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Depressive Symptoms in an Urban Kurdish Refugee and Immigrant Population: An Exploratory Study

Natalie Kay Worley
University of Tennessee - Knoxville

To the Graduate Council:

I am submitting herewith a thesis written by Natalie Kay Worley entitled "Depressive Symptoms in an Urban Kurdish Refugee and Immigrant Population: An Exploratory Study." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Social Work, with a major in .

Rodney Ellis, Major Professor

We have read this thesis and recommend its acceptance:

Sherry Cummings, Cindy Davis, Samuel MacMaster

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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DEPRESSIVE SYMPTOMS IN AN URBAN KURDISH REFUGEE AND IMMIGRANT POPULATION: AN EXPLORATORY STUDY

A Thesis
Presented for the
Master's of Science in Social Work
Degree
The University of Tennessee

Natalie Kay Worley
December 2007

DEDICATION

This thesis is dedicated to the memory of my father, Stanley; even though he cannot be here to share this achievement, I am told that he would be proud. I would also like to dedicate this work to my mother, Johanna, for always believing in me and supporting my curiosity about the world, and to my sister, Stephanie, for encouraging me to stay the course in the pursuit of my goals.

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I wish to thank all those who helped me in the completion of this thesis for my Master's of Science in Social Work. I am especially grateful to Dr. Cindy Davis, for her patience, guidance and humor throughout this process, and for her encouragement beyond the scope of this study. Thanks also go to Dr. Sam MacMaster and Dr. Sherry Cummings for their important feedback and for serving on my thesis committee. I also would like to thank Mohammed Ibrahim and the Kurdistan Cultural Institute, for being such affable partners and providing invaluable support to this study. Finally, I would like to thank my friends and family for their interest in my research and their support throughout the writing of this paper.

ABSTRACT

The purpose of this study was to explore the prevalence of depressive symptoms among the elderly Kurdish immigrant and refugee population living in the greater Nashville, Tennessee area. Nashville has the largest population of Kurds living outside of Kurdistan (Metropolitan Government of Nashville and Davidson County, 2004), but as is the case for many immigrant and refugee groups, little empirical research exists to aid social service practitioners in addressing the unique needs of this population (Williams & Westermeyer, n.d.). The investigator draws on the limited research about mental health in other immigrant and refugee populations as a basis for the rationale and design of the proposed study. Using a nonrandom sample of Kurds aged 50 or over living in metropolitan Nashville and Davidson County, the study collected information about participant demographics and measured depressive symptoms using oral administrations of the Geriatric Depression Scale (GDS) (Brink et al., 1997) and the Migratory Grief and Loss Questionnaire (MGLQ) (Casado & Leung, 2001). A significant minority of the study sample tested within the range of mild depression, and an additional one-quarter had scores placing them in the range for severe depression. There was a significant but limited correlation between GDS scores and total scores on the MGLQ. Further analysis, however, revealed a slightly stronger correlation between GDS scores and the MGLQ subscale of disorganization. Female subjects' depression and grief scores were consistently higher than males, regardless of the scale or subscale used. Composite English scores revealed low proficiency within the sample, with no significant differences between males and females. Results indicated a significant negative correlation between composite English scores and total scores on the GDS, the MGLQ,

and the MGLQ disorganization subscale. Due to the nonrandom sample and other study limitations, it would be inappropriate to generalize the results too broadly across the Kurdish immigrant and refugee population. The information gathered, however, will serve as a glimpse into the needs of this unique population and assist social service providers as they develop programs to most effectively meet the population's needs.

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LITERATURE REVIEW

For a small city, with a population of less than 600,000 people, Nashville, Tennessee is surprisingly diverse. According to the Refugee Service Program of Nashville's Metropolitan Social Services (2005), there are nearly 100 countries and 70 different languages represented within the Nashville area. Foreign-born residents accounted for 7% of Nashville's population in the 2000 U.S. Census, with two-thirds of these arriving between 1990 and 2000 (Metropolitan Government of Nashville and Davidson County, 2004). The major refugee and immigrant populations in this area include Kurds, Iraqis, Somalis, Sudanese, Bosnians, Latinos, and Southeast Asians (National Conference of State Legislatures, 2005).

The growth of the Kurdish population in Nashville began in the 1970s, when about a dozen families immigrated to the city from traditional Kurdistan, which encompasses regions of Turkey, Iraq, Iran and Syria. These first families were likely prompted to leave their homeland as the result of a failed Kurdish revolution against the standing Baghdad regime of the time. Similar waves of immigration have coincided with major political events in Kurdistan, following, for example, the defeat of Iraqi forces in the Iran-Iraq War and the subsequent Anfal issued by Saddam Hussein (1988); a failed Kurdish uprising during the Gulf War (1991); and an Iraqi army incursion which led to extended internal political strife (1996) (Kemp & Rasbridge, 2006). Often viewed by the governments of surrounding nations as a minority to be either exploited or use as a scapegoat for political tensions, the Kurds remain the largest ethnic group in the world without a separate nation (O'Leary, 2002).

Only 30 years after the first Kurdish families arrived in Nashville, there are thousands of Kurds living in Tennessee's capital city (Elmasry, 2005). Unfortunately, because Kurdish ethnicity is not linked to one particular nation, it is difficult to measure accurately the number of Kurds in any given area. Some refugees and immigrants name Kurdistan as their home country, while others name the recognized nation (for example, Iraq or Turkey) in which their region of Kurdistan lies. Adding further complication is the fact that "Kurdish" was not offered as an option for self-reported race or ethnicity in the 1990 or 2000 Censuses (Cornfield, et al., 2003). Given these challenges, the most recent reports estimate that the Kurdish refugee and immigrant population is 7,000 for the Nashville/Davidson County Metropolitan area, making it the largest population of Kurds outside of Kurdistan (Nashville Metropolitan Development and Housing Agency, 2006). This fact gained special attention in the historic 2004 Iraqi elections, when Nashville was chosen as one of the few voting sites in the nation due its large Kurdish community (Metropolitan Government of Nashville and Davidson County, 2004).

Kurdish immigration rates remain steady, as political unrest continues to mar the landscape in and around Kurdistan. Many refugees and immigrants choose to settle in Nashville because of its heritage of strong religious values and because of the strong business and cultural network established by the early immigrants (Elmasry, 2005). While these refugees and immigrants add to the diversity of the small city, it is important that social service providers recognize how this diversity affects current programming and policies in working with these clients. According to Carlsten and Jackson (2003), nowhere are the unique needs of refugees and immigrants more

apparent than in the area of mental health.

