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PREDICTIVE EFFECT OF POSITIVE CHILDHOOD EXPERIENCES ON  
PERSONALITY DISORDERS ”

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## THE MEDIATING ROLE OF PSYCHOLOGICAL RESILIENCE IN THE PREDICTIVE EFFECT OF POSITIVE CHILDHOOD EXPERIENCES ON PERSONALITY DISORDERS

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### ABSTRACT

This study aims to examine the mediating role of psychological resilience defined as the ability to cope with stress and difficulties, in the prediction of personality disorders stemming from traumatic early experiences and fixations, by positive childhood experiences associated with healthy personality development according to psychodynamic theories. The analyses were conducted on a community sample of 241 participants, consisting of 165 females and 76 males, with a mean age of 24.8 ( $SD = 7.22$ ). Data were collected through the Coolidge Axis II Inventory Turkish Short Form (Bilge, 2018), Positive Childhood Experiences Scale (Doğan & Aydın, 2020), and Psychological Resilience Scale (Doğan, 2015), and analyzed using correlation analysis and Process Macro (Hayes, 2017) Model 4. The results of the correlation analysis revealed a positive and statistically significant relationship between positive childhood experiences and psychological resilience ( $r = .25, p < .001$ ). The analysis also indicated negative and statistically significant relationships between positive childhood experiences and Schizotypal, Schizoid, Borderline, Obsessive-Compulsive, Avoidant, and Dependent personality disorders ( $-.35 < r < -.15, p < .05$ ). Lastly, negative, and statistically significant relationships were found between psychological resilience and all personality disorders ( $-.55 < r < -.17, p < .01$ ). According to the results of mediation analyses conducted using Hayes' macro, psychological resilience plays a statistically significant mediating role between positive childhood experiences and all personality disorders. The analyses showed that as positive childhood experiences increase, psychological resilience also increases, leading to a decrease in personality disorders. Particularly, the fully mediating and protective role of psychological resilience in the negative relationship between positive childhood experiences and Antisocial, Histrionic, Narcissistic, Obsessive-Compulsive, Avoidant, and Dependent personality disorders highlights the importance of this concept in understanding the relationship between childhood experiences and personality disorders. Therefore, focusing on individuals' levels of psychological resilience in therapy and prevention efforts is crucial for public health.

**Keywords:** Personality Disorders, Positive Childhood Experiences, Psychological Resilience, Mediation Analysis

## 1. INTRODUCTION

Personality disorders (PDs) are a group of mental health conditions characterized by enduring patterns of thoughts, feelings, and behaviors that deviate significantly from the norms of the individual's culture and lead to distress or impairment in functioning. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, American Psychiatric Association, 2013, p. 895-955), classifies personality disorders (PDs) into ten distinct categories that were grouped under 3 clusters based on shared characteristics: Cluster A (Odd Eccentric), Cluster B (Dramatic, Erratic), and Cluster C (Anxious, Fearful).

