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Borderline Personality Disorder (BPD), Prevalence and Association with some Socio–Demographic variables among Women in Kurdistan Region/ Iraq

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Abstract

Purpose: Borderline personality disorder (BPD) is a common psychiatric disorder that is often overlooked in treatment settings. The study aimed at measuring the prevalence rate of BPD and then examining the statistical differences of BPD according to socio-demographic factors' age, Academic achievements, social status, occupations and governorates' among women in Kurdistan Region/ Iraq.

Methods: 500 women participated from four governorates' Erbil, Suleymaniye, Duhok and Halabja' 'N=125 in each'. For BPD scale, the study relied on the exploratory method and a part of McLean Self-Screening Instrument for (MSI-BPD).

Results: the prevalence of BPD was significant among women. However, there was no significant difference in the level of BPD according to age, but there were significant differences in the level of BPD and academic achievements, social status and occupation among participants. Those women who were 'illiterates, divorced, not-occupied and those women who were from Erbil' suffered more from BPD when compared to others.

Conclusions: future studies are needed to further explore the relationships between other factors with BPD.

Keywords borderline personality disorders, socio-demographic factors & Women from Iraqi Kurdistan Region.

Borderline Personality Disorder (BPD), Prevalence and Association with some Socio-Demographic variables among women in Kurdistan Region/ Iraq

1. Introduction

Research Problem

Mature personality means a person's abilities to agree with others, and it has plenty of features that characterize the quality and validity of its relationship with others. However, immaturity means that the person despite the completion of his physical maturity but is unable to interact properly with others, and this person is confused and takes the manifestations of abnormal personality disorders. According to Meyer (1994), personality disorders affect about 5 to 10% of members of society (Ellison & shader, 1994, p. 259).

Unfortunately, the majority of these people with one or more personality disorder are unaware of their disorders and therefore do not seek treatment, but they are willing to resort to some drugs as well as committing many violations of the law (Ellison & shader, 1994, p. 259). On the other hand, (Osborne & McComish, 2006, p. 40-47) claimed that nurses find it difficult to work with those patients who diagnosed with personality disorders especially those who recognized by Borderline personality disorder because of their lack of understanding of the underlying dynamics of this disorder (Ntshingila, Poggenpoel, Myburgh & Temane, 2016, p. 110-111).

Generally, Kurdish women have been sacrificed, for many times, in the history of wars and genocides. Unsurprisingly, after that history, the numbers of men have been reduced, and a lot of

women became widows and orphans. Hence they worked outside or sought assistance. According to Omar (2010), 33% of those Kurdish women have no sources of support. Hence, in this case, Kurdish women have faced a lot of social, physical and psychological problems; such as sexual abuse, social delusion, physical injuries, personality disorders, depression, panic and anxiety and this reality supported by (Omar, 2010). It is clear that after wars, and according to (Sharpley-Whiting, 1997), women were the most suffering victims. The problem of the current research is that though Kurdish society has passed through harsh conditions in different situations of life, and it did not achieve mental health continuously. And obviously, these harsh conditions lead various psychological, mental, social and economic pressures and negatively affected personalities.

Research Importance

People with this disorder view the world as “all or nothing”, “black or white”, “all good or all bad”, so this way of thinking can make a lot of emotional suffering, especially devastating in relationships. For example, their view of another person (friend or partner) can change immediately from “that person is completely wonderful” to “that person is completely horrible” (Hoermann, Zupanich & Dombeck, 2019, p. 11). According to (Ntshingila et al., 2016), who worked in psychotherapy for seven years, more female patients diagnosed with borderline personality disorder than male patients. Today, women’s health is taking on a higher position in society because the health of families and communities are tied to the health of women. It is clear that a mother with a healthy mind and body will give birth to a healthy child. Also, people realized that while women have many of the diseases as

men, however, their symptoms and the way of treatments might not always be the same.

A borderline personality disorder is much more common than imagined. A recent study, on the prevalence of mental health disorders in the US, found that about 1.6 percent of the population has BPD, and this means that there are more than four million people with BPD in the US alone. As well as, this disorder is actually more common than many well-known disorders, such as Schizophrenia (S-Pedneaul, 2019, p. 1). Beside of this finding, numbers of studies reported that a person with borderline personality disorder presenting to primary care who harmed himself/herself repeatedly and marked emotional instability. Hence, this situation may also have a negative effect on society, as well.

Ntshingila et al. (2016), who aimed to explore and explain the experiences of women living with a borderline personality disorder, found that women who suffer from this disorder are characterized by psychosocial damage and high mortality, and up to 10% of those women commit suicide which is a rate almost 50 times higher compared with the general population (p. 111). Obviously, women are statistically the ones who mostly affected by borderline personality disorders. According to a research, done by (Shifiona, Poggenpoel and Myburgh, 2006:6), women are affected by life changes even under normal circumstances like marital problems, job changes and especially the evolution of an adult self during early and middle adulthood (Ntshingila et al., 2016, p. 112). In fact, there are some factors that are related to overall life, and can also increase the risk of developing borderline personality disorder among people; including age, social state, academic achievement, physical health being and also the job positions in society (Friedman & Schustack, 2009, p. 138).

1.1 Aims

1. Measuring the prevalence rate of borderline personality disorder (BPD) among women in the Kurdistan Region/ Iraq.
2. Examining statistical differences of variable borderline personality disorder (BPD) according to socio-demographic factors such as (age, academic achievement, social status, occupation and Governorates) among women in Kurdistan Region/ Iraq.

1.2 Limitation

The current research (2017-2020) has consisted of the Kurdish women in the Kurdistan Region/ Iraq.

1.3 Theoretical definition

A personality disorder is a diagnosis that falls into Axis II in the DSM-IV. Like other diagnoses, it is a condition that is personally and/or mal adaptive can cause great suffering. There are ten types of personality disorder, classified into three clusters (Gould, 2011). There are types of personality disorders, which consist of (Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent and Obsessive-compulsive) personality disorder.

Borderline personality disorder, according to Adolph Stern, 1938, proposed the term 'borderline personality' in the United States in 1938. Stern described a group of patients who 'fit frankly neither into the psychotic nor into the psychoneurotic group' and introduced the term 'borderline' to describe what he observed because it 'bordered' on other conditions (centre, 2009).

American Psychiatric Association (1994) also defines Borderline personality disorder (BPD) as a severe and persistent form of psychopathology characterized by pervasive affective, cognitive, interpersonal, and behavioural dysfunction, including emotional lability, interpersonal disturbances, impulsive and risky behaviours, and transient episodes of dissociation or paranoia (Bornovalova, 2011).