A report from the Institute for Research, Evaluation, Facilitation , and Training and the Latin American Research and Service Agency show that 83% of the refugee and immigrant population studied, which included African, Asian, and Central American individuals, self-reported a need for formal mental health services (Lodwick, Stewart, & Mitchell, 2004). Some countries, such as Sweden, offer a formal psychological assessment for all new arrivals (United Nations Refugee Agency, 2002), but even these countries fail to follow up with long-term monitoring (Williams & Westermeyer, n.d.). This is despite the fact that most serious mental health problems arise between 6 months and two years after arrival (Immigration and Refugee Services of America, 2004). Most receiving countries do not even go as far as to offer an initial psychological screening to refugees and immigrants (Mui, 1996).

Unfortunately, the most prevalent mental health problem of elderly people—depression—often goes unrecognized and untreated (Mui, 1996). The prevalence of mild depressive symptoms in late adulthood has been estimated to range anywhere from 5% to more than 30% (Ashford, Lecroy, & Lortie, 2001). The latest figures from the National Institutes of Health (2007) state that approximately 2 million of the 35 million Americans age 65 or older suffer from severe depression, with another 5 million suffering from less severe forms of the illness. The cumulative direct and indirect costs of depression are estimated at $43 billion dollars annually, in addition to the unnecessary somatic pain and diminished quality of life (American Association for Geriatric Psychiatry, 2004).

Major risk factors for depression such as poverty, low educational attainment,

poor physical health, and high rates of family dysfunction, are often prevalent among ethnic immigrant elders (Mui, 1996). Many researchers, however, have noted the dearth of studies pertaining to depression among elderly ethnic refugees and immigrants (Pernice & Brook, 1994; Cardozo, Talley, Burton, & Crawford, 2004; Bhui et al., 2002). As such, clinicians and researchers must be prepared to explore other academic disciplines, adopting and modifying ideas, concepts, and theories from analogous situations to identify and address potential issues (Williams & Westermeyer, n.d.). This is troublesome in working with ethnic groups, when each culture has a particular way of interacting with its environment. For example, Harker (2001) found that strong religious faith served as a protective factor in her sample of Latin American immigrants. In a study of Chinese immigrants, however, Stokes, Thompson, Murphy, and Gallagher-Thompson (2001) conclude that religiosity had no relationship to one's risk of depression. It does not benefit the client to receive services that were planned based on assumptions from studies of other ethnic groups without a thorough comparison of the compatibility with that client's culture.

According to the United States Citizenship and Immigration Service's Glossary and Acronyms (n.d.), a refugee can be defined as:

> A person who, because of a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, is forced to flee the country of his or her nationality and it unwilling or unable to seek the protection of his or her government.

An immigrant is defined under Permanent Resident Alien as:

> An alien admitted to the United States as a lawful permanent resident.

> Permanent residents are also commonly referred to as immigrants; however, the Immigration and Nationality Act (INA) broadly defines an immigrant as any alien in the United States, except one legally admitted under specific nonimmigrant categories. (United States Citizenship and Immigration Services, n.d.)

An asylee is forced to flee one's country under the same circumstances as a refugee. The distinction between these two classifications is that asylees apply for and are granted protection in a receiving country only after arrival in that country, whereas a refugee undergoes this process before entering the new country (Ellefsen, 2004).

Researchers who have studied depression amongst these populations have consistently studied either refugees or immigrants, considering their experiences dissimilar enough to warrant separate studies (Pernice & Brook, 1994). Although the circumstances that brought them to the United States might be different, refugee and immigrants face many of the same stressors, including "financial difficulties, broken extended families, loss of family support, cultural and linguistic isolation, and/or struggles to learn a new language and culture" (Barnes, 2001). They must also contend with the opinion of the receiving country about their presence in the country (Barnes). While some refugee groups have shown higher incidence of anxiety and post-traumatic stress disorder (Cardozo et al., 2004), studies have demonstrated that refugees and immigrants both have lower levels of mental health than those of the host country (Pernice & Brook, 1994; Sundquist, Johansson, DeMarinis, Johansson, & Sundquist, 2004). The United Nations Refugee Agency (2002) reports depression rates of between 47% and 72% for refugee populations. If the prevalence of depressive

symptoms is this strong for the refugee population, it stands to reason that immigrants would also have a significant rate of depression.

The demographics of the United States are undergoing two dramatic changes: the aging population is increasing, as is the ethnic and racial diversification of the population (Mui, Kang, Chen, & Domanski, 2003). With so many changes occurring simultaneously, and with refugee and immigrant elders only a small proportion of the total resettling population, it is easy to overlook the very real needs of this population (United Nations Refugee Agency, 2002).

Being elderly and having refugee or migrant status seems to pose a dual risk for developing depressive symptoms. Members of this population are often isolated, physically or linguistically, with limited opportunities for social and recreational programs in a culturally appropriate context (United Nations Refugee Agency, 2002). They may suffer from the loss of the role of wise elder, instead becoming dependent on more quickly acculturated younger generations (United Nations Refugee Agency, 2002). Older adults are more prone to medical conditions that mask the depression itself, including artery disease, neurological disorders, metabolic disturbances, certain types of cancer, and other conditions such as arthritis, sexual dysfunction, and deafness (Ashford et al., 2001). Elderly refugees and immigrants, unfamiliar with a new health care system, are less likely to seek professional treatment for these somatic symptoms (Stokes et al., 2001). Elevated rates of somatization and depression have been noted even five years after resettlement in certain refugee populations (Carlsten & Jackson, 2003).

Researchers studying the psychological effects of immigration have concluded

that feelings of migratory grief and loss are a major risk factor for the presence of other depressive symptoms. This relationship has been noted across several diverse cultures, including Korean (Ahn, 2006), Polish, Russian, Japanese, Haitian (Casado & Leung, 2001), Latinos, Indians, and Pacific Islanders (Gorospe, 2006). According to Casado and Leung (2001), grief is a relatively new concept in the study of mental health and immigrants, despite the fact that grief is a natural reaction to the losses faced by both immigrants and refugees. These losses can be either physical losses (tangible items, such as possessions or loved ones) or symbolic losses (intangible losses, such as social role or identity).

Casado and Leung (2001) argue that grieving is a natural and necessary process for people to accept loss and move on with their life, and that this grieving process is an essential component that allows people to grow. However, some elderly immigrants and refugees are unwilling or unable to move beyond the grief of these losses and adjust to a new country. Akhtar (1999) writes that this inability blocks access to ‘emotional refueling‘ and leaves immigrants and refugees (the latter whom he terms “exiles”) with an inflated sense of nostalgia for their homeland. In this way, the past becomes idealized, resulting in an inability to move beyond the mourning process (Akhtar, 1999).

Thus, the purpose of the current study is to assess the prevalence of depressive symptoms in the elderly Kurdish immigrant and refugee population in the Nashville area. Although previous research has identified risk factors for depression in elderly immigrants from other cultures, it is important to recognize the characteristics of depression in this unique population. Similarly, understanding the relationship

between depression and other factors, such as migratory grief and proficiency with the English language, allows for a better understanding of the specific needs of the group. This knowledge can then be used to identify ways in which existing service models can be adapted to most effectively address these issues.

