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The Impact of Forced Migration on Mental Health: A Comparative Study on Posttraumatic Stress Among Internally Displaced and Externally Migrated Kurdish Women

Cheka Gülşen[1,2], Jeroen Knipscheer[1,3], and Rolf Kleber[1]

Abstract

In Turkey, the large scale of internal displacement is caused by armed conflict that occurs because of the struggle of Kurds to obtain political recognition and rights in Turkey. As a result, many asylum requests were conducted in Europe and a massive wave of internal displacement took place in Turkey. Forced migration is known to influence mental health. This empirical study conducted with migrated Kurdish women (N = 1,127) both in the European Union (EU) and in Turkey aimed to explore the relationships between posttraumatic stress reactions, forced migration, and mental health status. Posttraumatic reactions were discovered to be highly related to mental health state. In addition, being internally displaced as well as having fled for war and oppression was significantly related to mental health status. The implications of these findings for posttraumatic stress theory and mental health professionals working with traumatized migrant populations are considered.

Keywords

culture, race, ethnicity, supportive interventions, violence and aggression

Literature on the psychological problems of refugees and migrants shows that (forced) migration is to be considered as a traumatic process (Fazel, Wheeler, & Danesh, 2005; Sundquist, Bayard-Burfield, Johansson, & Johansson, 2000). It is generally assumed that refugees and migrants are more vulnerable to mental disturbances due to the experience of migration itself, the demands of cultural adaptation, and a disadvantaged socioeconomic position. The resulting cultural adaptation is a prolonged and often laborious process. Migrants have to become accustomed to another language, to different attitudes, and to new roles. Furthermore, existing social networks have fallen apart, often resulting in a lack of both perceived and actual social support (e.g., Hondius, van Willigen, Kleijn, & van der Ploeg, 2000; Knipscheer & Kleber, 2006; Miller et al., 2002; Nicholson, 1997).

Vulnerability of ethnic minorities to posttraumatic health problems can partly be explained by their relatively low socioeconomic standing (Breslau et al., 1998), which in general is a risk factor for health problems (Bhugra, 2004). In addition, several studies have pointed explicitly to the role of minority ethnicity per se, in increasing the risk of developing posttraumatic stress disorder (PTSD; e.g., Al-Saffar, Borgå, Edman, & Hällström, 2003). For instance, the Enschede Disaster Health Study in the Netherlands showed that affected Turkish migrants reported more problems than affected indigenous Dutch respondents (compared with nonaffected control groups; Drogendijk et al., 2003). Moreover, culture has an evident impact on the ways that violence, war and disaster are experienced and processed by individuals, families, and the community at large (Boehnlein, 2002). Still, most studies on traumatic stress have been focused on the White population in the United States, Australia, New Zealand, and Western Europe (e.g., Brewin & Holmes, 2003; Ozer, Best, Lipsey, & Weiss, 2003). To date, the prevalence of mental health problems encountered by ethnic minority groups following traumatic experiences has hardly been adequately empirically investigated.

With a population of approximately 20 million, the Kurds constitute the largest minority group in Turkey. Many Kurdish people are themselves increasingly marginalized

[1]Utrecht University, Utrecht, Netherlands
[2]International Free Women's Foundation, Rotterdam, Netherlands
[3]Arq Foundation, Diemen, The Netherlands

Corresponding Author:
Jeroen Knipscheer, Utrecht University, Heidelberglaan 1, P.O. Box 80140, Utrecht, Netherlands 3508 TC
Email: j.w.knipscheer@uu.nl

and economically deprived. This is why significant segments of the Kurdish population tried their luck elsewhere, mainly Germany and France but also Sweden, the United Kingdom, and the Netherlands. Yet in most European studies, the group of Turkish migrants is considered homogeneous (Bengi-Arslan, Verhulst, & Crijnen, 2002; Virta, Sam, & Westin, 2004) whereas the Turkish group consists of many subgroups with different ethnic origins (Gülşen, 2002) and empirical studies have shown considerable ethnic-related mental health differences, most particularly between Turkish and Kurdish migrants, such as in Sweden (Bayard-Burfield, Sundquist, & Johansson, 2001) and in the Netherlands (Knipscheer, Drogendijk, Gülşen, & Kleber, 2009).

