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Turkish Journal of Applied Social Work is an international refereed journal. The journal started its publication life in 2018. The present scientific journal is published in December and June, with two issues per year. The working languages of the journal are English and German. *Turkish Journal of Applied Social Work* is meeting the academic community with the first issue in December, 2018 and the processes required to be screened in many indexes have already started. Our journal, which is the first academic Social Work Journal in Turkey operating in foreign languages (English and German), is planning to have a new lease on social work and expects the support of the authors.

Any publications which can contribute to the development of the social work academic field and the related areas are welcome to our journal.

AIM

Turkish Journal of Applied Social Work started its publication life in 2018. This journal has embarked on the Open Access Policy with the idea that scientific information produced by academics, professionals, and others can be accessed by anyone, both locally and internationally, without any limitation.

SCOPE

Any publications which can contribute to the development of the social work academic field and the related areas are welcome to our journal. Academic studies which were carried out by academicians from social work field, social workers, social work undergraduate and graduate students, professionals from different professions working in the field of social work, and other academic units with social work on mind are the scope of this journal.

PUBLICATION POLICIES

Turkish Journal of Applied Social Work is an international refereed journal that adopts double-blind peer-review process. Editorial board of our journal follows Editorial Policy of the Council of Scientific Committee.

PUBLICATION PERIOD

Our journal is published twice a year in June and December.

Publications are made from the following areas, which will contribute to the development of social work discipline and contribute to the literature:

Other disciplines assessed in relation to Social Work, Sociology, Medicine, Psychology, Psychological Counseling and Guidance, Human Rights, Social Policy, Philosophy, Law, Economics, Health Management, Nursing, Physiotherapy, Gerontology, Geriatrics, Child Development, Special Education.

EDİTÖRLERDEN

TR *Türk Uygulamalı Sosyal Hizmet Dergisi, Türkiye'de sosyal hizmet alanında yalnızca İngilizce ve Almanca dillerinde yayın yapan ilk akademik dergidir. Dergimiz, Editör Kurulu başta olmak üzere gönüllü pek çok akademisyen tarafından büyük emekler harcanarak yayın hayatına devam etmektedir. Dergimizin Danışma Kuruluna Türkiye'den akademisyenlerin yanı sıra İngiltere, ABD, Avustralya, İsveç, Almanya, Portekiz, Romanya, Polonya, Çekya, Bosna Hersek, Letonya ve Slovenya'dan akademisyen ve araştırmacılar katkı vermektedir. 2018 yılından beri düzenli olarak yılda 2 sayı olarak çıkmakta olan Dergimiz, istikrarlı bir şekilde gelişimini sürdürmektedir. 2020 yılında Dergimizin 4. sayısını siz değerli okurlarımızla buluşturuyoruz. Bu sayımızda bizlere çalışmaları ile Katkı sağlayan yazarlarımız; Büşra Uslu AK, Mehmet BAŞCILLAR, Ali TAŞÇI, Yunus AYDEMİR, Prof. Dr. İshak AYDEMİR, Doç. Dr. Fikret EFE, Yunus BAYRAM, Doç. Dr. Taner ARTAN, Dr. Öğr. Üyesi Beyza ERKOÇ, Prof. Dr. Fethi GÜNGÖR, Dr. Hülya AKSAKAL KUC, Dr. Öğr. Üyesi Fikri KELEŞOĞLU ve Dr. Kenan YERLİ'ye ve bu sayıda görev alan hakemlerimize teşekkürlerimizi sunuyoruz. Dördüncü sayımızı dolu dolu 7 makale ile sizlere sunuyor olmanın gururunu yaşıyor ve Editör Kurulu, Yayın Kurulu ve Danışma Kurulumuz başta olmak üzere Dergimize katkı vermeyi kabul eden tüm akademisyenlere tekrar sonsuz teşekkürlerimizi sunuyoruz.*

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EN

The Turkish Journal of Applied Social-Work is the first scientific journal in Turkey published in English and German in the field of social work. Our journal is developed in the editorial office with great commitment and many volunteer scientists. The advisory board of our journal is made up of established scientists and researchers from Turkey, Great Britain, the USA, Australia, Sweden, Germany, Portugal, Romania, Poland, the Czech Republic, Bosnia and Herzegovina, Latvia and Slovenia. Our journal has been published twice a year since 2018. We always try to develop ourselves in order to be the best possible, technically enriching source of information for our readers and are proud to present the 4th edition of our magazine to you despite the difficult circumstances in the corona pandemic. We thank the following authors for their scientific contributions: Büşra Uslu AK, Mehmet BAŞCILLAR, Ali TAŞÇI, Yunus AYDEMİR, Prof. Dr. İshak AYDEMİR, Assoc. DR. Fikret EFE, Yunus BAYRAM, Assoc. Dr. Taner ARTAN, Assoc. Dr. Beyza ERKOÇ, Prof. Dr. Fethi GÜNGÖR, Dr. Hülya AKSAKAL KUC and Dr. Fikri KELEŞOĞLU. We would also like to thank Kenan YERLİ and our jury for their support. Thank you again to all scientists, the advisory board and the editorial staff for their efforts in creating our journal.