RESEARCH DESIGN

Research hypotheses

Based on previous research exploring the evidence of depressive symptoms in immigrant groups of other cultures and ethnicities, the researcher hypothesized that similar rates of depression would be found in this study's elderly Kurdish subjects. It was further thought that a strong and significant relationship would be found between depression scores and levels of migratory grief, as well as English proficiency. The severity of the conditions which prompted members of this community to leave their native Kurdistan would logically have long-term implications on mental health and acculturation to a new society. Finally, the researcher theorized that depression and grief scores would vary based on gender, as both male and female Kurds adjust to a Western set of social norms governing gender roles.

Procedures

The study utilized an exploratory design consisting of oral administration of three survey instruments in face-to-face interviews, with the study sample consisting of a nonrandom group of volunteer participants selected using a snowball sampling technique.

Interviews were conducted at the Kurdistan Cultural Institute (KCI) or participants' homes by trained bi-lingual interviewers. The director of the KCI recruited a total of seven interviewers for assistance in data collection. There was a mix of male and female interviewers, several of which were college students.

All interviewers spoke one of the two main Kurdish dialects as a primary language and had had previous experience with the KCI. These interviewers participated in a two hour training session conducted by two professors from a local university, both of whom had extensive research experience. Because most of the interviewers did not come from a social science background, the training covered basic topics, such as confidentiality, in addition to data collection skills. It also provided the opportunity for interviewers as a group to review the translations of the survey instruments and discuss each item, making minor revisions (such as word choice) when deemed necessary. By utilizing members of the Kurdish community in the translation of instruments, data collection, and sample selection, the study eliminates much of the bias that might otherwise be present with the use of a culturally different research team.

This study design was carefully chosen for its sensitivity to the study population. Face-to-face interviews are often the preferred method employed in this type of study as they ensure design consistency between interviews, regardless of the participant's literacy level (Mui et al., 2003). In addition, previous studies have demonstrated that refugee and immigrant individuals are reluctant to participate in mental health interviews in a clinical setting. Changing the interview context to a familiar environment, in this case a local cultural center or their homes, puts the study subject at greater ease and encourages participation in the study (Barnes, 2001).

The national standards of Culturally and Linguistically Appropriate Services in Health Care (as quoted in Burgess, 2004) state that "patient-related

materials and signage must be provided in the commonly encountered patient language group(s).” As such, at the time of interview, participants were given a written version of the consent form in their native language; the interviewer then obtained verbal consent from all participants, ensuring the subjects’ understanding of voluntary participation regardless of their literacy level.

Ethical considerations/procedures

Of primary ethical importance in this study is the idea that participation is both voluntary and confidential. Because immigrants and refugees often feel themselves in a precarious position in the new society, they may feel pressured to participate in a study with which they are not entirely comfortable or do not understand. They also may be overly reluctant to participate, either out of concern of being stigmatized as ‘crazy’ or for fear of being deported or otherwise discriminated against in larger society for discussing their mental health problems (Barnes, 2001). To counter this possibility, participants were provided with an information letter, outlining the purpose of the research as well as the study procedures. Informed consent was obtained from all participants at the time of the interview. In working with immigrant and refugee populations, researchers often choose to accept verbal informed consent in the participants’ native language (Cardozo et al., 2004). This study adopted this same procedure, as literacy rates for this population are not available and selecting only those participants who are literate could introduce unnecessary bias into the sample.

An ethical consideration unique to the refugee, immigrant, and asylee population is raised in asking participants about recent stressful life events and trauma.

Quiroga & Berthold (2004) assert that the asylum process can be re-traumatizing for applicants as they are forced to recount the details of their experiences of persecution. Similarly, certain questions about the participants' histories, even their migration status, pose the risk of reintroducing painful memories to the participants (Sundquist et al., 2004). To mitigate any traumatic effects of the interview process, participants in need of support were given information about culturally appropriate support services following the interview.

Finally, the researcher took into account the possible effects of the survey process on the interviewer. Professionals who interact directly with refugees and immigrants often put themselves as risk for secondary trauma and personal stress as a result of emotional reactions to the stories they hear (United Nations Refugee Agency, 2002). The culturally and linguistically competent interviewers used in this data collection were personally connected to the Kurdish population through heritage or history, and the experiences they recorded resonated more deeply than if an objective but less culturally skilled interviewer had been used. Therefore, debriefing with a competent social worker also was offered to the interviewer at the completion of data collection.

As a final consideration of the ethical standards of this research, the study was approved by the University of Tennessee Institutional Review Board.

Instruments

Evidence of depressive symptoms was measured using Brink's Geriatric Depression Scale (GDS) (Brink et al., 1997). Researchers often prefer the GDS as

a measurement tool when studying elderly patients because it was designed specifically for use with this population (Stokes et al., 2001). There are no somatic items, which reduces the chance of reporting physical ailments as opposed to the depressive symptoms intended. The items are simply worded and require only a "yes" or "no" answer, making it accessible to participants with limited education (Mui, 1996) and even to cognitively impaired patients (Burke, Nitcher, Roccaforte, & Wengel, 1992). An additional noted benefit of the GDS is that one does not have to be a social work professional to administer and score the measure (Brink et al., 1994). Despite its seemingly simple design, however, the instrument is able to discriminate among normal and mildly and severely depressed older adults (Mui, 1996). As per the original instrument, a score of 0-10 indicates no depression, 11-20 indicates mild depression, and a score of 21 and above indicates severe depression (Brink et al., 1997).

The validity and reliability of the GDS has been proven in studies of various ethnic groups, and researchers have concluded that this instrument appears to be valid in a cross cultural context (Mui et al., 2003). The GDS has been translated into languages as varied as Chinese, Dutch, Hebrew, Hindi, Spanish, and Yiddish (Mui, 1996), and used in several studies of elderly Asian immigrants and refugees (Chan, 1996; Chiu, et al, 1994; Mui et al., 2003). Bach, Nikolaus, Oster, & Schlierf (1995) also note the tool's use in assessments both in Germany and England. For this study, the GDS had a Cronbach's alpha coefficient of .90; this is comparable to its use in other studies, where alpha scores ranged between .89 (Stokes et al., 2001) and .94 (Casado & Leung, 2001).

Despite its documented usefulness in other populations, the GDS is only as good as its cross-cultural translation. To ensure the internal reliability of the GDS with this Kurdish population, the instruments were translated into the major Kurdish dialects (Sorani and Kurmanji) by volunteers from the Kurdistan Cultural Institute (KCI), a Kurdish cultural center in Nashville, Tennessee. The KCI has worked with the Kurdish immigrant and refugee population in Nashville for the last decade, providing such services as social adjustment, ESL courses, and employment counseling (Kurdistan Cultural Institute, n.d.). Also providing interpretation services to local Kurds, this organization was ideal for the task of translating these instruments and providing the necessary cultural insight to the appropriateness of the questions. Following the initial translation of the instruments from English into the two Kurdish dialects, the instruments were translated back into English by a second interpreter. This translation/back-translation was repeated a second time and the results compared for a "highly valid and reliable instrument" (Harvard Program in Refugee Trauma, n.d.).