Through the years, besides economical factors, political factors became an important reason for the Kurdish migration. Due to oppression, Kurdish political refugees often have a history of violence, imprisonment, and torture (Gülşen, 2002). As other people who have been exposed to political violence (e.g., Latino Americans—Eisenman, Gelberg, Liu, & Shapiro, 2003; or Palestinian women—Punamaki, Komproe, Qouta, Elmasri, & de Jong, 2005; see also Rousseau & Drapeau, 2004), Kurds were found to experience political violence associated with impairments of mental health (especially PTSD) and poor health-related quality of life in conjunction with substantial reservations sharing their traumatic experiences with a clinician.

Women in particular are an at-risk group. Common struggles and concerns facing women in the Kurdish regions are gender-specific weapons of war such as rape and sexual humiliation—used as tools of repression, thus staining the victim's "honor." As a general environment of insecurity persists in the eastern and southeastern regions of Anatolia, violent acts and sexual abuse against women in the private sphere also increase. Instead of receiving treatment and support after enduring such abuse, often women face ostracization by their family and wider community, or in extreme, but not entirely uncommon cases, being killed to preserve the family's "honor" (*namus*). In Turkey, Kurdish women have particularly suffered as a result of conflict and forced internal migration. Not only are they vulnerable to state violence, including torture and rape, but also has the Turkish justice system failed to offer adequate protection or redress (Hardi, 2005).

In this article, we present results of an empirical study concerning the relationship between posttraumatic stress reactions and mental health symptoms among Kurdish women who have migrated within the territory of Turkey or resettled in an EU country. Possible problems and difficulties that these Kurdish refugee/migrant women had to face may be related to their ethnic origin, experiences of war, oppression of their national and cultural identity, displacement, and gender oppression. Studying these phenomena in conjunction among refugees and migrants from the same country of birth has been very rare which makes this study unique.

The key question is "What is the psychological impact of forced migration on Kurdish women who have been displaced within Turkey or have migrated to a country in the EU?" The sub–research questions are as follows:

1. What kind of traumatic events have the Kurdish women experienced?
2. What is the status of their mental health situation; how many women suffer from PTSD?
3. What is the relative contribution of posttraumatic experiences, forced migration, and migration adaptation demands on mental health?

Our hypothesis was that Kurdish migrant women would report substantial traumatic events that mainly relate to gender-based violence or to institutional violence. We believed that these events would also be related to high levels of posttraumatic stress reactions and high levels of health impairment.

Method

Design

The research design was a survey with a random convenience sample out of the population of female Kurdish victims of potential traumatic life events who had been internally or externally displaced. Via the networks of the International Free Women's Foundation (the Netherlands), the Centre d'Information du Kurdistan (France), Kurdish Women for Integration (Sweden), Roj Women's Association (the United Kingdom), Internationale Fraueninitiative e.V. (Germany), and Kurdischer Frauenverein DESTAN e.V. (Germany), a broad collaboration with diverse Kurdish organizations and local community agencies in Europe and Turkey has been created which guaranteed a representative sample.

Participants and Sample Characteristics

A total of 1,127 Kurdish women participated in the study—558 internally displaced persons in Turkey, and 568 externally displaced migrants living in one of the EU countries (Germany, $n = 333$; France, $n = 82$; the Netherlands, $n = 51$; Sweden, $n = 51$; and the United Kingdom, $n = 51$). The majority of the Kurdish women were born in Northern Kurdistan ($n = 993$, 88.3%), about 8% in Turkey ($n = 85$, 7.5%). Most people came from the Diyarbakır province ($n = 160$, 14.5%); other provinces where more than 5% of the sample was born are Mardin, Batman, Şırnak, and Hakkari. Table 1 presents more details concerning demographic characteristics of the sample.

