HEALTH, MIGRATION AND QUALITY OF LIFE AMONG KURDISH IMMIGRANTS IN SWEDEN

Marina Taloyan
To Rojan and Zoran
ABSTRACT

**Background** Although immigrants generally have poorer health and higher psychological distress than the native population, information on health, migration and quality of life among Kurdish immigrants is limited.

**Aims.** Study I: to explore the association between (i) ethnicity and self-reported health (SRH) and (ii) complaints of psychological distress. Study II: to determine whether there was an association between (i) sex and poor SRH and (ii) psychological distress in Kurdish immigrants. Study III: to examine the association between (i) ethnicity and poor psychological well-being (PW) and (ii) to assess the relationship between sociodemographic characteristics, SRH, somatic pain, GIC and poor PW. Study IV: to describe mental health among 14 Kurdish men based on their own individual stories with regard to migration. Study V: to explore the coping patterns reported by 10 Kurdish men through their individual life stories during the whole migration process.

**Methods.** Study I was based on responses from a total of 111 Kurdish men originating from Turkey and Iran from Inv-ULF (the first Swedish National Survey of Immigrants) and 1412 Swedish men from SALLS (Swedish Level-of-Living Surveys-SALLS) data collected in 1996 by Statistics Sweden. Study II was based on a whole Kurdish sample (n=197) from Inv-ULF. Study III, Kurdish sample from Inv-ULF and 1407 Swedes from SALLS were studied. The odds ratios with 95% Confidence intervals were calculated using unconditional logistic regression in all three quantitative studies (studies I-III). Studies IV and V, 10 men were interviewed face-to-face and one focus group of 4 participants was used. The analyses were done using Grounded Theory in study IV and Narrative analysis in study V.

**Results** Study I showed that the age-adjusted odds for poor SRH and sleeping difficulties among Kurdish men were about 3.5 times higher than among Swedish men. The odds decreased to 2.1 and 2.7 respectively in a model adjusted for age and the other explanatory variables. Study II showed that Kurdish men and women had a high prevalence of poor SRH and psychological distress. Sex differences in anxiety remained also when all explanatory variables were taken into account. Study III showed that the odds ratios for Kurdish individuals for having poor PW were twice as high as for Swedish individuals after adjustment for age, sex, employment and SRH. Men with poor SRH had more than threefold higher odds ratios for having poor PW compared to those with good SRH. Futhermore, being female, having somatic pain and recurrent GIC regardless of ethnicity increased the odds for poor PW. Study IV described emerged model with two major themes and interlinked categories. The themes were: 1) protective factors for good mental health (self-satisfaction, sense of freedom, sense of belonging, creation and re-creation of Kurdish identity) and 2) risk factors for poor mental health (dissatisfaction with Swedish society, lack of sense of freedom, yearning, worrying about the current political situation in the home country). Study V identified the coping strategies such as: contributing to the Kurdish culture and the home country; getting an education; creating one’s own society / building a family; achieving inner security and balance; being active and occupied and finally, coping with ongoing political instability in the country of origin.

**Conclusions** In the present thesis we found that Kurdish men and women reported a high prevalence of poor SRH and psychological distress. Negative experiences of pre-migration as well as post-migration were associated with the outcomes. Protective factors for good mental health and risk factors for poor mental health were emerged in this study. In order to cope with the Swedish society it was important for Kurdish men to be included in it and acknowledged as individuals and to be able to contribute to the Kurdish culture and the home country. Findings in this thesis may be helpful in enabling the primary health services to take the impact of the migration experiences of Kurdish men into account.

**Key words:** Immigrants, Kurds, ethnicity, self-reported health, psychological distress, psychological well-being, coping strategies, quantitative, qualitative, Sweden
LIST OF PUBLICATIONS


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<th>Description</th>
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<tr>
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<td>The Survey of Immigrant Living Conditions (Swedish)</td>
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<td>Gastrointestinal complaints</td>
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<td>GT</td>
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<td>PW</td>
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<td>CI</td>
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INTRODUCTION

MIGRATION

Migration is an old phenomenon. People have migrated extensively to other countries. Traditional countries of immigration in migration history are the United States, Canada, Australia and New Zealand. New countries of destination of migrants are Ireland, Italy, Norway and Portugal. The number of migrants in 2005 was estimated to be 191 million worldwide, which comprises 3% of the global population (1).

The European population includes 64.1 (8.8%) million migrants while 44.5 million were living in North America according to the statistics for 2005. As a result of conflicts in 52 countries 26 million individuals were internally displaced in 2007 (2). The global number of refugees reached approximately 10 million persons (3). According to the United Nations Census for 2005 countries in the Middle East have the highest immigration population percentage (3).

Migrants can choose to move voluntarily or are forced (involuntarily) to move. The estimated number of international migrants in Europe increased from 14.2 million (3.4%) of the population in 1960 to 64.1 million (8.8%) in 2005. According to Statistics Sweden (SCB), in the same year 12% of the Swedish population consisted of foreign-born persons (immigrants), including refugees who sought asylum due to political persecution in their home countries (4). The large influx of refugees from the Middle East has dominated the last few decades of immigration to Sweden.

Migration is a process of displacement, stress and loss in time and space (5). Migration includes multiple stresses and factors that affect the mental health of individuals (6, 7). The areas that might be affected are: the social support system, changes in identity, concept of self and adjustment to a new culture. These factors play an important role in the increasing rates of mental illness among immigrants (8). The whole migration process affects different individuals in various ways and with different individual responses. The migration process may cause poor mental health.
depending on several factors during periods of pre-migration, migration and post-
migration. Differences between forced and voluntary migration must be taken into
consideration when investigating the influence of migration (9-11). Migration in it-
self even within different parts of the same country has been shown to affect life sat-
isfaction and self-esteem negatively. Coping with cultural changes and adaptation to
new circumstances may lower the levels of life satisfaction (12).

**Ethnicity/Ethnic identity**

Many traditional societies undergo fast social and cultural changes as a result of
migration, demographic changes, industrialization and other economic changes and
integration. International migration has brought formerly isolated ethno-cultural
groups into contact with other group members. Migration and globalization during
the last few decades have given rise to new issues concerning the basis of the
common society.

Ethnicity is often defined as a collective identity. Hutchinson and Smith defined
ethnicity as the feeling of kinship, group solidarity and common culture (13). While
the anthropologist Eriksen defined ethnicity as an issue of relationship between at
least two groups, with a conception of cultural differences between these groups
(14). The general definition of ethnicity/ethnic group is often expressed as a self-
perceived group of people who hold onto common traditions not shared by others,
such as religious beliefs and practices, language, a sense of historical continuity and
common ancestry or place of origin (15). More specifically the group share attributes
of membership regarding racial, territorial, economic, religious, cultural and
linguistic uniqueness. Ethnic identity is essentially subjective, a sense of belonging
and an ultimate loyalty (15).

Identity is the individual self-concept (16, 17) and the interaction between the
individual and his surroundings (18). All identity aspects are social and are created in
interaction with the surroundings (18). Ethnic identity is an expression of ethnicity.
Identity, ethnicity and culture are an ongoing process of interaction (18-20).
Migration of Kurds

Kurds are an ethnic group living in the Middle East particularly in adjacent areas of eastern Turkey, Iran, Iraq and Syria. They are called “a nation without country” or “proto-nation” (14). About half of all Kurds live in Turkey, where they constitute about 20% of the total population of 70.5 million (in 2007). Kurds in Iran are estimated to be the third largest ethnic group, constituting 9% of the total population of 70.4 million (in 2006). The political developments of recent decades have resulted in the immigration of about 600,000 Kurds to Western Europe in 1992 (21, 22). The majority of Kurdish immigrants in Western countries have been forced to emigrate due to the political developments during recent decades and they often bear personal experiences of violence as a consequence of a war-like situation in their home countries (23-27).

The first Kurdish immigrants came to Sweden in the middle of the 1960s within the framework of labour recruitment from Central Anatolia in Turkey. Kurds from Turkey seeking protection on the ground of political persecution following the military coups at the beginning of 1971 and 1981 were the dominant group of migrants to Sweden. In the 1970s the majority of a Christian minority from eastern Turkey, Assyrians/Syrians, sought asylum in Sweden due to religious persecution. The migration of ethnic Turks and Assyrians/Syrians is now limited to family reunification, while the Kurds have been accepted for both political reasons (as refugees) and family formation/reunification since 1980s up to today (28). Kurds from Iran arrived in Sweden as refugees following the Islamic revolution and the subsequent Iran-Iraq war (29, 30). It is difficult to give an exact number of immigrants with Kurdish ethnicity in Sweden, because they are registered as citizens of the countries from which they come, but they are estimated to be around 50,000-60,000 (31). They originate predominantly from Turkey and constitute the third largest ethnic group of refugees from Iran in Sweden. More than half of the Kurds from Turkey have rural background, while those from Iran come from urban areas (30).
Previous studies on Kurdish immigrants have been based on their country of birth rather than their ethnicity (32, 33) while the uniqueness of this thesis is the use of data on self-reported ethnicity.

Registration by ethnicity is absent in the official Swedish statistics, while immigrants are identified according to country of birth, parents’ country of birth and citizenship. It is estimated that approximately one third of the population born in Turkey with residence in Sweden (shown in Table 1) are Kurds (4, 28).

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Men</th>
<th>Women</th>
<th>Total population</th>
</tr>
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<tbody>
<tr>
<td>Turkey</td>
<td>20.422</td>
<td>17.736</td>
<td>38.158</td>
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<tr>
<td>Iraq</td>
<td>54.842</td>
<td>42.671</td>
<td>97.513</td>
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<tr>
<td>Iran</td>
<td>29.961</td>
<td>26.555</td>
<td>56.516</td>
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<tr>
<td>Syria</td>
<td>9.107</td>
<td>9.122</td>
<td>18.229</td>
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**HEALTH**

The World Health Organization (WHO, 1946) defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (34).

Mental health is not just the absence of mental disorder either. It is defined, according to WHO, “as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (35). According to medical anthropology, ill health can be divided into three types: disease (the pathological process, deviation from a biological norm), illness (the patient’s
individual’s experience of ill health, even without the existence of disease) and sickness (the social dimension) (for references see (36)).

The data presented in this study are self-reported and include illness rather than only disease. However, the strong association between SRH and morbidity and mortality has been demonstrated in many international studies (37-39).

**Effects of migration on health**

Psychological, social and cultural problems affecting health status are common consequences of migration (40, 41). Several Swedish studies show an association between migration and poor SRH (33, 42, 43), higher risks for psychiatric ill health, intake of psychotropic drugs (44) and other indicators of psychological distress (23). Negative life events before migration, such as escape from war or war-like situations and political persecution in the home country, may also compound the adversity of the factors experienced in exile (45) and significantly impact upon poor SRH in immigrants and refugees (46). Many individuals with Kurdish ethnicity are known to have had negative personal experiences, including persecution and political violence (47-49) in their home countries. Despite this fact, there are few international studies based on national samples focusing on SRH and indicators of psychological distress experienced by this immigrant group.

There is a clear association between poor psychological well-being (PW) and somatic pain/gastrointestinal complaints (50-52). For example, it has been shown that various indicators of psychological stress such as recent life events and psychiatric disease are the most frequent risk factors for the incidence of gastrointestinal symptoms (53, 54). Studies on migration show that migration affects the individuals in various ways depending on their personality and the reason for migration. Migration of Kurds from Turkey, Iran, Syria, and Iraq is mainly forced migration. Consequences of trauma and torture before migration have a significant influence on health even after many years of resettlement in the new country (55).
A number of studies show that some negative consequences of migration include poor SRH (33, 43) and complaints indicating psychological distress (56) related to factors such as social isolation, low socio-economic status and language difficulties, as well as negative experiences from the home country, such as having been subjected to violence (45, 49). Kurdish immigrants in Western countries had been exposed to forced assimilation, deportation and persecution during many years in their home countries (57-59), which may increase their vulnerability to poor health and psychological distress (46, 55, 60).

Self-reported health

Well-being is an important determinant of health (61). SRH status is a major predictor of morbidity, mortality and health services utilization (37-39). In addition, SRH is an important indicator of the quality of life as well as a good predictor of future health (62, 63). Furthermore, age, sex, life satisfaction and heritability are factors related to poor SRH (64) as well as to poor PW (65-67).

Several studies indicate that SRH is lower among immigrant than native populations in many countries (8, 45, 68, 69). Belonging to an ethnic group has been shown to be a significant risk for higher levels of depression and anxiety, and a strong predictor of poor mental health and poor subjective health (70). However, there are some studies which show that immigrants in general have a higher prevalence of poor SRH and have higher indicators of psychological distress than the native Swedish population (23, 44).

A lack of studies on SRH among the Kurdish population in Turkey limited the exploration of differences in comparison with Kurdish individuals in Sweden. However a study from Iraqi Kurdistan shows that the prevalence of poor SRH is very similar to the figure for the native Swedish population in Sweden (71-73). The migration process is an important issue which has an impact on health and well-being (23, 74). Factors like earlier negative experiences in the home country and the process of acculturation can affect the health status as well (23, 74). In addition to this, social isolation and problems in the new country, such as the language barrier and difficulties connected with entering the labour market and low socio-economic
status might have negative consequences for health (33, 75, 76). Women immigrants in general are a particularly vulnerable group and are more affected than men by the negative effects of migration on their health status (75, 77, 78).

**Protective factors for good mental health**

Several studies have discussed protective factors for good mental health in general and some have focused on immigrants in particular. These factors may help individuals cope with stress and difficulties in life. They can be grouped into two categories:

a) **Social factors:**
   - Stability and emotional support from the family (79), social support of high quality (80); marital status (81-83), religion (84, 85), cultural fellowship (86), employment and economic security (87) and good health.

b) **Psychological factors:**
   - Capacity to cope with crises and difficulties, good self-esteem (88, 89), hope; sense of belonging and relating (with family and friends in society, cultural identity) and sense of life satisfaction.

**Risk factors for poor mental health**

Several studies have explored risk factors for mental health and coping mechanisms in immigrants (90). Schweitzer and co-authors, for example, showed in their narrative study the impact of pre-migration trauma, post-migration living difficulties and social support on the current mental health of Sudanese refugees in Australia and reported that perceived social support from the migrant’s ethnic community plays a major role in predicting mental health. In their report three themes were identified: religious beliefs, social support and personal qualities (91). Another study on Bosnian refugees living in the United States revealed two major themes: belonging (concepts of cultural memory, identity and difference, empathy and reciprocity) and adapting (coping with transitions, coping with memories of past and attendant losses, coping with accepting a new culture) (92). Especially losses of community, of important life projects and loss of valued social roles were identified, among others factors, as stressors of exile (93).
Acculturation and coping strategies

The individual who through migration, education, marriage or some other influence leaves one social group or culture without making a satisfactory adjustment to another finds himself on the margin of each but a member of neither. He is a “marginal man” (94).