Frankenburg & Zanarini (2004) explained that individuals with BPD often engage in dangerous behaviour, including deliberate self-harm and suicidal gestures, drug and alcohol abuse, unsafe sexual practices, and misuse of prescription medications (Bornovalova, 2011).

DSM-IV (2013) defined Borderline Personality Disorder as a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and presenting in a variety of contexts that are mentioned below (American Psychiatric Association, 2012; DSM-IV, 2013, p. 663). Borderline personality disorder indicated by five or more of the following symptoms:

- Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5 DSM-IV, 2013, p. 663).
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.

- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Gunderson, Weinberg & Choi-kain (2013) claimed that BPD is a chronic feeling of emptiness, inappropriate anger and difficulty to control anger, transient, stress-related paranoid ideation or severe dissociative symptoms (Gunderson, Weinberg & Choi-kain, 2013).

Depending on the entire above explanations and definitions, the researchers for their **experimental study** used the DSM-IV definition for borderline personality disorder and its symptoms. On the other hand, the **procedural definition** is related to the degree to which women achieved through answering all items of the borderline personality disorder's scale that are used in the current study according to their socio-demographic factors.

2. Literature Review

According to American psychoanalyst Adolph Stern (1938), it is well known that a large group of patients fit frankly neither into the psychotic nor into the psychoneurotic group and that this “border line group” of patients is extremely difficult to be handled effectively by any psychotherapeutic method (Stern, 2017, p. 467). Thus, in 1938, psychoanalyst Adolf Stern described the term “Borderline”, for the first time, in the history of psychology (Biskin & Paris, 2012, p. 1789). The data of the study showed that BPD is a serious public health problem (Oumaya, Friedman, Pham, Abou-Abdallah, Guelfi & Rouillon, 2008, p. 452). According to Zimmerman and Coryell (1989), Swartz et al. (1990), individuals with BPD constitute about 2%-3% of the population (Gunderson & Links, 2008, p. 1). On the other hand, Diagnostic and Statistical Manual of Mental Disorder DSM-5 (2013), reported that the median population prevalence of borderline personality disorder is estimated to be 1.6% but maybe as high as 5.9%. At the same time, BPD can be a difficult diagnosis because of similarities to other conditions, such as mood disorders (Biskin & Paris, 2012, p. 1789). S-Pedneaul (2019) mentioned that many people with BPD have not been recorded or they have been misdiagnosed.

On the other hand, patients who diagnosed BPD, nearly 85% have one or more additional mental health disorders, such as substance abuse/addiction, eating disorders, somatoform disorders, anxiety, depression, PTSD, Antisocial personality disorder and bipolar disorder. In that case, when patients are presented with a recognized mental health disorder, comorbid BPD should be considered (Hall & Riedford, 2017, p. 455). Widiger and Weissman (1991), who investigated the prevalence rate of BPD, in the general community, found that nearly 76% of borderline

personality disorder patients are female. On the other hand, according to DSM-5 (2013), a borderline personality disorder is diagnosed predominantly about 75% in female (p. 666). Environmental and sociocultural factors play an important role in causing BPD, especially among women, for example, experiencing traumatic life event such as sexual abuse especially at an early age or exposed to unstable and unhealthy relationships. This is supported by Ferreira, Pereira, Benevides and Melo (2018); they affirm that sexual abuse (SA) is known to be frequent among borderline personality disorder patients, especially among women.

Unfortunately, many areas of a person's life are damaged by this disorder. It can negatively affect close relationships, jobs conditions, education, and a lot of social activities. For example, losing a job or remaining jobless, not completing education, multiple legal issues, conflict-filled relationships (marital stress/divorced/ living without a partner), self-injuries and suicide attempt can be the results of BPD (Mayo Foundation for Medical Education and Research [MFMER], 2019, para. 7). Being younger is also significantly related to BPD (Swartz et al., 1990, p. 257), (Hessels, Laceulle, Van-Aken, Resch & Kaess, 2018, p. 20), and the more patients with BPD grow older the more symptoms seem to decline in frequency and severity (S-Pedneaul, 2019, p.1). However, according to Stepp and Pilkonis (2008), age did not affect the level of emotional distress, so older and younger are experiencing a similar level of personality disorders (p. 427). In contrast, another study reported that BPD traits could be problematic in older patients when compared to younger one (Schuster, Hoertel, Le-Strat, Manetti & Limosin, 2013, p. 757; Mattar and Farooq-Khan, 2017; p. 22-23). In a number of studies, it is reported that being younger, lower education, impaired job

performance or remaining jobless and low psychological work condition and living without a partner or being divorced or widowed are significantly associated with a higher number of BPD symptoms (Stansfeld & Candy, 2006, p. 443; Grant et al., 2008, p. 533-545; Huang, 2009, p. 46-53; Tomko et al., 2014, p. 734-750; Juurlink et al., 2018, p. 202). But, surprisingly, in a study conducted by Ten-Have (2016), it is that found a higher number of BPD symptoms related to higher professionals university-educated participants (p. 249).

Regarding the causes, a lot of researchers and scientists stated that the reasons of this disorder are not fully understood, but scientists agree that it is the result of a combination of some other factors, such as genetics, environmental factors and brain function. For example, the result of experiencing traumatic events can be BPD, as many people with BPD have been through traumatic life events, especially childhood sexual abuse or unhealthy relationships. However, at the same time, there are other patients with this disorder, who do not have a history of trauma, and many people who experienced traumas do not have BPD. Also, some physical changes in the brain may cause BPD, especially in areas that control impulsive behaviour and emotions. On the other hand, there is no definitive medical test to diagnose BPD, and a diagnosis is not based on one specific sign or symptom. However, BPD is best diagnosed by a mental health professional following a comprehensive clinical interview that may include talking with previous clinicians, reviewing previous medical evaluations and interviews with friends and family (National Alliance on Mental Illness [NAMI], 2017, para. 5-6; Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004, p. 453; National Institute of Mental Health [NIMH], 2016, para. 7).

3. Theories of Borderline Personality Disorder

3.1 DSM-IV

The essential feature of borderline personality disorder, according to DSM-5, is a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity that begins by early adulthood. It is also reported that this disorder is present in various contexts;

- A person who diagnosed with BPD makes frantic efforts to avoid real or imagined abandonment, also the perception of impending separation or rejection, or the loss of external structure, which can lead to profound changes in self-image, affect, cognition and behaviour.
- They also have a pattern of unstable and intense relationships.
- There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self.
- Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging. They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly.
- They also display recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
- Persons with BPD may display affective instability that is due to a marked reactivity of mood, for example, intense episodic

dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days.

