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IMPACT OF CHILDHOOD TRAUMA ON SOCIAL FUNCTIONING AND QUALITY OF LIFE IN INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER (BPD)

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Abstract

A complex psychiatric condition known as borderline personality disorder (BPD) is recognized to have a significant negative impact on a person's social adjustment and quality of life (QOL). The study aimed to investigate how childhood trauma affected the social functioning and overall quality of life among those individuals who had been diagnosed with borderline personality disorder (BPD). About 100 individuals with Borderline Personality Disorder (BPD) were enrolled in a cross-sectional study that used quantitative methods and a convenient sampling strategy. These patients met the required inclusion criteria for the study and were chosen from different hospitals in Peshawar. The Childhood Trauma Questionnaire (CTQ), the Social Adjustment Scale (SAS), and the Quality of Life Enjoyment and Satisfaction Scale (Q-LES-Q) were used in the data collection process, along with a structured self-reported questionnaire that included key demographic variables. The significant differences among borderline personality disorders with childhood trauma and without childhood trauma on social adjustment and quality of life were measured using independent sample t-test. Overall the results showed significant results on social functioning ($t(98)= 2.15$, $p < 0.05$) and quality of life ($t(98)= 6.48$, $p < 0.05$). Additionally, significant gender differences were also found. This

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research advances knowledge on the connections among childhood trauma, social functioning, and quality of life in BPD sufferers and provides insightful information for future research projects as well as therapeutic practice.

Introduction

Individuals' thoughts, feelings, and interactions with the outside world are significantly affected by personality disorders, which are a broad and complicated category of mental health illnesses. These disorders are characterized by persistent and pervasive patterns of thought, emotion, and behavior that dramatically depart from societal norms and cause discomfort, functional impairment, and challenges in establishing and sustaining relationships. Moreover, understanding the breadth and depth of human psychology and mental health greatly depends upon personality disorders (Sansone & Sansone, 2011; Rn et al., 2022; Burchett et al., 2023). According to a study, up to 25 percent of patients in primary care have personality disorders, which typically co-occur with additional needs for mental and physical health (Chanen & Nicol, 2023). According to studies, more than half of clients of community mental health services who are formally assessed have a personality problem (Keown et al., 2002). In specialized teams, such as those dealing with assertive outreach, this percentage rises to up to 90% of patients (Ranger et al., 2018). Despite all of this, personality disorder is frequently misdiagnosed, which probably limits the implementation of efficient management techniques. Although the conventional conceptualization of personality as having various types of disorders is refuted by a number of sources (Livesley, 2007).

Among numerous personality disorders, Borderline Personality Disorder (BPD) stands out as a distinctive and clinically significant condition. Like other personality disorders, BPD is a wide and complicated category of mental health issues that has a significant impact on how people think, feel, and interact with their environment (Şenol, 2023). It is critical to understand the intricate relationships among childhood trauma, social functioning, and quality of life in the context of people with Borderline Personality Disorder (BPD).

The development of personality disorders (PDs) is usually linked to adverse childhood experiences including abuse and neglect; nevertheless, research on the early lives of the

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majority of PD groups is still rare. The multisite study of Battle et al., (2004) include 600 patients with either a personality disorder i.e. borderline, schizotypal, avoidant, or obsessive-compulsive disorder, or major depressive disorder without personality disorder had their self-reported histories of abuse and neglect evaluated. According to the findings, there is a significant prevalence of childhood maltreatment among people with personality disorders reporting 73% abuse and 82% neglect. As anticipated, compared to other personality disorder diagnoses, borderline personality disorder was more frequently linked to childhood maltreatment and neglect.

A study conducted with an aim to examine the relationship between different childhood adversities and personality disorders in a general population. The results showed that those with personality disorders in the general population were substantially more likely to have experienced a wide range of childhood traumas. Childhood trauma in particular showed recurrent relationships with borderline and other personality disorders. Notably, even after adjusting for a number of other variables, such as mood disorders, anxiety disorders, substance use disorders, multiple personality disorder clusters, and socio demographic characteristics, the strongest relationships were still seen between child maltreatment and neglect and both cluster A and cluster B personality disorders (Afifi et al., 2011). A study conducted with the purpose to investigate how mental and personality issues affect a person's capacity to function socially. The findings showed that there was a significant negative impact on social functioning from personality disorders (Newton-Howes et al., 2008).

Borderline personality disorder

The term 'borderline' was coined by and American psychoanalyst Adolph Stern in 1938. Stern identified a group of individuals who, quite clearly, did not fall into either the psychotic or the psychoneurotic categories. He used the term "borderline" to characterize what he saw as it "bordered" on other disorders (Stern, 1938; Bateman, 2011). The DSM-III first listed borderline personality disorder (BPD) in 1980. The DSM-III's defining criteria have not significantly changed from the DSM-5 (Leichsenring et al., 2023). Borderline personality disorder (BPD) is a mental health disorder (American Psychiatric Association, 2013), which is

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characterized by a pattern of unstable emotions, relationships, negative self-image, and behavior. Individuals with BPD exhibit impulsive behaviors and have difficulty with regulating their emotions, which can lead to mood swings, unstable interpersonal relationships, self-harm and suicidal tendencies (Leichsenring et al., 2011).