This was pointed out by the sociologist Everett V. Stonequist in 1937, who elaborated the concept of “marginal man” conceived by Robert E. Park (95). According to Stonequist “the individual is not a marginal person until he experiences the group conflict as a personal problem” as the result of migration (94). It is discussed in this classic work that the marginal man has three possibilities to develop his biography: 1) assimilation into the dominant group; 2) assimilation into the subordinate group; or 3) some form of accommodation, perhaps only temporary and incomplete, between the two groups. A common consequence of the third case may be a creation of identity as the person is partially assimilated and psychologically identifies himself with the dominant group without being fully accepted (96).

Acculturation is defined as cultural changes and consequences of long contact between two culturally different groups. However acculturation is not a group-level phenomenon but an individual-level phenomenon, referred to as psychological acculturation (97). The lack of individual adjustments to current situation can cause reconstruction of self and his place or role in society – the personal-social process. The full transformation comes after a long and painful process (94).

Acculturation is also defined as a process of interaction between individuals or groups from different cultures followed by changes in one or both of the cultures (5, 98). Acculturative stress is regarded as the physiological and psychological state of the individuals caused by stressors in the environment in a process of coping to achieve satisfactory adaptation to new situations (97). Individual experiences of acculturation vary: for some individuals, acculturative changes might be stressors, while for others they might be seen as an opportunity (80, 99). Less acculturated in-
individuals experience more acculturative stress than more acculturated individuals (100).

Berry discussed four strategies in the acculturation process: integration, separation, assimilation and marginalization (101). Integration and assimilation into the ethnic heritage might be the best options for the individuals’ well-being, while ethnic marginalization of individuals may be correlated with poor well-being (97).

Several proxy measures of acculturation have been developed, for example, age at migration and years of resettlement in the new country (102), employment and language skills (33, 103).

The perception and influence of different experiences in immigrants are not static and might change during the life cycle (5). The length of residence in the host country might affect the immigrant’s health differently and not everyone experiences psychological distress (68). Low satisfaction with life in the new country is influenced by such factors as a high level of education and more advanced age at the time of emigration (48). It is suggested that the role of acculturation in understanding immigrant health is complex and may differ for various ethnic groups (104).

Acculturation is conceived as a process of adaptation to stressful changes (105). Coping is defined as a psychological phenomenon and a process of cognitive and behavioural changes, problem-solving or emotionally oriented strategies (106). Furthermore, acculturation and coping have been explored in many other migrant groups (105, 107, 108). A study in Bosnians concluded that coping is a dynamic process that involves the relationship between the individual and the environment (109).

There is a lack of knowledge on the process of acculturation and coping strategies among Kurdish immigrants in Sweden despite the fact that Kurds started to migrate to Sweden at the beginning of 1970. Unlike refugees with similar migration background from other countries the majority of Kurds have not been able to return to their home country which may cause distress and yearning.
AIMS

GENERAL AIM

To explore the health, migration and quality of life among Kurdish immigrants in Sweden.

SPECIFIC AIMS

Study I

The first aim of this study was to analyse whether there was an association between ethnicity and SRH and the three indicators of psychological distress (i.e having sleeping difficulties, using psychotropic drugs and experiencing feelings of anxiety/worrying). The second aim was to determine whether the association remains after adjusting for socio-economic status and demographic variables. The final aim was to give possible explanations of the differences through an analysis of some immigrant-specific variables.

Study II

The first aim was to analyse whether there was an association between gender and poor SRH and complaints indicating psychological distress in Kurds. The second aim was to analyse whether this association remains after adjusting for explanatory variables. The third aim was to explore possible reasons for gender differences by studying some migration-related variables.

Study III

The aim of this study was to examine the association between ethnicity and poor PW. Another aim was to assess the relationship between sociodemographic characteristics (age, gender, marital status and employment), SRH, somatic pain, recurrent GIC and poor PW.
Study IV
In this study we chose Kurds from Turkey to describe the events and experiences of the whole migration process and the impact of pre- and post-migration factors on mental health based on an emic view of individual stories among Kurdish men in Sweden.

Study V
The purpose of this qualitative study was to explore the coping pattern reported by 10 Kurdish men through their individual life stories during the whole migration process.

METHODS

Combining of quantitative and qualitative methods

In the present thesis quantitative and qualitative methods have been combined. These approaches refer to two different paradigms. The reason for combing these methods was to elucidate the main aim of this thesis. It was not possible to identify the participants of Kurdish origin in the Inv-ULF survey 1996. The results of the quantitative studies I-III prompted an interest in describing how Kurdish men experienced the migration process and how they managed its effects. Thus the choice fell on of focus group and the participants’ own narratives through the use of in-depth interviews which allowed us to achieve the aims of the last two studies IV and V.

Quantitative research

Quantitative research generally focuses on answering the questions “what?”, “how much?” and “why?” (110). Quantitative and qualitative paradigms have different viewing positions: ways and places from which to see (111). These positions are: epistemological (view of knowing), ontological (view of reality), axiological (view of what is valuable) and methodological (view of procedure of inquiry) (112).
According to the quantitative theoretical framework there is an absolute truth, “reality”. The knowledge is objective and neutral for the researcher using the quantitative method. It is referred to as “positivism” in contrast to qualitative research which knowledge is called “constructivism” (social, historical and individual contexts). In the quantitative approach, frequent use is made of structured questionnaires with set responses designed before starting the data collection. Quantitative researchers make different assumptions from those in qualitative research and use different data-collecting and analytical tools (110).

**Qualitative research**

Qualitative research is generally defined as research that utilizes open-ended interviews to explore and understand the attitudes, opinions and feelings of individuals or a group of individuals (113). The choice of qualitative methods is often made when the researcher is interested in exploring the lives of individuals, their life experiences, behaviours, emotions, social movements and cultural phenomena as well as other questions which cannot be answered using quantitative methods (114, 115). Qualitative research focuses on answering the questions “why?” and “how?”. In this thesis the main reason for using a qualitative method was the nature of the problem in focus. In this case our interest was in attempting to understand how Kurdish men experience and cope with the migration process and how this affects their mental health. There are different methods within qualitative research but we chose the Grounded Theory and the narrative analysis because we judged these two methods to suit the purpose and aims of studies IV and V. Qualitative research can take many forms; typical examples are focus groups, in-depth interviews, field observations and notes.

The following established criteria for scientific rigour in qualitative research have been suggested: credibility, dependability, confirmability and transferability (116); internal validity, objectivity and generalizability (117). According to Glaser fit, work, relevance and modifiability are the most central criteria in good constructions of the Grounded Theory (115). Use of these criteria has been suggested for the evaluation of the quality of the grounded theories (118). For improvement of the
validity, Mays and Pope, among others, have suggested triangulation and reflexivity (119, 120). According to Malterud, such criteria as relevance, validity and reflexivity are essential standards for qualitative inquiry (121).

**Grounded Theory**

The Grounded Theory (GT) approach is a “general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area” (115). GT has sometimes been referred to as “the constant comparative method of analysis” (122). According to the GT the data collection and the analysis of the in-depth interviews take place concurrently. Data analysis begins with open coding: the process of breaking down, comparing, examining, conceptualizing and categorizing data. This is followed by identification of the main themes. Using these themes, one continues with data collection. Questions and comparisons are developed as the data are examined and categorized and connections are made between categories. The emerging categories are grouped into core categories and a model or theory is developed. Theoretical saturation in the data collection is reached when no new data are generated from subsequent interviews or other resources used in collecting the data. It is of no use to have additional participants if the core categories are saturated (123). Sample selection and sample size in GT depend on the topic of interest and the emerging categories (124). The goal is to gather rich data to generate a theory or a model. The adequate number of participants for a study is determined by a combination of the research questions and data and external validity (121). The developed model is generated by means of a dialogue using data and conceptualization, subcategories and categories all the time. There is a continuous connection and control of the data during the analytical process.

**Narrative analysis**

“The human being is a narrative” is a repeatedly stated claim in various forms of the literature (125). Narrative as a social process is usually connected to issues of culture and power (120). Participants in the narrative inquiry have the power to define their
identities and experiences and individual story-telling is influenced by their social positioning (120).

Narrative is used as a tool in psychology, psychotery, anthropology, nursing and occupational therapy. It might give access to the individuals’ meaning-making processes and retains the temporal and sequential relation among life events (126, 127).

Narrative analysis is defined as the use of stories to describe human experience and action (126). There is no standard set of procedures for narrative analysis. Generally used methods of narrative data analysis are:

1. Keeping the overall perspective – the concept of plots, directions (128).
2. Understanding events from a narrative position – investigation of significant life events which reflect meaningfulness and coherence (129).
3. Forming categories and interpretation from narrative positioning by using of a comparative qualitative method or qualitative content analysis (130).

When analysing narratives, the researcher strives to actively find the voice of the participant in the context of a particular time, place or setting. This method of analysis is an attempt to provide a description of the participant’s stories and experiences based upon their recollections and statements about their own feelings and perspectives. The narrative process enables the participants to begin to restory and reconstruct their lives and critically reflect on the conditions that constrain their actions and create difficulties.

The interviews in study V were studied using the narrative analysis methodology, which is, from our point of view, more appropriate and increases insight into the individual coping pattern. In this study we used a holistic approach of narrative analysis (131). This approach is a procedure for discerning significant life events that make sense and give coherence (129), for arranging data into chronologies and for searching the life histories for plots. Narrative analysis is the method of looking at the individuals life’s story as construction of identity (132).
QUANTITATIVE STUDIES I, II and III

MATERIALS

All three quantitative studies are cross-sectional and are based on data from two surveys conducted by Statistics Sweden in 1996: (1) the first Swedish National Survey of the Living Conditions of four immigrant groups born in Chile, Iran, Poland and Turkey (Inv-ULF) and (2) the Swedish Level-of-Living Surveys (SALLS), which have been used annually by Statistics Sweden (SCB) for population-based studies (ULF).

The Swedish Annual Level-of-Living Survey (SALLS)

Since 1975, Statistics Sweden has conducted the Swedish Annual Level-of-Living Survey among representative samples of the Swedish population (n=7500) aged 16-84, selected by simple random sampling. This survey for population-based studies, collects quantitative data based on face-to-face interviews concerning various components of welfare in the Swedish population such as employment, housing, economy, health, leisure time, material resources, civil and social relations, security and education. The response rate is about 80%. Data in SALLS are subjective perceptions and are not based on objective measures. However the validity and reliability of the questions are high according to many studies using questions and self-reported measures from SALLS (133, 134). In addition, the reliability of the variables has been analysed by re-interviews (test-retest method) (133). The Swedish sample in the three quantitative studies was based on answers from the population living in Sweden in the age group 27-60 years. We used ULF - the Swedish abbreviation of SALLS in the presented studies.

The Survey of Immigrant Living Conditions (Inv-ULF)

In 1996, a large national survey The Survey of Immigrant Living Conditions, generally referred to as Inv-ULF, was conducted by Statistics Sweden (SCB) for the first time. The selected immigrant groups were from Chile, Poland, Iran and Turkey. These four countries represented the major nations from which the largest immigrant groups had emigrated during the 1980s and were covered by the Swedish immigrant
policy. The survey was conducted in collaboration between several national authorities such as the Swedish National Board of Health and Welfare, the Swedish Immigration Board (SIV), the National Institute of Public Health and the Swedish Government. Inclusion criteria were individuals aged 27-60 who had immigrated to Sweden during the years 1980-1989. Data in Inv-ULF are the same as in ULF with the addition of several questions pertinent to immigrants (for example, migration background, knowledge of Swedish and perceived discrimination). Subsequently, 108 individuals drawn from the Swedish population register did not fit the criteria (i.e., lived abroad or had left Sweden without informing the authorities) and were excluded from the national simple random sample of 3000 and the remaining 2892 persons were sent a written invitation to participate in the survey. The interviews were arranged by telephone and conducted in Swedish; however, one tenth of the interviews were conducted with the aid of a third person. The interviews were conducted face-to-face at the respondent’s home and lasted approximately one hour. A professional translator was used when needed or, in some cases, a family member or an adult child. Trained interviewers from Statistics Sweden administered the interviews. Participants were presented with questions and response alternatives. The interview instruments were in Swedish and translated into four languages – Persian, Spanish, Turkish and Polish which were used to support responses. The majority of the Kurdish respondents (94.4%) filled out the questionnaire by themselves; 1% got help from a professional interpreter, and family members assisted the rest.

**Non-respondents**

The overall response rate was 68.5% (n=1980). Of these, 46.5% were men and 54.5% women. The overall response rate was about 68.3% for persons born in Iran and 65.6 % for persons born in Turkey. The non-response rate was 31.7% for respondents born in Iran and 34.4% for those born in Turkey. About half of the non-respondents refused to join the study and the other half could not be reached. The non-respondents were approximately of the same age as the participants. Men from Stockholm and Gothenburg and those with low income were over-represented among the non-respondents.
Table 2. An overview of the five studies included in this thesis.

<table>
<thead>
<tr>
<th>Study</th>
<th>Data source</th>
<th>Outcome</th>
<th>Statistical method/method of analysis</th>
<th>Sample</th>
<th>Age</th>
<th>Study design</th>
<th>Interview period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>ULF and Inv-ULF</td>
<td>-Self-reported health&lt;br&gt;-Sleeping difficulties&lt;br&gt;-Intake of psychotropic drugs&lt;br&gt;-Feelings of anxiety</td>
<td>Logistic regression</td>
<td>111 Kurdish men 1412 Swedish men</td>
<td>27-60</td>
<td>Quantitative, Cross-sectional</td>
<td>1996</td>
</tr>
<tr>
<td>Study 2</td>
<td>Inv-ULF</td>
<td>-Self-reported health&lt;br&gt;-Sleeping difficulties&lt;br&gt;-General fatigue&lt;br&gt;-Feelings of anxiety</td>
<td>Logistic regression</td>
<td>111 Kurdish men 86 Kurdish women</td>
<td>27-60</td>
<td>Quantitative, Cross-sectional</td>
<td>1996</td>
</tr>
<tr>
<td>Study 3</td>
<td>ULF and Inv-ULF</td>
<td>-Psychological well-being (GHQ-12) &lt;br&gt;-Self-reported health&lt;br&gt;-Somatic pain&lt;br&gt;-Gastro-intestinal complaints</td>
<td>Logistic regression</td>
<td>197 Kurdish group 1407 Swedish group</td>
<td>27-60</td>
<td>Quantitative, Cross-sectional</td>
<td>1996</td>
</tr>
<tr>
<td>Study 4</td>
<td>Interviews</td>
<td>-Protective and risk factors for mental health</td>
<td>Grounded Theory</td>
<td>14 Kurdish men 10 Kurdish men</td>
<td>24-60</td>
<td>Qualitative</td>
<td>2005-2007</td>
</tr>
<tr>
<td>Study 5</td>
<td>Interviews</td>
<td>Coping strategies</td>
<td>Narrative analysis</td>
<td></td>
<td>24-60</td>
<td>Qualitative</td>
<td>2005-2007</td>
</tr>
</tbody>
</table>
**Study sample**

**Study I**

This study was based on the responses from a total of 1523 individuals: 1412 Swedish men from ULF and 111 Kurdish men from Turkey (n=97) and Iran (n=14) in the age group 27-60 years from Inv-ULF.