- Unfortunately, they may be troubled by chronic feelings of emptiness. Easily bored, they may constantly seek something to do.
- Those with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger. They may display extreme sarcasm, enduring bitterness, or verbal outbursts.
- During periods of extreme stress, transient paranoid ideation, or dissociative symptoms, such as de-personalization may occur (DSM-5, 2013, p. 633-634).

Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring depressive disorders or substance use disorders. Physical handicaps may result from self-inflicted abuse behaviours or failed suicide attempts. Recurrent job losses interrupted education, and separation or divorce are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with a borderline personality disorder. Common co-occurring disorders include depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with other personality disorders because they have certain features in common. It is therefore important to make a distinction among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria

for one or more personality disorders, in addition to borderline personality disorder, all can be diagnosed. (DSM-5, 2013, p. 665-666).

The impairment from the disorder and the risk of suicide is greatest in the young-adult years and gradually wane with advancing age. Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often life-long, and individuals, who engage in therapeutic intervention, often show improvement beginning sometime during the first year. While, the prevalence of borderline personality disorder may decrease in older age groups, during their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning. On the other hand, the female is at high risk to be diagnosed with a borderline personality disorder. Regarding Genetic and Physiological, a borderline personality disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, anti-social personality disorder, and depressive or bipolar disorders. (DSM-5, 2013, p. 665-666).

3.2 Dialectical Behavior Theory (DBT) ‘Late 1980s’ by Linehan M.

Dialectical Behavior Theory (DBT) can be considered a sub-type of Cognitive Behavioral Therapy (CBT), as its origins can be tracked to this theory. The psychologist, Marsha Linehan, originally developed DBT, especially to treat women with a borderline personality disorder. She began to notice that people with BPD have a powerful negative reaction to the heavy emphasis on change, and are also exceptionally sensitive. The theory of DBT

mentions that BPDs tend to have powerful emotional reactions to situations in which they feel invalidated. Their childhood histories often reflected a poor match between the emotional needs of such highly sensitive children and their parents. This mismatch between parents and children created an environment in which the child's emotions were frequently invalidated. Invalidation occurs when parents punish, minimize, criticize, reject, or deny the validity of the child's emotional experience. Linehan concluded that the changing emphasis of conventional CBT felt profoundly invalidating to her clients. To these highly sensitive clients, this emphasis on change caused them to feel as though something was wrong or unacceptable about them. This situation mirrored their painful childhood experiences of invalidation. As a result, they could not engage in, nor benefit from therapy because the therapy itself was experienced as painfully invalidating. In response to this insight, Linehan introduced several innovations to her therapeutic approach. The most important modification in DBT, compared to CBT, was a new emphasis on the acceptance and validation of the client's emotional and behavioural states. This acceptance counterbalanced the traditional CBT emphasis on changing those states. This presented a therapeutic dilemma for Linehan because acceptance and change are incompatible agenda. It is not possible for the therapist to suggest a better way to handle a situation without implicitly invalidating the way that the client handled it in the first place. Linehan's solution to this dilemma was to move back and forth between change and acceptance during therapy in a dialectical manner (Linehan, 2006, p. 113-119; American Addiction Center [MentalHelp], 2019).

Research Procedure

4.1 Population of the study

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According to the research problems and aims, the population was determined by female living in the community in the Kurdistan Region in Iraq (KRI). According to the ministry of planning in Erbil, a quick count of the population of KRI was conducted at the end of 2019, which consisted of (6,033,814) male and female from urban and rural. However, the targeted population of this study was the only female, which consisted of (3,003,925) with different level of education, social status and job quality or not working women. See appendix (1)

4.2 Sample of the study

The sample is part of the target population that used in the study; the researchers depended on non-random sample according to the styles of the study. As McLeod (2019) stated that sampling is the process of selecting a representative group from the population under study, and a sample is the group of people who take part in the investigation, and they referred to as 'participants'. In this regard, four governorates (Erbil, Suleymaniye, Duhok, Halabja) were selected among all of the cities and town around the Kurdistan. Then an equal number of participants, but according to their occupations, in each governorate were randomly selected, which consisted of (n=125) women, and in totally (N=500) participants among all selected governorates; see appendix (2).

4.3 Measurement

The researchers prepared or made the scale of borderline personality disorder through two different methods; firstly, through relying on exploratory method, and secondly depending on the part of the self-screening measure for DSM-IV BPD-the McLean Screening Instrument for Borderline Personality

Disorder (MSI-BPD). In overall, the prepared scale included 14 items and two alternative answers (yes and no); see appendix (3), and then for the purpose of ensuring the validity of the scale, it has extracted indicators of face validity before using, which presented to numbers of experts and specialists in the field of educational and psychological sciences with the speciality of psychology and sociology. The scale had its face validity with a percentage of 85% and more. Also, to extract the scale reliability, the study used the internal consistency method where it used an equation of Cronbach's Alpha to measure internal consistency, which was (0.71). The study used a split-half reliability method; the reliability of the scale is (0.75). And the researchers used the Spearman-Brown correction for the purpose of correcting the value of the reliability, so it was (0.86), which is considered as an acceptable reliability coefficient according to the items number. In addition, test-retest method, reported the Pearson Correlation Coefficient between the participants' result in both time of the test, and the correlation value was (0.87**), and this is a high correlation, which means that the scale has a high degree of stability.

Results and Discussion

5.1 Measuring the prevalence rate of borderline personality disorder (BPD) among participants

After processing and applying borderline personality disorder measurement on 500 women as a sample of the study, the result showed that the mean degree of the measurement is 40.1, with a standard deviation of 8.681. From this result, when comparing this degree of mean 40.1 with a hypothetical mean of the scale, which is 21 can be noticed that the former is greater than the later. Hence, examining the differences between the two means with using one-

sample t test, it was found to be significant at the level of 0.05 with the degree of freedom 499. On the other hand, as can be seen, the T-calculated Value 24.167 is bigger than the T-table value 1.960; see table (1).