The experience of migratory loss was measured using the Migratory Grief and Loss Questionnaire (MGLQ). This instrument was designed by Casado and Leung (2001) for a study of depression among elderly Chinese American immigrants, modeling symptoms of bereavement and loss identified by previous researchers and instruments. The MGLQ measures grief and loss in three main categories, namely disorganization, nostalgia, and searching and yearning. The disorganization subscale assesses the alienation an immigrant or refugee experiences in the host country. The nostalgia subscale examines the pleasant

thoughts and feelings a migrant has in regards to his or her homeland, while the searching and yearning subscale assesses the attachment immigrants and refugees feel toward the country and people they left behind. Responses fall along a four-point Likert Scale, with a possible score range between zero and 60. The instrument was not designed for clinical assessment and therefore does not have distinct levels to categorize the severity of migratory grief. It does, however, provide important information about a respondent's position in the natural process of grieving.

The MGLQ has not yet had extensive use in further research, but its validity and reliability have been demonstrated in doctoral research of Korean and Hispanic populations (Casado, personal communication, 2007). In the present study, the MGLQ had a Cronbach's alpha score of .95, slightly higher than the reliability of Casado and Leung's original instrument, which had an alpha coefficient of .94. The MGLQ subscales, however, had varying levels of reliability. The searching and yearning subscale produced an alpha coefficient of .91, the disorganization subscale an alpha of .90, and the nostalgia subscale an alpha of .76.

Demographic and characteristic information about the study participants was adapted from a study of elderly Chinese immigrants by Mui (1996) to be more culturally appropriate to a Kurdish population. The format and data gathered remained consistent with that from the original instrument, while changes made were primarily in terms of category labels, such as those for language and religion. The translation for this scale was identical to the GDS as described

above.

Among the characteristic information gathered were questions gauging subjects' self-rated language proficiency at reading, speaking, and understanding English. This data was used to create a composite score of subjects' English proficiency, with lower proficiency receiving a lower composite score. Each category (reading, speaking, understanding) followed the same scoring pattern. Answers of "not at all" were given a point value of 0, with each higher level receiving an incrementally higher score, so that answers of "very good" corresponded to a point value of 4. Scores from each category were combined to create a composite score, resulting in a range of possible scores between 0 and 12.

SAMPLE

Identifying and selecting a random sample of older Kurdish immigrants and refugees presented a number of logistical challenges, which similarly have been noted by previous researchers attempting to gain access to immigrant communities. In their study of Somali refugees living in the United Kingdom, for example, Bhui et al. (2002) noted that people from under-enumerated and socially excluded populations are difficult to engage in research surveys. The most effective option when attempting to study such isolated immigrant and refugees populations is to use a nonrandom convenience or snowball sample. Previous researchers have contacted initial participants in snowball samples through participant observation and social and cultural community gatherings (Bhui et al.), from English as a Second Language (ESL) class rosters, church resettlement programs (Pernice & Brook, 1994), ethnic restaurants and clubs (Aycan & Berry, 1996), and national resource centers that cater to the needs of newly arrived refugees (Momartin, Silove, Manicavasagar, & Steel, 2004). Given the target population for this study, it logically follows to begin where the immigrant elderly will most likely be found, namely local religious organizations and cultural or resource centers with local offices.

Thus, the initial participants were recruited through their involvement at the Kurdistan Cultural Institute. Snowball sampling was then used with participants identifying other eligible participants who were then contacted by the interviewers. Interviewers contacted potential participants by letter or phone call to arrange an interview. Introducing the purpose of the study in this way has

proven successful in past research utilizing a snowball sampling technique among refugee populations (Bhui et al., 2002).

There are several limitations to utilizing a nonrandom sampling method. In attempting to assess depressive symptoms in a particular population, for example, the researcher may be unable to locate those most affected by depression. Previous studies have demonstrated an inverse relationship between an immigrant's ability to speak the language of the receiving country, and risk of depression (see Ahn (2006), Casado & Leung (2001), Mui (1996), and Stokes et al. (2001)). This linguistic isolation often leads to social isolation; subsequently, these older adults are less likely to be visible or easily accessible to the researcher or community members. This could distort the findings of the study, masking the true prevalence of the problem of depression in the population.

A second, related limitation of a snowball sampling technique is the unintentional bias often introduced by study participants as they refer the interviewer and researcher to subsequent participants. In learning that the study is about depression, for example, subjects might refer the interviewer to someone who is known to exhibit depressive symptoms in an effort to help the researcher achieve pertinent information.

Finally, the greatest limitation to this sampling procedure is that which is present in all nonrandom samples, namely the inability to appropriately generalize the study's findings to the larger population. Due to the current lack of information about the Kurdish immigrant and refugee population, however, random epidemiological sampling is not an option for this study design. The results of this study, therefore,

cannot be applied too broadly to draw conclusions about the entire Kurdish population living in this metropolitan county, only to report the findings and make suggestions for future research with and services for this population.

To provide for a wider sample, and to take into account varying cultural definitions of age, the study included men and women over the age of 50. (In other studies, such as the United Nations Refugee Agency's employment studies (2002), this inclusive age limit has been set as low as 45 years of age). Additional inclusion criteria included residence in Nashville or Davidson County, Tennessee; must have emigrated from the regional homeland of Kurdistan; must be a speaker of Arabic, Kurdish (Sorani or Kurmanji dialect), Assyrian, Armenian, Turkish, or Farsi; must not suffer from any diagnosed form of senile dementia; and must have lived in the U.S. for a minimum of three months.

Using the above criteria, a total of 70 Kurdish immigrants and refugees were identified as appropriate for participation in this study. Ages of the subjects ranged from 50 to 79 years (see Table 1), with a mean age of 59 (SD = 7.0). Approximately 47% of subjects were male and 53% female. The length of residence in the U.S. among the study participants ranged from nine to 30 years, with a mean of 12.6 (SD = 3.5). A considerable majority (71%) reported having refugee status; 23% are in the U.S. on asylum, while only 6% have immigrant status. All participants (100%) reported Islam as their religion.