**Study II**

Within this sample individuals in Inv-ULF who identified themselves as having Kurdish ethnicity (n=197) and coming from Turkey (n=175; 97 men and 78 women) and from Iran (n=22; 14 men and 8 women) were selected for this study.

**Study III**

A total of 1604 respondents from ULF and Inv-ULF were analysed in this study: 1407 Swedish men and women from ULF and 197 Kurdish men and women from Inv-ULF.

**Outcome variables**

**Study I**

*Self-reported health* was based on the question: “How do you rate your general state of health?” Response alternatives were (1) good or (2) very good, versus (3) rather poor, (4) poor and (5) very poor. In this study SRH was dichotomized as (1) good [response alternatives (1) and (2)] or (2) poor [response alternatives (3)-(5)], respectively.

Three variables had been taken as indicators of *psychological distress*. They were:

*Have you had sleeping difficulties during the last two weeks?* Response alternatives were “yes” or “no”.

*Have you regularly or temporarily used sleeping medication (hypnotics), antidepressive medication or sedative medication (tranquillizers) during the last two weeks?* Response alternatives were “yes” or “no”.

*Do you have feelings of anxiety/worrying?* A “yes” response includes slight and
serious problems of worrying versus not having these feelings.

**Study II**

*Self-reported health* was based on same question as in study I: “How do you rate your general state of health?”

*Indicators of psychological distress* were implicated by an affirmative answer to any of the following question alternatives: (1) Sleeping difficulties: “Have you had sleeping difficulties during the last two weeks?” (2) General fatigue: “Have you during the last two weeks often experienced fatigue; had difficulties starting the day; felt exhausted during daytime; felt exhausted in the evenings?” (3) Feelings of anxiety: “Do you have feelings of anxiety?” We call the last variable *anxiety* in the following text.

**Study III**

*GHQ-12* includes 12 items: the ability to concentrate, loss of sleep because of worrying, feeling useful, ability to make decisions, being constantly under strain, inability to overcome difficulties, enjoyment of normal activities, facing up to problems, being unhappy and depressed, losing confidence in yourself, thinking of yourself as worthless and feeling reasonably happy.

The options for each item were dichotomized according to the response. Positive answers, i.e. 1 and 2, to each question were regarded as “0” while the negative answers, i.e. 3 and 4, were regarded as “1”. For example, in question one, “able to concentrate” with the response options 1 = “better than usual” and 2 = “as usual” were regarded as “0” while the answers, “worse than usual” = 3 and “much worse than usual” = 4, were regarded as “1”.

Finally, all negative values were summed up and, in the analyses, a cut-off point of three or more complaints was regarded as a proxy for poor psychological well-being. The selection of this cut-off was based on earlier research and recommendations (135).
Explanatory variables

Study I

*Kurdish ethnicity* was based on self-identification within the cohort of respondents who identified themselves as belonging to the Kurdish group in the INV-ULF study. *Age* at the time of the interview was categorized into the groups: 27-39, 40-49 and 50-60 years. *Marital status* at the time of the interview comprised two levels: Single (including never married, divorced or widowed) and cohabiting (including married). *Education* was categorised into three groups: low-level education (including no education up to primary school, or roughly 0-9 years), intermediate education (including secondary school, or roughly 10-11 years) and high-level education (university level, or roughly > 12 years). *Housing* comprised two groups: ownership and renting. *Employment status* was based on whether the respondent had been employed during the preceding week (any type of full or part-time employment including sick leave and vacation) or non-employed (all persons without employment including retired persons and students). *Number of children* comprised three levels: no children, 1-2 children and 3 or more children.

Study II

Age was classified in four groups: 27 – 34, 35 – 39, 40 - 44 and 45 – 60 years. Marital status, education and employment status were used as in study I.

Study III

*Self-reported health* included five responses: (1) good and (2) very good which were regarded as (1) good, versus (3) rather poor, (4) poor and (5) very poor which were regarded as (2) poor. *Age* was classified in four groups: 27–34, 35–39, 40-44 and 45–60 years. *Marital status and employment status* were used as in study I. *Somatic pain* comprised three questions regarding pain of musculoskeletal origin with reference to different locations: 1. Pain in neck, shoulders or scapula region;
2. Pain in back, hip or sciatica; 3. Pain in hands, elbow, leg or knee. Each of these had three response alternatives: “yes, severe”, “yes, minor”, “no”. Reporting complaints from more than one location was considered to be somatic pain. The reason for this cut-off was based on the median for reporting complaints. Recurrent gastrointestinal complaints comprised one question with the options “yes, severe”, “yes, minor” and “no”. Both options “yes, severe” and “yes, minor” were regarded as a gastrointestinal complaint.

**Descriptive variables**

**Study I**

Descriptive variables consisted of immigrant-specific questions included in the Inv-Ulf study, analysed for in-depth insight into the situation of Kurdish men. An important difference is that they are not included in the multivariate analysis due to the absence or low number of Swedish men responding. The questions used for the descriptive analysis were:

*What kind of community did you grow up in?* Response alternatives were: “capital city”; “other large city (100,000-1 million inhabitants)” or smaller city” (<100,000 inhabitants), and “town” or “village” (<10,000 inhabitants).

*What was the main reason for your migration to Sweden?* The question included five response alternatives: “Family reunion”; “Political/religious reason/war/political instability in the home country”; “Studies”; “Employment” and “Other reasons”. Of these, the second response alternative indicating political (and other) instability in the home country was selected as a descriptive variable.

*Were you or someone close to you exposed to violence due to war and political persecution in your home country?* The question included five response alternatives: “Yes, I was exposed”; “Yes, a close relative”; “Yes, both a close relative and I”; “No, nobody” and “No response”.

*Do you wish to stay in Sweden permanently or do you have a desire to move back?* Answers included four alternatives. The answer “I wish to stay in Sweden” was dichotomized against four alternatives indicating “I desire to move back” (“I wish to leave during the coming years”; “I wish to leave in the future” and “I don’t know/have no idea if I wish to stay”).
Affirmative answers such as “I worry about the international situation/political situation in my home country” were grouped as worrying about the situation in the home country. The affirmative answers “I (often or frequently) worry about my economic situation; ... the children’s future; ...my own health” were interpreted as indicating a second category of all other worries.

Perceived discrimination: The question about the perception of being discriminated against was: “Do you think you receive equal treatment in comparison to Swedish people...at work or at the employment agency; ... at the housing agency or by the landlord; ... by neighbours; ... at the bank; ... when you seek health care from doctors or at hospitals; ... at the insurance agency; ... at social service agencies; ... at the police station and ... at restaurants? Response alternatives were “Yes better”; “Yes equal”, “No worse”, “No much worse” and “I don’t know”. The answers “No, worse” and “No, much worse” were taken to be indicative of a perception of being discriminated against.

Access to cash margin: The question on access to cash was formulated as “If you suddenly should find yourself in an unexpected situation and needed cash, are you able to raise 14,000 SEK within a week?” (The sum 14,000 SEK indicated a minimum margin of cash for an average Swedish consumer indexed for 1996). Response alternatives were “Yes” and “No”.

Study II

The following three questions in this study were the same questions as in study I.

What was the main reason for your migration to Sweden?

Were you or someone near to you subjected to violence in the home country as a consequence of war or political unrest? The answers “yes, often” and “yes, on occasion” were interpreted as affirming subjection to violence.

Perceived discrimination: Answers to the question Do you think you receive equal treatment in comparison to Swedish persons at work or at the employment agency... the housing agency or by the landlord... by neighbours... at the bank... the health centre... the insurance agency... the social service agency... the police station... at restaurants? consisted of the alternatives: (1) yes, better, (2) yes, equal, (3) no, worse, and (4) no, much worse.
Perceived level of control over one’s life: Answers to the question *Do you usually feel that you are in charge of your own life?* consisted of two alternatives: (1) yes and (2) no. No answers were interpreted as a perception of a low level of control over own life.

Having worries: Answers to the question *Have you recently felt worried over the international situation, for example the risk for war or political unrest in your home country/ your children’s future/ your own health/ that you or a family member will be exposed to violence or threats because of your ethnic or religious affiliation/ your or your family’s economic situation during the coming year?* consisted of (1) no, (2) often and (3) occasionally. The answers “often” and “occasionally” were interpreted as indicating the presence of worries over the respective situations.

Statistical analysis

Study I

The prevalence of outcome variables (SRH, having sleeping difficulties, use of psychotropic drugs and feelings of anxiety/worrying) between Kurdish and Swedish men were estimated as percentages. The relations between outcome variables and ethnicity and other explanatory variables were calculated using unconditional logistic regression models (136). Two models were taken into consideration, one adjusting for age (Model 1) and the other adjusting for age and all other explanatory variables (Model 2). The statistical programs SAS and STATA were used in the analysis.

Study II

The prevalence of poor SRH and indicators of psychological distress (outcome variables) were estimated separately as percentages for men and women. The association between sex and the outcome variables was calculated using an unconditional logistic regression model (136). Results were shown as odds ratios (ORs) with 95% confidence intervals (CI). Two models were taken into consideration: one adjusted for sex and age (*Model 1*) and the other adjusted for age and other explanatory variables (*Model 2*). Variables related to the migration process were analysed using Pearson’s chi2-test.
Study III

The prevalence of the outcome variable for both Kurdish and Swedish individuals was calculated separately using the statistical software program Stata v.9 (137). Pearson’s chi-2 test was used to test the level of significance. Unconditional logistic regression was used to calculate the odds ratios (ORs) and the 95% Confidence interval (95% CI) in five models. In the first model, age and sex were included in addition to ethnicity. All significant variables were introduced in further models. For example, in Model 2 we introduced employment in addition to age and sex. In a separate model (not shown in the table), we introduced somatic pain in addition to age, sex, employment and SRH. Nevertheless, because of a strong correlation between somatic pain and SRH, we decided to add each variable, i.e, SRH, somatic pain and recurrent GIC separately in different models, i.e. 3, 4 and 5. The fit of the models was judged by the Hosmer-Lemeshow goodness-of-fit test. The models were considered acceptable at p>0.05 and all models met this demand.

Ethical considerations

Participation in the study was voluntary. Confidentiality was ensured for all respondents. All respondents remained anonymous to the study team. The regional ethical committee of the Karolinska Institute (Stockholm) approved this study in 2004 (reference number 04-617/5).
QUALITATIVE STUDIES IV and V

Study sample used in both IV and V

Since the aims of these studies were to describe the mental health of Kurdish men in relationship to the migration process, the selection of participants was highly limited to a specific group. Participants in this study were recruited using the snowball sampling technique (138). The first contact person was a member of Kurdish cultural network who was asked to list others with similar characteristics and those persons were approached for an interview. This procedure was repeated from one participant to the next and so on. This sampling method is used particularly to find a marginal research population that is often difficult to study, as for example, such as specific immigrant groups (139). We considered having a wider range of age in regard to the methods of analysis - Grounded Theory (study IV) and Narrative analysis (study V).

A total of 14 Kurdish men participated in study IV which was based on one focus group (n=4) and in-depth, face-to-face interviews (n=10). Study V used ten in-depth interviews for the analysis. Interviews were done at the participant’s home (n=1), workplaces (n=7) or other places (n=6). All participants in the in-depth interviews were recruited by phone. The interviews were focused on open-ended questions and concerned the participants’ experiences and their own life stories since migration to Sweden. Inclusion criteria were: Kurdish men, aged 24 to 60 and born in the South-Eastern part of Turkey. Ten of the participants escaped from Turkey during and after the military coup in 1980 in Turkey. Years of residence in Sweden ranged between 8 and 28 years. Ten individuals were married, three were divorced and one was single. Eleven of them had children while three had no children. All of them were employed at the time of the interviews with experience of unemployment before then. This study was conducted during the years 2005-2007.

Focus group
Data collection began with focus group consisting of four men. After agreeing to participate, each participant received a letter with information and semi-structured
interview guide with themes on their experiences in Sweden, values and norms and cultural identity to discuss freely. When the transcriptions were done, copies were sent to all four participants to check if they were in conformity with the original conversation during the focus group interview. All participants returned the copies with their approval.

**In-depth interviews**

Ten in-depth interviews lasted from 60 to 120 minutes and were audio-taped. The participants were informed of the purpose of the research and interview and were ensured confidentiality and that they could withdraw whenever they wanted. All participants were contacted by the first author by phone and had the opportunity to choose the language to be used during the interviews. The interviews were conducted in both in Swedish (n=7) and Kurdish (n=3) languages. The last three interviews were translated and back-translated by the first author and the person who was not involved in this research and whose mother tongue is Kurdish and who has a good command of Swedish. The transcriptions were done the same day or on consecutive days. These interviews (n=10) were used in study V.

**Analysis**

**Study IV**

Data collection and the analysis of the in-depth interviews took place concurrently according to the qualitative inductive method, i.e. Grounded Theory (122). The guide for in-depth interviews was based from the beginning on questions arising from the focus group interview and was constantly updated during the conduct of the interview. Data analysis began with open coding: the process of breaking down, comparing, examining, conceptualizing and categorizing data. This was followed by identification of the main themes. With these themes we continued data collection. Questions and comparisons were developed as the data were examined, categorized and connections between the categories were made. The emerging categories were grouped in core categories and the model was developed. Theoretical saturation of the data collection was reached (122). The developed model was generated by dia-
logue with data and conceptualization, subcategories and categories all the time. There was a continuous connection and control of the data during the process of analysis (124).

**Study V**

The data gathered from ten in-depth interviews was analysed using a narrative approach. In the beginning we focused on a single interview: (i) every story was read separately. Then we (ii) identified the significant issues regarding the life of particular individuals. The next step (iii) was to find connections between different aspects of the whole story and (iv) arrange it chronologically: pre-migration, initial migration (first phase after arriving in Sweden) and post-migration. Finally, we developed (v) key terms and (vi) the “core story” (plot) was created (140). These six steps followed for every story separately. In this way we gathered the pieces for a mozaic/total picture (141) shown in the figure below.