The study conducted a prospective examination of the factors leading to and the developmental trajectory of symptoms associated with BPD from infancy to adulthood. The study used 162 people as part of a risky sample and their longitudinal data. Diagnostic interviews were used to determine the number of BPD symptoms at age 28. The study supported the relationships between BPD symptoms, current adult problems (such as self-harm, dissociation, substance use, and interpersonal aggression), and a history of abuse. For example, internal (temperament) and external (e.g., attachment disorganization, parental hostility) influences during early childhood, as well as disturbances across various child functioning domains (e.g., attention, emotion, behavior, relationships, and self-perception) in middle childhood and early adolescence, were found to be significant antecedents of BPD symptoms in adulthood. Additionally, self-perception played a substantial role in mediating the link between attachment disorganization and BPD symptoms. These findings are examined in the context of developmental psychopathology, with a focus on how continuing interactions between people and their environments create self-process disruptions (Carlson et al., 2009).

Borderline personality disorder (BPD) known to be a complex mental health. However, numerous studies have assumed that BPD has to be the outcome of several factors such as neurological, environmental, and genetic rather than a single cause (Baird et al., 2005; Amad et al., 2014; Chapman et al., 2023).

According to Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the prevalence of borderline personality disorder in first-degree biological relatives is approximately five times higher than in the general population. Additionally, there is a higher likelihood of a family history of substance use disorders, antisocial personality disorder, and bipolar or depressive disorders (American Psychiatric Association, 2013). Similarly, the study of Chapman et al., (2023) found that up to 70% of persons with BPD have a history of emotional,

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sexual, or physical abuse. Inadequate maternal attachment, maternal separation, incorrect family boundaries, severe parental psychopathology, and parental substance misuse are other environmental factors that have been associated to the development of BPD. The etiology of BPD is mostly influenced by the interplay of hereditary variables and traumatic experiences in infancy (Leichsenring et al., 2023). Additionally, the study of Amad et al., (2014) suggests that with an estimated 40% heritability, familial and twin studies primarily support the idea that BPD may have a genetic vulnerability at its core. Moreover, neuroimaging studies have also found abnormalities in the amygdala, hippocampus, and medial temporal lobes in people with borderline personality disorder. These studies also show that people with borderline personality disorder misidentify negative emotions (fear, fury, disgust) to neutral faces more frequently than controls or other patients, despite having the perception of happy and upset faces that are similar to those groups. (Crowell et al., 2009; Chapman et al., 2023). Studies on the neurobiology of borderline personality disorder suggest that serotonin and other neuropeptides may operate less effectively in people with the disorder. According to a meta-analysis study, patients with borderline personality disorder fared worse on neuropsychological tests in the areas of attention, cognitive flexibility, learning and memory, planning, speed processing, and visuospatial ability (Baird et al., 2005). The quality of life and social functioning of those with BPD are significantly impacted by childhood trauma, according to emerging research, which also implies that it is a common risk factor for developing BPD. (Zanarini et al., 1989; Paris & Zweig-Frank, 2001; Herman et al., 1989; Ogawa et al., 1997; Gunderson et al., 2016).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) contains the recognized diagnostic criteria for borderline personality disorder. However, five (or more) of the following characteristics, beginning in early adulthood and present in a range of circumstances, suggest a pervasive pattern of interpersonal connections, self-image, and affective instability as well as notable impulsivity:

1. Intense attempts to prevent actual or imagined abandonment.

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2. Alternating between extremes of idealization and depreciation, an unstable and intense interpersonal interaction pattern.
3. Identity disturbance: A self-image or feeling of self that is noticeably and consistently unstable.
4. Impulsivity in at least two situations that have the potential to be harmful to oneself (such as when it comes to binge eating, spending, sex, or using drugs or alcohol).
5. Recurring acts of self-mutilation, suicidal threats or gestures.
6. Affective instability brought on by a high reactivity of mood (such as acute episodic dysphoria, irritation, or anxiety, which rarely lasts longer than a few days).
7. Persistent emptiness in the heart.
8. Unacceptable, extreme anger or trouble managing anger (examples: frequent outbursts of rage, ongoing rage, frequent violent altercations).
9. Severe dissociation symptoms or transient paranoid ideas due to stress (American Psychiatric Association, 2013).

Only those over the age of 18 are diagnosed with BPD (Şenol, 2023). About 75% of female patients with borderline personality disorder have a female diagnosis (American Psychiatric Association, 2013).

According to studies, borderline personality disorder affects between 10 and 20 percent of psychiatric patients as well as 1 to 6 percent of the general population. The condition seems to affect both sexes equally, despite the fact that it was originally believed to be more common in women than in males (Şenol, 2023). Similarly, according to Grant et al., (2008) approximately 1-2% of the population are affected and women are more likely to be affected than man. Although it can reach 5.9%, estimates place the frequency of borderline personality disorder in the general population at 1.6%. Borderline personality disorder affects about 6% of patients in primary care settings, 10% of patients treated in outpatient mental health clinics, and 20% of patients hospitalized to psychiatric hospitals. In later age groups, the prevalence of borderline personality disorder may decline (American Psychiatric Association, 2013).

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There are many variations in the course of borderline personality disorder. While the majority of people start showing symptoms in late adolescence or early adulthood, some people may wait until later in life to seek psychiatric services. The prognosis for people who have gotten treatment or had a professional mental evaluation is better than initially thought, contrary to popular belief. Within five to ten years of receiving the initial diagnosis, research shows that at least half of people with borderline personality disorder significantly improve to the point where they no longer satisfy the diagnostic criteria (Zanarini & Frankenburg, 2003). It is still unclear how much of this improvement is a result of therapy, given that there is evidence to imply that a sizable percentage is spontaneous and associated with growing maturity and self-awareness.