Table (1) One-Sample Test to measure the prevalence rate of borderline personality disorder among participants

Variable	Numbers of sample	Mean	Std. Deviation	Hypothetical mean	T value		Sig.
					Calculated	Table	
BPD	500	40.1	8.681	21	24.167	1.960	Sig. 0.05

From the above table, it can be noticed that the prevalence rate of borderline personality disorder is significant among women and this finding is inconsistent with the numbers of studies conducted by (Swartz et al., 1990; Widiger & Weissman, 1991; Oumaya et al., 2008, p. 452). This result can be explained according to the DSM-5 (2013) borderline personality disorder is diagnosed predominantly about 75% in female (p. 666). In addition, Wirth-Cauchon (2000) stated that BPD is applied to women so much more often than to men and defined as “a pervasive pattern of instability of self-image, interpersonal relationship, and mood beginning in early adulthood and present in a variety of contexts”. Women are said to be unstable when they are trying to reconcile often contradictory and conflicting social expectations (para. 2).

5.2 Examining statistical differences of variable borderline personality disorder (BPD) according to participants' age, academic achievement, social status, occupations and Governorates.

5.2.1 Differences in BPD according to the age variable

In order to achieve this aim, which is comparing age groups of participants and its relation to the level of BPD, one way ANOVA method was used, and it is reported that there is no significant main effect of age with all groups; see table (2). The age of participants was distributed among four groups [(21-30), (31-40), (41-50), (51-60)].

Table (2) One-way ANOVA to examine statistical differences in BPD according to variable age among participants

Source of contrast BPD/age	Sum of squares	df	Mean square	F value		Sig.
				Calculated	Table	
Between Groups	49.204	3	16.401	2.30	2.62	Non. Sig.
Within groups	3538.594	496	7.134			
Total	3587.798	499				

From the above table, it can be noticed that the F-calculated Value 2.30 is smaller than the F-table value 2.62 at the degree of freedom 3-496 and the level of significance 0.05, which means that there are no significant differences in the level of borderline personality disorder according to the age of the participants. This result is not similar to those studies that reported age as being

significantly related to BPD (Swartz et al., 1990, p. 257; Schuster et al., 2013, p. 757; Mattar and Farooq-Khan, 2017, p. 22-23; Hessels et al., 2018, p. 20; S-Pedneaul, 2019, p.1). However, the result of this study is supported by the study conducted by Stepp & Pilkonis (2008) who reported that age did not affect the level of emotional distress of being older and younger, and are experiencing a similar level of personality disorders (p. 427). Hence, all women with different age groups suffer from the BPD to one degree or another. From this result, it can be explained that the BPD is not limited to age with different groups so that all women suffer from the same degree to another of BPD.

5.2.2 Differences in BPD according to academic achievement

Another aim of this study was to examine the statistical difference between BPD according to 500 participants' academic achievements. Results of One-way ANOVA showed that there is a significant main difference between the variable academic achievements and BPD; see table (3). Academic achievements of the sample of the study were distributed among six groups (Higher-education, bachelor, diploma, secondary, primary and illiterates).

Table (3) One-way ANOVA to examine statistical differences in BPD according to variable academic achievements among participants

Source of contrast BPD/AA	Sum of squares	df	Mean square	F value		Sig.
				Calculated	Table	
Between Groups	357.064	5	71.413	10.919	2.23	Sig.
Within groups	3230.734	494	6.540			
Total	3587.798	499				

As shown in the above table, the F-calculated value is bigger than F-table value [(F-calculated value= 10.919 > F-table value = 2.23)] at the degree of freedom 5-494 and the level of significance 0.05, which means that there are significant differences in the prevalence rate of BPD among women according to the variable academic achievements. In order to determine the trend of differences, the study used (Scheffe) for their second analysis, and it was found that all the values of comparison were statistically significant at the degree of freedom 0.05; see table (4).

Table (4) Scheffe method to show the values of the differences between means of borderline personality disorder among participants according to academic achievements



Academic Achievement/ BPD	Mean	N	Std. deviation	Comparing value	Sig. 0.05
Illiterate	21.20	85	4.438		
Primary	20.88	76	3.217	0.32	Sig.
Higher education	19.14	47	2.673	2.06	Sig.
Secondary	18.66	76	3.221	2.54	Sig.
Diploma	18.33	108	2.543	2.87	Sig.
Bachelor	17.59	108	2.312	3.61	Sig.
Total	18.10	500	2.681		



Unsurprisingly, those women who were illiterates ($M=21.20$, $SD=4.438$) more suffered from BPD and scored higher in the level of BPD compared to other participants from other groups, this finding supported by (Stansfeld & Candy, 2006, p. 443; Grant et al., 2008, p. 533-545; Huang, 2009, p. 46-53; Tomko et al., 2014, p. 734-750; Juurlink et al., 2018, p. 202). This result is dissimilar with Ten-Have (2016) study that found a higher number of BPD symptoms related to higher professionals university-educated participants (p. 249). Then women with the level of primary, higher educated, secondary and diploma [$(M=20.88$, $SD=3.217)$, $(M=19.14$, $SD=2.673)$, $(M=18.66$, $SD=3.221)$ and $(M=18.33$, $SD=2.543)$] one after the others suffer from BPD. the last group of women were those who had bachelor degree ($M=17.59$, $SD=2.312$) and they were affected and suffered less from BPD than all the other groups in the same factors.

5.2.3 Differences in BPD according to the social status variable

Another aim of this study was to examine the statistical difference between BPD according to 500 participants' social status. Results of One-way ANOVA showed that there is a significant main difference between the variable social status and BPD; see table (5). Social status of the sample of the study was distributed among four groups (Single, Married, Divorced and Widowed).

Table (5) One-way ANOVA to examine statistical differences in BPD according to variable social statues among participants

Source of contrast BPD/SS	Sum of squares	df	Mean square	F value		Sig. 0.05
				Calculated	Table	
Between Groups	489.968	3	163.323	26.150	2.62	Sig.
Within groups	3097.830	496	6.246			
Total	3587.798	499				

As shown in the above table, the F-calculated value is bigger than F-table value [(F-calculated Value = 26.150 > F-table value = 2.62)] at the degree of freedom 3-496 and the level of significance 0.05, which means that there are significant differences in the prevalence rate of BPD among women according to the variable social statues. In order to determine the trend of differences, the study used (Scheffe) for their second analysis, and it was found that all the values of comparison were statistically significant at the degree of freedom 0.05; see table (6).