**My role as a researcher**

Throughout the research, I attempted to follow the role of reflexivity: critically examining my own position as a female member of the Kurdish ethnic group. My personal identity was created on the basis of my integration into Georgian and Russian culture. During the whole process of analysis I was aware of my role as a researcher as an objective tool for data collection and analyses (120). I was aware of the need not to choose sides despite my personal feelings and emotions. But it is possible that my background affects the presentation of the Discussion section in the qualitative studies. In the views of three persons who have no connection with the interviews, the author and co-authors are quite objective.

On the other hand, I was helped by my own life experiences in multicultural society, previous qualitative research on the Kurdish population in Georgia and in Sweden and ethnographic observations during my 17 years in Sweden. My own comprehension was a good instrument for making the final connections between categories and to discuss the results of this study. My own reflexivity created the relationship between me as a researcher and the participants based on mutual trust and respect (142).
MAIN RESULTS

Study I

In general, Kurdish men were younger, more often cohabiting or married, had a higher percentage of primary school level education, lived more often in rental dwellings, were more often unemployed and had more children compared to Swedish men. The prevalence of the outcome variables poor SRH, having sleeping difficulties, use of psychotropic drugs and feelings of anxiety/worrying in the two groups is shown in Table 3. The unadjusted prevalence of poor SRH was twice as high among Kurdish men (30.6%) as among Swedish men (15.2 %). The prevalence of poor SRH increased with age in both ethnic groups. Kurdish men reported a higher prevalence of psychological distress: having sleeping difficulties (32.4 % versus 12.4%), use of psychotropic drugs (4.5 % versus 2.8%) and having feelings of anxiety/worrying (16.2% versus 10.4%) than Swedish men. Unemployment created some similarities. There was a positive association between poor SRH, having sleeping difficulties and unemployment for both ethnic groups. Unemployed Swedish and Kurdish men had twofold increased odds for poor SRH. Having sleeping difficulties was also higher in the two groups than in employed men. Unemployed Kurdish men reported more sleeping difficulties than their Swedish counterparts, whereas unemployed Swedish men reported a higher use of psychotropic drugs and feelings of anxiety/worrying more often than employed Swedish men as well as unemployed Kurdish men. Thus the impact of ethnicity was decreased in this comparison. On the other hand, Kurdish men with three or more children reported poorer health (42.4 %) more often than Swedish men (12.5%) and they also had more sleeping difficulties (35.6% versus 14.0%), used psychotropic drugs more often (5.1% versus 2.2%) and experienced more anxiety/worrying (16.9% versus 8.8%) than Swedish men.
Table 3. Prevalence of the outcome variables (%): poor SRH, sleeping difficulties, use of psychotropic drugs and feelings of anxiety by ethnicity (men, percentages).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Poor self-reported health</th>
<th>Sleeping difficulties</th>
<th>Use of psychotropic drugs</th>
<th>Feelings of anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swedish</td>
<td>Kurdish</td>
<td>Swedish</td>
<td>Kurdish</td>
</tr>
<tr>
<td>Total</td>
<td>15.2</td>
<td>30.6</td>
<td>12.4</td>
<td>32.4</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27-39</td>
<td>9.3</td>
<td>23.4</td>
<td>12.7</td>
<td>31.2</td>
</tr>
<tr>
<td>40-49</td>
<td>14.1</td>
<td>36.4</td>
<td>12.0</td>
<td>29.5</td>
</tr>
<tr>
<td>50-60</td>
<td>23.8</td>
<td>100.0</td>
<td>12.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>14.4</td>
<td>32.3</td>
<td>11.4</td>
<td>30.2</td>
</tr>
<tr>
<td>Single</td>
<td>17.5</td>
<td>20.0</td>
<td>15.4</td>
<td>46.7</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>21.1</td>
<td>29.5</td>
<td>10.7</td>
<td>22.7</td>
</tr>
<tr>
<td>Intermediate</td>
<td>15.8</td>
<td>31.7</td>
<td>14.1</td>
<td>39.0</td>
</tr>
<tr>
<td>High</td>
<td>9.6</td>
<td>30.8</td>
<td>10.4</td>
<td>38.5</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>14.8</td>
<td>40.9</td>
<td>11.4</td>
<td>27.3</td>
</tr>
<tr>
<td>Rental</td>
<td>16.1</td>
<td>28.1</td>
<td>15.3</td>
<td>33.7</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12.9</td>
<td>20.3</td>
<td>11.1</td>
<td>29.7</td>
</tr>
<tr>
<td>No</td>
<td>33.5</td>
<td>51.3</td>
<td>23.2</td>
<td>37.8</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>18.8</td>
<td>20.7</td>
<td>13.5</td>
<td>27.6</td>
</tr>
<tr>
<td>1-2 children</td>
<td>11.6</td>
<td>13.0</td>
<td>10.7</td>
<td>30.4</td>
</tr>
<tr>
<td>3 or more children</td>
<td>12.5</td>
<td>42.4</td>
<td>14.0</td>
<td>35.6</td>
</tr>
</tbody>
</table>
The crude odds for poor SRH for Kurdish men was 2.5 times higher than for Swedish men (not shown in table). Upon adjusting for age, the odds ratio (OR) for poor SRH in Kurdish men increased to 3.47 and the odds for having sleeping difficulties increased to 3.44. The OR for using psychotropic drugs and feelings of anxiety/worrying also increased to 2.13 and 1.62, respectively (Table 4a, Model 1, Swedish men as reference). Table 4a, Model 2 shows the odds ratios for poor SRH and indicators of psychological distress among Kurdish men after adjusting for age and all other explanatory variables. After adjustments, the OR for poor SRH among Kurdish men decreased to 2.10 and the OR for having sleeping difficulties decreased to 2.65. The OR for use of psychotropic drugs decreased from 2.13 to 1.21, but the difference was not statistically significant and could not be analysed due to the small number of cases. The odds for feelings of anxiety/worrying decreased from 1.62 to 1.33 and were non-significant when an adjustment was made for housing and employment (results not shown in table).

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>Poor SRH</th>
<th>Sleeping Difficulties</th>
<th>Use of psychotropic drugs</th>
<th>Feelings of anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model 1</td>
<td>Model 1</td>
<td>Model 1</td>
<td>Model 1</td>
</tr>
<tr>
<td>Kurdish Men</td>
<td>3.47 (2.21-5.45)</td>
<td>3.44 (2.22-5.34)</td>
<td>2.13 (0.79-5.73)</td>
<td>1.62 (0.94-2.79)</td>
</tr>
<tr>
<td></td>
<td>Model 2</td>
<td>Model 2</td>
<td>Model 2</td>
<td>Model 2</td>
</tr>
<tr>
<td></td>
<td>2.09 (1.20-3.64)</td>
<td>2.65 (1.55-4.51)</td>
<td>1.21 (0.36-3.99)</td>
<td>1.33 (0.70-2.54)</td>
</tr>
</tbody>
</table>

The reduction in OR for poor SRH from 3.47 to 2.10 is demonstrated by stepwise inclusion of the variables in Table 4b. When an adjustment was made for housing, the OR for poor SRH decreased to 3.10. When an adjustment was made for employment, the OR decreased to 2.49 and, finally, when an adjustment was made for the number of children, the OR decreased to 2.10. Compared to Swedish men, Kurdish men were more than twice as likely to report poor SRH after adjustments were made for all explanatory variables.
Table 4b. Odds ratios with 95% confidence intervals for poor SRH by stepwise inclusion of explanatory variables, using logistic regression, in Swedish and Kurdish men (n=1523).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>+ Marital status</th>
<th>+ Education</th>
<th>+ Housing tenure</th>
<th>+ Employment</th>
<th>+ No. of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kurdish</td>
<td>3.47 (2.21-5.45)</td>
<td>3.63 (2.30-5.72)</td>
<td>3.48 (2.20-5.52)</td>
<td>3.10 (1.88-5.08)</td>
<td>2.49 (1.49-4.19)</td>
<td>2.09 (1.20-3.64)</td>
</tr>
<tr>
<td>(Swedish reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1.15 (0.78-1.71)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1.75 (1.15-2.67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediary</td>
<td>1.53 (1.05-2.22)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing tenure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.04 (0.72-1.50)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.18 (2.21-4.58)</td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 reference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.21 (0.83-1.76)</td>
</tr>
<tr>
<td>3 or more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.68 (1.04-2.73)</td>
</tr>
</tbody>
</table>
Table 4c also demonstrates the decrease in the likelihood of having sleeping difficulties after stepwise inclusion of each explanatory variable. After an adjustment for employment, the OR for having sleeping difficulties decreased to 3.06 and when the number of children was included, the OR fell to 2.65. Kurdish men had a more than twice higher odds for having sleeping difficulties than Swedish men.
Table 4c. The odds ratios with 95% confidence intervals for sleeping difficulties by stepwise inclusion of explanatory variables, using logistic regression in Swedish and Kurdish men (n=1523) (Swedish men as reference group).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>+ Marital status</th>
<th>+ Education</th>
<th>+ Housing tenure</th>
<th>+ Employment</th>
<th>+ No. of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kurdish (Swedish ref)</td>
<td>3.44 (2.22-5.34)</td>
<td>3.66 (2.35-5.71)</td>
<td>3.98 (2.53-6.28)</td>
<td>3.46 (2.12-5.65)</td>
<td>3.06 (1.86-5.05)</td>
<td>2.65 (1.55-4.52)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(married reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1.44 (0.95-2.18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(high reference)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>0.86 (0.54-1.36)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediary</td>
<td>1.31 (0.91-1.88)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing tenure</td>
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</tr>
<tr>
<td>(yes reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.21 (0.84-1.74)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(yes reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.99 (1.35-2.94)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(1-2 reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0.91 (0.61-1.36)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 or more</td>
<td>1.39 (0.86-2.25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The most important variables with a significant impact on differences in reporting poor SRH in Kurdish men, as compared to Swedish men, were housing, employment and number of children. Employment and number of children had a significant impact on having sleeping difficulties. Nevertheless, differences remained.

Table 5 presents the frequency of descriptive variables specific to the immigrant group. As many as 87.4% of the Kurdish men in this study reported political unrest or war/religious persecution as the main reason for immigrating to Sweden and 62.2% reported having had experiences of violence against themselves or a close relative in their home countries. More than half (54.3 %) of the Kurdish men reported having worries about their economic situation, about their children’s future or their own health. Nearly all of them (91.0 %) reported worries about the political situation in the home country. Furthermore, 81.1% perceived themselves to be highly or moderately discriminated against in Sweden.

Table 5. The distribution of immigrant-specific descriptive variables, poor SRH and sleeping difficulties in Kurdish men (n=111) (percentages).

<table>
<thead>
<tr>
<th>Descriptive variables</th>
<th>Yes</th>
<th>Outcome variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background in rural area (population &lt; 100,000) of the home country</td>
<td>60.4</td>
<td>Poor SRH 55.9 66.7</td>
</tr>
<tr>
<td>Reason for emigrating: political, religious, war or war-like situation in the home country</td>
<td>87.4</td>
<td>85.3 94.4</td>
</tr>
<tr>
<td>Subjected to violence in the home country</td>
<td>62.2</td>
<td>67.6 75.0</td>
</tr>
<tr>
<td>Desire to move back to the home country</td>
<td>55.0</td>
<td>35.3 38.9</td>
</tr>
<tr>
<td>Worries about political situation in the home country</td>
<td>91.0</td>
<td>100 91.7</td>
</tr>
<tr>
<td>All other worries</td>
<td>54.3</td>
<td>76.5 69.5</td>
</tr>
<tr>
<td>Perception of being discriminated against in Sweden</td>
<td>81.1</td>
<td>91.2 91.7</td>
</tr>
<tr>
<td>Does not have access to Cash margin (14,000 SEK)</td>
<td>39.6</td>
<td>50.0 50.0</td>
</tr>
</tbody>
</table>
Study II

The distribution of the explanatory and outcome variables by sex is shown in Table 6. Age distribution was similar in the two groups, with a mean age of about 37.5 years. In general Kurdish women were significantly more often single \( (p< 0.002) \), had lower-level education \( (p< 0.001) \) and were more often unemployed \( (p< 0.000) \) than men. Table 6 also shows the prevalence of poor SRH and indicators of psychological distress in women and men. The unadjusted prevalence of poor SRH and indicators of psychological distress were generally higher in women.
Table 6. Distribution of background and outcome variables in Kurdish women and men, percentages (n=197).

<table>
<thead>
<tr>
<th>Explanatory variables</th>
<th>Total</th>
<th>Poor SRH</th>
<th>Sleeping difficulties</th>
<th>General fatigue</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>43.6</td>
<td>56.4</td>
<td>45.4</td>
<td>30.6</td>
<td>41.7</td>
</tr>
<tr>
<td>Age in years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27-34</td>
<td>36.1</td>
<td>27.9</td>
<td>41.9</td>
<td>16.1</td>
<td>36.7</td>
</tr>
<tr>
<td>35-39</td>
<td>30.2</td>
<td>29.7</td>
<td>50.0</td>
<td>30.3</td>
<td>42.3</td>
</tr>
<tr>
<td>40-44</td>
<td>19.7</td>
<td>26.1</td>
<td>35.3</td>
<td>37.9</td>
<td>37.5</td>
</tr>
<tr>
<td>45-60</td>
<td>14.0</td>
<td>16.3</td>
<td>58.3</td>
<td>44.4</td>
<td>58.3</td>
</tr>
<tr>
<td>Marital status*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>73.3</td>
<td>86.5</td>
<td>41.3</td>
<td>32.3</td>
<td>37.7</td>
</tr>
<tr>
<td>Single</td>
<td>26.7</td>
<td>13.5</td>
<td>56.5</td>
<td>20.0</td>
<td>52.2</td>
</tr>
<tr>
<td>Education*</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>66.3</td>
<td>39.6</td>
<td>48.2</td>
<td>29.6</td>
<td>43.6</td>
</tr>
<tr>
<td>Medium</td>
<td>23.3</td>
<td>37.0</td>
<td>35.0</td>
<td>31.7</td>
<td>35.0</td>
</tr>
<tr>
<td>High</td>
<td>10.4</td>
<td>23.4</td>
<td>55.6</td>
<td>30.8</td>
<td>44.4</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>18.6</td>
<td>19.8</td>
<td>43.8</td>
<td>40.9</td>
<td>42.7</td>
</tr>
<tr>
<td>Rental</td>
<td>81.4</td>
<td>80.2</td>
<td>45.7</td>
<td>28.1</td>
<td>37.5</td>
</tr>
<tr>
<td>Employment*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37.2</td>
<td>66.7</td>
<td>40.6</td>
<td>20.3</td>
<td>38.7</td>
</tr>
<tr>
<td>No</td>
<td>62.8</td>
<td>33.3</td>
<td>48.1</td>
<td>51.4</td>
<td>43.4</td>
</tr>
</tbody>
</table>

*p<0.001
The results of the two logistic analyses by stepwise inclusion of explanatory variables showed that when an adjustment was made for age only the odds for poor SRH in Kurdish women was two times higher than for men. Women also had 45% higher odds for sleeping difficulties (OR=1.45); 68% higher odds for general fatigue (OR=1.68) and more than three times increased odds for anxiety (OR=3.39) than men. After adjusting for age as well as for other explanatory variables, the odds for poor SRH among Kurdish women decreased and were no longer significant. Also, the sex differences in sleeping difficulties and general fatigue disappeared as well. However, the odds for poor SRH was about 2½ times higher (OR=2.46) in unemployed Kurdish individuals.