Familial composition was largely consistent among the subjects (see Table 2). Most participants (91%) reported currently being married, and 86% said that they lived with their spouse and children. Only 6% reported being widowed, and

Table 1: Demographic Characteristics of Study Subjects

Variable	Number	Percentage
Gender		
Male	33	47.1
Female	37	52.9
Age		
50-59	44	62.9
60-69	19	27.1
70-79	7	10.0
Immigration Status		
Immigrant	4	5.7
Refugee	50	71.4
Asylum	16	22.9
Years in United States		
Less than 10	1	1.4
10-14	55	78.6
15-19	12	17.1
20-24	0	0
25-29	1	1.4
30 or more	1	1.4

Table 2: Familial Characteristics of Study Subjects

Variable	Number	Percentage
Marital Status		
Married	64	91.4
Widowed	4	5.7
Divorced	2	2.9
Living Arrangement		
Alone	3	4.3
With spouse	4	5.7
With spouse and children	60	85.7
With children	3	4.3
Number of Adult Children		
0	4	5.7
1-5	51	72.9
6-10	13	18.5
11 or more	2	2.9
Number of Grandchildren		
0	39	55.7
1-5	20	28.6
6-10	6	8.6
11-15	4	5.8
16 or more	1	1.4

an even smaller number (4%) said that they lived alone. Numbers of children and grandchildren introduced slightly more variation among the subjects. Subjects reported having between zero and 12 adult children, with a mean value of 4 (SD = 2.5). The majority (73%) reported having one to five adult children, while 6% had no adult children and 3% had more than 12. The reported number of grandchildren of the subjects ranged from one to 18, with a mean of 2 (SD = 3.8). A little more than half (56%) of subjects had no grandchildren.

Self-reported language proficiencies varied among the study participants (see Table 3). The subjects' primary languages were fairly balanced between the two major dialects, Kurdish Sorani (44%) and Kurdish Kurmanji (56%). The majority of subjects (70%) did not report having proficiency in any second language. Of the reported secondary languages, Arabic was the most frequent response (14%), followed by Farsi (10%). More than half of subjects were not able to read their primary language (54%), corresponding to the fact that 56% reported having no formal education. Only 9% of subjects had obtained a college degree.

Although only 1% of subjects cited English as a secondary language, many more reported varying levels of proficiency in reading, speaking and understanding English (see Table 4). A little more than half (54%) or subjects reported not being able to read English at all, but 19% rated their ability to read English as "good" or "very good." Approximately one-third of participants (37%) reported not being able to speak any English, while slightly fewer (34%) said that they could not understand English at all. Similarly, 14% reported their ability to

Table 3: Language and Education of Study Subjects

Variable	Number	Percentage
Primary Language		
Kurdish Sorani	31	44.3
Kurdish Kurmanji	39	55.7
Secondary Language		
Arabic	10	14.3
Kurdish Sorani	2	2.9
Turkish	1	1.4
Farsi	7	10.0
English	1	1.4
No secondary language	49	70.0
Literacy		
Not able to read	38	54.3
Read primary language	10	14.3
Read primary and English	22	31.4
Education		
No formal education	39	55.7
Grade school	8	11.4
High school	10	14.3
Some college	6	8.6
College degree	6	8.6

Table 4: English Proficiency

Variable	Number	Percentage
Ability to read English		
Not at all	38	54.3
Little	14	20.0
Fair	5	7.1
Good	9	12.9
Very good	4	5.7
Ability to speak English		
Not at all	26	37.1
Little	10	27.1
Fair	15	21.4
Good	6	8.6
Very good	4	5.7
Ability to understand English		
Not at all	24	34.3
Little	14	20.0
Fair	15	21.4
Good	13	18.6
Very good	4	5.7

speak English as “good” or “very good,” while 25% rated their ability to understand English as such.

RESULTS

Data analyses were performed using SPSS version 15.0 for windows. Descriptive statistics were first generated on the Geriatric Depression Scale and the Migratory Grief and Loss Questionnaire and its subscales (see Table 5). The mean GDS score was 13.5 (SD = 7.4). Scores on the GDS ranged from 0 to 30, covering the entire scale of possible scores. One-third of participants (32.9 %) scored in the normal/average range (with a score between 0-9); 41.4% had scores of 10-19, indicating mild depression; and 25.7% had scores of 20 or greater, placing them in the range for severe depression.

Total scores on the MGLQ ranged from 3 to 60, with a mean of 42.8 (SD = 13.4). The mean for the MGLQ subscale of searching and yearning was 18.2 (SD = 5.6). The subscale of disorganization had a mean score of 15.8 (SD = 5.9), and the subscale of nostalgia had a mean score of 8.9 (SD = 2.9). A notable finding was the number of subjects who received the highest possible (most grief) score on both the total MGLQ and its subscales. 14.3 % of subjects had a total MGLQ score of 60, the maximum possible grief score for that instrument. Similarly, 21.4% achieved maximum scores on the searching and yearning subscale, 15.7% on the disorganization subscale, and 21.4% on the nostalgia subscale.

Pearson's Correlation Analyses were performed to determine the relationship between subjects' total scores on the GDS and the MGLQ and its subscales (see Table 6). Results indicated a significant positive correlation between total scores on the GDS and MGLQ ($r = .235$, $p = .05$). These analyses

Table 5: Means, standards deviations, and ranges of GDS and MGLQ scores

Variable	Mean	SD	Minimum	Maximum
Total GDS Scores	13.5	7.4	0.0	30.0
Total MGLQ Score	42.9	13.4	3.0	60.0
Searching/Yearning	18.2	5.6	1.0	24.0
Disorganization	15.8	5.9	0.0	24.0
Nostalgia	8.9	2.9	0.0	12.0

Table 6: Pearson's Correlations with GDS Scores

Variable	Depression	Significance
Total MGLQ Score	.235	.050
MGLQ: Searching/Yearning	.138	.253
MGLQ: Disorganization	.335	.005
MGLQ: Nostalgia	.131	.281

also indicated a significant positive correlation between total GDS scores and the MGLQ subscale of disorganization ($r = .335$, $p = .005$). Table 7 shows the statements associated with this subscale and the percentage of participants' responses to each. In asking subjects how often they feel "lost," "like a stranger," or "different," the subscale assesses subjects' adjustment to life in the receiving country in relation to their personal identity. However, it is important to note that although statistically significant, these correlations are limited in their strength of association.

Table 8 shows the means, standard deviations, and t-test values of depression scores for male and female subjects. There was a significant difference between mean GDS scores of males and females ($t = -1.94$, $p = .057$), with males reporting significantly less depression (mean = 11.8, SD = 7.8), compared to females (mean = 15.1, SD = 6.8). There was a significant difference between male and female scores on the disorganization subscale of the MGLQ ($t = -2.46$, $p = .017$), with males having a mean score of 13.9 (SD = 6.7) and females having a mean score of 17.4 (SD = 4.7). Thus, females reported significantly more feelings of alienation and self-doubt in their host country compared to men.