Instruments

Core variables in the instruments are based on theoretical insights on trauma, health consequences, and migration and

Table 1. Descriptive Statistics of Demographic Variables of the Kurdish Sample (N = 1,127)

Variable	*M*	*SD*	Range
Age	37.7	11.3	16-86
Years in the host country	14.7	7.5	0-69
	n	%	
Childhood circumstances			
Urban	412	36.7	
Rural	710	63.3	
Living status			
Alone (single, widow, divorced)	376	33.9	
With family	744	66.1	
Education			
Low	268	44.4	
Middle	220	36.4	
High	116	19.3	
Employment status			
Paid job	225	20.2	
Via partner/children	473	42.4	
Social benefit/illness payment	242	21.6	
Other (e.g., study)	117	10.5	
Religion			
Sunni Muslim	836	74.4	
Alevitic	184	16.4	
Other	40	3.6	
Nonreligious	63	5.6	

concern subjectively experienced health status and posttraumatic reactions. A survey containing culturally well-validated standardized questionnaires was administrated. All of these instruments were translated and validated in Kurdish.

Sociodemographic information. A demographic questionnaire was used to obtain information about age, nation of birth, ethnicity, marital status, highest educational achievement, religious affiliation, urbanization rate of childhood surroundings, source of income, preferred languages and fluency in the language of the host country, length of stay in the host country, and reason for migration. The most frequently mentioned reasons for migration were "political reasons" (n = 417, 37.0%), "war and oppression" (n = 397, 35.2%), "marriage/family reunion" (n = 163, 14.5%), and "labour or education" (n = 115, 10.2%).

Traumatic experiences. In this study, we used a broad definition of trauma. The following major life events were assessed: any (major) physical violence (including rape, sexual violence, or childhood abuse); political violence (including torture and imprisonment time); a serious (life-threatening) accident or natural disaster; death of a family member or close friend; a life-threatening illness; robbery or burglary; and forced migration.

Health symptoms. To assess the occurrence and severity of general health symptoms, the General Health Questionnaire (GHQ–28-item version) was used (Goldberg & Hillier, 1979). This questionnaire measures the recent state of subjective well-being in four areas, namely, (a) psychosomatic symptoms; (b) anxiety and insomnia; (c) social dysfunction; and (d) (severe) depression. Some examples from the questionnaire are as follows: "Have you recently been getting any pains in your head?" (somatization); "Have you recently lost much sleep over worry?" (anxiety and insomnia); "Have you recently been able to enjoy your normal day-to-day activities?" (social dysfunction); "Have you recently felt that life is entirely hopeless?" (depression). All items were evaluated on a 4-point Likert-type scale: 0 = *less than usual*, 1 = *as usual*, 2 = *more than usual*, and 3 = *much more than usual*. The GHQ total score is obtained by summing up the item scores. Cross-cultural validity of the GHQ-28 has been established, for instance with Turkish samples in the Netherlands (Bengi-Arslan, Verhulst, & Crijnen, 2002). The internal consistencies for the GHQ-28 subscales in our sample were excellent, with a Cronbach's alpha for total GHQ 28 score of .91.

Posttraumatic reactions. To assess the characteristic posttraumatic stress responses, 23 items measuring intrusion, avoidance, and hyperarousal were administered by means of an adaptation of the Structured Interview for PTSD (SI-PTSD: Carlier, Lamberts, van Uchelen, & Gersons, 1998). Each item is weighted endorsed on a 2-point Likert-type scale (*present* or *absent* scored 0 and 1, respectively), reflecting the occurrence of reactions during the past 7 days. A total score is obtained by summing all scores, a higher score implying more and severe problems. Examples of items are as follows: "Are there certain things that remind you of the event against your will?" (intrusion); "Are you trying to avoid activities, places, or people that arouse recollections of the event?" (avoidance); and "Do you get easily frightened (even from a small sound)?" (hyperarousal). The scale was found to be statistically reliable, with excellent internal consistencies (Cronbach's alpha for the total scale score was .88). Based on the premise that on intrusion at least one, on avoidance at least three, and on hyperventilation at least two symptoms were scored as well as that the complaints lasted longer than 3 months and obstructed the main part of the daily life, respondents were diagnosed as suffering from a PTSD.