The odds for anxiety remained significantly higher among women throughout stepwise inclusion of the explanatory variables in the analysis of sex differences. Kurdish women, according to Table 6 were often younger, more likely to be single, had lower level of education and higher rates of unemployment than men. Women had three-to four-fold increased odds for anxiety than men after adjustments for age (OR=3.35), education (OR=3.94), marital status (OR=3.76), housing (OR=3.67) and employment (OR=3.26).

An analysis of immigrant-specific descriptive variables among women and men (Table 7) shows that a significantly higher percentage of the Kurdish men arrived in Sweden alone (73.0%) and sought political asylum (87.4%). High percentages of both women and men had experiences of violence in their home countries. About 90% of all respondents had worries about the political unrest in the home country and about 70% had worries about their economic situation. A significantly higher (p< 0.001) proportion of men (81.1%) than women (60.5%) perceived themselves as being discriminated against and a higher proportion of women (43.0%) reported that they felt they had a low level of control over their lives than men did (22.5%).
Table 7. Distribution of selected immigrant-specific descriptive variables (percentages).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Women (n=86)</th>
<th>Men (n=111)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-migration experiences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Seeking political asylum in Sweden</td>
<td>44.2</td>
<td>87.4*</td>
</tr>
<tr>
<td>• Travelling alone to Sweden</td>
<td>31.4</td>
<td>73.0*</td>
</tr>
<tr>
<td>• Subjection to violence in the home country</td>
<td>47.7</td>
<td>62.2</td>
</tr>
<tr>
<td><strong>Post-migration experiences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medium/high degree of discrimination</td>
<td>60.5</td>
<td>81.1*</td>
</tr>
<tr>
<td>• Low sense of control over own life</td>
<td>43.0</td>
<td>22.5*</td>
</tr>
<tr>
<td>Worry about:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• International situation (risk for war or political unrest in the home country)</td>
<td>89.5</td>
<td>91.0</td>
</tr>
<tr>
<td>• Children’s future</td>
<td>67.4</td>
<td>53.2</td>
</tr>
<tr>
<td>• Own health</td>
<td>55.8</td>
<td>40.5</td>
</tr>
<tr>
<td>• Being exposed to violence or threats due to ethnic or religious affiliation</td>
<td>51.2</td>
<td>45.0</td>
</tr>
<tr>
<td>• Own economic situation</td>
<td>73.3</td>
<td>69.4</td>
</tr>
</tbody>
</table>

*p<0.005

**Study III**

**Sociodemographic background**

In total, 197 Kurdish men and women were compared with 1407 Swedish men and women. The proportions of men and women were quite similar. The Swedish population was older with a mean age of 42 years and the range was 27-60 years, while the Kurdish population was younger with a mean age of 37 years and a range of 27-59 years. For example, about 47% of Swedish individuals were in the age group 45-60 years, while only 15.2% of Kurds were in that group. Eighty-seven per cent of the Swedish-born subjects had employment compared to only 53.8% of the
Kurdish-born subjects. The proportions of married/cohabiting and single subjects were similar in both groups.

Psychological well-being

Table 8 shows the studied variables by ethnicity. The left part of Table 9 shows a comparison between Swedish women and Kurdish women, and the right part a comparison between Swedish men and Kurdish men. It is obvious from Table 9 that individuals with Kurdish background reported poorer PW, poorer SRH, more anxiety, more recurrent GIC and more somatic pain. For example, 26% of Kurdish-born subjects reported poor PW compared to 10.5% of Swedish-born subjects. Poor SRH was reported by 37.6% of Kurdish-born subjects compared to 18% of Swedish-born subjects. In addition, somatic pain was more common among Kurdish-born subjects than among Swedish-born ones. About 47% of the Kurdish subjects reported pain in more than one location compared to 32.7% of the Swedish-born subjects.

Table 8. Prevalence (%) of poor PW, poor SRH and somatic diseases and complaints in Kurdish immigrants and the Swedish sample (n=1604).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Swedish-born (n= 1407)</th>
<th>Kurdish-born (n= 197)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor PW</td>
<td>10.5</td>
<td>26.0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Poor SRH</td>
<td>18.0</td>
<td>37.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>39.2</td>
<td>40.0</td>
<td>0.922</td>
</tr>
<tr>
<td>Eczema or skin rash</td>
<td>15.4</td>
<td>14.8</td>
<td>0.824</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.7</td>
<td>2.6</td>
<td>0.410</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>4.1</td>
<td>1.5</td>
<td>0.079</td>
</tr>
<tr>
<td>Urinary tract complaints</td>
<td>3.6</td>
<td>5.1</td>
<td>0.290</td>
</tr>
<tr>
<td>Anxiety, fear</td>
<td>13.8</td>
<td>26.0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Overweight, obesity</td>
<td>20.2</td>
<td>14.8</td>
<td>0.075</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>6.5</td>
<td>1.5</td>
<td>0.006</td>
</tr>
<tr>
<td>Recurrent GIC</td>
<td>11.7</td>
<td>20.4</td>
<td>0.001</td>
</tr>
<tr>
<td>Pain in back, hip or sciatica</td>
<td>37.0</td>
<td>46.4</td>
<td>0.010</td>
</tr>
<tr>
<td>Pain in hands, elbows, legs or knees</td>
<td>27.1</td>
<td>36.2</td>
<td>0.008</td>
</tr>
<tr>
<td>Pain in shoulders, neck or scapula region</td>
<td>41.6</td>
<td>58.2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Somatic pain</td>
<td>32.7</td>
<td>46.7</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

1More than one somatic pain regardless of location (pain in back, hip or sciatica; pain in hands, elbow, leg or knee and pain in shoulders, neck or scapula region).
In general, the same pattern of differences exists between the total numbers of Swedish-born and Kurdish-born subjects regardless of sex (Table 8). Kurdish women reported poorer PW, poorer SRH and more somatic pain than Swedish women. This was also true for Kurdish-born men and Swedish-born men. Also, anxiety was more common among Kurdish-born subjects than among Swedish-born ones regardless of sex. However, it is of interest to note that recurrent GIC were more common among Kurdish-born men than among Swedish-born men. Nevertheless, this difference among Kurdish women and Swedish-born women was not significant (Table 9).

**Logistic regression**

The odds ratio in the unadjusted logistic regression model for poor PW among Kurdish-born subjects was about three times higher than among Swedish born-subjects (OR= 2.99; 95% CI 2.1-4.3) (not shown in table). Significant variables were included in the logistic regression models and are shown in Table 10. When age and sex were included in model 1, the OR for being Kurdish-born subjects and having poor PW was 2.88 (95% CI 2.08-4.30) compared to Swedish-born subjects. The odds ratio for being women and having poor PW was 2.31 (95% CI 1.67-3.18) regardless of ethnicity. The age group 45-60 years had a lower odds ratio for having poor PW than the reference group (27-34). When employment was introduced into the model 2, the OR for PW was only slightly affected, i.e. 2.51 (95% CI 1.66-3.78).

In the last three models, we had included SRH, somatic pain and recurrent GIC separately in each model. An adjustment for SRH in model 3 showed that subjects with poor SRH had OR=3.85 (95% CI 2.72-5.43), compared to those with good SRH in the first three models. Furthermore, this affected the OR for PW, which declined from 2.51 to 2.03. In model 4 we introduced somatic pain, and those with such pain had OR=1.99 with a 95% confidence interval of 1.45-2.72 compared to those without somatic pain. Finally, in the last model, model 5, even those with recurrent GIC had a higher odds ratio (OR=2.36; 95% CI 1.61-3.47) than subjects without this complaint. However, Kurdish-born subjects had a two to three times higher OR for having poor PW compared to Swedish-born subjects in the presented models, and this remained significant.
Table 9. The prevalence (%) of outcome and explanatory variables by ethnicity and sex.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Swedish women, n= 50.3 (707)</th>
<th>Kurdish women, n= 43.7 (86)</th>
<th>P-value</th>
<th>Swedish men, n= 49.7 (700)</th>
<th>Kurdish men, n= 56.3 (111)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor PW</td>
<td>13.9</td>
<td>38.4</td>
<td>&lt;0.0001</td>
<td>7.0</td>
<td>16.2</td>
<td>0.001</td>
</tr>
<tr>
<td>Poor SRH</td>
<td>21.5</td>
<td>46.5</td>
<td>&lt;0.0001</td>
<td>14.4</td>
<td>30.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>40.7</td>
<td>43.0</td>
<td>0.684</td>
<td>37.7</td>
<td>36.9</td>
<td>0.875</td>
</tr>
<tr>
<td>Eczema or skin rash</td>
<td>18.0</td>
<td>21.2</td>
<td>0.481</td>
<td>12.7</td>
<td>9.9</td>
<td>0.398</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.7</td>
<td>3.5</td>
<td>0.245</td>
<td>1.7</td>
<td>1.8</td>
<td>0.951</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>4.4</td>
<td>1.2</td>
<td>0.153</td>
<td>3.7</td>
<td>1.8</td>
<td>0.301</td>
</tr>
<tr>
<td>Urinary tract complaints</td>
<td>5.0</td>
<td>10.6</td>
<td>0.033</td>
<td>2.1</td>
<td>0.9</td>
<td>0.380</td>
</tr>
<tr>
<td>Anxiety, fear</td>
<td>17.9</td>
<td>38.8</td>
<td>&lt;0.0001</td>
<td>9.7</td>
<td>16.2</td>
<td>0.040</td>
</tr>
<tr>
<td>Overweight, obesity</td>
<td>22.9</td>
<td>21.2</td>
<td>0.715</td>
<td>17.4</td>
<td>9.9</td>
<td>0.048</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>7.9</td>
<td>2.3</td>
<td>0.062</td>
<td>5.0</td>
<td>1.0</td>
<td>0.051</td>
</tr>
<tr>
<td>Recurrent GIC</td>
<td>13.2</td>
<td>16.5</td>
<td>0.410</td>
<td>10.2</td>
<td>23.4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Pain in back, hip or sciatica</td>
<td>39.2</td>
<td>55.3</td>
<td>0.004</td>
<td>34.7</td>
<td>39.6</td>
<td>0.309</td>
</tr>
<tr>
<td>Pain in hands, elbow, leg or knee</td>
<td>32.1</td>
<td>38.8</td>
<td>0.209</td>
<td>22.1</td>
<td>34.2</td>
<td>0.005</td>
</tr>
<tr>
<td>Pain in shoulders, neck or scapula region</td>
<td>50.3</td>
<td>74.1</td>
<td>&lt;0.0001</td>
<td>32.9</td>
<td>45.9</td>
<td>0.008</td>
</tr>
<tr>
<td>Somatic pain</td>
<td>38.2</td>
<td>55.8</td>
<td>0.002</td>
<td>27.1</td>
<td>39.6</td>
<td>0.007</td>
</tr>
</tbody>
</table>
Table 10. The odds ratios (ORs) and 95% confidence interval for poor PW in Kurdish-born individuals with Swedish-born individuals as reference group.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1 + age, sex</th>
<th>Model 2 + employment</th>
<th>Model 3 + SRH</th>
<th>Model 4 + Somatic pain</th>
<th>Model 5 + Recurrent GIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurdish-born</td>
<td>2.88 (2.08-4.30)</td>
<td>2.51 (1.66-3.78)</td>
<td>2.03 (1.32-3.11)</td>
<td>2.31 (1.52-3.50)</td>
<td>2.46 (1.62-3.73)</td>
</tr>
<tr>
<td>Age groups (years) (27-34 reference)</td>
<td>1.23 (0.81-1.88)</td>
<td>1.28 (0.84-1.96)</td>
<td>1.16 (0.75-1.80)</td>
<td>1.21 (0.79-1.86)</td>
<td>1.36 (0.89-2.10)</td>
</tr>
<tr>
<td>35-39</td>
<td>0.72 (0.44-1.20)</td>
<td>0.74 (0.45-1.23)</td>
<td>0.64 (0.38-1.10)</td>
<td>0.70 (0.42-1.17)</td>
<td>0.77 (0.46-1.28)</td>
</tr>
<tr>
<td>40-44</td>
<td><strong>0.64</strong> (0.44-0.96)</td>
<td><strong>0.66</strong> (0.44-0.97)</td>
<td><strong>0.48</strong> (0.32-0.73)</td>
<td><strong>0.59</strong> (0.40-0.88)</td>
<td><strong>0.64</strong> (0.43-0.95)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women (Men reference)</td>
<td>2.31 (1.67-3.18)</td>
<td>2.22 (1.61-3.10)</td>
<td>2.04 (1.46-2.83)</td>
<td>2.07 (1.49-2.86)</td>
<td>2.25 (1.61-3.12)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (Yes reference)</td>
<td>0.69 (0.47-1.02)</td>
<td><strong>0.95</strong> (0.63-1.41)</td>
<td>0.74 (0.50-1.10)</td>
<td>0.77 (0.52-1.14)</td>
<td></td>
</tr>
<tr>
<td>SRH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.85 (2.72-5.43)</td>
</tr>
<tr>
<td>Poor (Good reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic Pain (&gt;1 location)</td>
<td></td>
<td></td>
<td></td>
<td>1.99 (1.45-2.72)</td>
<td></td>
</tr>
<tr>
<td>Recurrent GIC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.36 (1.61-3.47)</td>
</tr>
</tbody>
</table>
Study IV

The analysis identified two core categories: **protective factors for good mental health** and **risk factors for poor mental health** and are presented in order below.