PROF. DR. MEHMET ZAFER DANIŞ
ASST. PROF. DR. ÖZDEN GÜNEŞ

ANMERKUNG DES HERAUSGEBERS

DE *Das Turkish Journal of Applied Social-Work ist die erste wissenschaftliche Zeitschrift in der Türkei, welches im Bereich der sozialen Arbeit in englischer und deutscher Sprache veröffentlicht wird. Unsere Zeitschrift wird in der Redaktion mit großem Engagement und vielen freiwilligen Wissenschaftlern entwickelt. Der Beirat unserer Zeitschrift setzt sich zusammen aus etablierten Wissenschaftlern und Forschern aus der Türkei, Großbritannien, den USA, Australien, Schweden, Deutschland, Portugal, Rumänien, Polen, der Tschechischen Republik, Bosnien und Herzegowina, Lettland und Slowenien. Unser Journal, erscheint seit 2018 regelmäßig zweimal im Jahr. Wir versuchen uns stets weiter zu entwickeln um unseren Lesern eine bestmöglich, fachlich bereichernde Informationsquelle zu sein und sind stolz, trotz den schwierigen Umständen in der Corona-Pandemie Ihnen die 4. Ausgabe unseres Magazins vorstellen zu dürfen. Dafür danken wir folgenden Autoren für Ihre wissenschaftlichen Beiträge: Büşra Uslu AK, Mehmet BAŞCILLAR, Ali TAŞÇI, Yunus AYDEMİR, Prof. Dr. İshak AYDEMİR, Assoc. DR. Fikret EFE, Yunus BAYRAM, Assoc. Dr. Taner ARTAN, Assoc. Dr. Beyza ERKOÇ, Prof. Dr. Fethi GÜNGÖR, Dr. Hülya AKSAKAL KUC und Dr. Fikri KELEŞOĞLU. Außerdem bedanken wir uns sehr herzlich bei Kenan YERLİ und unserer Jury für Ihre Unterstützung. Vielen Dank nochmals allen Wissenschaftlern, dem Beirat und der Redaktion für Ihren Einsatz zur Erstellung unseres Journals.*

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EMPOWERMENT OF HUMANITARIAN WORKERS IN THE CONTEXT OF MIGRATION AND CONFLICT: A CASE STUDY FROM IZMIR, TURKEY

ÇATIŞMA VE GÖÇ BAĞLAMINDA İNSANİ YARDIM ÇALIŞANLARININ GÜÇLENDİRİLMESİ: İZMİR VAK'A ÇALIŞMASI

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ABSTRACT

Since Syrian crisis started in 2011, people who are affected from the conflict have been seeking asylum from neighbouring countries. Turkey now hosts the largest population of Syrian refugees in the world which is about 3.6 million. Not possessing experience of dealing with many refugees from the past, the government of Turkey, international and local non-governmental organizations have taken action as emergency response to the crisis. Most local non-governmental organizations with the funds from the government, the EU and the UN have provided services in almost every sector such as protection, education, employment and health. However, the majority of the humanitarian workers (HWs) who are actively operating in the field do not possess the academic background to be able perform social work at professional level, therefore it is necessary to empower them with the techniques that can facilitate their work in the field. This paper offers an overlook to empowerment of the HWs through a training session focusing on conflict mapping technique in order to raise the awareness of the HWs about the basic concepts of conflict studies and provide them a technique with a practical value to facilitate their work in the field.

Keywords: Conflict Mapping, Humanitarian Work, Migration, Training

ÖZ

Suriye krizinin 2011 yılında başlamasından bu yana, çatışmadan etkilenen bireyler komşu ülkelerden sığınma talebinde bulunmaktadır. Türkiye şu anda yaklaşık 3,6 milyon Suriyeli bireye ev sahipliği yapmaktadır. Geçmişten günümüze bu denli büyük bir mülteci akını ile başa çıkma deneyimine sahip olmayan Türkiye'de; hükümet, uluslararası ve ulusal sivil toplum örgütleri krize müdahale etmektedirler. Ulusal kaynaklar, AB ve BM'den fon alan yerel sivil toplum örgütlerinin çoğu koruma, eğitim, istihdam ve sağlık gibi hemen hemen her sektörde hizmet vermektedir. Bununla birlikte, sahada aktif olarak faaliyet gösteren insani yardım çalışanların çoğunluğu, sosyal hizmet uygulaması yapabilmek için akademik geçmişe ve mesleki yeterliliğe sahip değildir. Bu nedenle onları, sahadaki çalışmalarını kolaylaştırabilecek tekniklerle güçlendirmek gerekmektedir. Bu çalışma, çatışma dönüşümünün temel kavramları hakkında insani yardım çalışanlarının farkındalığını artırmak ve onlara çalışmalarını kolaylaştırmak için uygulamalı bir teknik sağlamak amacıyla, çatışma haritalama tekniğine odaklanan bir eğitim aracılığıyla insani yardım çalışanlarının güçlendirilmesine bir bakış sunmaktadır.

Anahtar kelimeler: Çatışma Haritalama, Eğitim, Göç, İnsani Yardım

INTRODUCTION

Social work practices at micro, mezzo and macro levels involves the stages of engagement, assessment, planning, implementation, evaluation, termination, follow-up and closure. All stages are vital for an effective social work intervention.

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Moreover, at the engagement and assessment part collecting data is of an important role because the data regarding the individual, the group or the community are going to shape the all the stages that follows. The social workers do benefit from the techniques that are of visual elements to map the situation in detail. This mapping helps social workers to see and assess the situation. Using visuals such as mapping technique is widely accepted as useful as it describes the situation in a page instead of narrating it, which takes large amount of time and effort.

Social workers focus on the interactions and relations among the individuals, groups, families and communities by using ecological perspective (Germain, 1979: 1-25). People sustain their lives in the physical, social and cultural layers of their environment. Physical environment includes the nature, structures and the gaps among them while the social environment consists of friends, family and communities as well as the legal, political and social structures. In the context of migration, social workers plan and realize their interventions considering these layers and structures.

Turkey currently hosts the largest population of Syrian refugees in the world which is about 3.6 million (General Directorate of Migration Management, 2020). The country is not of the experience of dealing with such a large number of asylum seekers from the past (Yıldız, 2018: 144-145) Therefore, the government of Turkey, international and local non-governmental organizations have taken action as an emergency response to the refugee crisis. Most local non-governmental organizations with the funds from the government, the EU and the UN have provided services in almost every sector such as protection, education, employment and health since 2011. However, not all of the humanitarian workers (HWs) who are actively operating in the field possess the academic background to be able perform social work at professional level, therefore it is necessary to empower them with the techniques that can facilitate their work in the field.

