assist in buffering the negative effects of risks but also how an individual can recognize and access these protective factors. By having a better understanding of protective factors we can look at specific ways to promote their use within the individual, family, and external environment. More specifically, the role of social support within external networks such as schools, communities, and clinical settings needs to be better
understood. The findings suggest that the traditional view of risk factors as directly responsible for maladaptive outcomes may need to be explored further. There is some suggestion that exposure to risk might act as inoculation (i.e., steeling effect) to negative events and thus strengthen individuals for further risks and this could explain the outcomes of the non-BPD sisters (Rutter, 2006). While this argument might help explain the non-BPD sisters’ outcomes it does little for our understanding of those with BPD. Thus more research is needed to understand those conditions under which risk factors actually strengthen an individual and allow steeling to happen.

The findings of this study suggest that more research is needed to understand how sexual abuse is linked to the development of BPD. Numerous empirical studies have linked sexual abuse to the development of BPD and clearly this risk factor plays a role in this disorder (e.g., Bandelow, 2005; Zanarini, 2000). However since the sister pairs’ narratives of their understanding and explanations for their differential psychological outcomes related to this risk factor differ, further clarification is needed. The women with BPD suggest that multiple perpetrators might account for their increase in symptomology and psychopathology, whereas the non-BPD sisters attributed the different mental health outcomes to the severity of the sexual abuse; thus, the source of the report should also be further examined for its moderating effects and to explore which attributions are most relevant to the development of BPD. Further research could also examine how the women with BPD come to have experienced multiple forms and highly severe victimized conditions.

Moreover, the findings suggest a narrative of how BPD develops and relationships among parental psychopathology, abuse, and BPD. The sister pairs’ narratives suggested that parental psychopathology leads to an increase in abuse experiences and this increase
can lead to the development of BPD. However, the meditational role of parental psychopathology and the strength of these effects remain directions for future research. A meditational analysis that seek to quantify the importance of the relationship among these variables seems warranted in developing a understanding of the risk factors involved in the aetiology of BPD.

These findings suggest that the family environment plays a significant role in the development of BPD in that all members of the family are involved in the dysfunctional and abusive behaviours. These sister pairs’ accounts provided evidence that abuse was not confined to their parents but rather multiple members of the family, including siblings, were abusive to each other. Sibling abuse is an important aspect of the family environment adding another layer of dysfunction and needs further inquiry to help us develop an understanding of its unique contribution to BPD.

The findings suggest new areas of exploration within the field of resilience- the notion of recovery from psychopathology. This relatively new notion, recovery from a personality disorder like BPD suggests that we search for positive life experiences that might help people improve from BPD from those for whom the disorders persist. The women with BPD narrated that having children was a reason they wanted to get better. Perhaps their children provide them with purpose and motivation for self improvement. More research can look at how life events that promote meaning, purpose, and motivation in women who have experienced adversities and are at risk for developing psychopathology. Thus, it is germane to search for positive life experiences as protective factors that can help people cope and overcome their risks.

Taken together, these two manuscripts provide a solid basis for future research studying siblings of women with BPD, on exploring the dynamics within the family, and
giving a voice to other family members who have often been ignored and underrepresented in the research. In addition, these two manuscripts provide a solid rationale for more qualitative research that provides insight into the human side and lived experiences of individuals with a BPD diagnosis. Qualitative studies that attend to the voices of individuals with BPD and capture the richness of their experiences can add depth and breadth and provide another layer of understanding to our current knowledge base.

Summary

The current program of research sought to explore the experiences of risk and protective factors linked to the development of BPD. Qualitative data analytic methods, thematic analysis (Braun & Clarke, 2006) and a multiple case study (Stake, 2006) were employed to explore sister pairs’ experiences of childhood adversities and their differential psychological outcomes. The findings of the two manuscripts provide an in depth understanding of the experiences of risks that increase the likelihood of developing BPD and the protective factors that buffer the risks associated with developing this disorder. Clinical interventions require a shift to resilience to prevention and treatment of mental disorders that tap into individuals’ strengths, resources, and skills, knowledge of protective factors as well as risk factors, and what strengths also exist in the individuals’ family and environment that can be improved. These findings suggest that more research is warranted in developing an understanding of how an individual can recognize and access their protective factors. Also more research is needed to understand the relationship and the meditational role among risk factors. Furthermore, given that resilience can teach us about health and human adaptation, research should look for additional novel protective factors that buffer risks and prevent psychopathology.
Bibliography


Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS


Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS


153


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Running Head: A QUALITATIVE EXPLORATION OF PAIRS OF SISTERS


Yen, S., Shea, M.T., Battle, C.L., Johnson, D.M., Zlotnick, C., Dolan-Sewell, R., ...


Appendix A: Interview Protocol

1. Do you feel different from your sister? How do you explain it?
2. Do you feel that your parents treated you differently? How do you explain it?
3. Do you feel that there is somebody in your family that resembles you?
4. Is there a history of mental health difficulties in your family? To your knowledge, anybody ever experience burn out or a nervous breakdown?
5. Did these problems affect you when you were young? How? What about now?
6. Do you feel that what happened in your childhood had an impact on your present life?
7. Presently, how would you describe your life in these 3 domains, relationships, and work, social?
8. Presently, when things are not going well, whom do you rely on/ confide in/ share with? (e.g., explore the participant’s ability to form social supports)
9. When you were a child, did you have somebody to confide in when things were not going well? (e.g., explore the participant’s ability to form social supports in childhood and adolescence)
10. Is there anything you would like to add that I forgot to ask?
Table 1: Characteristics of Participants

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<th>Current relationship status</th>
<th>Current Employment status</th>
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### Table 2

Summary of Overarching Themes, Themes and Subthemes from the Thematic Analysis of the 12 Pairs of Sisters (Manuscript 1)

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Table 3

Summary of Overarching Themes and Themes from the Cross-Analysis of the 12 Pairs of Sisters (Manuscript 2)

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