Procedure

Participants were recruited by means of snowball sampling, a sampling method that is being used with increasing frequency to study hard-to-reach populations (de Jong & van Ommeren, 2002). The first stage of the snowball sampling involves selecting individuals using referrals by insiders within the population to be studied. An individual who has been selected based on a certain characteristic (in this case being a Kurdish woman, having experienced a traumatizing event, and being internally displaced or externally migrated) will be asked to list others with identical characteristics. From this list (at least) one person was randomly selected and approached

for an interview. In return, the interviewee was asked to list others and the same procedure was repeated several times. The technique is especially useful and feasible when trying to reach marginal research populations that are often difficult to study using conventional sampling techniques, such as traumatized refugees and torture survivors (e.g., Crescenzi et al., 2002). In addition, mental health care agencies and individual psychotherapists were approached according to the snowball method.

Only adults (18 years and older) who were born in Turkey or had at least one parent born there, were invited to participate in the face-to-face interview. If a person expressed an interest in participating in the study, the person was asked to provide a contact phone number or a direct appointment was made. We aimed to collect data from as many people as possible. Attempts were made to maximize sociodemographic diversity.

Approximately, 90% of the solicited persons agreed to participate, independent of the recruitment method (so the way women were approached did not influence their willingness to participate). It was not possible to compare those who chose to participate in the interview with those who declined.

The respondents were recruited at several community centres, agencies, and organizations run by and for members of the Kurdish communities as well as in home visits in various places in Turkey and the five countries in the EU. In all 102 different interviewers (all females with a Kurdish background) administered the semistructured interviews. Guidelines on assessment research with ethnic minorities stress the involvement of expert cultural and ethnic consultants (Okazaki & Sue, 1995). In line with these recommendations, we consulted various key persons in the Kurdish community during the development of the measures and the interpretation of the results (e.g., during "experts meetings"). All instruments were translated into Kurdish applying a back-translation procedure. A preliminary version of the questionnaires was pilot tested with 10 women and both content and format were revised on the basis of the results. Interrater reliability across the interviews was enhanced by means of a protocol and a practical training. The protocol guided the interview process and consisted of questions that derived from the themes mentioned in the Introduction. Interviewers from all regions in which the study was conducted followed an intensive training provided by the project coordinator and two Kurdish psychiatrists (S. Işcanlı and Z. Gün). The training concerned the aim and implementation of the study, the way in which the interviews should be conducted, how to handle possible risks of (re-)traumatization as well as ethical aspects concerning the personal data-collection process. The interviewers came together on a regular basis to extensively discuss how questions were administered, how answers were noted, and how special situations were dealt with (such as respondents who refused to answer certain questions or who did not understand certain questions). Counselling visits to the regional groups were made by the project coordinator. In addition, the interviewers could call the research coordinator (first author) for advice. An evaluation meeting attended by representatives of the regional groups of interviewers was organized, where they could share their experiences, contribute to the midterm evaluation of the research results (due to the presentation of the evaluation of 500 questionnaires), and receive supervision to reflect on possible effects of the interview process.

The respondents were informed of the aim of the study by means of an information sheet. The interviewers were instructed to read the information sheet to illiterate respondents. It was emphasized that anonymity would be guaranteed. Participation was voluntary. Participants were reassured about confidentiality and told that they were not obliged to answer questions that they did not wish to answer. The interviews mainly took place at the respondents' homes. In some cases, they were conducted at community centres, associations, or public places (like cafeterias)—depending on the preference of the participant. The majority were interviewed in the Kurdish language. In most of the interviews, no translator was involved (n = 947, 85.0%). The duration of the interviews varied from 40 to 180 min (mean duration about 1 hr). The answers were noted on paper by the interviewer (in the questionnaire forms that had been numbered and distributed by the project coordinator according to a proportional contingent of Kurdish population) and later processed by the researcher (second author).