HYPOTHESIS

The hypothesis of this study is that most of the HWs working in the migration field are not social workers and they are in need of theoretical and practical knowledge on conflict. By introducing them to theoretical knowledge on basic concepts of conflict and the technique of conflict mapping, this study aims to support and empower HWs. Through conflict mapping technique, it is expected that HWs will be able to discover the nature of the conflict and intervene in order to prevent, manage, transform and/or resolve a conflict situation. It is also hypothesized that a training session will help with the initiation of a support network among the HWs working at various NGOs in the context of migration for future reference.

THEORETICAL FRAMEWORK

Humanitarian aid work is commonly comprehended as a part of "charity" which has its drive from individual or collective conscious. It is mostly a reaction to a certain action which requires immediate attention. However, it can also be interpreted as a practical outcome of a combination of social sciences such as social work, peace and conflict studies, educational science, psychology, political science and so on. This proves that this practical area of work namely humanitarian work has its base on scientific studies. Therefore, this study has two foci which are theory and practice.

Conflict is an evolving process of dynamic interdependence between two or more actors pursuing their respective aspirations but being unable to achieve them because they view that one actor stands in the way of the other actor's goal attainment (Arai, 2017: 18). Taking this definition into account, conflict analysis can support the orientation for future action. Conflicts are dynamic systems. Any intervention becomes part of the system and should focus on supporting the creative, positive energies, in the system or related to the system. Conflict analysis can be used individually or in a participatory manner in a group (Galtung, 2000:38).

Making an analysis does not lead to an objective understanding of the conflict. Rather it makes one's subjective perceptions transparent. This way they can be reflected on and more clearly communicated. With a holistic point of view; individuals, families, groups and communities directly affect one another in their physical, cultural and social environment. Interaction of individuals, groups, families and communities not only affect the environment but also get affected by it. Individuals exist within his/her environment (Gitterman & Germain, 2008: 51-72). Conflict analysis can entail verifying if one is dealing with a conflict or not, determining the actors or parties involved and the conflict boundaries. By using conflict analysis tools, it is possible to focus on certain aspects of the conflict and organize information.

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The social workers commonly use genograms to depict the family and family relations, cultural genograms to discover the cultural background and current situation and eco-maps to show the individual and family in a social context (Sheafor & Horejsi, 2012:203-225).

Conflict mapping among other mapping techniques is a tool for the social workers who especially practice in the migration context. It is believed that adding the conflict mapping technique to the already existing mapping techniques used by the social work practitioners will positively impact the effectiveness of the social work practice. At this point it is found out that conflict mapping is of a functional role in depicting the interactions and nature of the relationships concerning the clients.

Conflict mapping technique, like a geographic map that simplifies a terrain, a conflict map simplifies a conflict, and serves as a visual to the actors involved and their functions, limits, their power or their influence in the conflict, their relationship nature with each other, and the conflict theme and/or issues (Lederach, 1995:43). A conflict map represents a specific view point of a specific conflict situation. It aims to clarify relationships between actors, to visualize and reflect on the impact of various actors and to represent the conflict on one sheet of paper giving a first conflict overview.

Conflict mapping focuses on actors and their interrelationships. It is a good tool to start analysing a conflict (Lederach, 1997:10-11). Animosity and alliances are symbolized with different types of lines. It can be used to clarify the conflict from parties' own perspectives. Or it can be used jointly, to understand both sides' view of the conflict. A third party such as a mediator or HWs could interview the conflicting parties, draft a map, ask the parties to modify it from their perspectives, redraft it, and present it as a first joint step toward cooperative resolution. Alternatively, this could be done by parties on one side who would solicit cooperation from their opponents in creating an accurate conflict map.

Conflict theory according to Entelman (2002:201) locates conflict in relations. Conflict springs from interactions as an expression of incompatibility of goals. And so, when what a person wants is incompatible with what others want, conflict arises. From that idea we have to understand relations among parties in order to describe conflict. Before understanding can come, observation of the relations is necessary. The elements of the observation are structured in the methodology of mapping which are subjects, interests, awareness of conflict, power, needs, emotions, relations and alliances. Observation and understanding of each element and its relationship with the other enable an understanding of a conflict situation (Lederach, 2003:38-39).

Therefore, HWs must identify the parties of the conflict among the persons connected with the situation. For each party, we must identify the interests which are in conflict; whether they are recognized as part of the conflict (awareness); what resources are available; what the reference values in the conflict are; what emotions are present; the relations between the parties and the identification of alliances among persons. With the information of all these elements, HWs can reach an understanding of the situation, which enables them to understand it and therefore to take decisions to intervene. Through conflict mapping, it is hypothesized that HWs can discover the nature of the conflict and intervene to make it clarified and resolved.

RATIONALE

Because the information of the clients should be taken from a holistic perspective especially while assessing the case and determining the intervention model and the targeted outcomes (Teater, 2011:16-39) it is thought that HWs can benefit from the conflict mapping technique in understanding the nature of the conflicting interactions and relationship patterns and lead them to better intervene in the process.

The content of the training has been determined upon a focus-group meeting conducted with seven HWs who work at a Non- Governmental Organization in Izmir. The information gathered through this meeting is as follows:

- This NGO started its operations in January 2017, aiming to support building the problem-solving capacity for people with disabilities and vulnerable groups living in and around Izmir and providing the necessary services for them, identifying those who have high vulnerability and/or are unable to reach the services through communication based field studies and in-office services by field workers and provides them with assistance, through financial support of European Civil Protection and Humanitarian Operations (ECHO). In the supervision of a psychologist and a health educator, mental health psycho-social support services, extended guidance and case management activities are performed.
- The HWs working at the NGO are graduates of the departments of Sociology, International Relations, English Literature, Physio-therapy & Rehabilitation and Psychology. Besides the multi- disciplinary background of the HWs, it is found out that HWs experience "conflict" in their daily lives at work and their personal lives.