Personality disorders (PDs) are psychopathologies that were defined as maladaptive and enduring patterns of feelings, thoughts and behaviors that lead to distress, dysfunction, and impaired interpersonal communications. These feeling, thought and behavior patterns are usually opposing or deviating from what defined as acceptable and normal by the individual's society and culture. In the latest edition of The Diagnostic and Statistical Manual of Mental Disorders PDs were consist of 3 clusters based on shared characteristics: characterized by oddness and eccentric behavior there is Cluster A, with erratic, dramatic and theatric behaviors there is Cluster B, and with an anxious, inhibited, rigid and fearful profile there is Cluster C. People with Cluster A personality disorders exhibit eccentric behaviors and since they struggle to connect with others on a deeper level, they may appear socially isolated. Cluster A PDs include Paranoid (distrust and suspicion, interprets harmless situations as threats), Schizoid (withdrawn, apathetic and alone), and Schizotypal (eccentric, magical thinking, deviant) PDs. Cluster B personality disorders are usually characterized by their theatrical, dramatic, and impulsive behavior; they have a low ability to maintain healthy interpersonal relationships, and their emotions are often destabilized. Cluster B PDs include Antisocial (manipulative, criminal, and exploitative behavior; low empathy), Borderline (emotional instability, impulsivity, and intense but unstable interpersonal relationships; fear of abandonment and feelings of emptiness), Histrionic (emotionality, theatricality, and attention-seeking behaviors; strong need to be the center of attention), and Narcissistic (a maladaptively exaggerated sense of self-importance, a lack of empathy accompanied with a need for admiration; often exploits others to achieve their own goals) PDs. Lastly, people with Cluster C personality disorders tend to act anxious, fearful, and overly inhibited. They often have difficulty expressing their emotions and may appear rigid or overly controlled in social situations. Cluster C PDs include Avoidant (maladaptive levels of social inhibition to the degree of social withdrawal, persistent beliefs and of inadequacy alongside of feelings of inferiority, and a hypersensitivity and over-reaction to negative evaluations like rejection; often avoids social situations for fear of rejection or humiliation), Dependent (usually an illogical fear of separation, omnipresent need for care, lacks confidence in ability to self-care), and Obsessive-Compulsive (preoccupation with tidiness and perfectionism to a degree which impairs daily functioning, and a maladaptive need for control) PDs. These disorders are prevalent, affecting approximately 7.8% of the population worldwide (Winsper et al., 2020), and have a significant impact on individuals' lives, including their relationships, work, and overall well-being. The etiologic research done in the personality disorders has shown that alongside of biological factors like genetic predisposition and neurological differences and social factors like dysfunctional family environments and cultural

influences, childhood experiences play a major decisive role in the development and emergence of PDs (Millon, 2004, pp. 74-116). Although a major section of the contemporary literature focuses on adverse childhood experiences like abuse, neglect, and trauma, it is also evident that Positive Childhood Experiences (PCEs), e.g., having a stable home environment and loving parents, supportive relationships, and opportunities for growth and development, have been associated with a reduced risk of PDs (Skodol et al., 2007; Gunay-Oğe et al., 2020; Flynn et al., 2021). Skodol et al. (2007) hypothesized that PCEs act as a protective factor for personality disorders by fostering resilience at an early age. Psychological Resilience (PR) is the ability to adapt to the adverse and distressing situations and regain the balance: it is a dynamic process that involves a combination of personal and environmental factors (Sisto et al., 2019). Resilient individuals have the capacity to cope with challenges, maintain a positive outlook, and continue to pursue their goals despite setbacks. Although Skodol et al. (2007) hypothesized that PCEs protect from personality via fostering psychological resilience, the nature of this association and the role of psychological resilience were not statistically examined in their study. Flynn et al. (2021) investigated the relationship between Adverse Childhood Experiences (ACEs) and personality disorders and the role of childhood resiliency and found that at a low level of ACEs childhood resiliency acts as a protective factor, without any regard to PCEs. These limitations underscore the need for further research on PCEs and PR. The present study aims to investigate whether psychological resilience acts as a mediator in the relationship between positive childhood experiences and the development of personality disorders.

## 2. METHODS

### 2.1. Sample Characteristics

The analysis employed a correlation and mediation model approach to investigate the relationships between positive childhood experiences, psychological resilience, and personality disorders. The data was collected from a community sample of 241 participants, consisting of 165 females and 76 males, with a mean age of 24.8 years ( $SD = 7.22$ ). The inclusion criteria for this study were as follows: participants must be between the ages of 18 and 65 and willing to provide informed consent to participate in the study. The exclusion criteria were as follows: participants who are not fluent in Turkish or have a diagnosed cognitive impairment that would prevent them from understanding the surveys. Table 1 provides detailed sociodemographic information about the sample.

**Table 1. Sociodemographic Characteristics of the Sample**

	Female		Male		Total		
	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%	
<b>Age Groups</b>	18-24	119	49.4	42	17.4	<b>161</b>	<b>66.8</b>
	25-34	32	13.3	24	10.0	<b>56</b>	<b>23.2</b>
	35-44	8	3.3	8	3.3	<b>16</b>	<b>6.6</b>
	45+	6	2.5	2	.8	<b>8</b>	<b>3.3</b>
<b>Marital Status</b>	Single	142	58.9	62	25.7	<b>204</b>	<b>84.6</b>
	Married	20	8.3	11	4.6	<b>31</b>	<b>12.9</b>
	Separated	3	1.2	3	1.2	<b>6</b>	<b>2.5</b>
<b>Level of Education</b>	Primary education	3	1.2	1	.4	<b>4</b>	<b>1.7</b>
	High School	20	8.3	12	5.0	<b>32</b>	<b>13.3</b>