Composite English scores covered the full range of possible scores, from 0 to 12, with a mean of 3.5 (SD = 3.6). More than half of study participants (60.0%) received a composite English score of 3 or lower, with 32.9% having the lowest possible score of 0 (see Table 9). Only 5.7% had a composite English score of 12, rating their proficiency in reading, speaking and understanding English as "very good." Unlike results of the GDS and MGLQ, there was no significant difference

Table 7: Subjects' Responses on MGLQ Subscale of Disorganization (percentages)

Variable	Never	Occasionally	Often	Always
I feel like leaving my homeland was like having a part of me cut off.	14.3	21.4	27.1	37.1
I feel like a stranger in this country.	11.4	21,4	28.6	38.6
I feel like crying when I recall memories of my homeland.	7.1	27.1	35.7	30.0
It upsets me to think about being far away from my homeland.	8.6	20.0	42.9	28.6
I feel I am not sure of who I am since I moved to this country.	17.1	24.3	24.3	34.3
I feel different since I moved to this country.	5.7	14.3	41.4	38.6
I feel lost in this country.	12.9	24.3	31.4	31.4
I feel I need to have something that reminds me of my homeland.	2.9	10.0	27.1	60.0

Table 8: Means, standard deviations, and t-values of depression scores between male and female subjects

Variable	Male (SD)	Female (SD)	t-test	Significance
Total GDS Scores	11.8 (7.8)	15.1 (6.8)	-1.936	.057
MGLQ:				
Total Scores	40.0 (15.9)	45.4 (10.3)	-1.667	.100
MGLQ:				
Searching/Yearning	17.7 (6.6)	18.7 (4.6)	-0.748	.457
MGLQ:				
Disorganization	13.9 (6.7)	17.4 (4.7)	-2.456	.017
MGLQ:				
Nostalgia	8.4 (3.4)	9.3 (2.3)	-1.302	.197

Table 9: Composite English Scores

Score	Frequency	Percentage
0	23	32.9
1	2	2.9
2	8	11.4
3	9	12.9
4	2	2.9
5	7	10.0
6	6	8.6
7	1	1.4
8	2	2.9
9	6	8.6
12	4	5.7

in composite English scores between males and females (t = .839, p = .405). Males had a mean composite English score of 3.9 (SD = 3.5), while females had a mean score of 3.2 (SD = 3.7). Pearson's Correlation Analyses were performed to determine the relationship between subjects' composite English scores and total scores on the GDS, the MGLQ and its subscales (see Table 10). Composite English scores were found to have a significant negative correlation with total GDS scores (r = -.288, p = .016); total MGLQ scores (r = -.237, p = .048); and the MGLQ disorganization subscale (r = -.281, p = .019). In other words, depressive symptoms, grief, and feelings of alienation increase as English proficiency decreases.

Table 10: Pearson's Correlations with Composite English Scores

Variable	Correlation	Significance
Total GDS Scores	-.288	.016
Total MGLQ Score	-.237	.048
MGLQ: Searching/Yearning	-.164	.176
MGLQ: Disorganization	-.281	.019
MGLQ: Nostalgia	-.204	.090

DISCUSSION

Interpreting Results

In discovering that more than one-fourth of study subjects had GDS scores indicating severe depression, this study reveals that depression is a considerable concern for this sample of elderly Kurdish immigrants and refugees in the Nashville metropolitan area. Comparing current statistics from the National Institute of Health (2007), the percentage of subjects reporting severe depression is more than four times the rate of the general population of American elderly. Consistent with the general population, however, is the finding that female participants were significantly more depressed than their male counterparts. Mulé (2004) argues that this difference is a result of environmental factors, including gender stereotypes and identity roles. These factors would be especially powerful for immigrant and refugee women, as they often are essentially a minority within a minority. These women must contend not only with shifts in their societal role that come as a natural part of aging, but also with the stereotypes and new expectations of their host country.

This study also found a significant positive correlation between depression as measured by the GDS and migratory grief as measured by the MGLQ. This finding is consistent with results from previous studies (see Casado & Leung, 2001). The association between the two variables, however, was somewhat weaker in the present study, indicating that grief is not as strongly correlated with depression in the elderly Kurdish immigrant and refugee population as in previously studied groups. As such, programs designed to address depression in

this population should examine the extent to which grief and loss contribute to an individual's level of depression. To provide effective services, however, it is critical that practitioners not limit explanations of depression to the impact of grief, but rather continue to explore other probable contributing factors.

A stronger correlation was noted between depression scores and the MGLQ subscale of disorganization. The factors in this subscale are most closely related to feelings of alienation and changes in roles and status, identified by previous researchers as risk factors for depression in later life (Casado & Leung, 2001; Mulé, 2004; Pernice and Brook, 1994). Older immigrants and refugees must contend simultaneously with changes in their roles as a natural process of aging and their loss of status in a new and unfamiliar society. This is an additional challenge to practitioners, as they must draw from research in gerontology and the psychological effects of grief and loss to effectively address this issue.

The results indicating a significant correlation between English proficiency and depression echo similar findings from previous studies with other immigrant and refugee populations (see Ahn, 2006; Stokes, Thompson, Murphy, & Gallagher-Thompson, 2001; Casado & Leung, 2001; Mui, Kang., Chen, & Domanski, 2003). Older members of immigrant and refugee populations are at a greater risk of linguistic isolation than their younger counterparts, as they have fewer natural avenues for interaction with the larger society, such as through school or employment. In addition to the practical disadvantages of being unable to speak the primary language of the receiving country, lack of English proficiency can have a negative impact on an individual's self-esteem and self-

identity (Casado & Leung, 2001).

That language was found to have a significant correlation with depression and grief scores clearly speaks to the need for more professionals who can speak the dialects of this particular group. In addition to being a significant factor to depression that would cause an immigrant or refugee to need to seek services, lack of a common language can actually become a barrier to receiving those needed services. The traditional tendency is to place responsibility for learning English on immigrants and refugees so that they may integrate into their host country. Although developing English proficiency within the older Kurdish population would assist them in this adjustment and allow them greater access to available services, Casado and Leung (2001) warn that learning a new language later in life is a challenge that might actually cause psychological distress for immigrants and refugees. Rather than exacerbate these factors, professionals should seek ways in which to implement the native language of immigrants and refugees into service delivery plans.

Limitations

The results of the current study must be interpreted with consideration of several limitations, some of which were addressed in previous sections. As is often the case with studies of refugees and immigrants, this research design is limited in lack of previous investigation of the given population and therefore a lack of baseline data (Pernice & Brook, 1994; Cardozo et al., 2004; Williams & Westermeyer, n.d.). The study is also limited in its cross-sectional design. The

researcher is unable to establish if depressive symptoms developed after emigration from one's homeland, or if these symptoms appeared long before this stressful life event (Mui, 1996). To develop a complete understanding of the issue of depressive symptomology among the Kurdish refugee and immigrant population, one ideally would be able to compare depression rates in the country of origin, in the receiving country, and in the refugee/immigrant population simultaneously (Barnes, 2001).