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The examples to conflict is mostly regarding polarization from macro to micro level in Izmir context.

• It has been explicitly stated that the HWs need for practical techniques regarding conflict resolution to understand and deal with "conflict" in the field. Since they are from different disciplines and not experts on Social Work or Peace Studies, it is concluded that providing not only practical but also theoretical content on conflict will have a positive impact on the professional and personal lives of the HWs.

• Lastly, the lack of a common platform among HWs in migration context in Turkey necessitates a network for HWs. It is thought that a support network among HWs might be a good resource through which they can share their experience, problems which can be analysed and resolved together in a collaborative manner. It is possible to compensate this lack of support network and initiate one among the HWs in Izmir starting from this NGO.

The Training Session on Conflict Mapping

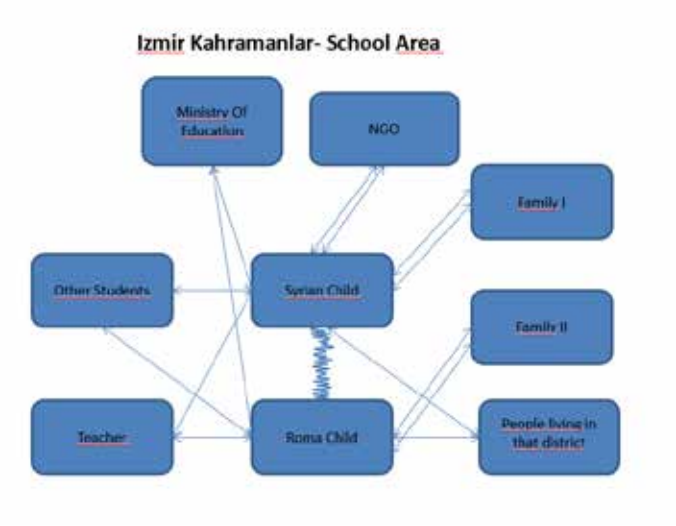
In order to empower the HWs, a training session has been planned and implemented. The session has started with the introduction of main concepts of Conflict. Firstly, the definition of the term conflict has been elicited from the HWs and personal perceptions on Conflict have been discussed. The term polarization has been brought up by the participant HWs and link between conflict and polarization has been stated. After that the concepts of Polarization, Conflict Analysis, Conflict Management, Conflict Transformation and Conflict Resolution are illustrated with their literal definitions, metaphors and examples.

Upon the analysis of the main concept and a break has been given and during that time the classroom has been rearranged for the Example Scenario. Scenario was about a Local Bazaar Situation where one Syrian and one Turkish salesman work. According to the scenario, a conflict emerged between two customers one of whom shops from the Syrian salesman but challenged by another customer about doing so. Through role- playing, the HWs played their roles as salesmen and two customers. After the role- play, mapping of this conflict has been illustrated on the board and the relationship symbols has been introduced to the participant HWs.

After the whole analysis and mapping of the example conflict scenario, the HWs has been asked to work in pairs and come up with a conflict situation that they came across in the field working as a HW. They have been given 20 minutes to discuss and use the conflict mapping technique to further analyse the situation.

Upon completion of their discussions and maps, the HWs have been asked to report back and share the conflict that they have analysed and present the map. Five maps have been presented and their content is as follows:

Map 1: A Conflict between a Syrian Child and a Roman Child in front of a Public School in Kahramanlar District of Izmir



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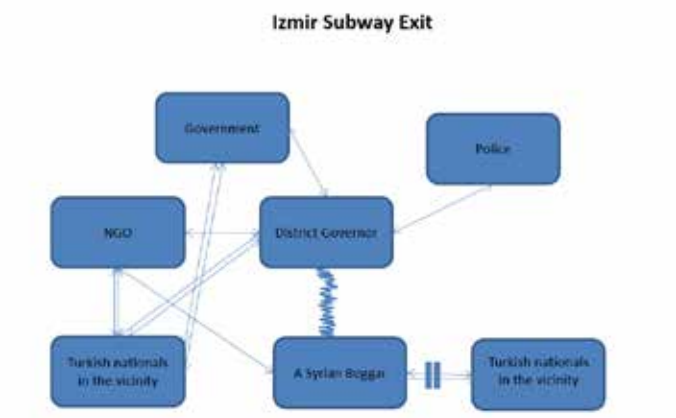
Kahramanlar district of Izmir province is a known area for its consisting people from different minority groups such as Kurds, Romans and most recently Syrians who are also from different ethnic groups. In most contexts, it is believed by the local residents that Syrians have broken the balance in the area and a competition among these groups have occurred.

In the map, describing the conflict between Syrian and Roman children, the actors are stated as Syrian Child, Roman Child, the other children in the school, the teachers, the local residents, families of the children, the non-governmental organizations and the Ministry of National Education. While presenting the maps, the HWs mentioned the hidden competition element. According to this, the Syrian children are more hard-working than the Roman children at school. Despite their language barriers, they are more successful and grasp the attention of the teachers. With these underlying facts in mind, the HWs have analysed the conflict stemming from jealousy, discrimination and the need for power demonstration to preserve the life conditions. The HWs also added that one of the family members who showed up afterwards asked his child why he did not fight back and scolded him fiercely.

Map 2: A Conflict between a Syrian Woman begging at a Subway Exit and the Turkish Community in Konak District of Izmir



Konak is a famous area of Izmir where mostly people with economically good conditions reside. This conflict has been witnessed by the HWs by coincidence in rush hours after a working day at the subway exit. The parties involved in this conflict is reported as Syrian beggar, an officer from the State department of Social Work, police officers, Turkish local community, and the non-governmental organizations.