	University	142	58.9	63	26.1	<b>205</b>	<b>85.1</b>
<b>Economic Level</b>	Low-income	34	14.1	21	8.7	<b>55</b>	<b>22.8</b>
	Middle-income	127	52.7	51	21.2	<b>178</b>	<b>73.9</b>
	High-income	4	1.7	4	1.7	<b>8</b>	<b>3.3</b>
<b>Is receiving psychological help?</b>	Yes	17	7.1	4	1.7	<b>21</b>	<b>8.7</b>
	No	148	61.4	72	29.9	<b>220</b>	<b>91.3</b>
<b>Does need psychological help?</b>	Yes	106	44.0	28	11.6	<b>134</b>	<b>55.6</b>
	No	59	24.5	48	19.9	<b>107</b>	<b>44.4</b>

## 2.2. Data Collection Instruments

Coolidge Eksen II Envanteri Türkçe Kısa Formu (Coolidge Axis II Inventory Turkish Short Form, Bilge, 2018): This short form of the Coolidge Axis II Inventory assesses various personality disorders, including Paranoid, Schizotypal, Schizoid, Antisocial, Borderline, Histrionic, Narcissistic, Obsessive-Compulsive, Avoidant, and Dependent personality disorders. The Coolidge Axis II Inventory (Coolidge, 2006) is a self-report measure of personality disorders. It was translated and adapted into Turkish by Bilge (2014; 2018), who also developed a short form of the inventory. The inventory consists of 78 items and 10 subscales, each assessing a different personality disorder. The short form has a Cronbach's  $\alpha$  reliability of .66 to .77 and a test-retest reliability of .77 to .89. The convergent validity coefficients for the short form range from .35 to .64 with the Personality Belief Questionnaire Short Form and from .27 to .78 with the Structured Clinical Interview for DSM-III-R Personality Disorders.

Olumlu Çocukluk Yaşantıları Ölçeği (Positive Childhood Experiences Scale, Doğan ve Aydın, 2020): This scale measures positive childhood experiences, including supportive relationships, nurturing environment, and opportunities for growth. It is a self-report inventory designed to assess an individual's recollections of their childhood environment. This 22-item scale uses a 5-point Likert format (1 = Strongly Disagree, 5 = Strongly Agree) and measures a single dimension: positive childhood experiences. There are no reverse-scored items. Total scores range from 22 to 110, with higher scores indicating a more supportive, nurturing, and opportunity-rich childhood. The scale demonstrates good psychometric properties: Reliability is supported by a Cronbach's  $\alpha$  coefficient of .96, indicating strong internal consistency. Validity is evidenced by an exploratory factor analysis explaining 55% of the variance and a confirmatory factor analysis supporting a one-factor structure, with factor loadings ranging from .45 to .91. Overall, this scale serves as a reliable and valid tool for researchers and clinicians to investigate positive childhood experiences and their potential impact on well-being.

Psikolojik Sağlamlık Ölçeği (Psychological Resilience Scale, Doğan, 2015): This scale assesses psychological resilience, individual's ability to adapt to the adverse and distressing situations and maintain mental well-being. This is a 6 Likert scale type (1 = Strongly Disagree, 5 = Strongly Agree) item self-report measure. Minimum score is 6 which indicates the lowest resilience towards adverse and distressing situations and the maximum score is 30, highest resilience which indicating greater psychological strength. The scale's psychometric properties are acceptable, including a Cronbach's  $\alpha$  coefficient between .80 and .91, test-retest coefficient

between .62 and .69, indicating strong internal consistency. Validity is supported by exploratory factor analysis revealing a single-factor structure that explains 57-67% of the variance and by the scale's positive correlations with factors like ego strength, optimism, and social support while exhibiting negative correlations with factors like pessimism, depression, and perceived stress.