Statistical Analyzes

All variables were summarized using standard descriptive statistics such as frequencies, means, and standard deviations. To determine which covariates had to be controlled for, the variables age, length of residence in the host country, childhood surroundings (rural of urban circumstances), living circumstances (single vs. having a family), highest educational level, source of income (paid job or social benefit), religion, migration reasons, traumatic events, type of migration (internal vs. external), and posttraumatic reaction scores were univariately analyzed with the dependent variable (GHQ total score).

Provided that the distributions were approximately normal or nonskewed (criteria < 0.5; $\alpha > 1.5$), mean scores on continuous variables were analyzed with parametric methods using student's t tests for independent samples and one-way analyzes of variance (ANOVAs). Severely skewed continuous variables were analyzed with the Mann-Whitney U test.

As a priori hypotheses regarding theoretically relevant predictors have been formulated, hierarchical regression is an adequate approach to analysis. Moreover, subjecting the data to more theoretically sensitive analyzes is recommended in lieu of the selected sample (Tabachnick & Fidell, 2001). Therefore a hierarchical multiple regression analysis (stepwise) was conducted. Results of the preanalyzes yielded each demographic covariate to significantly associate to the

Table 2. Descriptive Statistics of Traumatic Events Mentioned by the Kurdish Sample (N = 1,127)

Variable	*n*	%
Death/life threatening disease suffered by a loved one (child/husband)	560	49.7
Political violence, detention, and torture	309	27.4
Military violence and destruction	305	27.1
Crime	242	21.5
Migration issues	84	7.5

dependent variable—except for living circumstances and religious affiliation.

Results

Half of the interviewed Kurdish women had experienced the death or a life-threatening disease of a loved one (mostly child/husband), a quarter had to endure political violence, detention, or torture, and a quarter had to face the consequences of military violence and destruction. Experiencing racism and discrimination due to being a Kurd also had a substantial impact on their lives and was frequently mentioned as well. The traumatic experiences mentioned by the respondents are displaced in Table 2. More than 80% experienced the event more than 5 years ago (n = 822, 82.5%), 6% (n = 62) experienced this less than a year ago.

Most respondents reported severe posttraumatic reactions such as intrusions (n = 1,016, 90.2%), avoidances (n = 902, 80.0%), and hyperarousal (n = 933, 82.2%). The level of posttraumatic reactions that is indicative for the diagnosis of PTSD was reported by more than three quarters of the respondents (n = 860, 76.3%). For 710 persons (71.4%), the complaints lasted longer than 3 months, and for 604 women (60.6%), the complaints obstructed the main part of their daily life.

Almost half of the respondents could be diagnosed as suffering from PTSD (n = 523, 46.4%). Type of migration, severity of posttraumatic stress symptoms, migration reason, and fluency in the language of the country migrated to predicted the presence of mental health symptoms best, $R^2 = .16$, $F(4,773) = 37.8$, $p < .0001$ (see Table 3). Internally displaced women with severe PTSD symptoms who had fled because of war and political oppression or who had poor fluency in the language of the country migrated to were most at risk for developing mental health problems.