While presenting the Map, the HWs have mentioned that a local called the police and complained about a Syrian woman with her baby was begging at the subway exit. Upon this call, an officer from the State department of Social Services and police officers showed up at the scene asking the Syrian woman to come with them to the police station. The woman did not speak Turkish but when she understood that they want to take her in police custody, she became agitated and started to hurt her baby. At that point, local resident intervened making harsh comments on her motherhood, her leaving her country and her breaking the peaceful environment that Konak used to have. The HWs assumed the responsibility to translate but find themselves as mediators among the police, the locals and the Syrian women. The HWs repeatedly stated that they were not ready for such role and they added they felt lucky that the conflict did not turn into a physical fight. At the end of the presentation, some of the HWs asked about whether or not taking part in such conflict is part of humanitarian work and if passing by such conflict after working hours would be ethically correct or not.

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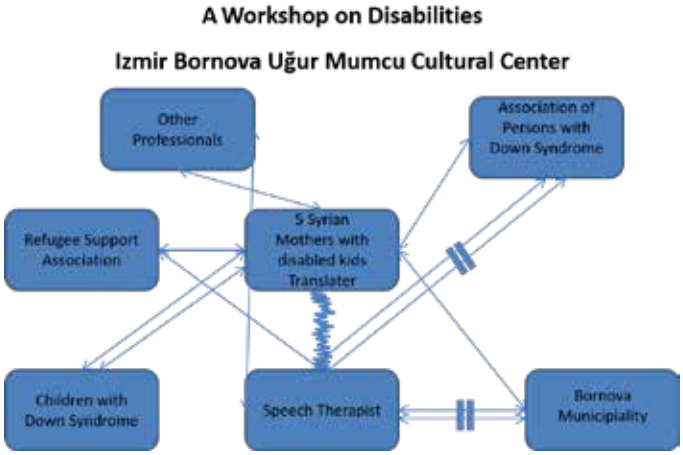
One participant gave the example of a medical doctor who passed by a man who just had a heart attack on the street and the further analysis and links to humanitarian work have been made.

Map 3: A conflict between 5 Syrian Women and Language Therapists at Bornova Municipality Workshop on Disability in Izmir



Bornova is a district in Izmir with a Municipality with an anti-government political view just as the Izmir Metropolitan Municipality. Municipalities' being anti- government can sometimes lead to hardships regarding the services for the Syrians in the city as it is commonly agreed that the government is to "blame" for the problems related to the Syrians. However, the municipalities are not totally disregarding the situation and they design services such as giving Turkish classes, distribution of food and non-food items, workshops, etc.

Bornova Municipality arranged a workshop on Disability at Ugur Mumcu Culture Center on 10.05.2017 in cooperation with the Izmir Association for People with Down syndrome. The HWs were also the attendants to the workshop and reported that a conflict between Syrian mothers of kids with Down syndrome and the Turkish experts (Language Therapists) emerged during the workshop. The other actors were stated as the translator, Bornova Municipality, Izmir Association for People with Down syndrome, Turkish mothers attending the workshop, Turkish Children with Down syndrome attending the workshop.

The Turkish Experts did not accept the Syrians participation and protest against them during the speech was being translated into Arabic. The HWs as the translators were felt that they were being protested but in fact they want Syrian mothers and children out of the Conference hall. The Turkish participants applauded, talked and yelled during the workshop. Syrian mothers and children started crying wanted to leave.

While analyzing the conflict through mapping, the HWs mentioned Turkish nationalism, polarization, ethnic discrimination against Arabs as the reasons. However, discussing further, the HWs mentioned "fear" as a core element to the relevant conflict. The fear of losing power or potential loss of being a part of the majority was also mentioned. It is also added that not protesting Syrians might mean that they are fine with the Government's policy on Syrians under temporary protection, which might lead to lose or harm their political identity.

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Map 4: A Conflict between A Syrian Worker and A Turkish Employer at Isıkkent Shoe- Making Site in Izmir

Within this conflict example which emerged at Isikkent Shoe-making Site on 01.05.2017, the HWs identified the parties to the conflict as the Syrian worker, Turkish Employer, the Police Force, Social Security Institution, Non- governmental Organizations, Worker Unions, Other Syrian Workers at the Shoe- making Site, Other Turkish Workers at the Shoe-making Site and the Families of the workers. The Shoe-making Site in Isikkent/ Izmir is a known area where people from different minority groups work without work permits and social insurance. This area can be categorized under socio-economically deprived places in Izmir Province. The employers at the site are commonly believed that they make children and adults work under harsh conditions with long hours and often fail to pay the salaries in timely manner or avoid paying them at all. The similar cases of Syrians living under temporary protection in Izmir province often come to the attention of the HWs working at the RSC. The Syrians mostly complain about the fact that the language barrier has a direct negative impact on their livelihood and they have their difficulties in finding jobs. They feel obliged to settle for whatever job they are being offered even if it means working illegally and under hard conditions.

When it comes to the specific example that the HWs have raised during the training session, it also fits the general condition that Syrians come across in the context of the livelihood issue. In this context, a Syrian worker has not been p at all, although it has been working more than two months. The employer seems to postpone paying him using the language barrier as an excuse for not being able to understand what he asks for.

When the Syrian workers has confronted with the Turkish employer, a potentially violent conflict has emerged and other Syrian and other Turkish workers at the Site gather around them. The HW has the function to be the translator and the mediator since naturally language is of the medium of understanding. It is stated that no physical contact has been made however, the situation was extremely volatile. The HW has mentioned the fact that he felt insecure and did not know what to do. The HW wanted to call the police officers but he thought about the illegal condition of the Syrian worker and refrained himself from calling the authorities. After the presentation has been completed a question "What would you do in the situation" to the whole group has been directed. Half of the group has stated that they would have called the authorities but half of the HWs s that they would not since it is against the wellbeing of the Syrian worker. A small discussion regarding the ethical dilemma that the HW in that situation experienced. It is added that it is also a part of the conflict resolution to overcome these ethical dilemmas in such cases.