### 2.3. Procedure and Data Analysis

Participants were given an informed consent form, a sociodemographic information form, and an inventory. They were informed that participation was voluntary and that they could withdraw at any time. They were asked to complete the inventory fully. The data were analyzed descriptively, and no participants were excluded due to not meeting the inclusion criteria. Missing data analysis revealed no missing data. The data were tested for normality and then the internal consistency coefficients were calculated. Variables with skewness and kurtosis values within the  $\pm 2$  range were assumed to be normally distributed. After the data cleaning stage, the data analysis stage was carried out. The correlations between the variables were examined using the Pearson Moment Correlation Analysis package included in the SPSS 25.0 software. The research models, which are basic mediation models, were tested with Hayes's Macro (Hayes, 2017), an add-on that specializes in mediation and moderation analyses in the SPSS 25.0 software. The minimum p-value required for the results of the analyses to be considered statistically significant was set at 0.05. Statistical significance for the mediation analyses was determined by examining the confidence intervals on the %95 level. Only confidence intervals that did not encompass zero were considered statistically significant.

### 3. RESULTS AND DISCUSSION

To assess the data for assumptions of normality and reliability in order to carry out parametric statistical analysis, tests of normality and Cronbach's  $\alpha$  Internal Reliability analyses were conducted. Analyses revealed that none of the variables failed to pass the tests of normality, which permits the conduction of parametric analyses, namely Pearson Correlation and Mediation Analysis. As for Cronbach's  $\alpha$  Internal Reliability, the analysis revealed that despite the fact that Schizoid and Antisocial Personality Disorders' coefficients were lower for an ideal internal reliability, they are still in the range of acceptability (George and Mallery, 2019, p. 240). Detailed results of the analyses can be seen in Table 2.

**Table 2. Research Variable Mean, Standard Deviation, Kurtosis, Skewness, and Cronbach Alpha Reliability Values**

Variables	Mean±SD	Kurtosis	Skewness	Cronbach's $\alpha$
Psychological Resilience	17.80±5.81	-.61	-.09	.87
Positive Childhood Experiences	78.74±22.09	-.69	-.49	.96
Cluster A PD	49.30±10.76	-.27	.15	.85
Cluster B PD	72.74±16.11	-.61	.04	.90
Cluster C PD	54.90±13.71	-.60	.21	.90
Paranoid PD	19.85±5.24	-.70	.15	.77
Schizotypal PD	16.49±4.99	-.48	.35	.74
Schizoid PD	17.18±4.23	-.18	.31	.64
Antisocial PD	14.31±4.48	-.19	.71	.68
Borderline PD	21.78±6.45	-.78	.01	.81
Histrionic PD	17.54±4.23	-.65	.02	.71
Narcissistic PD	22.05±4.90	-.53	-.22	.73
Obsessive-Compulsive PD	22.25±5.41	-.57	.09	.73
Avoidant PD	18.41±5.34	-.85	.02	.79
Dependent PD	14.25±4.82	-.35	.60	.81

After the confirmation of normality and the internal reliability of the variables, Pearson correlation analyses were conducted. The analysis demonstrates significant negative correlations between positive childhood experiences and several personality disorders, including Schizotypal ( $r=-.27, p<.001$ ), Schizoid ( $r=-.35, p<.001$ ), Borderline ( $r=-.29, p<.001$ ), Obsessive-Compulsive ( $r=-.18, p<.01$ ), Avoidant ( $r=-.18, p<.01$ ), and Dependent ( $r=-.15, p<.05$ ) personality disorders. The analysis also reveals significant negative correlations between psychological resilience and a range of personality disorders, including Paranoid ( $r=-.38, p<.001$ ), Schizotypal ( $r=-.31, p<.001$ ), Schizoid ( $r=-.22, p<.001$ ), Antisocial ( $r=-.17, p<.01$ ), Borderline ( $r=-.55, p<.001$ ), Histrionic ( $r=-.35, p<.001$ ), Narcissistic ( $r=-.32, p<.001$ ), Obsessive-Compulsive ( $r=-.53, p<.001$ ), Avoidant ( $r=-.52, p<.001$ ), and Dependent ( $r=-.55, p<.001$ ) personality disorders. The correlation results can be seen in more detail in Table 3.