*Protective factors for good mental health* consist of four categories with interlinked subcategories: *self-satisfaction; sense of freedom; sense of belonging; creation and re-creation of Kurdish identity.*

*Self-satisfaction*
This category arose from different factors expressed by the participants. Accepting both the past and the reason for migration made it easier to accept their present situation in the new country. This meant that they could move forward and not stagnate. Pursuing education, finding employment, marriage and building a family meant settlement and finding their own place in the new country. Security and inner satisfaction with their live were the end results and were thus expressed as self-satisfaction.

*Sense of freedom*
The new host country offered the men freedom which for the most of them who had experienced denial and eradication of major portions of their identity, was very valuable. Being free to use their original language, to participate in political, social and cultural activities to strengthen their Kurdish identity and thus being able to preserve their Kurdish identity gave them a great appreciation for the sense of freedom in the new country.

*Sense of belonging*
Having the freedom to express oneself and self-satisfaction with the security attached to it, made it easier to connect with others especially with those they shared common values, similar experiences and goals, i.e. mainly other Kurds.
Creation and re-creation of Kurdish identity

Feeling secure within oneself gives the strength to develop and actualize one’s own dreams and ambitions. Being free to do so and having the resources in the sense of belonging to a group paved the way for some of the participants to pursue their dreams and ambition to create a Kurdish identity. The creation of the Kurdish identity was not limited to putting the pieces of their identity back together and to developing it more actively in the new country where they had the possibilities to do so.

As one might notice, the above categories are almost knitted into each other and contributed to the growth and development of one another. The sense of being able to be oneself, be active, realize one’s dreams and wishes without being afraid of repercussions or punishment was nurtured. Enjoyment of the freedom allowed in the new country enabled the participant to feel well adjusted. These categories thus acted as protective factors for good mental health for these participants.

The second part of the model was risk factors for poor mental health including four categories with interlinked subcategories. These were respectively: dissatisfaction with Swedish society; yearning; lack of sense of freedom; worrying about the current political situation in the home country.

Dissatisfaction with Swedish society
The image of Kurdish men as presented by the Swedish mass media during three specific incidents (the assassination of the prime minister and two so-called honour killings), produced a feeling of prosecution without any basis. This in turn created a feeling of being unrightly discriminated against and judged by Swedish society. A threat to the Kurdish identity was especially exaggerated during that time. The feelings of not being accepted and of being a stranger in the new country made many feel disappointed and dissatisfied with Swedish society.

Yearning
When expectations concerning the new country are not met, one tries to compensate by creating images of a new ideal society. These images may be unrealistic and
amplify the feeling of missing one’s country of origin despite all its negative sides. There is a feeling of nostalgia which only grows. The sense of being alone in this misery also grows daily. Here one has no support or consolation that can give rise to other familiar feelings from the old country.

*Lack of sense of freedom*

The treatment one experienced above in the new country can be expressed as a lack of freedom since it imposes different limitation on one’s activities. This has led to a sense of guilt and frustration over one’s own situation and inability to change what is happening in one’s surroundings. It has lead to passivity and getting stuck in the middle and not being able to move forward. One cannot go back either to the home country because of the unstable situation.

*Worrying about the current situation in the home country*

This was a constant feeling together with the above feelings (of guilt, frustration and incapacity to contribute to any meaningful activities). This was a constant reminder of one’s incapacity to act, to contribute and help family and friends in the home country.

Those who end up in this situation are not capable of acting. They find themselves standing still in the same place not able to move forward or backward. These factors were expressed by some participants as contributors to their poor mental health or to the fact that they did not feel well and could not function normally in the new society.
Validation of the developed model

Validation is “a judgment of the trustworthiness or goodness of a piece of research” (143). The model was validated using several strategies (144):

1) We used triangulation: the first author collaborated with another researcher who examined whether or not the coding, interpretations and conclusions are supported by the data. On the other hand this procedure enhances the reliability of the study (116).

2) Validation of the model was based on a dialogue with the participants and data (115).

3) After the development of the model the first author went back to informants (9 from the in-depth interviews) and asked whether this model and the included categories were in accord with their perceptions from previous interviews. Several of them wanted to validate the model individually and not in a single focus group. In addition, we engaged with 3 new persons.
satisfying criteria similar to those applied to the initial participants for modifiability of the model (118).

Study V

The results are presented in a chronological plot in the figure below. The whole migration process is shown in three periods: pre-migration, initial migration and post-migration.

**Chronological Plot**

Pre-migration

The reasons for migration reported by the participants in this study were predominantly existential: to flee for their lives. Such significant issues as being subjected to different kinds of threats to their ethnic identity: prohibited from using of the Kurdish language or imprisonment if they were suspected of involvement in any political undertaking were identified in the telling of their stories to us. They said that everyone who could read and write was taken into captivity after the military coup in Turkey. A large number of young men and women were involved in the political movement against the government and military forces, some of them...
survived while others died. Losing friends and family members led to feelings of
guilt after the migration due to the experiences of the participants.

**Initial migration**

The first period after arriving in Sweden was defined as *the initial migration*. Many
Kurdish political activists escaped Turkey after the military coup in 1980. They had
plans to return and to continue their political activities. At that time Sweden was one
of the countries in Western Europe that accepted Kurdish refugees and the reason for
their migration. Kurdish identity, particularly the Kurdish language, was officially
accepted as being an independent language. According to the majority of the
participants in the present study, their plans to return were still active during the
initial period. It was possible to establish Kurdish political and cultural organizations
in Sweden as a good basis for keeping up their activities.

**Post-migration: coping strategies**

According to the narratives in the present study life in a new environment and culture
had and may still have three facets: opportunities, resources and difficulties. As
opportunities, one might mention: the development of an ethnic identity and culture
and democratic human rights. On the other hand there were many difficulties and
stressful conditions (obtaining employment, housing and psychosocial security)
expressed in the stories we analysed. To illuminate these situations and conditions,
six examples of the capacity to cope with pre-migration, initial migration and post-
migration stressors are presented in the stories. There are different ways to cope with
life in a new country and new culture, as expressed in the interviews. In general all
participants had used the agentic (active) method of problem-solving. We will
illustrate these six coping responses below.

1. **Contributing to Kurdish culture and the home country**

The most frequently reported coping pattern that came up in the interviews was to
contribute to the Kurdish culture, particularly to the development of the Kurdish
language, and to spread information about Kurdish political issues in Swedish
society.
2. *Getting an education*

Another coping strategy was personal development/success through education. Some of the men in this study had goals of getting a higher education from the day they immigrated to Sweden, others realized this opportunity later. It is obvious that individuals had various dreams and plans.

3. *Creating one’s own society/building a family*

One major stress condition in all the stories was employment/unemployment. To be discriminated against in the labour market was a stress factor. To be forced to segregation was another issue of distress and discrimination. The desire to belong and to relate to Sweden coloured many stories. Creation of one’s own society was the way out when mixing with the major society was not allowed. Building a family was both a way to organize one’s own life and also to change one’s plans for returning and letting life go on.

4. *Achieving inner security and balance*

The next strategy to handling the feeling of being an outsider, i.e. of being perceived as a guest despite many years of residence in Sweden was to achieve inner security and balance. To accept this fact was included in the process of self-help.

5. *Being active and occupied*

Another coping strategy defined in the stories was to be active and occupied with tasks (writing in Kurdish, being a member of a Kurdish network and party, finding occupation etc.) as a psychological defence mechanism against trauma and feelings of separation from the home country, family and friends and relatives. Taking up active employment prevented a sense of loneliness. This was also a self-defined coping strategy to prevent depression and feelings of guilt and responsibility.

6. *Coping with ongoing political instability in the country of origin*

The degree of being active and coping with ongoing political instability in the home country and the sorrow over being abroad differed among the participants. They had one wish in common: to contribute to the well-being of the Kurdish people, as expressed in their stories.
Comparison of Kurdish group with other ethnic groups born in Turkey

In addition to the five studies presented in this thesis, we analysed data on other immigrant groups in order to be able to compare our results with those for other ethnic groups born in Turkey. We present in Table 11 the prevalence of poor SRH, sleeping difficulties, use of psychotropic drugs, general fatigue, anxiety and poor PW among Swedish-born (n=1407), Kurdish-born (n=197), Assyrian-born (n=81) and other groups (n=90). The source of data is Inv-ULF for 1996 (not published). This shows that there are differences between Kurdish, Assyrian and other groups in the prevalence of poor SRH, sleeping difficulties, general fatigue and poor PW. However, these differences are not statistically significant. Nevertheless, anxiety is significantly more often reported in other immigrant groups than among Kurds and Assyrians. Comparisons of Kurdish immigrants (n=197) with Assyrians (n=81) and other immigrants born in Turkey (n=90) (total n=368) are shown in Table 11.

Table 11. Prevalence (%) of poor SRH, sleeping difficulties, feelings of anxiety, general fatigue and PW by ethnicity, %, n=368.

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>Swedish-born, n=1407</th>
<th>Kurdish-born, n=197</th>
<th>Assyrian-born, n=81</th>
<th>Others, n=90</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor SRH</td>
<td>18.0</td>
<td>37.6</td>
<td>46.9</td>
<td>45.6</td>
<td>0.241</td>
</tr>
<tr>
<td>Sleeping difficulties</td>
<td>37.0</td>
<td>40.5</td>
<td>41.0</td>
<td></td>
<td>0.768</td>
</tr>
<tr>
<td>Anxiety</td>
<td>13.8</td>
<td>26.0</td>
<td>27.8</td>
<td>42.2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>General fatigue</td>
<td>51.3</td>
<td>53.1</td>
<td>58.9</td>
<td></td>
<td>0.484</td>
</tr>
<tr>
<td>Poor PW</td>
<td>10.5</td>
<td>26.0</td>
<td>27.2</td>
<td>31.1</td>
<td>0.654</td>
</tr>
</tbody>
</table>
DISCUSSION

MAIN FINDINGS

Quantitative studies I-III

Study I focused on SRH among Kurdish men in comparison with Swedish men. The crude odds for poor SRH for Kurdish men were 2.5 times higher than for Swedish men. The age-adjusted odds ratio (OR) for poor SRH in Kurdish men increased to 3.47 and the odds for having sleeping difficulties increased to 3.44 compared to Swedish men.

Study II focused on SRH and anxiety among Kurdish women and men and showed that Kurdish women had a higher odds ratio for poor SRH and anxiety than Kurdish men.

Study III focused on PW among Kurdish-born women and men compared to Swedish-born women and men and showed that poor PW was significantly and independently related to ethnicity (Kurdish-born v. Swedish-born) when the impact of all confounders (age, sex, SRH, somatic pain, recurrent GIC) was taken into account. Furthermore, poor SRH, being a women, reporting somatic pain and recurrent GIC were significantly and independently related to poor PW, also when adjusted for all confounders.

Qualitative studies IV and V

Study IV identified protective and risk factors for mental health in Kurdish men based on GT. The results indicate that the participants in the study had a strong sense of collective Self with self-satisfaction when maintaining activities in the creation and re-creation of Kurdish ethnic identity. This was reached with interaction with Swedish society and a sense of belonging. On the other hand ongoing worry about the political situation in the home country, yearning after the home country and feelings of a lack of freedom in Sweden were strong contributing factors to poor
mental health and a sense of non-belonging despite many years of resettlement in the host country.

Study V was based on a narrative analysis and showed that in order to cope with Swedish society it was important for the Kurdish men to be included and acknowledged as individuals and to be able to contribute to the Kurdish culture and developments in the home country. Furthermore, the findings in this study also show that the majority responded actively to stressful situations in their life stories and were able to manage in an active and problem-solving way. The ways with negative consequences on mental health were not chosen by the participants themselves but were a result of an interaction between the individual and society of the host country. These results do not mean that all men of Kurdish origin in Sweden are able to handle difficulties and barriers in a similar manner.

**Effects of migration on health**

Explanations for the high prevalence of poor SRH, sleeping difficulties and general fatigue in Kurdish immigrants in general, and greater odds for high levels of anxiety in Kurdish women, can be sought in different aspects of the migration process. First of all, pre-migratory “push” factors leading to the decision to leave the home country were followed by a transitory period involving a lengthy phase of seeking a residence permit in a new country. Then comes an even more protracted phase of acculturation that includes learning a new language, new skills, seeking new employment, and mastering new life habits in order to integrate with a new society (7).

In the case of Kurdish immigrants in Europe, the strongest “push” factor is related to persecution, regression and non-recognition of the Kurds. In addition to socioeconomic inequities endured because of their minority status (145) from time to time they also experience war-like situations with the political and ethnic superstructure of their home country (146). About 87% of the men and about 44% of the women in this study sought political asylum in Sweden, and a high percentage of the respondents (62.2%) had been directly or indirectly exposed to violence in their home country. In 1996, when this study was conducted, an armed struggle between the army
and Kurdish guerrilla forces was going on in Turkey. Because of this conflict many villages were destroyed and many people suffered violence, displacement and forced migration (146). Persons subjected to such situations may suffer somatic, emotional and cognitive problems even after many years (47). There may also be “pull” factors such as the fact that 83.7% of the women in this study had a husband or fiancé (66.3%) or other relative (17.4%) in Sweden in this study. Among Kurdish men 10.8% had a wife or girl-friend in Sweden, and 36% had other relatives. The majority of Kurds in this study immigrated to Sweden during 1980-1989. During this period Sweden had a more open immigration policy for Kurds, making it easier to receive residency permits. Poor health among persecuted Kurdish immigrants and others was also associated with a preoccupation with the current political situation (46). Our study also corroborates that a preoccupation with the unrest in the home country was a major reason for worry in 90% of all respondents.

A study of Turkish and Moroccan immigrants in the Netherlands shows that ethnicity is a strong independent risk factor for psychiatric disease (147). Ejerlertsson has shown that being an immigrant is related to poor health (148). These findings agree with the results found in this study. There could be many reasons for immigrants’ poor health and poor PW. Some authors report that social integration (Self in relationship to the social structure) and social comparison (Self in relationship to others) are factors related to health (149), while others report that there are links between PW, health and numerous biomarkers (149, 150). We believe that the migration process in and of itself could be a reason for the poor health or poor PW of immigrants. This is supported by other studies (7, 23, 33, 65, 67) in which migration could be found to be a stress-inducing phenomenon (66, 69). However, the issue is complex, and even if a relationship can be shown between PW and ethnicity or other factors, a causal relationship or the direction of the association can be demonstrated only in prospective studies. Further studies are needed to elucidate why some individuals are more vulnerable than others.

The reported poor PW among immigrants of Kurdish ethnicity found in this study disagrees with a Swedish study in which Kurds and Turks were combined into one group and showed no significant increase in psychological distress compared with
Polish men and women (23). Nevertheless, this study does not compare immigrants with the native population. Several other studies show, however, that immigrants have poorer PW than the native population (65, 74, 75). This is the first study in which the Kurdish population born in Turkey and Iran was identified and compared with the native Swedish population.