Childhood trauma

Childhood trauma, which includes events like abuse, neglect, or unfavorable home circumstances, has long been acknowledged as a significant factor in how someone develops psychologically and emotionally (Fergusson et al., 1996). Numerous studies and discussions have been conducted on the long-term impact of childhood trauma on mental health and wellbeing, particularly in relation to its connection to psychiatric disorders like BPD. A study conducted by Telfar et al., (2023) found that the likelihood of developing mental health issues as an adult was enhanced by having experienced childhood abuse. More precisely, having experienced severe childhood abuse increased the likelihood of developing a mental health issue by 1.8 to 2.6 times. In addition, Herman and colleagues (1989) discovered that patients with BPD were more likely to report a past history of childhood sexual abuse compared to patients with other psychiatric disorders. Similarly, Bandelow et al., (2005) conducted study regarding traumatic life events that occurred during childhood, patients with borderline personality disorder (BPD) were contrasted with a healthy control group. A thorough retrospective interview with 203 questions about traumatic childhood events was used to examine the patients and control group in the study. The study found that compared to healthy control group, patients more frequently described traumatic childhood events, such as violence, childhood sickness, parental divorce, sexual abuse, and other incidents.

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A study was carried out in order to determine if childhood trauma may have an impact on how often borderline personality disorder affects teenagers who engage in high-risk behaviors. 60 BPD adolescents and 60 non-BPD adolescents were chosen from among 120 people aged 12 to 18. According to the study, all adolescent patients with BPD had some sort of psychotraumatic episode as a child. Compared to the non-BPD group, the BPD group experienced more traumatic incidents. Additionally, within the group of females with BPD, statistically significant relationships between the results of the emotional abuse and eating disorders scales were discovered. In males with BPD, there were moderate associations between emotional maltreatment and suicide behaviors. Additionally, it was discovered that emotional abuse and emotional neglect were the most important contributors in the development of addictive behaviours in adolescents with BPD (Zashchirinskaia & Isagulova, 2023).

Bornovalova et al. (2008) performed a meta-analysis in order to investigate the connection between childhood trauma and interpersonal dysfunction in people with BPD. According to the study, childhood trauma was found to be strongly connected with interpersonal dysfunction in people with BPD, and this association was found to be higher in those with BPD than in people without the disorder. After reviewing a number of studies, Silk (2010) came to the conclusion that there is proof that childhood trauma and BPD are causally related. Furthermore, a study recruited 11,872 subjects from all over the United States for a longitudinal research that followed 9 to 10 year olds. Existing research supports the link between adolescent trauma and emotion-driven impulsivity. The study's objective was to investigate the long-term relationships among childhood trauma and impulsivity motivated by emotions in a sizable nationwide sample of kids. The results demonstrated a correlation between early childhood trauma and higher levels of later impulsivity driven by both negative and positive emotions (Weiss et al., 2023).

Moreover, Bozzatello et al. (2021) undertook a study in order to examine the impact of early traumatic experiences, such as emotional and physical abuse, on the emergence of Borderline Personality Disorder (BPD), from a bio psychosocial perspective. The research also

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looked at the intricate interactions between biological and environmental factors that lead to the development of BPD. The study analyzed data from previous studies on the psychological, social factors, and biological associated with the development of BPD. The researchers found that early traumatic experiences, particularly emotional and physical abuse, are significant risk factors for the development of BPD. The authors suggest that these experiences can lead to alterations in brain structure and function, resulting in emotional dysregulation, impulsivity, and difficulties in social relationships that are characteristic of BPD. The complicated interactions between biological and environmental factors in the formation of BPD were also highlighted by the study. For example, genetic predisposition to emotional dysregulation may interact with early traumatic experiences to increase the risk of developing BPD. Similarly, environmental factors such as family dysfunction, peer rejection, and social stigma can exacerbate the early impact of stressful events and the risk of developing BPD. Overall, the study emphasizes the importance of a bio psychosocial approach to understanding the development of BPD. It emphasizes the necessity for interventions that deal with both the biological and environmental aspects of the condition that contribute to it. These interventions may include psychotherapy, pharmacotherapy, and other types of support to improve emotional regulation, enhance social functioning, and reduce the negative impact of early traumatic experiences on individuals with BPD.

Social functioning

The ability of a person to form and maintain meaningful connections, conform to social standards, and deal with interpersonal difficulties is known as social functioning (Gross & Thompson, 2007). Even while social functioning issues are frequently present in people with BPD, research on the precise contribution of childhood trauma to these issues is still ongoing.

Numerous researches have studied the relationship between social functioning and childhood trauma in BPD sufferers. The study by Zanarini and colleagues (1989) examined how social adjustment is affected by childhood maltreatment in people with BPD. They found that a majority of patients with BPD had experienced childhood physical or sexual abuse, neglect, or emotional abuse. Tragesser et al. (2007) conducted a study to investigate the relationship

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between childhood emotional abuse, interpersonal problems, and social functioning in individuals with Borderline Personality Disorder (BPD). The researchers recruited 57 participants who had been diagnosed with BPD and assessed those using self-report metrics. The Childhood Trauma Questionnaire (CTQ) was used to evaluate the participants' childhood experiences with emotional abuse, the Interpersonal Problems Inventory (IPI) to assess their interpersonal problems, and the Social Adjustment Scale - Self-Report (SAS-SR) was used to evaluate how well they interact with others. The study found that childhood emotional abuse was significantly associated with greater interpersonal problems and lower social functioning in individuals with BPD. Specifically, participants who reported higher levels of emotional abuse during childhood also reported more interpersonal problems, such as difficulty trusting others, feeling rejected, and having problems with intimacy. They also reported lower social functioning, such as decreased social activity, poorer social adjustment, and greater social isolation. The result implies that childhood emotional abuse may have long-term impact on the interpersonal and social functioning of individuals with BPD. The study highlights the importance of early intervention and prevention efforts aimed at reducing childhood emotional abuse and its potential long-term consequences.