The relatively modest sample size and nonrandom sampling technique similarly limit the ability to which the study can be applied to the larger ethnic community (Momartin et al., 2004). The nonrandom sampling technique, for example, introduces the possibility of a skewed sample. As the subjects were recruited through their participation at the KCI, the sample could be biased toward those Kurdish elderly who are integrated and mobile enough to allow for their participation at a local cultural center, in which case the actual rate of depression could be much higher than reported. Conversely, the sample could be biased in terms of recruiting those individuals who are unable to seek services and support beyond the KCI, due to linguistic or other barriers, meaning the actual rate of depression could be lower than the study results would suggest.

A third limitation lies in using oral administration of the study questionnaires. This research design was chosen so as not to exclude any willing participants on the basis of their literacy. While the design allowed for a more thorough representation of the intended population, it did not provide participants the opportunity to complete the questionnaire anonymously. Although the

interviewers received training on ethics and confidentiality in gathering data, study subjects may have found it difficult to reveal their daily struggles and inner feelings aloud with another person.

Furthermore, one must also take into account the impact of cultural roles and norms. Although Kurdish culture is generally less conservative than other traditional Muslim societies, the impact of gender on the interview process must not be overlooked. Previous researchers using similar study designs have noted that subjects are generally more willing to cooperate if a female interviewer is used, regardless of the sex of the participant (Bhui et al., 2002). Using a mix of male and female interviewers in the current study may have impacted the results if participants felt uncomfortable providing answers that they felt were inappropriate for someone of their gender particularly if the interviewer was of the opposite sex. Age differences could have a similar impact. Older subjects may have been wary of providing younger interviewers with responses that could make them appear weak, as traditional Kurdish culture observes strict formalities governing interactions between those of different generations.

One must also consider the possibility that participants provided socially desirable answers in order to represent their culture in a positive light. Despite the significant Kurdish population in Nashville, Kurds remain largely invisible to the general population. As such, those outside of the Kurdish community know little about the group or their culture. Given the opportunity to impact the perception of the Kurdish community in the larger society, participants may have given what they interpret as desirable answers in order to present an idealized image of their

group. Similarly, with immigration a frequent and controversial issue in current local and national politics, participants may have minimized their needs so that they would not be seen as a negative presence

In weighing these limitations, however, one must acknowledge the relatively high percentage of participants who reported mild or severe depressive symptoms. As the noted limitations would tend to skew the results in favor of more desirable responses, the actual incidence of depression in this population would be higher than study results have indicated. This would only further emphasize the need for appropriate services to address the issue of depression in this population.

IMPLICATIONS

As outlined in previous sections of this paper, the study as conducted is limited in terms of its nonrandom sample, cross-sectional rather than latitudinal design, and the lack of baseline data for this particular ethnic refugee and immigrant group. However, it is this paucity of research about the Kurdish population in any receiving country which makes this proposed study significant.

This study's most important impact on policy and practice is simply to emphasize that this population is at risk for depressive symptoms based on risk factors cited in previous research with other ethnic refugee and immigrant groups. By addressing these potential risk factors in policy and practice changes, professionals can alter the environments that exacerbate risk of depression. For example, by noting that self-identity is often linked to job status, and loss of this status as the result of migration is a risk factor for depression, social service providers can work to establish more secure employment alternatives that match the immigrants' qualifications (Aycan & Berry, 1996). Similarly, in developing culturally appropriate recreational programs that encourage socialization and reduce isolation, the service provider improves the immigrants' chances for optimal mental health (Schmitz, Jacobus, Stakeman, Valenzuela, & Sprankel, 2003; United Nations Refugee Agency, 2002).

In planning for changes in policy and practice, it is important to remember that depressive symptoms in refugees and immigrants may develop many years after resettlement (Williams & Westermeyer, n.d.) and that long-term monitoring for symptoms is recommended (Quiroga & Berthold, 2004). The present study

sample is evidence of this, with subjects reporting depressive symptoms 10, 20 or even 30 years after arrival in the United States. Therefore, professionals who work with refugees and immigrants beyond the initial resettlement period, such as health-care workers, ESL instructors, and employees of culture-specific senior centers, should be trained to identify the early signs of depression among their senior clients (Immigration and Refugee Services of America, 2004). Finally, health-care workers should include a brief assessment, such as the GDS, in routine examinations, as overburdened multicultural practitioners often overlook depressive symptoms (Jackson & Baldwin, 1993).

Although this exploratory study in and of itself will have limited direct impact on the lives of the people studied, its significance lies in bringing to light the evidence of depressive symptoms among this unique population. When this knowledge is then used as the foundation to develop new policy and practice, its effects are most readily apparent. Schmitz et al. (2003) note that "in ideal programs, members of the refugee and immigrant communities are pivotal in the development and delivery of services." Through participation in this study, members of the Kurdish community will take a role in identifying gaps in services for the refugee and immigrant population, rather than relying on Western models to fulfill their unique cultural needs.

Identifying the existence of mental health concerns in the Kurdish community also alleviates some of the stigma and isolation felt by those who suffer needlessly from depressive symptoms. This grants many immigrants and refugees the freedom to establish an ongoing therapeutic relationship with a

mental health professional, as they may continue to experience periodic stressors as they adapt to their receiving country (*DSM-IV*, 1994). Clarifying the issue of depression for refugees and immigrants also benefits the community at large. Early identification of depressive symptoms helps "to avoid the 'downstream' social and health care costs which would otherwise be associated with addressing mental health problems which become more complex," including repeated treatment for associated somatic complaints (United Nations Refugee Agency, 2002).

As mentioned in discussion of the study's limitations, a cross-sectional exploratory study can only suggest relationships between variables; therefore, future research should focus on longitudinal designs that document changes in the mental health of this particular group of refugees and immigrants as agency and governmental policies concerning these groups change (Cardozo et al., 2004). Additionally, as noted by Mui et al. (2003), "a priority in future studies should be the development and validation of culturally appropriate and sensitive measures for use among different ethnic/nationality elderly groups." Adapting pre-existing instruments may disguise the depth of culture within each ethnic group. The literature review for this proposal demonstrated that while studies of depression among the ethnic elderly are relatively few, the limited samples used in these studies further restricts the studies' usefulness. Future research, therefore, should attempt to replicate the conclusions of this early exploratory study by using larger, more systematic samples (Barnes, 2001).

Finally, research should focus not only on appropriate diagnosis and

treatment of depressive symptoms in the Kurdish and other immigrant populations, but also on mental health promotion and ways to increase protective factors (Status of Women Canada, 2002). Only by exploring the full spectrum of culture and experience that refugees and immigrants bring to their receiving country will we as professionals be able to provide the most appropriate and effective services.