The correlation analysis findings between PCEs and PDs might be interpreted as individuals who report higher levels of positive childhood experiences tend to exhibit fewer symptoms associated with personality disorders. This suggests that a nurturing and supportive childhood environment may serve as a protective factor against the development of personality disorders later in life. Similarly, the statistically significant negative correlations between psychological resilience and PDs might suggest individuals with higher levels of resilience are less likely to exhibit symptoms associated with these disorders. Also, the positive and statistically significant correlation between Psychological Resilience and PCEs suggests that both variables are protective factors in the context of PDs. Given the negative correlations observed between positive childhood experiences, psychological resilience, and personality disorders, it is plausible to consider psychological resilience as a potential mediator in the relationship between positive childhood experiences and the development of personality disorders. In other words, positive childhood experiences may contribute to the development of psychological resilience, which, in turn, mitigates the risk of personality disorders. However, Pearson correlation analysis

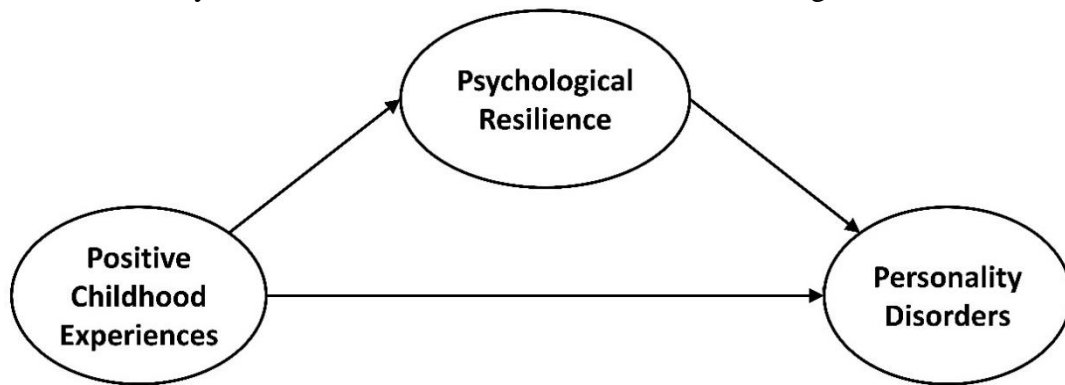
is not sufficient for drawing such ambitious conclusions. To further support this hypothesis statistically, a series of mediation analyses were conducted.

**Table 3. Research Variable Correlation Relationships**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
PR														
PCE	<b>.25</b>													
Cluster A PD	<b>-.39</b>	<b>-.28</b>												
Cluster B PD	<b>-.44</b>	<b>-.14*</b>	<b>.67</b>											
Cluster C PD	<b>-.60</b>	<b>-.19**</b>	<b>.66</b>	<b>.73</b>										
Paranoid PD	<b>-.38</b>	-0.12	<b>.83</b>	<b>.68</b>	<b>.60</b>									
Schizotypal PD	<b>-.31</b>	<b>-.27</b>	<b>.88</b>	<b>.63</b>	<b>.61</b>	<b>.59</b>								
Schizoid PD	<b>-.22</b>	<b>-.35</b>	<b>.71</b>	<b>.26</b>	<b>.35</b>	<b>.31</b>	<b>.60</b>							
Antisocial PD	<b>-.17**</b>	-0.11	<b>.55</b>	<b>.73</b>	<b>.41</b>	<b>.47</b>	<b>.55</b>	<b>.31</b>						
Borderline PD	<b>-.55</b>	<b>-.29</b>	<b>.66</b>	<b>.89</b>	<b>.73</b>	<b>.63</b>	<b>.63</b>	<b>.31</b>	<b>.58</b>					
Histrionic PD	<b>-.35</b>	-0.04	<b>.48</b>	<b>.86</b>	<b>.64</b>	<b>.58</b>	<b>.45</b>	<b>0.05</b>	<b>.48</b>	<b>.71</b>				
Narcissistic PD	<b>-.32</b>	0.03	<b>.50</b>	<b>.83</b>	<b>.63</b>	<b>.55</b>	<b>.46</b>	<b>.16*</b>	<b>.40</b>	<b>.61</b>	<b>.73</b>			
OCPD	<b>-.53</b>	<b>-.18**</b>	<b>.66</b>	<b>.70</b>	<b>.87</b>	<b>.63</b>	<b>.59</b>	<b>.36</b>	<b>.43</b>	<b>.67</b>	<b>.59</b>	<b>.61</b>		
Avoidant PD	<b>-.52</b>	<b>-.18**</b>	<b>.56</b>	<b>.58</b>	<b>.88</b>	<b>.48</b>	<b>.52</b>	<b>.34</b>	<b>.29</b>	<b>.59</b>	<b>.51</b>	<b>.51</b>	<b>.62</b>	
Dependent PD	<b>-.55</b>	<b>-.15*</b>	<b>.51</b>	<b>.66</b>	<b>.89</b>	<b>.49</b>	<b>.50</b>	<b>.20**</b>	<b>.37</b>	<b>.68</b>	<b>.58</b>	<b>.53</b>	<b>.66</b>	<b>.71</b>