The association between well-being, age and sex is also well documented (24, 37, 65, 67, 75, 149). As in our study, other reports show that women report poorer health than men (23, 33). Poor SRH is an important factor affecting psychological symptoms and disorders and this is in line with our findings (151). Furthermore, there are other factors that can affect PW, such as family support (151).

**Negative consequences of migration**

The majority of the Kurdish men in this study (87.4 %) had left their countries for political reasons, to escape a war or a war-like situation and the majority (62.2 %) had experienced violence against themselves or a close relative. More than half of the Kurdish men had a rural background (60.4%). Most Kurdish men from Turkey and Iran had come to Sweden not because of a choice they made for personal or economic fulfilment, but because of conditions imposed by traumatic political circumstances (21, 45, 47, 49), which may have even threatened their physical existence. It is common knowledge that such conditions as fleeing war or a war-like situation and political/racial persecution have long-lasting psychological effects that compound the effects of adverse factors in exile (11, 45). It is suggested that men’s experiences make them more vulnerable to suffering psychological damage than those of women (49).

Forced migration entails a breakdown of relationships with family and friends for varying periods of time. Family disconnection and breakdown constitute a loss of great importance. Kurdish communities in both Turkey and Iran (as well as in Iraq and Syria) are in political conflict with the superstructure of their respective home countries (29, 57-59, 152). The majority of Kurds live in poverty, in rural communities without access to social welfare and other social security services.
Under these conditions, cohesion between members of the family is of the utmost importance (153). The Kurdish family has, in fact, throughout the centuries, safeguarded the social, psychological and economic security of its members through strong cohesion and commensurability (154). The importance of the family as a basic resource of security and self-reliance is more acutely felt in exile. A Swedish study has demonstrated that Kurdish refugees often worry about the political situation in the home country and the safety of the extended family they left behind (46). Our findings confirm this: the minds of Kurdish men are occupied with thoughts regarding the political and safety aspects of the conditions that led them into exile.

Many Kurdish men decided to flee, to leave the home country for a few years with the intention of returning to their country of origin at some point in their lives. They came to Sweden with a collective identity and they began their journey of waiting. As early as the beginning of their settlement in Sweden the sense of Self, the process of creating and re-creating their identity, began. Communication and interconnection between the men’s own Kurdish political group and Swedish society was initiated. Maintaining their function and role in the creation and re-creation of a Kurdish identity was the most important issue among Kurdish men. During the initial period in Sweden, they were given the freedom to present themselves officially as Kurds in Sweden by the authorities, mass media and society in general. Free communication for the Kurds in Swedish society and plans of returning to their home country impacted the process of strengthening their Kurdish identity. Poor social, physical and psychological well-being affects the quality of life negatively, however (155-157).

**Self-reported health**

Poor SRH has consistently been shown to be associated with increased mortality even after controlling for a wide range of health measurements and known risk factors (158, 159). This may also be of some importance, since it is a frequent finding accompanying general psychological distress as well as the posttraumatic stress syndrome (160, 161). A study based on 54 Kurdish refugees from three different countries also reported a very high prevalence (88.9 %) of sleepi
problems in the form of nightmares (48).

It is a well-known fact that poor SRH is an important factor associated with increased morbidity, health service consumption and mortality (37-39). Also, immigrants’ poor health is well documented in many studies (24, 33, 46). This study highlights the relations between SRH and PW in addition to other important factors such as somatic pain and recurrent GIC.

Other Swedish studies also report higher risks for poor SRH in immigrant groups compared to the host population. In a study of ethnic differences in SRH carried out in southern Sweden in 1994, Lindström and co-authors found significantly higher odds ratios for poor SRH in most ethnic groups, but they were greatly reduced when adjustments were made for psychosocial and economic factors. In another study based on the large national samples from Inv-ULF data (33), threefold increased crude odds for poor SRH in men born in Turkey and Iran were found, but the odds decreased to non-significance after the inclusion of explanatory variables indicating socio-economic status and (Swedish) language proficiency.

Contrary to these findings however, this study of men of Kurdish ethnicity shows that the increased odds for poor SRH and sleeping difficulties remained twice as high despite adjustments for explanatory variables and a decrease in the crude odds ratios. Thus the explanatory variables entered into the analysis only partially explained the differences.

The principal finding of study II is that Kurdish women had somewhat higher odds for poor SRH and anxiety than Kurdish men in age-adjusted models. This association remained significantly higher for anxiety after adjusting for possible confounders. Another study we conducted, based on the same data and comparing Kurdish and Swedish men (162), revealed two-fold increased odds for poor SRH and 2.7 times higher odds for sleeping difficulties among Kurdish men than among Swedish men.

In an earlier study Wiking and colleagues (33) showed that the risk of immigrants
born in Turkey and Iran (including Kurds) reporting poor SRH was about 3 times higher for men and 5 times higher for women than for the native Swedish population.

Life satisfaction also appears to be an important factor affecting health, which is reasonable because PW could affect life satisfaction and health (67). For example, a Swedish study showed that subjects with poor life satisfaction reported increased odds for having poor health (OR=15) compared to those who report good life satisfaction (67). In addition, the same study reported that country of birth, depression and reporting many symptoms were related to poor health (67).

**Protective and risk factors for mental health**

The findings that 81.1% of the respondents reported that they perceived themselves to be discriminated against and about 40% reported a lack of access to a given amount of cash in case of an emergency, implying economic difficulties, are important factors that may influence their health. The wording of the question on discrimination as to whether the respondents perceived themselves as being discriminated against, presupposes a subjective evaluation, whereas asking about the experience of discrimination may have led to a more objective account. At any rate, the very high frequency of reporting the perception of being discriminated against is consistent with findings from other Swedish studies which show that non-European immigrant men in Sweden generally perceive a high level of discrimination against themselves (23, 33). Men of Kurdish ethnicity were actually the second largest group (after ethnic Persian men) reporting themselves to be highly discriminated against in Swedish society (163). Lange also demonstrated that ethnic Kurdish men often worried about their personal security in Sweden. The perception of being discriminated against is strongly associated with psychosomatic complaints as well as psychiatric disease (44). Some authors suggest that post-migratory experiences, such as discrimination, coupled with unemployment, economic difficulties, a low sense of coherence and a poor sense of control may affect the odds for poor SRH and psychological distress to a higher extent than negative pre-migratory experiences, including persecution and violence in the home country (23, 47, 49). On the other
hand, traumatic experiences before migration and the extensive process of seeking asylum make refugees vulnerable to new challenges such as learning a new language, finding employment and adjusting to the lifestyle in a new country. This in turn leads to alienation, loneliness and various symptoms of psychological distress.

Migration is not an easy experience. Even when undertaken to escape highly adverse conditions and within the borders of the home country, migration can cause psychological distress (8, 145). At each step new problems present themselves. Recipient countries can be reluctant to accept immigrants and refugees; waiting periods up to several years for a residence permit can cause passivity; absence of health care except for acute cases may exacerbate psychological distress. When the residence permit is granted, a new set of problems is presented in the form of prejudice and discrimination (11, 33, 43, 163), unemployment (164) and socio-economic marginalization. Going through all these stages contribute to migration stress and can lead to a low sense of coherence and a low sense of control of one’s life. These feelings can sometimes be stronger risk factors for psychological distress in exile than exposure to violence before migration (40, 165).

In this study, Kurdish men perceived themselves to be more often discriminated against than Kurdish women. Kurdish women perceived discrimination too; however, they also expressed a lower sense of control over their lives than men. Higher employment rates among men (67.0%) appear to be both a protective factor (better coping and more control over their own life), and a possible reason for increased feelings of discrimination since work can involve more contact with society. Sundquist and co-authors suggested that a sense of poor control over one’s life can be associated with altered social roles and identities (23). Kurdish cultural traditions are characterized by collectivism and strong social cohesion. The status of a women is linked to her standing within the family and in relation to her male relatives (166). There is some evidence that through migration Kurdish women lose their traditional environment and that this causes psychological distress (145). About 63% of the women in this study came to Sweden not on their own initiative, but for the purpose of reuniting with their husbands or other family members who had come earlier. It is also noteworthy that a higher proportion of the women were single, a
rather unusual finding in traditional Kurdish communities which may indicate difficulties in building and/or maintaining the family structure in which Kurdish women confirm their identity. These losses may be the underlying factors causing the sense of poor control over life in Kurdish women. In addition, the lower employment rates in women (37.0%), lower level of education and being unmarried could mean lower status, lower social cohesion and more loneliness and isolation. The finding that there was a strong relation between unemployment and poor SRH and anxiety suggests that the socio-economic status of women also has an impact on their well-being.

Findings in this study are in line with those of previous studies on the impact of migration on mental health. A qualitative study done in Canada on Iranian immigrants showed that the many challenges faced when coming to a new community results in mental problems. Such immigration-related risk factors as a lack of proficiency in English, under- or unemployment, cultural differences and a lack of social support caused unsuccessful acculturation (90).

In an overview by Bhugra and Jones on migration and mental health, the possible vulnerability factors for upcoming psychiatric illness in migrants were divided into two levels: macro-factors and micro-factors. As macro-factors, the authors cited preparation for migration, the process of migration itself and the acceptance of migrants by the new society. Such factors as personality traits, cultural identity, social support and acceptance by others in their own ethnic groups were considered to be micro-factors (167). According to Bhugra and Jones social support and low expressed emotions in an ethnically dense society (the density of the same ethnic group around an individual) may act as protective factors in the beginning and during the relapse period. In this study our results indicated that a ethnically dense society acts as a protective factor even after many years in the host country. Separation from family and thus patterns of secure attachment and lower self-satisfaction and achievement may also impact mental health. Söndergaard and colleagues showed that the negative life events in the host country were significantly associated with self-reported deteriorated health in refugees from Iraq (46). Our findings show that
the unstable political situation in the home country is a significant factor contributing to poor mental health even after many years of resettlement.

On the other hand, all migrants did not have similar experiences before or after migration. The perceptions and different experiences of immigrants are not static but change during their life cycles. Not everyone experiences poor health and the impact of the length of stay in the host country on immigrant health varies. The role of acculturation in understanding immigrant health is complex and may differ for various ethnic groups (168). This conclusion is in agreement with other studies in which it was reported that some immigrants achieve resilience (a long process of positive adaptation within the context of significant adversity) (169) in their current lives in the new country (86). The concept of Self, cultural identity and the degree of positive feelings towards the new culture, religious rituals, meeting places for discussion of private problems and the culture itself are suggested to be protective factors for dealing with stress and predicting mental disorders (69).

As mentioned before even though the Kurds come from a collective society with a collective identity (large families, large tribes) they still considered themselves to be part of the home country. “My home country is one part of me; I am one part of my home country”- was an expression repeated by the majority of informants in the context of an identity issue. Current unchanged political, economic and social situations in the home country, not pertaining to Swedish society and discrimination on the labour market and in housing had an impact of strengthening emotional ties with the home country. It became more meaningful to contribute to home country from Sweden.

Finally, migration from socio-centric society to egocentric society produces more stress specifically for those without any social support. Also ethnic density in the host country is linked to the changing of concepts of Self as suggested by Bhugra (86). Massive migration for political reasons may increase psychological vulnerability. Loss of status, social support and relationships with significant others may lead to depression and grief. A sense of alienation and cultural distance can
affect the individual’s self-esteem negatively followed by insecurity and higher vulnerability.

Acculturation and coping strategies

Kurds come from a collective society with large families and tribes. They had been subjected to oppression by the Turkish government and to assimilation politics for many years (57, 59). Kurdish identity was imprisoned and the Kurdish language was forbidden (170). The main strategy for assimilating the Kurds in Turkey had been language suppression (27). The Turkish language was the only allowed language in schools. The Kurds in Turkey are still not officially accepted as a nation or ethnic group despite the large population.

The impact of experiences of migration on well-being and life satisfaction was embedded within a comparative framework. For example, the participants relate their stories and current experiences of Kurdish identity within the context of belonging to Kurdish communities and as members of large families with collective self-identification before their forced migration to Sweden. Several participants reported experiences of trauma/torture and discrimination in the home country as the consequences of political, economic and social isolation and persecution by the Turkish army and government. The decision to flee was made suddenly and unplanned and with one goal – physical protection and survival. Participants in this study had been prepared for trauma and torture. They knew that because of their Kurdish ethnicity they could be abused both physically and psychologically. Several of the participants wrote biographies and own stories and published their experiences about torture in Turkish prisons in Sweden. Some were published in Kurdish while others in Swedish. But they were young with great responsibilities, with dreams about a better life with future life projects and extended families. During all these years of exile they were fighting to find a meaning of life – to create and re-create a Kurdish identity. Present experiences of self as a Kurdish individual in Sweden were described in terms of a sense of belonging and expectations in a new country.
The findings in this thesis are in line with previous research conclusions concerning coping and adaptation to new stressful and environmental changes (91, 105, 107, 108). For example, findings in a study on the mental health of Asian American college students suggest that acculturative stress increases the risk of mental health problems independently of global perceptions of stress (107). In the same study Hwang and co-authors showed that not belonging to the United States majority culture was related to greater psychological distress and depression. However, acculturative stress was a more important factor (107). In another study Caplan showed that separation from family and lack of a community support was related to migration stressor for new Latino immigrants in the USA (105). Acculturative stress was associated with higher levels of anxiety and depressive symptoms in a sample of Mexican American college students (108). The authors report that an active coping style was associated with lower depression, whereas an avoidant coping style predicted higher levels of depression and anxiety.

Migration is a stressful phenomenon (7). The subjects faced many distressing problems and coping in a new environment (171). Mechanisms of adaptation and stress take a central position in the individual’s life. To understand the relationship between life events and health conditions, the perspective of individual stories analysed by a qualitative method is needed. However, the meaning of life events experienced by individuals affects mental and physical health differently (129, 172).
STRENGTHS AND LIMITATIONS

The major strength of this thesis is that it combined quantitative and qualitative approaches in order to explore factors related to poor health and to identify coping strategies. This thesis is the first to describe Kurdish men’s perception of their life events, experiences and mental health during the whole migration process.