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APPENDIX

APPENDIX: Study Questionnaire

Participant ID code number: _____

GENDER *(check only one)*
- _____ Male
- _____ Female

AGE _____

CURRENT MARITAL STATUS *(check only one)*
- _____ Married
- _____ Widowed
- _____ Divorced
- _____ Separated
- _____ Single/never married

PRIMARY LANGUAGE SPOKEN *(check only one)*
- _____ Arabic
- _____ Kurdish Sorani
- _____ Kurdish Kurmanji
- _____ Assyrian
- _____ Armenian
- _____ Turkish
- _____ Farsi
- _____ English
- _____ Other _____

HOW WOULD RATE YOUR ABILITY TO READ ENGLISH
- _____ Not at all
- _____ Little
- _____ Fair
- _____ Good
- _____ Very Good

HOW WOULD RATE YOUR ABILITY TO SPEAK ENGLISH
- _____ Not at all
- _____ Little
- _____ Fair
- _____ Good
- _____ Very Good

HOW WOULD RATE YOUR ABILITY TO UNDERSTAND ENGLISH
- _____ Not at all
- _____ Little
- _____ Fair
- _____ Good
- _____ Very Good

EDUCATION *(check only one)*

_____ No education
_____ Grade school
_____ High school
_____ Some college
_____ College degree
_____ Other training

LITERACY *(check only one)*

_____ Not able to read
_____ Able to read first language
_____ Able to read first language and English

RELIGION *(check at least one)*

_____ Islam
_____ Sunni
_____ Christian
_____ Judaism
_____ Other religion
_____ No religion

INDIVIDUAL INCOME *(check only one)*

_____ Less than $500 per month
_____ $501-$1,000 per month
_____ More than $1,000 per month

YEARS OF STAY IN THE UNITED STATES _____

PLACE OF BIRTH _____

IMMIGRANT/REFUGEE/ASYLUM STATUS *(check only one)*

_____ Immigrant
_____ Refugee
_____ Asylum
_____ Other (please specify _____)

CURRENT LIVING ARRANGEMENT *(check only one)*

_____ Alone
_____ With spouse
_____ With spouse and children
_____ With children
_____ With other relatives
_____ Other (please specify _____)

FAMILY NETWORK *(please give number)*

_____ Number of adult children
_____ Number of sons- and daughters-in-law
_____ Number of grandchildren
_____ Number of other relatives

DO YOU NEED HELP WITH ANY OF THE FOLLOWING?

Housing	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Financial	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Health	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Nutrition	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Transportation	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Communication	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No
Social Support	____ Yes ____ No	If yes, have you sought help? _____ Yes _____ No

HAVE YOU SEEN A SOCIAL WORKER?

_____ Yes
_____ No

REASONS FOR NOT SEEKING HELP *(check all that apply)*

_____ No other Kurdish clients
_____ The professionals are not Kurdish
_____ The professionals do not understand my culture
_____ The professionals do not speak my language
_____ The programs are not specialized for Kurdish people
_____ I do not know where to go for help
_____ I do not have the money to go for help
_____ Other (please specify _____)

(continues on next page)

Geriatric Depression Scale

Please obtain a clear yes or no answer for each question.

1. Are you basically satisfied with your life? Yes ***No***
2. Have you dropped many of your activities and interests? ***Yes*** No
3. Do you feel that your life is empty? ***Yes*** No
4. Do you often get bored? ***Yes*** No
5. Are you hopeful about the future? Yes ***No***
6. Are you bothered by thoughts you can't get out of your head? ***Yes*** No
7. Are you in good spirits most of the time? Yes ***No***
8. Are you afraid that something bad is going to happen to you? ***Yes*** No
9. Do you feel happy most of the time? Yes ***No***
10. Do you often feel helpless? ***Yes*** No
11. Do you often get restless and fidgety? ***Yes*** No
12. Do you prefer to stay at home rather than going out and doing new things? ***Yes*** No
13. Do you frequently worry about the future? ***Yes*** No
14. Do you feel that you have more problems with memory than most? ***Yes*** No
15. Do you think it is wonderful to be alive? Yes ***No***
16. Do you often feel downhearted and blue? ***Yes*** No
17. Do you feel pretty worthless the way you are now? ***Yes*** No
18. Do you worry a lot about the past? ***Yes*** No
19. Do you find life very exciting? Yes ***No***
20. Is it hard for you to get started on new projects? ***Yes*** No
21. Do you feel full of energy? Yes ***No***
22. Do you feel that your situation is hopeless? ***Yes*** No
23. Do you think that most people are better off than you are? ***Yes*** No
24. Do you frequently get upset over little things? ***Yes*** No
25. Do you frequently feel like crying? ***Yes*** No
26. Do you have trouble concentrating? ***Yes*** No
27. Do you enjoy getting up in the morning? Yes ***No***
28. Do you prefer to avoid social gatherings? ***Yes*** No
29. Is it easy for you to make decisions? Yes ***No***
30. Is your mind as clear as it used to be? Yes ***No***

Migratory Grief and Loss Questionnaire

We are interested in what you think and feel about your homeland. For each statement, please circle the number that most accurately describes how often you have felt this way during the PAST 30 DAYS

	Never	Occasionally	Often	Always
1. I miss my homeland.	0	1	2	3
2. I feel things were nicer in my homeland.	0	1	2	3
3. I dream about going back to my homeland.	0	1	2	3
4. Since I left my country, I feel that I have more strongly adopted the customs of my homeland.	0	1	2	3
5. I think and worry about my homeland and its people.	0	1	2	3
6. I feel there is no better place than my homeland.	0	1	2	3
7. I feel my thoughts are drawn to things associated with my homeland.	0	1	2	3
8. I think of pleasant things about my homeland.	0	1	2	3
9. I feel I did things better in my homeland.	0	1	2	3
10. I feel leaving my homeland was like having a part of me cut off.	0	1	2	3
11. I feel like a stranger in this country.	0	1	2	3
12. I find myself thinking about my homeland.	0	1	2	3
13. I only have pleasant memories of my homeland.	0	1	2	3
14. I feel like crying when I recall memories of my homeland.	0	1	2	3
15. It upsets me to think about being far away from my homeland.	0	1	2	3
16. I feel I am not sure of who I am since I moved to this country.	0	1	2	3
17. No matter where I am, if eel my homeland will always be my home.	0	1	2	3
18. I feel I am different since I moved to this country.	0	1	2	3
19. I feel lost in this country.	0	1	2	3
20. I feel a need to have something that reminds me of my homeland.	0	1	2	3

VITA

Natalie Worley was born in a small desert town in Arizona but spent most of her childhood in the mountains of western North Carolina. She graduated summa cum laude from Wake Forest University in 2000, with a double B.A. in anthropology and sociology. Her choice of undergraduate academic fields allowed her to participate in a variety of international experiences, including a year's study abroad at Franklin College in Switzerland and cultural field studies in Honduras, Greece and South Africa. After graduating, Natalie spent time in Australia, Boston and Poland before returning for graduate studies. She graduated from the University of Tennessee, Knoxville in 2007, receiving a Master's of Science in Social Work with a concentration in Management and Community Practice.