Table 3. Summary of Hierarchical Multiple Regression Analysis on GHQ Total Score

Model	*B*	*SE*	Beta	95% CI for *B*	
				Lower bound	Upper bound
1					
PTSD indication	11.433	1.076	.356***	9.320	13.546
2					
PTSD indication	11.319	1.063	.353***	9.233	13.406
Internally displaced	4.866	1.066	.151***	2.774	6.959
3					
PTSD indication	10.723	1.081	.334***	8.602	12.844
Internally displaced	4.595	1.066	.143***	2.502	6.687
Level of language knowledge	–0.005	0.002	–.093**	–0.008	–0.001
4					
PTSD indication	10.694	1.078	.333***	8.578	12.809
Internally displaced	3.766	1.123	.117**	1.562	5.971
Level of language knowledge	–0.004	0.002	–.084*	–0.008	0.000
Migration reason: War and oppression	2.768	1.211	.080*	0.391	5.146

Note: CI = confidence interval. $R^2 = .17$, adjusted $R^2 = .16$; $F(4,773) = 37.8$, $p < .0001$.
*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

This study investigated posttraumatic reactions and mental health symptoms among Kurdish women who were either internally displaced within Turkey or had externally migrated to a country in the EU. Results confirm the findings of previous studies (e.g., Silove, Manicavasagar, Coello, & Aroche, 2005; Steel et al., 2005) that documented a high prevalence of traumatic events and mental health problems among migrated individuals. Our finding that the majority of our sample reported considerable mental health symptoms is consistent with a growing literature indicating that persons who experience (political) trauma develop significant psychological distress and psychiatric morbidity (e.g., Shrestha et al., 1998). Almost half of the respondents could be diagnosed as suffering from PTSD. The PTSD levels in this sample of Kurdish women are substantially higher than the levels of posttraumatic stress disturbances in Turkish people affected by a disaster in the Netherlands (Drogendijk et al., 2003) and considerably higher compared with the PTSD rate among earthquake survivors in Turkey (23% at the epicentre and 14% in Istanbul; Başoğlu, Kılıç, Şalcıoğlu, & Livanou, 2004). Our results are confirmed by the meta-analysis on the impact of displacement on mental health (Porter & Haslam, 2005) that reported poorer mental health outcomes for particularly those migrants who were displaced internally within their own country.

As it was hypothesized that the impact of the uprooting process from their natural surroundings, culture, and language

in addition to the difficulties in social and political participation in a foreign country would have detrimental effects on their health status, several possible explanations need to be considered for the relatively better mental health status obtained for the externally migrated women. One option is the possibility that they successfully resettled in a stable environment in one of the EU countries (the United Kingdom and Sweden, in particular, stand out) and therefore may adapt well from a mental health perspective once they are resettled, although that tentative inference warrants testing on other ethnic groups. Another explanation can be that externally displaced persons may have obtained more self-confidence as a consequence of the geographical and cultural distance they have achieved compared with those who stayed in the Turkish society. It is also important to endure contextual factors before and after displacement as moderators of mental health to understand the psychological after-effects not only as the product of an acute and discrete stressor but also as the economic, social, and cultural conditions from which forced immigrants are displaced and in which they are placed (Porter & Haslam, 2005). Therefore, the diverse stressors that accumulate over the preflight, flight, exile, and resettlement/repatriation periods should be taken into consideration. Finally, the health difference between forced refugees and internally displaced persons could be explained by so-called protection mechanisms. In most cases, internal displacement is a result of conflict between different ethnic groups or between governments and ethnic, racial, linguistic, or religious minority groups; international agencies and the host state care for the refugee problems whereas the cases of internally displaced persons are considered "internal matters" and are left "unprotected" which could have adverse health consequences (Celik, 2005). Nonetheless, protective factors within the Kurdish culture such as a strong sense of shared victimization, a high endorsement of the ethnocultural identity as well as internal solidarity and social support among these women should not be diminished (see Berruti, Doru, Erle, Gianfelici, & Khayati, 2002).