Table (6) Scheffe method to show the values of the differences between means of borderline personality disorder among participants according to social statues variable

Social Status	Mean	N	Std. deviation	Comparing value	Sig. 0.05
Divorced	21.40	93	1.955		
Widowed	21.30	81	2.910	0.10	Sig.
Married	17.84	171	2.604	3.56	Sig.
Single	17.75	155	2.312	3.65	Sig.
Total	18.10	500	2.681		

Unfortunately, the above table shows that the prevalence rate of BPD was high among first divorced then widowed women [(N= 93/19%, M= 21.40, SD = 1.955); (N= 81/16%, M= 21.30, SD = 2.910)] compared to others. It means they suffered more from BPD as compared to other participants from two other groups. This finding supported by Stansfeld & Candy, 2006, p. 443; Grant et al., 2008, p. 533-545; Huang, 2009, p. 46-53; Tomko et al., 2014, p. 734-750; Juurlink et al., 2018, p. 202. Then married women (N= 171/34%, M= 17.84, SD = 2.604) suffered from BPD. Finally, the last group of women was those women who were single (N= 155/31%, M= 17.75, SD = 2.312) and they were affected and suffered less from BPD with compared to the rest of the women from other groups.

5.2.4 Differences in BPD according to occupations variable

Another goal of the study was to examine the statistical difference between BPD according to 500 participants' occupations. Results of One-way ANOVA showed that there is a significant main difference between the variable occupations and BPD; see table (7). Occupations variable were distributed among

nine groups (Doctors, engineers, lawyers, teachers, employments, NGO members, students, housewife and not-occupied women).

Table (7) One-way ANOVA to examine statistical differences in BPD according to variable occupations among participants

Source of contrast BPD/ Occupation	Sum of Squares	DF	Mean Square	F Value		Sig. 0.05
				Calculated	Table	
Between Groups	397.351	8	49.669	7.644	1.96	Sig.
Within Groups	3190.447	491	6.498			
Total	3587.798	499				

As shown in the above table, the F-calculated value is bigger than F-table value [(F-calculated value= 7.644 > F-table value = 1.96)] at the degree of freedom 8-491 and the level of significance 0.05, which means that there are significant differences in the prevalence rate of BPD among women according to the variable occupations. In order to determine the trend of differences, the study used (Scheffe) for their second analysis, and it was found that all the values of comparison were statistically significant at the degree of freedom 0.05; see table (8).

Table (8) Scheffe method to show the values of the differences between means of borderline personality disorder among participants according to occupations variable

Occupations	Mean	N	Std. deviation	Comparing value	Sig. 0.05
Not-occupied	20.15	60	3.165		
Housewife	18.90	56	2.929	1.25	Sig.
Doctors	18.30	56	2.093	1.85	Sig.
Students	18.22	56	2.544	1.93	Sig.
Teachers	18.11	56	2.294	2.04	Sig.
Lawyers	17.50	52	2.572	2.65	Sig.
Engineers	17.45	52	1.998	2.70	Sig.
Employments	17.31	56	2.627	2.84	Sig.
NGO members	17.05	56	2.513	3.10	Sig.
Total	18.10	500	2.681		

As it is expected, the prevalence rate of BPD was higher among not-occupied women and among housewife women with [(N= 60/12%, M= 20.15, SD= 3.165) and (N= 56/11.2%, M= 18.90, SD = 2.929)] one after the other. These two groups of women suffered more from BPD compared to other participants from other groups. This finding supported by Stansfeld & Candy, 2006, p. 443; Grant et al., 2008, p. 533-545; Huang, 2009, p. 46-53; Tomko et al., 2014, p. 734-750; Juurlink et al., 2018, p. 202. However, the third and fourth group were doctors and students with [(N= 56/11.2%, M= 18.30, SD = 2.093) and (N= 56/11.2%, M= 18.22, SD = 2.544)] who suffered from BPD, then teachers, lawyers, engineers and employments women [(N= 56/11.2%, M= 18.11, SD = 2.294), (N= 52/10.4%, M= 17.50, SD = 2.572), (N= 52/10.4%, M= 17.45, SD = 1.998) and (N= 56/11.2%, M= 17.31, SD = 2.627)] one after the others suffered from BPD. Finally, the last group of women was those women who work for non-government organizations (N= 56/11.2%, M= 17.05, SD = 2.513)

and they were affected and suffered less from BPD with compared to the rest of the women from other groups.

5.2.5 Differences in BPD according to Governorates

Also, the study aimed to examine the statistical difference between BPD among 500 participants according to their governorates. Results of One-way ANOVA showed that there is a significant main difference between the variable governorates and BPD; see table (9). All participants were distributed among four governorates, which are (Erbil, Suleymaniye, Duhok and Halabja).

Table (9) One-way ANOVA to examine statistical differences in BPD according to variable governorates among participants

Source of contrast BPD/G	Sum of squares	df	Mean square	F value		Sig. 0.05
				Calculated	Table	
Between Groups	61.721	3	20.574			
Within groups	3526.077	496	7.109	2.894	2.62	Sig.
Total	3587.798	499				

□

As shown in the above table, the F-calculated value is bigger than F-table value [(F-calculated value= 2.894 > F-table value = 2.62)] at the degree of freedom 3-496 and the level of significance 0.05, which means that there are significant differences in the prevalence rate of BPD among women according to the place they leave. In order to determine the trend of differences, the study used (Scheffe) for their second analysis, and it was found that all the values of comparison were statistically significant at the degree of freedom 0.05; see table (10).

Table (10) Scheffe method to show the value of the differences between mean of BPD among participants according to governorates variables



Governorates	Mean	N	Std. deviation	Comparing value	Sig. 0.05
Erbil	18.53	125	3.076		
Duhok	18.20	125	2.460	0.33	Sig.
Suleymaniye	17.87	125	2.335	0.66	Sig.
Halabja	17.59	125	2.611	0.94	Sig.
Total	18.10	500	2.681		



The above table shows that the prevalence rate of BPD was higher among participants from Erbil governorates [(N= 125/25%, M= 18.53, SD= 3.076). According to this statistical fact, women in Erbil suffered more from BPD as compared to other participants from other governorates. However, Halabja recorded with less prevalence rate of BPD [(N= 125/25%, M= 17.59, SD= 2.611) among all, and the two other governorates stayed in between with [(Duhok; N= 125/25%, M= 18.20, SD= 2.460) and (Suleymaniye; N= 125/25%, M= 17.87, SD= 2.335)] and they were affected and suffered less from BPD with compared to Erbil governorates.