Ortega-Díaz et al. (2020) conducted a study to investigate social functioning in individuals with Borderline Personality Disorder (BPD) and their first-degree relatives compared to a control group. The researchers recruited 37 participants with BPD, 37 healthy controls, 24 first-degree relatives of BPD sufferers, and 24 BPD sufferers. They used the Social Functioning Scale (SFS) to evaluate their social functioning. The SFS assesses social functioning across a number of areas, including pro-social activities, interpersonal behavior, social engagement, work, and independence-competence. The study found that both individuals with BPD and their first-degree relatives reported significantly lower social functioning compared to the healthy control group. Specifically, they had lower scores on the pro-social activities, interpersonal behavior, independence-competence, and social engagement domains of the SFS. These findings suggest that social functioning issues may run in families affected by BPD as a trait. This is consistent with previous research suggesting that BPD has a

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strong genetic component, and that a variety of mental and behavioral issues are more likely to affect family members of people with BPD. The study emphasizes the value of evaluating social functioning in people with BPD and their families as social functioning difficulties may have implications for treatment and management of the disorder. It also suggests the potential benefits of family-based interventions aimed at improving social functioning and reducing the risk of social isolation and interpersonal difficulties in individuals with BPD and their family members.

Zanarini et al. (2021) carried out a study, for a deeper comprehension of the associations between childhood trauma, social ties, and social isolation in people with borderline personality disorder (BPD). The researchers recruited 103 participants who had been diagnosed with BPD and assessed those using self-report measures. They used the Childhood Trauma Questionnaire to assess the subjects' exposure to childhood trauma (CTQ), their social ties using the Social Connectedness Scale (SCS), and their level of social isolation using the Social Isolation Scale (SIS). The study discovered that people with BPD who reported more childhood trauma also reported less social interaction and more social isolation. Participants who had experienced emotional, physical, or sexual abuse in childhood specifically reported having less close relationships and having less social contact on a regular basis. They also reported higher levels of social isolation, such as feeling alone, lacking companionship, and having fewer social opportunities. These results imply that childhood trauma may affect BPD sufferers' social relationships and social isolation over time. The study emphasizes how crucial it is to address childhood trauma in the management and treatment of BPD because it may be a factor in the disorder's enduring issues with social interaction and social isolation. This may involve developing interventions aimed at improving social skills, building social support networks, and addressing the underlying emotional and interpersonal challenges associated with BPD.

Quality of life

A person's subjective evaluation of their general well-being and level of happiness with their life, which takes into account physical, psychological, and social characteristics, is referred

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to as their quality of life (The WHOQOL Group, 1995). A crucial area of research focuses on how BPD and childhood trauma affect the afflicted people's quality of life since it illuminates the wider effects of these experiences.

IsHak et al., (2013) study looks at the quality of life for people with borderline personality disorder (BPD). The study illuminates the subjective well-being and life satisfaction of those coping with BPD by using a thorough assessment approach. The results highlight the significant negative effects of BPD on various aspects of quality of life, such as physical health, mental health, and social functioning. This study emphasizes how crucial it is to comprehend the complex problems that people with BPD confront and the requirement for specialized therapies to improve their general quality of life. Recently in 2022 a study was conducted to better understand the psychopathological aspects that affect people with Borderline Personality Disorder (BPD) and their quality of life. The study also investigates the relationship between mental health problems and the general wellbeing and life satisfaction of people with BPD. The results emphasize the significance of psychopathological factors in defining the level of functioning that people with this condition experience (Stefanatou et al., 2022).

Additionally, Guillén et al., (2021) examines how BPD patients' wellbeing and life satisfaction are impacted by their resilience both before and after receiving therapeutic therapies. The results underline resilience's important significance in predicting the level of life satisfaction felt by those with BPD and emphasize its potential to play a substantial role in determining post-treatment outcomes. Moreover, the study by Sansone and Sansone (2013) investigated the relationship between childhood sexual abuse and peoples' general quality of life diagnosed with Borderline Personality Disorder (BPD). The researchers recruited 141 participants diagnosed with BPD and assessed them using self-report measures. The participants' experiences of sexual abuse as children were evaluated using the Childhood Trauma Questionnaire (CTQ), and their general quality of life was assessed using the World Health Organization Quality of Life-BREF (WHOQOL-BREF). According to the study, people with BPD had a lower overall quality of life when they experienced childhood sexual assault. Specifically, participants who reported experiencing childhood sexual abuse had lower scores

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on the WHOQOL-BREF, indicating lower overall quality of life compared to those who did not report experiencing sexual abuse. These findings suggest that childhood sexual abuse may have a long-term effect on BPD patients' overall quality of life. The research highlights the importance of addressing childhood trauma, particularly sexual abuse, in the treatment and management of BPD. This may involve developing interventions aimed at improving overall quality of life, reducing the negative impact of childhood sexual abuse, and addressing the underlying emotional and interpersonal challenges associated with BPD.

J. R. Kuo et al. (2015) conducted a study to examine the relationship between childhood physical abuse and people's physical well-being with Borderline Personality Disorder (BPD). The researchers recruited 137 participants diagnosed with BPD and assessed them using self-report measures. The participants' experiences of physical abuse as children were evaluated using the Childhood Trauma Questionnaire (CTQ), and The World Health Organization Quality of Life-BREF (WHOQOL-BREF) to assess their physical health. According to the study, people with BPD have a lower physical quality of life as a result of experiencing physical abuse as children. Specifically, participants who reported experiencing childhood physical abuse had lower scores on the WHOQOL-BREF physical health domain, indicating lower physical quality of life compared to those who did not report experiencing physical abuse. The results imply that childhood physical abuse may have long-term impact on the physical well-being of individuals with BPD. The research highlights the importance of addressing childhood trauma, particularly physical abuse, in the treatment and management of BPD. This may involve developing interventions aimed at improving physical quality of life, reducing the negative impact of childhood physical abuse, and addressing the underlying emotional and interpersonal challenges associated with BPD.