In interpreting the results of the present study, a number of caveats need to be acknowledged. To start with, the sample was not selected randomly. The so-called snowball sampling technique can be used to explore relatively unknown populations, such as refugees and migrants. This method is not strictly random and cannot be compared with representative sampling methods. Nevertheless, the method is recommended in cases where one does not know population characteristics and expects a reluctance to cooperate with researchers (Kaplan, Korf, & Sterk, 1987). Given the anticipated reservation of Kurdish women to take part in scientific research, this sampling technique is advisable (Okazaki & Sue, 1995). Moreover when people are traumatized (especially because of political reasons), they are often suspicious and mistrustful of someone asking them personal questions. Consequently, the present sample may not be fully representative of the wider group of Kurds in the community. Those suffering the greatest psychosocial impairment might not have the motivation to join the interview whereas those who are healthy and/or who have sound social supports may not want to participate either. Nonetheless, the response rates are high. It is likely, therefore, that the present sample represents a midrange of psychosocial impairment among traumatized women with Kurdish decent. Furthermore, studies have shown that discrepancies may arise because social stigmas attached to mental illness in Kurdish society and cultural differences in responses to psychiatric questionnaires may exist. Concerns have been expressed about the accuracy of using Western diagnostic assessments in assessing mental disorder across cultures. Such procedures may lead to the neglect of indigenous expressions of distress and yield misleading prevalence rates. Consequently, there could be a cultural tendency for Kurds to underreport symptoms—and that the health status may be even worse. However, it is also possible that the participants may accentuate their difficulties with the hope that publicity will rally sympathy to their plight (to get public awareness and support for their case). Thus, the possibility that the data are biased cannot be entirely discounted, although the pattern of results suggests that participants were responding honestly to questions. In addition, cultural differences in the way that the concepts of "trauma," trauma exposure, and PTSD symptoms are operationalized and understood are known to exist. Our survey questionnaires were not formally culturally validated for the ethnic groups in which they were used, and the likelihood of cultural response bias to questionnaire items cannot be excluded. However, the inclusion of indigenous members in the advisory board aimed to address these concerns adequately.

Notwithstanding the limitations, the present study provides needed documentation of the sequential stressors experienced by individuals who have migrated from Turkey to a country in the EU. It is precisely the cluster of traumatic and migration factors that mental health care providers have to address in service application to traumatized migrants. There is a need for structural attention to the experiences that people have been through (and still are in) and for the coping strategies to adapt to the many transitions in the migration process.

Our findings have implications regarding the policies and psychosocial treatments aimed at traumatized migrants and ethnic minorities. Mental health professionals dealing with traumatized migrants should not limit their evaluation efforts to posttraumatic symptoms. Mental health may deteriorate as a result of a combined impact of traumatic migration experiences and postmigration problems (see also Knipscheer et al., 2009). Clinicians should inquire about a history of political violence experiences in migrant patients whenever the differential diagnosis includes trauma-related illnesses, such as depression and PTSD (see Rohlof, Knipscheer, & Kleber, 2009).

The results can contribute to the development of policy and practice. Forced internal displacement has negative effects

on the individual's psychological situation as has war and violence. Having experienced these two events together results in an increase of the psychological problems and disorders. The solutions to this problem should also be considered in a multidimensional perspective. The trauma experiences of both internally and externally displaced persons should be examined in terms of factors that occur before, during, and after a traumatic event. In addition to political, legal, and economic assistance which is urgently needed, health, especially psychological health programs, should be included. In this respect, community-based approaches could be effective in which Kurdish women themselves are lay people to help one another. These approaches, organized on a local community level, that respond to the specific situation and needs of Kurdish women for health care, education, and empowerment by means of seminars and public meetings may form effective measures. A special effort should be made to ensure the establishment of such treatment facilities for traumatized women in regions with a high number of internally displaced population.

In conclusion, this study contributes to the literature on trauma among migrants and ethnic minorities by illustrating the diversity of traumatic experiences within a group of migrants and refugees from the same country. It also accentuates the relationship between gender and trauma, indicating the detrimental aspects of gender-based violence. Overall, our findings emphasize the urgency of preventing traumatic events. Initiatives that decrease trauma exposure may ultimately have a greater impact in terms of reducing psychopathology than treating maladaptive coping strategies that contribute to symptoms of mental health distress.

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