Recommendations

- Government and society need to pay more attention to women and provide health care services to protect them from different kind of personality disorders and psychological health problems that they suffer from, as well as, to find ways and mechanisms to improve the psychological pressures they suffer from and increase their quality of life.
- Borderline personality disorder could be the result of a combination of some factors. If it is found that more women have BPD than men, then attention should be turned to risk factors for BPD. Perhaps, biological and sociocultural differences, life experiences, all account for the prevalence rates of BPD.
- Researchers mention that, just as a borderline personality disorder is increasingly considered a lifetime developmental disorder, so scientist need to put emphasis on risk factors and signs in the developmental trails to BPD, especially, from the early age in order to qualify early detection and intervention. Additionally, some social relationship, personal relationship and many other environmental factors like adverse childhood experiences can be considered important in adolescents who are at risk for BPD.

Suggestions

- Future studies are needed to further explore the relation between borderline personality disorder and other different variables.
- Future studies are needed to further explore the relation between borderline personality disorder and other personality disorder as this disorder has its comorbidity with other psychological and mental disorders.
- Future studies are needed to further explore the relation between borderline personality disorder and other demographic factors such as gender differences.

References

- Association, A. P. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.
- Biskin, R. S., & Paris, J. (2012). Diagnosing borderline personality disorder. *Cmaj*, 184(16), 1789–1794.
- Bornovalova, M. A., Hicks, B. M., Patrick, C. J., Iacono, W. G., & McGue, M. (2011). Development and Validation of the Minnesota Borderline Personality Disorder Scale. *Assessment*, 18(2), 234–252.
- Centre, N. C. (2009). Borderline Personality Disorder. Royal College of Psychiatrists.
- de Aquino Ferreira, L. F., Queiroz Pereira, F. H., Neri Benevides, A. M. L., & Aguiar Melo, M. C. (2018). Borderline personality disorder and sexual abuse: A systematic review.
- Ellison, JM. & Shader, R. (1993). The pharmacologic treatment of personality disorders: A dimensional approach. In: Shader R, ed. *Manual of Psychiatric Therapeutics*, 2nd Edition, Boston: Little, Brown, and Co., 259-274.
- Friedman, H. S., & Schustack, M. W. (2009). Personality classic theories and modern research (4th ed.). USA: Pearsons.
- Gould, C. (2011a). Why the histrionic personality disorder should not be in the *DSM*: A new taxonomic and moral analysis. *International Journal of Feminist Approaches to Bioethics*, 4(1), 26.

- Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., Smith, S. M., Dawson, D. S., Pulay, A. J., & Pickering, R. P. (2008). Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder. *J. Clin. Psychiatry*, 69(4), 533-545.
- Gunderson, J. & Links, P. (2008), *Borderline Personality Disorder. A Clinical Guide*, 2nd Edition. Washington, DC, American Psychiatric Publishing.
- Gunderson, J. & Weinberg, I. & Choi-Kain, L. (2013). Borderline Personality Disorder. FOCUS: The Journal of Lifelong Learning in Psychiatry. 11. 249-260.
- Hall, M. A., & Riedford, K. M. (2017). Borderline Personality Disorder: Diagnosis and Common Comorbidities. *Journal for Nurse Practitioners*, 13(9), e455–e456.
- Hessels, C. J., Laceulle, O. M., van Aken, M. A. G., Resch, F., & Kaess, M. (2018). Differentiating BPD in adolescents with NSSI disorder: the role of adverse childhood experiences and current social relationships. *Bord Personal Disord Emot Dysregul*, 5(1).
- Hoermann, S., Zupanick, C. E., & Dombeck, M. (2019, January 1). Personality Disorders: Examples of Personality Disorders With Distorted Thinking Patterns. https://www.gulfbend.org/poc/view_doc.php?type=doc&id=475&cn=8
- Huang, Y., Kotov, R., de Girolamo, G., Preti, A., Angermeyer, M., Benjet, C., Demyttenaere, K., de Graaf, R., Gureje, O., &

- Karam, A. N. (2009). DSM–IV personality disorders in the WHO World Mental Health Surveys. *Br J Psychiatry*, 195(1), 46-53.
- Juurlink, T. T., ten Have, M., Lamers, F., van Marle, H. J. F., Anema, J. R., de Graaf, R., & Beekman, A. T. F. (2018). Borderline personality symptoms and work performance: a population-based survey. *BMC Psychiatry*, 18(1).
 - Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet*, 364(9432), 453-461.
 - Linehan, M. M. (2006). The Empirical Basis of Dialectical Behavior Therapy: Development of ^[1]_{SEP} New Treatments Versus Evaluation of Existing Treatments, 7(1), 113-119.
 - Mattar, S., & Khan, F. (2017). Personality disorders in older adults: diagnosis and management. *Progress in Neurology and Psychiatry*, 21(2), 22–27.
 - Mayo. (2019, July 17). Borderline Personality Disorder - Symptoms And Causes. <https://web.archive.org/web/20190920100529/https://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/symptoms-causes/syc-20370237>
 - McLeod, S. (2019, January 1). Sampling Methods. <https://www.simplypsychology.org/self-concept.html>
 - MentalHelp. (2019, January 1). Dialectical Behavior Therapy For Personality Disorders (DBT). American Addiction

Centers. <https://www.mentalhelp.net/dialectical-behavior-therapy/for-personality-disorders-dbt/>

- National Alliance for Mental Illness. (2017, January 1). Borderline Personality Disorder. <https://www.nami.org/Learn-More/Mental-Health-Conditions/Borderline-Personality-Disorder>
- NIMH. (2016, January 1). NIMH » Borderline Personality Disorder. <https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>
- Ntshingila, N., Poggenpoel, M., Myburgh, C., & Temane, A. (2016). Experiences of women living with a borderline personality disorder. *Health SA Gesondheid*, 21, 110-119.
- Omar, A. (2010). Anfal campaigns and their impacts on economic, social, psychological conditions of the remained survived women. The Swedish Parliament Stockholm: north of Kurdistan.
- Osborne, L. L., & McComish, J. F. (2006). Working with Borderline Personality Disorder: Nursing Interventions Using Dialectical Behavioral Therapy. *JPN*, 44(6), 40-47.
- Oumaya, M., Friedman, S., Pham, A., Abou Abdallah, T., Guelfi, J.-D., & Rouillon, F. (2008). Personnalité borderline, automutilations et suicide : revue de la littérature. *L'Encéphale*, 34(5), 452-458.
- Salters-Pedneault, K. (2019, September 4). How Common Is Borderline Personality Disorder?.