This study aims to explore the intricate connections among childhood trauma, social functioning, and quality of life in individuals with BPD. We seek to contribute to a greater understanding of the variables that affect the functioning and well-being of people with BPD by carefully analyzing these variables and any potential interactions, which will in turn inform therapeutic interventions and support methods.

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Rationale

The rationale behind this study is to examine how people with borderline personality disorder (BPD) deal with social functioning and quality of life issues as a result of childhood trauma. Traumatic events during childhood continue to shape mentality and manifest in a variety of unpleasant ways, including an antisocial attitude, a depressive way of life, and a loss of motivation for anything. There are still gaps in the research on BPD, despite the substantial progress that has been made in recent years. The lack of valid diagnostic criteria is one of the biggest gaps. Many clinicians rely on subjective evaluations, which might result in under or over diagnosing BPD. As a result, those who have BPD might not get the proper treatment, and those who don't have it might mistakenly be given the disorder's categorization. Additionally, a past history of childhood trauma, such as sexual or physical abuse, is frequently linked to BPD. However, it is still unclear exactly how trauma contributes to the emergence of BPD, there is still much that needs to be done to close these gaps and enhance the lives of those who are affected by this complex condition. The importance of this study lies in the potential to advance our understanding of how childhood trauma affects social functioning and quality of life in BPD patients residing in Peshawar, Pakistan. The results of this study may aid mental health experts in creating effective therapies to enhance the social functioning and general quality of life of BPD sufferers who endured traumatic events in their childhoods. The research is also essential for increasing understanding of how childhood trauma affects mental well-being and the significance of early treatments to stop long-term negative consequences. The results of the study might also affect how BPD is identified and treated. People with BPD may experience a major impact from the significant relationship on their quality of life and social functioning. It may be important to include screening for childhood trauma in the diagnosis process. Similarly, therapies that address childhood trauma may be required to enhance treatment results if it is discovered that social functioning and standard of life of patients with BPD are negatively impacted by childhood trauma. Therefore, the basic aim of this research is to examine the relationship of social functioning, and quality of life with childhood trauma in borderline personality disorder (BPD) patients.

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Objectives

1. To assess the relationship between quality of life and childhood trauma among individuals with BPD.
2. To find out the association between social functioning and childhood trauma in individuals with BPD.

Hypotheses

1. There will be a difference in social functioning between BPD patients with and without a history of childhood trauma
2. There will be a difference in quality of life between BPD patients with and without a history of childhood trauma.

Methodology

The methodology chapter act as a fundamental framework for the research study, it also provides the organized structure through which information is gained, queries are addressed, and understanding is deepened. This chapter describes how to negotiate the complexities of research design, data gathering, and analysis, as well as the ethical issues that direct the study.

Sample

It was a correlational study for which the data was collected using a convenient sampling method from patients diagnosed with borderline personality disorder in Peshawar, Pakistan. The total number of participants (n=100) was divided into two groups; comprising of patients who have not had a traumatic childhood and those who had.

Participants were recruited from psychiatric clinics, mental health clinics, and hospitals in Peshawar such as Khyber Teaching Hospital (KTH), Lady Reading Hospital (LRH), and Hayatabad Medical Complex (HMC). Data was collected using questionnaires, and clinical assessments.

Inclusion criteria:

- Adults in KP who have received a BPD diagnosis from a licensed mental health professional was included in the study.
- They ranged in age from 18 to 30 years.

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Exclusion criteria:

- Individuals above or below the specified age range, i.e., 18 and 30 years were excluded from the sample.
- Individuals who had a history of psychological, neurological, or other serious illnesses were excluded from this study.

Instruments

The study measures included the demographic sheet, the Childhood Trauma Questionnaire (CTQ), the Quality-of-Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) and the Social Adjustment Scale (SAS).

Demographic sheet

Data on the participant's age, gender, family structure, and prior history of mental health treatment was collected using the demographic information sheet.

Childhood Trauma Questionnaire (CTQ)

David P. Bernstein and Laura Fink developed the Childhood Trauma Questionnaire (CTQ) in 1998 as a self-report instrument to evaluate maltreatment during childhood, including sexual, emotional, and physical abuse, as well as emotional and physical neglect. It consists of 28 items that are categorized into five subscales representing different types of maltreatment. Each item is rated by respondents on a five-point scale, with a higher score suggesting more traumatic experiences as a child. Through its widespread use in research and clinical settings, the CTQ is demonstrated to be a valid and reliable tool for assessing childhood trauma, with Cronbach's alpha values ranging from 0.79 to 0.96.

Social Adjustment Scale (SAS)

The Social Adjustment Scale (SAS), developed by Weissman and Bothwell in 1976 as a self-report instrument is used to evaluate social functioning across a variety of contexts, including job, leisure activities, and relationships with family, friends, and significant others. It comprises 54 items which are scored on a Likert scale of 1 to 5, where 1 represents very good adaptability and 5 extremely poor adaptability. Higher scores imply lower social adjustment. The SAS has been extensively used in research and clinical settings to assess social functioning in different

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populations, including individuals with borderline personality disorder. With Cronbach's alpha coefficients ranging from 0.61 to 0.73, the SAS has shown strong reliability and validity as a measure of social adjustment.

Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)

In 1997 Frank J. P. Culhane, David J. Broussard, and Jean Endicott created the Q-LES-Q questionnaire to evaluate a person's level of enjoyment and satisfaction in various facets of life, including physical health, interpersonal relationships, and leisure activities. The Q-LES-Q is made up of 93 items reported on the Likert scale ranging from 1 (very poor) to 5 (very acceptable) on a scale of 5. The scale's higher scores correspond to greater happiness and enjoyment in numerous facets of life. It has been shown that the Q-LES-Q is a valid and its Cronbach's alpha value of 0.83 makes it reliable as an indicator of quality of life in a variety of demographics, including people who suffer from mental illnesses such borderline personality disorder.

Procedure

To facilitate the data collection process, formal approval was diligently sought from the head of the hospital's psychiatry ward, who served as the primary administrative figurehead in charge of managing patient-related research efforts inside the psychiatric department. Individuals who were eligible to participate in the study were sensitively approached and went through an in-depth informed consent process after receiving the necessary institutional clearances. This critical stage made sure that those voluntarily participating in the research understood the goals, potential consequences, and voluntary nature of their involvement.

Participants were attentively informed of the broad objectives and scope of the research after providing their informed consent. Additionally, the vital demographic data was thoroughly gathered in order to confirm that they adhered to the stated inclusion criteria, improving the reliability and precision of the study. A series of standardized questionnaires, including the Childhood Trauma Questionnaire (CTQ), Social Adjustment Scale (SAS), and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q), were then attentively

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given to the participants. In order to ensure that participants felt encouraged and empowered throughout the data collection process, clear instructions were provided.

Participants received sincere and enthusiastic acknowledgment for their invaluable contributions and their generous time gift to further the study of mental health. This act of gratitude served to recognize their involvement and to reaffirm the study's ethical commitment to each participant's well-being and dignity.

Ethical consideration

The exacting ethical standards that apply to any study involving human subjects were strictly followed in this work. All prospective participants were sincerely asked for their explicit and informed consent prior to participating in the survey, stressing their autonomy and their freedom to withdraw at any time without penalty. In addition, the research project's consistent commitment to maintaining participant confidentiality was upheld at all times. In order to ensure that the participants' well-being remained of the utmost importance, participants were also thoughtfully provided with thorough information regarding accessible mental health resources and a variety of support services.

Data analysis

The statistical program for social sciences (SPSS) 26th edition was used to analyze the data and produce the findings. An independent sample t-test was applied to examine the link between childhood trauma, social functioning, and quality of life in individuals with BPD.

Results

The results chapter provides a thorough summary of the conclusions drawn from the study's methodology as the product of meticulous investigation and data analysis. It also aims to provide a clear, evidence-based narrative that directly addresses the research questions and achieve the study's stated goals, adding to the body of knowledge in the field of inquiry and fostering a deeper grasp of the subject. This is accomplished through a methodical exploration of the results.

A total of 100 participants with borderline personality disorder, including 50 patients with childhood trauma and 50 patients without childhood trauma were recruited in order to

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provide a diverse sample for a more in-depth analysis of the study concerns. Understanding the potential effects of gender, age, family structure, and early trauma in the context of the study is facilitated by the complete assessment of the samples demographics (see table 1 for additional information). The first stage is to provide an overview of the demographics of the research participants and to describe their distribution frequencies (details are given in Table 1). Table 2 demonstrates the reliability and internal consistency of the scales employed in the study. Table 3 contains the scale's descriptive statistics. To test the significant mean difference among borderline personality disorder with childhood and without childhood trauma patients, independent sample t test was used. Table 4 shows the details about the mean differences of borderline patients (with/ without childhood trauma) on social adjustment scale. Whereas, the mean difference between patients of borderline personality disorder with and without childhood trauma on quality of life enjoyment and satisfaction scale are shown in table 5 respectively.

Table 1

Demographic information of the subjects

	F	*%*
Gender		
Male	36	36
Female	64	64
Age		
18	18	18
19	12	12
20	18	18
22	10	10
23	10	10
24	10	10
25	10	10

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26	4	4
29	4	4
30	4	4
Family structure		
Joint family	70	70
Nuclear family	30	30
Childhood trauma		
BPD patients with childhood trauma	50	50
BPD patients without childhood trauma	50	50

Note: f=frequency, *%*=percentage

Table 1 presents the demographic information of the study's participants. According to their demographic data 100 participants recruited for the study are a diverse group of people. According to the table, 64% of participants identified as female, as opposed to 36% of participants identified as male. The participants' ages varied, with 48% of the sample consisting of people between the ages of 18 and 20, which is considered to be the majority age group. The majority of the participant's family structure consisted of joint families, which made up 70% of the sample, and nuclear families, which made up the remaining 30%. Additionally, the sample's response to the question on past childhood trauma was evenly split, with 50% of participants indicating they had and the other 50% had not.

Table 2

Psychometric Properties of the Scales

Scales	*No. of items*	*M*	*SD*	Coefficient Of alpha
CTQ	28	49.78	8.016	.745
SAS	54	85.04	18.28	.727

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Q-LES-Q	93	226.1	36.28	.910

Note; CTQ= Childhood Trauma Questionnaire, *SAS=* Social Adjustment Scale, *Q-LES-Q=* Quality of Life Enjoyment and Satisfaction Scale, M=Mean, SD=Standard Deviation,

Table 2 indicates that the scales utilized in the study's psychometric properties show good reliability. The Childhood Trauma Questionnaire (CTQ) made up of 28 items, produced a mean score of 49.78 and a standard deviation of 8.016. With a coefficient alpha of 0.74> 0.70, it demonstrated remarkable internal consistency and reliability. With 54 items, the Social Adjustment Scale (SAS) generated a mean score of 85.04 and a standard deviation of 18.28. With a coefficient alpha of 0.72> 0.70, indicating good internal consistency, further demonstrating its dependability in gauging social adjustment. The Quality of Life Scale (Q-LES-Q) with 93 items yielded a mean score of 226.1 and a standard deviation of 36.28. It revealed excellent internal consistency, as reflected by a coefficient alpha of .910> 0.70, affirming its reliability in evaluating quality of life and satisfaction.