Quantitative studies I-III

Strengths

An additional strength of this study is that it is based on the first cross-sectional survey of a representative sample of immigrants from four countries living in Sweden, collected through a validated and highly reliable questionnaire (133). The data herein consist of responses from a homogeneous group of Kurdish men and women who identify themselves with their actual ethnicity and not with a classification based on country of birth or regional and geographic affiliation. Despite the small sample size, the study may be considered highly representative of Kurdish men and women from Iran and Turkey living in Sweden, assuming the same non-response rate as among other Iranian and Turkish nationals. Even if we cannot generalize our findings for all men and women of Kurdish ethnicity in Sweden, the results of this study are nevertheless important due to the fact that about half of all Kurds worldwide live in Turkey and the majority of the respondents in this study (87%) originated from Turkey. Thus the results of this study can be said to provide a reliable baseline for future studies.

Limitations

A major limitation is that the sample represents Kurdish men and women from only two countries - Turkey and Iran. Even if the majority of Kurds live in Turkey, the results cannot be generalized to all men and women of Kurdish ethnicity due to the absence of Kurds from Iraq and Syria in the sample. The cross-sectional nature and the small number of participants in the study preclude the possibility of drawing extensive causal conclusions. The fact that the material was based on self-selected
ethnicity may have caused a loss of some individuals of Kurdish ethnicity due to their identifying themselves with the respective countries from which they come. For the same reason, we were not able to estimate the number of Kurdish non-respondents. Another limitation may have emerged due to the original survey questionnaire not being translated into any of the three dialects of the Kurdish language spoken in Turkey and Iran (21).

**Qualitative studies IV and V**

**Strengths**

*Studies IV and V* have several strengths. They are the only qualitative studies conducted in Sweden among Kurdish men based on self-identification. They highlight the effect of analysing different ethnic groups from the same country, such as Turkey, due to such factors as different political, cultural and socio-economic situations in the country of origin and different reasons for migration. A description of the whole migration process during 20-25 years among individuals with different migration backgrounds and different personalities is the strength of these two studies. Furthermore, the authors have experiences and backgrounds which are useful as tools for determining which criteria are important for a realistic, truthful validation based on the Grounded Theory method (118). An important strength of *study IV* is its validation of the developed model with already validated questions (173) thus demonstrating the feasibility of using the model in primary health care services.

**Limitations**

Two of the limitations of these studies are the sample size and the selection criteria. Only men were included due to the fact that refugees with a political migration background are often men. This does not negate the fact that women may migrate for the same reason but perhaps to a lesser extent than men. Our future intention is to conduct a follow-up study in which Kurdish women will be interviewed about their experiences of the migration process. As to the sample size, when using in-depth interviews and focus groups and employing qualitative methods, namely Grounded Theory, as we did here, once saturation is reached, there is no need for additional participants. Saturation in this study was already reached after interview number 8.
and it is valued in GT for the identification of models and theories (124).
Nevertheless, we continued with two additional interviews to check further for
saturation and we reached the same results. The reliability of categories and
subcategories was tested by using triangulation of researchers.

A weakness of narrative study V is having to validate and judge the accuracy of the
reported information by the individuals and whether the reported information really
reflects reality. However, the information reflects experienced events perceived by
the individuals (127, 174). Meanwhile, this study is the first of its kind among Kurd-
ish immigrants in exile in which we explore the migration process using a qualitative
approach.

CONCLUSIONS

It can be concluded that the high odds for poor SRH and sleeping difficulties among
Kurdish men in this study appear to be a result of manifold factors, including
negative experience of political persecution (sometimes including violence), family
breakdown or disconnection and political insecurity related to the home country,
coupled with the perception of being highly discriminated against in the new country.
The minds of Kurdish men in this study were preoccupied with thoughts and worries
related to the unstable political conditions in the home country and their insecure
position regarding employment, discrimination and their economic situation in the
new country. More than half of the men wish to move back to their home country,
which also indicates feelings of alienation from mainstream Swedish society.

Kurdish women and men have high prevalence of poor SRH and indicators of psy-
chological distress. Kurdish women display an even higher risk for anxiety than
Kurdish men. Negative experiences prior to migration as well as some post-
migration experiences such as unemployment, economic difficulties, preoccupation
with the political situation in the home country, perceived discrimination and feel-
ings of poor control over one’s life were associated with these outcomes.
Poor PW in Kurds was significantly and independently related to ethnicity, age, sex, poor SRH, somatic pain and recurrent GIC when the impact of all confounders were taken into account. This study provides important information about Kurdish immigrants’ PW and could be useful in clinical practice.

The developed model of protective and risk factors for mental health has pointed, on the one hand, to certain factors that contribute to the well-being and good mental health of Kurdish men in relation to the migration process on one hand. On the other hand it pointed to certain risk factors that could contribute to poor mental health in this group. These results are important in the sense that it would be worthwhile for health care providers to be aware of these factors and perhaps test the model as an aid to understanding this group’s life experiences and the effect on their mental health.

The findings in this thesis are important for planning primary health care. They highlight the crucial importance of being aware of the impact of different migration factors on the health status of immigrants in Sweden, particularly now when thousands of individuals are fleeing from the war in the Middle East.
SUMMARY IN SWEDISH

BAKGRUND

SYFTE
Det övergripande syftet var att analysera hälsa, migration och livskvalitet bland kurdiska immigranter bosatta i Sverige. Mera konkret: 1) att undersöka kurdiska mäns självrapporterade hälsa och sömnbesvär i jämförelse med svenska mäns, 2) att analysera förekomsten av psykologisk stress hos den första generationens kurdiska män och kvinnor, 3) att studera nedsatt psykiskt välbefinnande / psykisk ohälsa och somatiska besvär hos den kurdiska gruppen jämfört med en svensk grupp, 4) att belysa kurdiska mäns perspektiv på migration och psykisk hälsa utifrån den livsresa de gått igenom och 5) att undersöka vilka coping strategier som kurdiska män använder sig av för att bearbeta migrationsstressten under migrationsprocessen.

METOD
Undersökningen är av tvärvetenskaplig karaktär och består av fem delar och integrerar kvantitativa och kvalitativa ansatser.

Delarbete 1: Hundratala kurdiska män från Turkiet (97) och Iran (14) jämfördes med 1412 svenska män i åldern 27-60 år från ordinarie ULF-undersökningen samma år
Utfallsvariabler som studerades var: självrapporterat hälsotillstånd, sömnbesvär, ångest och intag av psykofarmaka. Sambandet mellan ohälsa och etnicitet analyserades med logistisk regression, varvid kurdiska män jämfördes med svenska män. Oberoende variabler som ingick var ålder, civilstånd, utbildning, sysselsättning, bostadsdisposition och antal barn. Svaret på frågan om huruvida skillnader i hälsa mellan kurdiska och svenska män kvarstod eller inte bedömdes när vi tog hänsyn till dessa variabler i den logistiska modellen.

Delarbete 2: I delarbetet studerades om de i delarbete 1 funna skillnaderna kvarstod om kurdiska män jämfördes med kurdiska kvinnor och således fokuserades frågeställningen på könsperspektivet. Samma 111 kurdiska män, som i delarbete 1, jämfördes med 86 kurdiska kvinnor. I första ledet analyserades etniska skillnader (delarbete 1) och därefter könsskillnader (delarbete 2) avseende sömnsvårigheter, trötthet och ångest samt självuppskattat hälsotillstånd. Könsskillnader analyserades med logistisk regression, där kurdiska män jämfördes med kurdiska kvinnor. Oberoende variabler som ingick var civilstånd, utbildning, sysselsättning och bostadsdisposition.

Delarbete 3: I delarbetet jämfördes 197 personer av kurdiskt ursprung i Inv-Ulf 1996 med 1407 svenska respondenter i Ulf - 1996. Utfallsvariabel var nedsatt psykiskt välbefinnande / psykisk ohälsa som mättes med ett index (GHQ-12) som baseras på General Health Questionnaire vilket anvÄnts internationellt i många år. Detta index är en kortversion av GHQ-60 då inga konkreta psykiska sjukdomar kan identifieras men instrumentet är till hjälp vid identifiering av latenta fall av psykiska störningar som kan bli möjliga att diagnostisera vid senare tillfälle. I analysen av 12 frågor (Goldberg, 1972) har vi, enligt rekommendationerna, anvÄnt cut-off 3 vilket innebar att prevalens större än 3 uppfattats som en tydlig indikator på psykisk ohälsa. Tre oberoende variabler (självrapporterad hälsa, somatisk vÄrk och återkommande magtarmbesvÄr) har anvÄnts som förklaringsvariabler. Somatisk vÄrk är en samlingsvariabel för självrapporterad värs i (i) skuldror, nacke eller axlar; (ii) ryggsmÄrtor, ryggvÄrk, hÖftsmÄrtor eller ishias och (iii) vÄrk eller smÄrtor i hÄnder, armbÄgar, ben eller knÄn. Svarsalternativen angavs som "ja", dvs svÄr och lÄtt vÄrk, och "nej" dvs
ingen värk. Skillnaderna mellan grupperna analyserades med logistisk regression, där kurdiska män och kvinnor jämfördes med svenska män och kvinnor.

Delarbete 4: I delarbetet besvarades frågor om hur kurdiska män upplevde sin hälsa och vilka faktorer som påverkade deras psykiska hälsa. Den kvalitativa metodik som användes var Grounded Theory (fokusgrupper och djupintervjuer). Dessa personer fick beskriva sin livsresa och faktorer som påverkade den psykiska hälsan under hela migrationsprocessen. Ett urval av kurdiska män, med ursprung i den östra delen av Turkiet (Van och Diyarbakir med omnejd), för närvarande bosatta inom Stockholms län, rekryterades. Genom ett strategiskt urval (snöbollsmetoden) bland bekanta till dessa personer kontaktades ytterligare personer som tillfrågades om de ville delta i studien. Totalt deltog 14 kurdiska män i en fokusgrupp (n=4) och djupintervjuer (n=10).

Delarbete 5: I detta arbete analyserades 10 kurdiska mäns livsberättelser i kronologisk ordning och coping strategier under hela migrationsprocessen identifierades genom narrative analys.

RESULTAT

Analys av resultaten av delarbete 1 visade att kurdiska män hade 2.5 gånger högre odds för att rapportera nedsatt självuppskattad hälsa jämfört med svenska män. När man tog hänsyn till ålder ökade oddsen till 3.5. Kurdiska män hade också 3.4 gånger högre odds att rapportera sömnsvårigheter jämfört med svenska män. Efter justering för alla förklaringsvariabler hade kurdiska män 2.1 gånger högre odds vad avser rapportering av nedsatt hälsotillstånd och 2.7 gånger högre odds vad avser rapportering av sömnsvårigheter jämfört med svenska män.

Delarbete 2 visade att kurdiska män och kvinnor hade hög prevalens av självrapporterad nedsatt självuppskattad hälsa, sömnsvårigheter, allmän trötthet och ångest. Åldersjusterad odds för ångest var högre hos kurdiska kvinnor jämfört med hos kurdiska män. Könsskillnader för ångest kvarstod även efter justering för civilstånd, utbildning, boende och yrkesstatus.
I delarbete 3 visades att odds ratio för kurdiskfödda individer att uppskatta sitt psykiska välbefinnande som nedsatt var två gånger högre än för svenskfödda individer efter justering för ålder, kön, yrkesstatus och självrapporterad hälsa. Män och kvinnor med nedsatt självrappordet hälsa hade mer än tre gånger högre odds ratio för nedsatt psykiskt välbefinnande jämfört med de som rapporterade god hälsa. Utöver detta, oberoende av etnicitet, ökade följande faktorer sannolikheten för själuvuppskattat nedsatt psykiskt välbefinnande: att vara kvinna, att ha somatiskt smärta och att ha återkommande gastro-intestinala besvär.

Delarbete 4 resulterade i en genererad modell med skydds- och riskfaktorer för god respektive nedsatt psykisk hälsa. De faktorer som angavs av deltagarna som skyddsfaktorer var bevarandet alternativt återskapandet av den kurdiska identiteten, känsla av frihet samt känsla av tillhörighet och nöjdhet med sig själv. Som riskfaktorer för psykisk ohälsa identifierades faktorerna känsla av ofrihet, längtan, missnöje med det svenska samhället och oro över den aktuella politiska situationen i hemlandet.

I delarbete 5 analyserades livsberättelserna från de tio kurdiska män som deltog i studien. Analysen genomfördes i kronologisk ordning: pre-migration, första fasen av migrationen och post-migration. I bearbetningen av migrationsstresen som upplevdes i exilen identifierades sex coping strategier. Det genomgripande temat i dessa livsberättelser var betydelsen för kurdiska män att få ”vara med” och bli bekräftade som individer i det svenska samhället. Ytterligare ett väsentligt tema var att kunna bidra till utvecklingen av den kurdiska kulturen. Hemlandet var en viktig del i det meningssfulla livet i Sverige. Majoriteten av deltagarna i studien hade reagerat som aktörer i de stressiga livsituationerna. Tillvägagångssättet var inte valt av endast deltagarna själva utan var resultatet av interaktionen mellan individer och samhället i det nya landet. Detta innebär dock inte att alla kurdiska män bemöter livssvårigheter med likadana coping strategier.

SLUTSATSER
Flera slutsatser kan dras i den aktuella avhandlingen. För det första fanns flera faktorer som påverkade rapporteringen av självuppskattad nedsatt hälsa och
sömnsvårigheter bland kurdiska kvinnor och män. Faktorer såsom skälet för utvandringen, politisk förföljelse i hemlandet (i vissa fall även innefattande våld), oro över den nuvarande politiska situationen i hemlandet och faktorer efter utvandringen såsom att känna sig diskriminerad i det svenska samhället, oro över den politiska situationen i hemlandet samt oron över den ekonomiska otryggheten i Sverige kan uppfattas som möjliga orsaker till utfallet.

Bland kurdiska kvinnor fanns socioekonomiska faktorer såsom arbetslöshet, oro över den politiska situationen i hemlandet och känslan av att inte kunna styra sitt eget liv. Dessa faktorer kan möjligen förklara den höga sannolikheten för att rapportera självuppskattad ångest bland kurdiska kvinnor jämfört med de kurdiska männen. Att den kurdiska gruppen hade högre sannolikhet att rapportera nedsatt självuppskattad psykiskt välbefinnande och somatiska besvär jämfört med den svenska gruppen är en viktig kunskap för sjukvården vid bemötandet av kurdiska individer med den bakgrunden och som kan underlätta omhändertagandet av dessa individer.

Den genererade modellen av skydds- och riskfaktorer för psykisk hälsa har påvisat ett antal faktorer som är viktiga att ta hänsyn till inom vården och som kan vara till hjälp vid förståelsen av individuella livserfarenheter och upplevelser och hur dessa påverkar psykisk hälsa. Att vara uppmärksam på migrationsbakgrund (frivillig eller påtvingad flykt) är en angelägen fråga att ha i minnet vid bemötande av patienter med ursprung i länder med politiska oroligheter och förföljelser.
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