<https://web.archive.org/web/20190918080759/https://www.verywellmind.com/how-common-is-bpd-425184>

- Salters-pedneault, K. (2019, July 15). How The Severity Of BPD Symptoms May Decrease As A Person Ages. <https://web.archive.org/web/20190918170145/https://www.verywellmind.com/why-do-bpd-symptoms-decline-with-age-425211>
- Schuster, J.-P., Hoertel, N., Le Strat, Y., Manetti, A., & Limosin, F. (2013). Personality Disorders in Older Adults: Findings From the National Epidemiologic Survey on Alcohol and Related Conditions. *The American Journal of Geriatric Psychiatry*, 21(8), 757-768.
- Shifiona, N., Poggenpoel, M., & Myburgh, C. (2006). Life stories of depressed adult women in peri-urban Namibia. curationis, 29(2).
- Stansfeld, S., & Candy, B. (2006). Psychosocial work environment and mental health—a meta-analytic review. *Scand J Work Environ Health*, 32(6), 443-462.
- Stepp, S. D., & Pilkonis, P. A. (2008). Age-Related Differences in Individual DSM Criteria for Borderline Personality Disorder. *Journal of Personality Disorders*, 22(4), 427-432.
- Stern, A. (2017, October 10). Psychoanalytic Investigation Of And Therapy In The Border Line Group Of Neuroses. <https://web.archive.org/web/20190907074604/https://www.tandfonline.com/doi/abs/10.1080/21674086.1938.11925367>

- Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the Prevalence of Borderline Personality Disorder in the Community. *Journal of Personality Disorders*, 4(3), 257-272.
- Ten Have, M., Verheul, R., Kaasenbrood, A., van Dorsselaer, S., Tuithof, M., Kleinjan, M., & de Graaf, R. (2016). Prevalence rates of borderline personality disorder symptoms: a study based on the Netherlands Mental Health Survey and Incidence Study-2. *BMC Psychiatry*, 16(1), 249
- Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of Borderline Personality Disorder in a Community Sample: Comorbidity, Treatment Utilization, and General Functioning. *Journal of Personality Disorders*, 28(5), 734-750.
- Widiger, T. A., & Weissman, M. M. (1991). Epidemiology of Borderline Personality Disorder. *PS*, 42(10), 1015-1021.
- Wirth-Cauchon, J. (2000). *Women and Borderline Personality Disorder*. Rutgers University Press.
- Zanarini, M. C., Vujanovic, A. A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A Screening Measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). *Journal of Personality Disorders*, 17(6), 568–573.
- Zimmerman, M., & Coryell, W. (1989). The Reliability of Personality Disorder Diagnoses in a Nonpatient Sample. *Journal of Personality Disorders*, 3(1), 53–57.

Appendix (1) Study Population

KRG Population to 2019					
Male	Female	Total	Urban	Rural	Total
3,029,889	3,003,925	6,033,814	4,911,795	1,122,019	6,033,814
		6,033,814			6,033,814

Appendix (2) Study Sample

Dem. Factors	Variables	N.	%	Dem. Factors	Variables	N.	%
Age	21-30	128	%26	Occupations	Doctors	56	11.2%
	31-40	146	%29		Engineers	52	10.4%
	41-50	124	%25		Lawyers	52	10.4%
	51-60	102	%20		Teachers	56	11.2%
	Total	500	%100				
Social Statues	Single	155	%31		Employ.	56	11.2%
	Married	171	%34		NGOs	56	11.2%
	Divorced	93	%19		Students	56	11.2%
	Widowed	81	%16		Housewife	56	11.2%
	Total	500	%100				
Educational Levels	HigherEd.	47	%9		No-job	60	12.0%
					Total	500	100%
	Bachelor	108	%22	Residence	Erbil	125	%25
	Diploma	108	%22		Suleymani.	125	%25
	Secondary	76	%15		Dohuk	125	%25
	Primary	76	%15		Halabja	125	%25
	Illiterate	85	%17		Total	500	%100
	Total	500	%100				

Appendix (3-A)

The Scale of Borderline Personality Disorder (English Version)

N	Items	Yes	No
1	My closest relationships been troubled by a lot of arguments or repeated breakups.		
2	I deliberately hurt myself physically (e.g., punched myself, cut myself, burned myself) or I made a suicide attempt.		
3	I had at least two other problems with impulsivity (e.g., eating bings and spending sprees, drinking too much and verbal outbursts).		
4	I chronically felt empty.		
5	I often felt that I had no ides of <u>who</u> I am or that I have no identity.		
6	I either love someone or hate <u>them</u> , with nothing in between.		
7	I am a very moody person.		
8	I feel that my life is dull and meaningless.		
9	When I am angry, I prefer to be alone and being quiet.		
10	I don't believe in love.		
11	I conflict with a person who made me angry.		
12	I don't believe in imagination		
13	I suspect everyone.		
14	I feel anxious and fear whenever I am angry.		

Appendix (3-B)
The Scale of Borderline Personality Disorder (Kurdish Version)

ئەخىر	پەلەن	پەرگەکان	ژ
		پەيوەندىم بە كەسە نەزىكەكانم بە ھۆى دەمەقائى كردنى زۆر يان عاجزبونىكى دووبارە رووبەرۆى كىشە پۈنەتەو.	1
		مەن بە مەبەستەو ئازارى چەستەين خۇم داو (لە خۇدان، بىرىنى چەستەم، سوتاندنى خۇم) يان خود ھەولنى خۇكۆشتەم داو.	2
		بە لاپەنى كەم دوو لەم كىشانەم ھەيە (زۆر خۇزى، زۆر خەرج كردن، زۆر خوارەنەوئى ئەلكە جول و توند قەسە كردن).	3
		ھەمىشە ھەستەم كردووە كە بەتائەم.	4
		ھەستەم كردووە كە ھىچ رايەكەم نەبوو كە مەن كىم يان ھىچ ناسنامەيەكەم ھەيە.	5
		مەن يا كەسيكەم خۇشەوئەيت يا رەقەم ئىيەتەن، بە بىن ھەبوونى ھىچ ئە نىوا نەمان دا.	6
		كەسيكى زۆر مەزاجىم.	7
		ھەستە دەكەم كە ژيانىكى بىزاركەرو بىن مانام ھەيە.	8
		كاتىك تۆرە دەبەم، جەز دەكەم بە تەنیا و بىدەنگ بىم.	9
		ھەستە بە خۇشەوئەيتى ناكەم.	10
		شەر دەكەم ئە گەل ئەو كەسەى كە تۆرەى كردووم.	11
		بە لاى مەووە خەيال كردن گرینگەن بى.	12
		گۇمان ئە ھەموو كەس دەكەم.	13
		ھەر كاتىك تۆرە دەبەم ھەستە بە ترس و دلەراوگى دەكەم.	14