Map 5: A Conflict between Turkish Families and Syrian Families during a Vaccination Campaign in Izmir

Turkish Ministry of Health in cooperation with the World Health Organization and UNICEF have started a vaccination

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campaign in February this year. With this project, all Syrian Children under the age of five are targeted to be vaccinated against infectious diseases. In each city in Turkey, local NGOs supported the project by disseminating information and providing translators.

In Izmir, Konak District as well the project aimed to be implemented. Therefore, Syrian children and their families were gathered around Gultepe Community Health Centre on 11.05.2017.

A conflict among Turkish people and Syrian Families who brought their kids for vaccination took place. The HWs identified the actors to the conflict as a Turkish family, Syrian family, the Police officer, Muhktar (elected district leader), doctors, nurses, translators and the non-governmental organizations on the Conflict Map.

While presenting and analysing the map, the HWs stated that the reason behind the conflict and the narrative used were about Government's favouring the Syrians and ignoring the Turkish nationals. The Turkish families were inclined to be violent, however, the HWs reported that they were able to manage the crowd by stating the fact that vaccinating the Syrian children will help preserving the Turkish children's health from the diseases sourced from the Syrians. The HWs were able to transform the conflict by privately talking to the Turkish families saying that the government is working for the Turks not the Syrians since they want to protect them against the potential diseases coming from the Syrians. The HWs added that they felt dishonest because they could tell one part of the truth and could not share the fact that they believe vaccination is a rightful service to Syrian children just like it is for any Turkish children.

RESULTS

HWs' feedback on conflict mapping technique training and its practicality was taken after a week from the training session through individual meetings online. The feedback was mostly positive regarding the use and the practicality of the Conflict Mapping Technique. To be more detailed the HWs stated that the conflict mapping technique has given them the opportunity to have a look at the conflict situations from a broader perspective. It is also reported that identifying actors and parties to a conflict situation has been also a great asset to possess especially in starting the case management cycle in the humanitarian work. The analysis of the nature of relationships among the parties and the actors within a conflict and determining whether they are allies or where the relationship is broken or not are reported to be very helpful in case management in humanitarian work.

They also acknowledge that humanitarian work requires understanding and comprehending all the actors and parties involved and possessing the potential to involve in a conflict to better handle such a situation as professionals, which means that HWs raise awareness regarding the importance of conflict resolution in the humanitarian sector.

In addition to the feedback about above mentioned positive impacts of conflict analysis, the HWs have also stated that they are in need of further support to further understand the conflict situations including the polarization between the Turks and the Syrian which has reached to the climax in Izmir context lately.

Initiation of a support network as an objective of this field report has been suggested by the HWs before mentioned by myself as the facilitator of the training session. Although the original plan of the support network involved HWs' coming together monthly or biweekly and deciding the agenda of the meeting by themselves, the HWs come up with a rather novice and technological solution. One of the HWs took an initiative to start a private chat room named it as a "Self- Support Network".

This chat room has been active for about three weeks now and the HWs share problems, questions, anecdotes and concerns regarding their job and to my understanding from the feedback received and the active participation in the chat room, they feel satisfied by this online initiative. With this, the objective of founding a support network for the HWs has been achieved surprisingly with complete effort from the HWs themselves.

CONCLUSION

All in all, it can be said that this training has been successfully achieved its aims since the HWs have raised their awareness about conflict resolution, have been introduced to the main concepts of conflict such as the definition of conflict, conflict management, conflict resolution, polarization and the needs-based understanding of conflict. They have also been introduced to the conflict mapping technique theoretical and practically through real life scenarios and role- playing. Upon being presented and practicing conflict mapping technique, the participant HWs also produced their own conflict maps in pairs by analysing a real conflict they have come across recently in their professional lives.

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The training session regarding the conflict mapping technique has received positive feedback which has been taken individually through online meetings a week after the session.

Finally, a support network among the HWs has been set up through complete efforts and initiation of the participant HWs. The idea was put forward by the HWs and the form of it is also decided by themselves as well. They prefer doing the network online by using private chat room and named it "Self- Support Network" which has been actively used by the HWs to share questions, problems, solutions, concerns and experiences.

As for the limitations of this field work, taking only one technique as subject of the fieldwork under the umbrella term conflict and the academic discipline of Conflict Studies is obviously not adequate to equip the HWs with the necessary theoretical and practical knowledge of Conflict Resolution.

When it comes to recommendations in line with Richardson (2006), a common curriculum of knowledge, skills, and experience needed for different areas of work within the humanitarian sector; identification of existing needs of the HAWs for training and collective action to develop training to fill the gaps should be developed. Besides, a commitment from all relief organisations to empower the staff or volunteers who are new to social work practice and is of no educational background in social work. Further research should be done to investigate the views of HWs concerning development needs, and current barriers to their practices in the humanitarian sector.

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DIFFICULTIES FACED BY WOMEN ASYLUM-SEEKERS IN TURKEY: CASE OF BATMAN

TÜRKİYE'DE SIĞINMACI KADINLARIN KARŞILAŞTIKLARI GÜÇLÜKLER: BATMAN ÖRNEĞİ

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ABSTRACT

The aim of this study is the examination of the difficulties encountered by Syrian women protected under the Temporary Protection Regulation in the case of Batman (Turkey) province. This study was based on the general screening model to determine the difficulties faced by female asylum-sekeers. The universe of the research consists of the Syrian Women living in the provincial centre of Batman under temporary protection status. Snowball sampling method is used in the direction of the research purpose. Interviews were conducted with 301 female asylum seekers who agreed to participate in the study. 97.7 per cent of the women had a temporary protection document, 13 per cent had applied and were in the process of obtaining one, and 1 per cent did not have a temporary protection document. It was found that 76.7 per cent of the women had not received any in-kind and/or cash aid from the government, foundation institutions etc. and 23.3 per cent of the women had received such assistance. 55.5 per cent of the women want to go back to their country when the war ends and 44.5 per cent do not want to return.