Table 3

Descriptive Statistics of the Scales

Scales	*M*	*SD*	Skew	Kurtosis	Range	Min-Max
Childhood trauma questionnaire (CTQ)	63.72	7.50	-.42	-.14	44	44-78
Social adjustment scale (SAS)	85.04	18.28	.48	.92	97	51-148
Quality of life enjoyment and satisfaction scale (Q-LES-Q)	225.9	36.37	-.40	-.41	155	137-292

Note: M=Mean, SD=Standard Deviation

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Table 3 presents the descriptive statistics of childhood trauma questionnaire, social adjustment scale, and quality of life enjoyment and satisfaction scale. The skewness values, which range from -1 to 1, show that the data distribution for the used scales follows a normal distribution.

Table 4

T values showing difference between BPD patient with childhood trauma and without childhood trauma on the social adjustment scale.

	With childhood trauma (n=50)		Without childhood trauma (n=50)				
Variables	*M*	*SD*	*M*	*SD*	*t*(98)	*P*	Cohen's *d*
SAS	81.18	16.88	88.90	2.68	2.15	0.03	0.63

Note: SAS= Social Adjustment Scale, *M*= mean, *SD*= standard deviation; *P*= probability

Table 4 indicates the mean differences for borderline personality disorder patients on social adjustment scale. An independent sample t test was conducted in order to find the mean differences among borderline personality disorder (BPD) patients with childhood trauma (n=50) and patients without a history of childhood trauma (n=50). The data shows that BPD patients without childhood trauma had significantly higher SAS scores (*M*=88.90, *SD*=2.68) than BPD patients with childhood trauma (*M*=81.18, *SD*=16.88). A statistically significant difference is shown by the t-statistic (t(98)= 2.15, p< 0.05), and the corresponding p-value (p=0.03 < 0.05). Cohen's d indicates that the effect size is 0.63, which denotes a moderate effect. According to higher SAS scores, these results suggest that BPD patients with no history of childhood trauma tend to have better social adjustment than those with such a history.

Table 5

T values showing difference between BPD patient with childhood trauma and without childhood trauma on the quality of life enjoyment and satisfaction scale.

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	With childhood trauma (n=50)		Without childhood trauma (n=50)				
Variables	*M*	*SD*	*M*	*SD*	*t*(98)	*P*	Cohen's *d*
Q-LES_Q	206.16	33.62	245.80	27.20	6.48	0.00	1.29

Note: Q-LES-Q= quality of life enjoyment and satisfaction scale, *M*= mean, *SD*= standard deviation; *P*= probability

Table 5 shows the results of independent sample t-test between two groups of Borderline Personality Disorder (BPD) patients, among which 50 were those who had a history of childhood trauma and 50 without a history of childhood trauma on Quality of Life Scale (Q-LES-Q). The results analysis revealed a substantial difference in Q-LES-Q scores, with BPD patients with a past history of childhood trauma scores significantly lower (*M*=206.16, *SD*=33.62) than those who had not had childhood trauma (*M*=245.80, *SD*=27.20). The t-statistic (t(98)= 6.48, p> 0.05) and the corresponding p-value is 0.00, both of which show that the difference is highly statistically significant. Whereas, Cohen's d-effect size is 1.29, which denotes a significantly large effect. Additionally, the findings indicate that patients with BPD who have experienced trauma as children likely to report lower levels of quality of life satisfaction and enjoyment on the Q-LES-Q compared to those without such a history, underlining the important influence of childhood trauma on their overall quality of life.

Discussion

This study examined how childhood trauma affected people diagnosed with borderline personality disorder (BPD) in terms of social functioning and quality of life. The section will delve into potential explanations for the results of the study, their correspondence with the previous studies, their clinical ramifications, and directions for future research.

In this study, the first hypothesis proposed that there would be a significant difference in social functioning between Borderline Personality Disorder (BPD) patients who had a history of childhood trauma and those without a history of childhood trauma. The

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findings of this study are consistent with a growing body of literature that consistently shows a high correlation among childhood trauma and poor social functioning in BPD sufferers (Zanarini & Frankenburg, 2003; A. L. Chapman, 2019; Linehan, 2018). Prior research has consistently shown that people with BPD who have experienced childhood trauma tend to display more serious interpersonal difficulties, such as difficulties establishing and maintaining stable relationships, higher rates of conflict, and issues with emotional regulation in social settings (Bornovalova et al., 2008). The hypothesis that was examined in this study is supported empirically by these consistent findings.

The observed variations in social functioning between BPD sufferers with and without a history of childhood trauma can be explained by a number of reasonable arguments. The severe effects of early trauma on attachment patterns and interpersonal behaviors may be one important cause. Childhood trauma frequently prevents the formation of strong attachment ties, which causes people to adopt unhealthy coping mechanisms including emotional deregulation, mistrust, and impulsivity, which are the essential features of BPD (Bandelow et al., 2005; A. L. Chapman, 2019; Tragesser et al., 2007). As a result, individuals with BPD who have experienced childhood trauma may find it especially difficult to forge and keep stable, wholesome relationships, which is shown in lower scores on the Social Adjustment Scale (SAS). Additionally, the long-lasting psychological effects of childhood trauma, such as post-traumatic stress disorder symptoms and increased emotional sensitivity, might make it more difficult to operate socially. Hyper vigilance, emotional disengagement, and trouble expressing emotions correctly in social settings are some examples of the manifestations of these symptoms. As a result, BPD patients with a history of trauma would encounter more difficulties in effectively interacting with others, which could explain the observed variations in social adjustment scores.