\*  $p < .05$ , \*\*  $p < .01$ ; All values in bold are significant at  $p < .001$  level; PR = Psychological Resilience, PCE = Positive Childhood Experiences, PD = Personality Disorder, OCPD = Obsessive-Compulsive PD

Since there are 10 different personality disorders as dependent variables in the research model, 10 different mediation models were designed to investigate the role of psychological resilience in the relationship between positive childhood experiences and personality disorders. The general model that symbolizes all 10 of the models can be seen in Figure 1.



**Figure 1. General Research Model**

After the mediation analyses were conducted, it was found that psychological resilience was a partial mediator in the Paranoid PD model ( $\beta = -.0073 \pm .0013$ ,  $p < .01$  for the direct effect path and  $\beta = -.0220 \pm .0067$ , 95% CI [-.0364, -.0101] for the indirect effect path), partially mediated in the Schizotypal PD model ( $\beta = -.0464 \pm .014$ ,  $p < .01$  for the direct effect pathway and  $\beta = -.0147 \pm .0051$  for the indirect effect pathway, 95% CI [-.0259, -.0058]), and partially mediated the schizoid PD model ( $\beta = -.0601 \pm .0119$  for the direct effect pathway,  $p < .001$  and  $\beta = -.0069 \pm .0035$  for the indirect effect pathway, 95% CI [-.0148, -.0011]). General results of the analyses for the Cluster A PDs show that a partial mediation role of PR exists between PCEs and PDs. This could be interpreted as even though the mediation role of PR is indeed actively mediating this relationship, other alternative mediators should be accounted for.

When the models related to Cluster B personality disorders were analyzed, it was found that psychological resilience played a fully mediating role in the Antisocial PD model ( $\beta = -.0150 \pm .0133$ ,  $p > .05$  for the direct effect pathway and  $\beta = -.0078 \pm .0037$ , 95% CI [-.0155, -.0008] for the indirect effect pathway), a partial mediating role in the Borderline PD model ( $\beta = -.0482 \pm .016$ ,  $p < .01$  for the direct effect pathway and  $\beta = -.0368 \pm .0102$ , 95% CI [-.0576, -.0177]), fully mediated in the Histrionic PD model ( $\beta = .0086 \pm .012$ ,  $p > .05$  for direct effect and  $\beta = -.0172 \pm .0052$ , 95% CI [-.0282, -.0081]) and fully mediated the Narcissistic PD model ( $\beta = .0256 \pm .014$ ,  $p > .05$  for the direct effect pathway and  $\beta = -.0191 \pm .0061$  for the indirect effect pathway, 95% CI [-.032, -.0085]). General results of the analyses for the Cluster B PDs show that PR mostly exists as a full mediator between PCEs and PDs, except for Borderline PD. This highlights the importance of the PR in the relationship between PCEs and PDs, meaning PCEs are protecting people from Cluster B PDs by fostering PR capabilities. Results of Borderline PD could be interpreted as alternative mediators might be playing a more active and dominant mediator role, even though the mediation role of PR is mediating the relationship between PCEs and PDs.