شلەژانی کەسایەتی هەددی، پێژەیی بە لاوبوونەوهی، وە پەيوەندی بە هەندیک لە فاکتەرە دیموغرافیکەکان لە سەر ئاستی ئافەرەتانی کورد لە هەریمی کوردستان/عێراق

پوختە:

ئامانجەکان شلەژانی کەسایەتی هەددی، بە شلەژانیکی دەررونی بەرەلەو دادەنرێت کە لە سیستەمەکانی چارەسەری دا گرینگییەکی تایبەتی پێی نەدراوە. ئامانجی ئەم توێژینەوهیە، پێوانەکردنی تیکرای رێژەیی بە لاوبوونی شلەژانی کەسایەتی هەددی یە، وە دواتر تاقیکردنەوهی جیاوازی ئاماری لە سەر ئاستی گورپووی شلەژانی کەسایەتی هەددی بە پێی هەندیک فاکتەرە دیموغرافیکەکانی وەک (تەمەن، دەستکەوتە زانستییهکان، باری کۆمەلایەتی، بواری کار و پیشە "یا خۆد بێ کاری" وە شوینی نیشتهجی بوون) لە سەر ئاستی ئافەرەتی کورد لە هەریمی کوردستان/ عێراق.

رێکارەکان ۵۰۰ ئافەرەت لە هەر چوار پارێزگای کوردستان "هەولێر، سلێمانی، دهۆک و هەلەبجە" وە لە هەر پارێزگایەکیشت 125 ئافەرەت بەشداریان کردووە لەم توێژینەوهیەدا. بۆ پێوهری شلەژانی کەسایەتی هەددی، توێژەرەکان هەلساوان بە ئامادەکردن و دروست کردنی پێوانەکە لە رێگای پشت بەستن بە شیوازی پیاگەرەکان و راپرسی سەرەتایی/ "Exploratory method"، بەشیک لە پێوهری 'McLean BPD For Instrument Self_Screening'، وە هەرودها تیوری 'DSM-IV' "پێوهری شلەژانی کەسایەتی هەددی پیک دیت لە 14 بڕگە بە پلەیی راستگویی لە سەدا 85% وە بە پلەیی جیگیری 87%.

ئەنجامەکان دۆزینەوهی ئاستیکی بەرز و بایەخدار، لە تیکرای رێژەیی بە لاوبوونەوهی شلەژانی کەسایەتی هەددی لە سەر ئافەرەتانی کورد. هەرودها، نەبوونی گۆفاری توێژەر/ بەرگی ۳ / ژمارە ۲ / بەهاری ۲۰۲۰

هیچ جیاوازییه کی به لگه داری ئاماری له تیکرای ریژه ی به لاوبوونه وه ی شله ژانی که سایه تی
 هه ددی به پپی گۆراوی "ته مه ن" ی به شداربووانی توژیینه وه که، به لام هه بوونی
 جیاوازییه کی به لگه داری ئاماری له تیکرای ریژه ی به لاوبوونه وه ی شله ژانی که سایه تی
 هه ددی به پپی گۆراوه کانی "ده سته وته زانستییه کان، باری کۆمه لایه تی، بواری کار و
 پیشه "یا خۆد بی کاری" و شوینی نیشته جی بوون" له سه ر ئاستی ئافره تانی کورد له
 کوردستان. به و پپی یه ی که ئه و ئافره تانه ی که "نه خوینده وارن، جیابوونه ته وه، بیکارن
 وه ئافره تانه ی خه لکی شاری هه ولێرن" به ئاستیکی به رزتر و زیاتر دهنالینن به ده ست
 نه خۆشی شله ژانی که سایه تی هه ددی به به راورد له گه ل که سانی تر.

ده رکه وته کان له کۆتایی دا، به به ر چاوگرتنی ده ره نجامه کانی ئه م
 توژیینه وه یه، پپووسته له سه ر توژیهران و توژیینه وه کانی ئایینه ده لیکولینه وه ی زیاتر بکه ن
 له سه ر دۆزینه وه ی په یوه ندی نیوان شله ژانی که سایه تی هه ددی و فاکته ره کانی تر و
 جۆره کانی تری کیشه کانی ته ندروستی دروونی و عه قلی.

إضطراب الشخصية الحدية ، نسبة الإنتشار، وعلاقتها ببعض المتغيرات الديموغرافية بين المرأة الكوردية في إقليم كردستان/ العراق

ملخص:

الغرض : إضطرابات الشخصية الحدية، هي من الإضطرابات النفسية الشائعة، و غالبا ما يتم تجاهله في أماكن العلاج. هدفت الدراسة إلى قياس إنتشار إضطراب الشخصية الحدية ودلالة الفروق الإحصائية لهذه الإضطراب تبعا للعوامل الديموغرافية مثل (العمر ، الإنجازات الأكاديمية ، الوضع الإجتماعي ، المهن والمحافظات بين المرأة في كردستان / العراق) .

الطريقة : مشاركة (٥٠٠) امرأة من أربع محافظات وهي أربيل ، سلیمانیة ، دهوك وحلبجة . بعدد (١٢٥) امرأة في كل محافظة . لقياس إضطراب الشخصية الحدية إستخدمت الدراسة على الدراسة الإستطلاعية وعلى جزء من أداة الفرز الذاتي ل (ماكلين) . (MSI-BPD)

النتائج : كانت إنتشار إضطراب الشخصية الحدية دالة إحصائيا بين المرأة . وأشارت النتائج أيضا عدم وجود فروق دالة إحصائيا في إضطراب الشخصية الحدية تبعا للعمر ، ووجود فروق دالة إحصائيا في مستويات إضطراب الشخصية الحدية تبعا للإنجازات الأكاديمية ، الوضع الإجتماعي ، المهن بين المشاركات . حيث كانت النساء الأميات ، المطلقات ، الغير العاملات و نساء اللواتي في المدينة أربيل أكثر معاناتا مقارنة بالآخریات.

الاستنتاجات: هناك حاجة لدراسات مستقبلية لمواصلة استكشاف العلاقات بين إضطراب الشخصية الحدية وعوامل أخرى .

الكلمات المفتاحية : اضطرابات الشخصية الحدية ، العوامل الديموغرافية ، المرأة الكوردية في كردستان / العراق.