These findings have important relevance for future study as well as clinical practice. The findings highlight the vital need for systematically screening and treating childhood trauma among those with BPD in clinical practice. The development of specialized treatment strategies can be guided by an understanding of how trauma affects social functioning. Within the

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context of BPD treatment, therapists need to think about incorporating trauma-focused therapies and addressing attachment-related problems (Linehan, 2018). Moreover, an extensive, multidisciplinary approach to treatment is also essential because of the connection between childhood trauma and poor social functioning in BPD patients (Ortega-Díaz et al., 2020). The likelihood of enhanced social functioning for this population can be increased by incorporating social skill development, emotion control tactics, and trauma processing procedures into therapeutic interventions.

The second hypothesis of the study proposed that Borderline Personality Disorder (BPD) patients who had a history of childhood trauma would have a significantly lower quality of life than people without such a history. The findings of this study are consistent with previous studies demonstrating a strong relationship between childhood trauma and decreased quality of life in people with BPD. According to previous study results by () people with BPD who experienced childhood trauma typically display a lower overall quality of life, as seen by lower levels of life satisfaction, enjoyment, and fulfillment. The hypothesis that was the subject of this investigation is supported empirically by these consistent findings.

The significant differences in quality of life between BPD suferers with and without a history of childhood trauma can be attributed to a number of reasons. The persistent psychological pain linked to childhood trauma is one important element. Trauma survivors frequently struggle with ongoing emotional deregulation, increased susceptibility to mood disorders, and problems handling stress. These symptoms can diminish a person's overall life satisfaction, making it difficult for BPD patients with a trauma history to find satisfaction and happiness across a variety of spheres of their lives. Furthermore, there may be a bidirectional relation between childhood trauma and the symptoms of Borderline Personality Disorder (BPD). Moreover, the childhood trauma may make BPD symptoms worse, resulting in more severe emotional and social problems that, in turn, lower quality of life. Additionally, there may be a cyclical relationship between worsening BPD symptoms and a lower quality of life. Therefore, the observed variations in quality of life might be an effect of the intricate interactions between childhood trauma, BPD symptoms, and general well-being.

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These findings have important ramifications for clinical practice and future study. The findings highlight how crucial it is in therapeutic practice to address how childhood trauma affects the quality of life for people with BPD. Therapists and other mental health practitioners should be aware of individuals' trauma histories and how these could affect their general wellbeing. For BPD patients who have suffered childhood trauma, tailored interventions such as trauma-informed care and methods to strengthen emotional control and coping skills should be taken into consideration. Additionally, the significant effect size (Cohen's d = 1.29) implies that the cumulative effects of childhood trauma on BPD patients' quality of life are significant. Due to their lowered quality of life, people with BPD who have suffered trauma urgently need extensive assistance and services. This could lead to ongoing suffering and diminished functioning.

Conclusion

The main aim of the current study was to explore how childhood trauma affected people with borderline personality disorder (BPD) in terms of social functioning and quality of life in the clinical population of Peshawar, Pakistan. Strong empirical data revealed significant disparities in social functioning and quality of life between BPD patients with and without a history of childhood trauma, supporting the proposed hypotheses of the study. The main inferences, implications, and their overall importance for clinical practice and research in mental health have been outlined in this section.

The findings of the study revealed that BPD patients with a history of childhood trauma had considerably lower social adjustment scores than those without that background. Additionally, the findings showed a significant difference in the overall quality of life, as trauma-exposed BPD patients reported significantly lower levels of life satisfaction and enjoyment. These results are consistent with other studies emphasizing the negative impacts of trauma on the quality of life and social functioning in this population, and they indicate the significant influence of childhood trauma on the overall well-being of people with borderline personality disorder.

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Consequently, this research illuminates the crucial connections between childhood trauma, BPD, social functioning, and quality of life. The evidence put forth emphasizes the urgent requirement for a comprehensive strategy for assessment and intervention in clinical practice. We can give people with BPD the potential for improved social adjustment and a more fulfilled life by recognizing the long-lasting impacts of childhood trauma and modifying therapeutic procedures accordingly.

Limitations and Suggestions

Following are the limitations and suggestions of the research study,

- The current study is limited to the clinical population of Peshawar.
- Sampling bias exists because the sample only included people who had BPD; more groups should be included for generalizability.
- The causal relationship cannot be inferred from cross-sectional designs, hence longitudinal designs should be used in future studies.
- Reliance on self-report metrics may result in biases in response.
- Future studies should address the potential influence of unexplored third variables, such as comorbid conditions or current stressors.
- Future research should examine how treatment characteristics affect outcomes since the present study did not consider the prior treatment histories or therapy attendance of patients.
- Longitudinal studies should be performed to examine the development and progression of BPD symptoms, social functioning, and quality of life in people who have gone through trauma in childhood.
- To further understand the connection between childhood trauma, BPD, and outcomes, mediating and moderating factors such as attachment types, coping mechanisms, and social support networks should be examined in future studies.
- Future research shall examine the efficacy of individualized therapy approaches for BPD patients who experienced childhood trauma, including trauma-focused therapies and integrated treatments.

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- Future research should use a more diverse and culturally representative sample to take cultural influences on trauma and BPD outcomes into account.
- Future research should conduct comparative studies with different clinical populations to discover whether the correlations revealed in BPD are unique or common.

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