Finally, models related to Cluster C personality disorders were examined and psychological resilience was found to be fully mediated in the Obsessive-Compulsive PD model ( $\beta = -.0121 \pm .0139$ ,  $p < .05$  for the direct effect pathway and  $\beta = -.0314 \pm .0089$ , 95% CI [-.0493, -.0149] for the indirect effect pathway), fully mediated in the Avoidant PD model ( $\beta = -.0130 \pm .0138$ ,  $p < .05$  for the direct effect pathway and  $\beta = -.0299 \pm .0087$ , 95% CI [-.0481, -.0140] for the indirect effect pathway) and Dependent CK model ( $\beta = -.0027 \pm .0122$  for direct effect pathway,  $p < .05$  and  $\beta = -.0295 \pm .0083$  for indirect effect pathway, 95% CI [-.0468, -.0140]). Overall, the results of the analyses for the Cluster C PDs show that PR exists as a full mediator between PCEs and PDs in all of the mediation models. This highlights the importance of the PR in the relationship between PCEs and PDs, meaning PCEs are protecting people from Cluster C PDs by fostering PR capabilities. The results of these mediation analyses are summarized in Table 4.

Even though the research models were proven to be statistically significant, the hypothesis tested by these analyses can only be defended with a couple of pre-assumptions since the relational analyses conducted in this study never meant to draw causal conclusions. It is only when supported by a robust and comprehensive theory we can suggest causal relations between variables.

**Table 4. Results of Mediation Analysis for All the Personality Disorders**

	X→Y (c')		X→M→Y		Mediation Type
	(Direct Effects)		(Indirect Effects)		
	$\beta \pm SD$	p	$\beta$	95% CI	
Paranoid PD	-.0073 ± .0013	.002	-.0220 ± .0067	[-.0364, -.0101]	Partial
Schizotypal PD	-.0464 ± .014	.0011	-.0147 ± .0051	[-.0259, -.0058]	Partial
Schizoid PD	-.0601 ± .0119	.0000	-.0069 ± .0035	[-.0148, -.0011]	Partial
Antisocial PD	-.0150 ± .0133	.2608	-.0078 ± .0037	[-.0155, -.0008]	Full
Borderline PD	-.0482 ± .016	.0029	-.0368 ± .0102	[-.0576, -.0177]	Partial
Histrionic PD	.0086 ± .012	.4723	-.0172 ± .0052	[-.0282, -.0081]	Full
Narcissistic PD	.0256 ± .014	.0676	-.0191 ± .0061	[-.0320, -.0085]	Full
OCPD	-.0121 ± .0139	.3833	-.0314 ± .0089	[-.0493, -.0149]	Full
Avoidant PD	-.0130 ± .0138	.3466	-.0299 ± .0087	[-.0481, -.0140]	Full
Dependent PD	-.0027 ± .0122	.8263	-.0295 ± .0083	[-.0468, -.0140]	Full

X→Y (c') is the effect of Positive Childhood Experiences on Personality Disorders after controlling for Psychological Resilience; PD = Personality Disorder, OCPD = Obsessive-Compulsive PD

After reviewing all the descriptions of psychological resilience in the psychology literature, Sisto et al. (2019) defined psychological resilience as a dynamic process that evolves depending on the interactions between personality traits, biological factors, family, and societal support. According to this definition, it can be assumed that positive childhood experiences and social support from family and society might foster psychological resiliency and protect from the development of personality disorders and vice versa. As can be seen in the definition made, psychological resilience is a complex construct that consists of a lot of different factors, which should be examined in more detail to shed light on the complex relationship between PCEs and PDs. Also, like many psychological concepts, psychological resilience should be viewed on a continuum, where so little PR would make a person unable to cope with any stressful life event, too much of it would hinder its capacity for post-traumatic growth; both has adverse effects on a person's healthy development. All these assumptions require further examination.

This study is subject to limitations that must be considered when interpreting the results. Firstly, the reliance on self-assessment measures for all variables introduces potential bias. PDs, PCEs and RS were assessed through self-reports, which can be influenced by personal perception and memory. This overlap raises concerns that the correlations observed may reflect common biases rather than true relationships between the concepts. This, alongside the sample characteristics being unbalanced, especially age and gender-wise, are the major limitations of our study. In future research, it is suggested to account for these limitations.

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