Keywords: Temporary protection, asylum-seeker, social work, community pressure, gender, social exclusion

ÖZ

Amaç: Geçici Koruma Yönetmeliği kapsamında korunan Suriyeli kadınların karşılaştıkları güçlüklerin Batman ili örneğinde incelenmesidir. Yöntem: Bu çalışmada kadın mültecilerin karşılaştıkları güçlükleri belirlemeye yönelik olarak genel tarama modelini esas almıştır. Araştırmanın evreni, Batman il merkezinde yaşayan geçici barınma statüsündeki Suriyeli kadınlardan oluşmaktadır. Araştırmanın amacı doğrultusunda kartopu örnekleme yöntemi kullanılmıştır. Çalışmaya katılmayı kabul eden 301 kadın ile görüşme gerçekleşmiştir. Bulgular: Araştırmaya katılan kadınların geçici koruma belgesi edinme durumlarına ilişkin dağılıma bakıldığında, %97.7'sinin geçici koruma belgesinin olduğu, %13'ünün sürecinin devam ettiği, %1'nin geçici koruma belgesinin olmadığı saptanmıştır. Kadınların %76.7'sinin devlet, vakıf vb. kurum-kuruluşlardan ayni ve/veya nakdi yardım yardım almadığı, %23.3'ünün de yardım aldığı tespit edilmiştir. Kadınların %55.5'inin savaşın bitmesi halinde ülkesine geri dönmek istediği, %44.5'inin de geri dönmek istemediği belirlenmiştir.

Anahtar Kelimeler: Geçici koruma, sığınmacı, sosyal hizmet, toplum baskısı, toplumsal cinsiyet.

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1. INTRODUCTION

This study, within the scope of the social work, aims to reveal the difficulties female Syrian refugees that live under the temporary protection status face, to shed light on the problems that attract the attention of society, the government and the NGOs that work on this topic, and to create awareness about this issue.

The concepts asylum-seeker, refugee, temporary protection, and migrant, however interchangeably they are often used, in fact have legally and acdemically different meanings. The definition of 'refugee' does not cover individuals or groups of people who leave their country only because of war or other civil disturbance, famine, natural disasters or in order to seek a better life (Phillips, 2011). The terms "refugee", "asylum-seeker" and "migrant" are often used interchangeably but it is important to distinguish between them as there is a legal difference (Amnesty, 2018). In this study, the concept of asylum-seekers and temporary protection is discussed.

Asylum-seekers are people who enter a country without legal documents, or whose documents expire once they have arrived and who claim refugee status (Nash and Trlin, 2004). Alternatively, "an asylum-seeker is a person who has asked for protection but has not received a decision on their application to become a refugee, or is waiting for the outcome of an appeal or an asylum-seeker is a person who has crossed an international border in search of safety and applies to be given refugee status under the 1951 UN Convention (UNHCR,1951). Temporary protection can be supplied to foreigners who are forced to leave their country, cannot return to the country where they left, come or pass our borders aggregately for the purpose of finding urgent and temporary protection (LAW, 6458).

The unfolding refugee crisis represents the worst post Second World War humanitarian crisis and largest movement of refugees (SCIE, 2015). Today, migration movements have political, economic, social and cultural dimensions and are actively discussed and debated in all geographies where globalization is felt, not only in the countries that receive the migration. Human movements, because they have such a profound effect on the societies that accept them, have become the main determinants of international relations and politics (Turkish Ministry of Interior, 2016).

Acoording to The United Nations Human Rights Council, the forcibly displaced population increased in 2017 by 2.9 million and 68.5 million people were forcibly displaced worldwide as a result of conflict persecutions, wars, or generalized violence. Of the 68.5 million forcibly displaced people, 25.4 million refugeees, mandate, 19.9 million refugees under UHRC (United Nations High Commissioner for Refugees)'s, and 3.1 million were asylum-seekers (UNHRC, 2017).

As a result of the civil war in Syria, ongoing since 2011, asylum-seekers have flocked to neighbouring countries (especially Turkey, Lebanon, Jordan, Iraq) as well as Europe (Greece, Austria, Italy, Germany, and others). Between 2014 and 2017 alone, the number of such Syrian asylum seekers reached nearly six million people.

Syrians have migrated to Turkey, Lebanon, Iraq and Jordan primarily because these countries share borders with Syria and they readily accept these migrants. However, as can be seen from written and visual media, many of the Syrians in these countries wish to migrate to other countries with higher economic and employment opportunities and better standards of living.

According to the UNHRC Report (2017) over 105,000 refugees and migrants entered Europe and over 2,290 are thought to have died along land and sea routes while undertaking the dangerous journeys (UNHRC, 2017). Thousands of migrants risk their lives to try to reach Europe from the opposite shores, and many of them die in the process (Freedman, 2015).

On the other hand, the majority of Syrian migrants have stayed and resided in different regions of Turkey because European countries closed their borders and have not accepted refugees and asylum-seekers since 2017. Beyond not being able to leave, Syrian refugees also stay in Turkey because of the common culture, relationships with relatives, and because they do not feel alienated.

While there are total 5,636,302 registereed Syrian asylum seekers in need of international protection worldwide, the largest portion of this population is being hosted in Turkey. As of March 7, 2019, The Turkish Interior Ministry's General Directorate of Migration Administration has received a total of 3,644,342 Syrian asylum-seekers and has registered them according to their biometric data. 1,977,150 of them are men and 1,667,192 are women. In addition, 142,676 of them live in camps, while 3,501,666 of them live elsewhere (Turkish Ministry of Interior, 2019).

Syrians living under temporary protection reside all throughout Turkey. It is believed that they encounter problems such as unemployment, finding accomodation, feelings of strangeness, lack of language, lack of skill, anxiety of exclusion, education and health in the areas where they reside.

Since the year 2011, applications to Europe have been made by asylum-seekers in Turkey and their number has exceeded one million. The 28 Member States of the European Union (EU) granted protection status to 538,000 asylum-seekers in 2017, and the largest group of beneficiaries of protection status in the EU in 2017 remained citizens of Syria (175,800 persons, or 33 % of the total number of persons granted protection status in the EU Member States), followed by citizens of Afghanistan (100,700 or 19%) and those of Iraq (64,300 or 12 %) (Eurostat, 2017). However, the number of asylum-seekers in Turkey is 3,644,342. Nominally, the number of asylum-seekers in Turkey is 7 times the size of those in the European Union (Turkish Ministry of Interior, 2019).

2. LEGISLATION FOR REFUGEES AND ASYLUM-SEEKERS IN TURKEY

The 1951 Geneva Convention is the key legal document and has been ratified by 145 State parties. It defines the term 'refugee' and outlines the rights of the displaced, as well as the legal obligations of states to protect them (UNHRC, 1951). Turkey has ratified the 1951 Refugee Convention and acceded to the 1967 Protocol relating to the Status of Refugees. However, since ratification, Turkey has maintained the geographical reservation to the application of these treaties, with the effect that "Turkey does not extend refugee status to persons fleeing conflicts or other situations outside Europe" (Doğar, 2017; Bidinger et al., 2015).

The first general refugee policy in Turkey was created by Regulation No. 1994/6169 on the Procedures and Principles related to Population Movements and Aliens Arriving in Turkey (Regulation, 6169). The 1994 Regulation was replaced by the Temporary Protection Regulation that came into force in October 2014, following the entry into force of the new Turkish Law on Foreigners and International Protection (LAW, 6458).

Even though Turkey is a signatory to the Geneva Convention, it does not grant refugee status to those applying from outside the United States and Europe due to the geographical reservation. Temporary protection status is applied for this purpose. According to Article 91 of Law No. 6458, "Temporary protection can be supplied to foreigners who are forced to leave their country, cannot return to the country where they left, come or pass our borders aggregately for the purpose of finding urgent and temporary protection." (LAW, 6458).

Syrian asylum-seekers are subject to a special "temporary protection regime" and do not fall under the normal procedures established for non-European asylum-seekers (Özden, 2013). The "Temporary Protection Regulation", which also includes the Syrians, was published in the Official Newapaper dated 22 October, 2014 and numbered 29153 and it entered into force (Regulation, 6883).

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Temporary protection is proteection provided to foreigners forced to leave their country, cannot return to the country they left, come to our borders aggregately for the purpose of finding urgent and temporary protection, come or pass the borders of Turkey individually in the cycle of aggregate movement and for whom an international protection request cannot be taken individually (LAW, 6458). Regulations define the scope of "Temporary Protection", the rights and obligations of people who will be evaluated within this scope, the registration process, other determinative criteria regarding staying in the country, and limitations that may be applied to the rights of people falling under this status. This regulation is especially important in terms of determining the rights and obligations of the Syrians.

The provinces where they reside provide such services to such asylum-seekers as medical services, education, access to labor market, social aid and services, interpretership and similar services (Turkish Ministry of Interior, 2016).

Although approximately half of the remaining asylum-seekers in Turkey are women, these women shoulder more of the burden than male asylum-seekers, as women take on the majority of the responsibility of supporting their families, and raising the children that make up a large part of the Syrian population in Turkey. Below, the problems and difficulties encountered by women Syrian asylum-seekers are addressed.

2.1. Difficulties (Psycho-social and Economic)Faced By Famale Asylum-Seekers

According to the United Nations (UN), gender differences also evince themselves during war and women face many problems that men in war do not, such as violence, domestic violence, sexual abuse, early marriage, or unwanted pregnancies. According to the United Nations' data, 70 % of the world's refugees are women and children (UNHRC, 2017).

Being an asylum-seeker or refugee and also being a woman asylum-seeker is even more difficult for disadvantaged populations. The problems faced by asylum-seekers and the difficulties that arise due to these problems are characteristic of a very different reality Such serious problems include hindrances in the supply of basic physiological requirements (such as accommodation, nutrition, dressing, health), education, and employment, the experience of social exclusion, or a lack of security.

According to statistics from the Ministry of the Interior Immigration Administration, 3,644,342 Syrians in Turkey are under temporary protection (Turkish Ministry of Interior, 2019). Therefore, those who stay out of the camps need to supply their housing requirements on their own. Asylum-seekers not in the camps are forced to continue their lives in a place that is proportional to income. Due to migration, many families prefer to live together to be able to afford the rent (Karaca & Doğan, 2014). The vast majority of apartment dwellers prefer basements as there the rent is cheaper. The majority of these houses have heating and humidity problems. They try to procure some of their household needs from their neighbors and some from charity associations (Karataştan, 2017). Some shopkeepers allow their families to stay in their shops at night (Kaya & Kıraç, 2016).

Migrant women face marriage and pregnancy at an early age. In particular, it is seen that asylum-seekers from Syria become pregnant at very short intervals because they do not resort to protection methods (Karaca & Doğan, 2014). Reasons such as having a large number of children, not choosing family planning methods, being willing to have boys, approving early marriage as normal, and polygamy, affect women's health negatively (Gümüş et al., 2017). The woman who was abused in the place she migrated to cannot complain because she does not know her rights. Unwanted pregnancies, depression, and sexually transmitted diseases are among the problems women will experience (Deniz, 2014). On January 17, 2018, Hürriyet Newspaper stated that 115 children in Turkey under the age of 18 were pregnant, of which 39 were Syrian. Despite the fact that it is "compulsory" to report such cases to the police, these had not been (Hürriyet Newspaper, 2018).

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One of the most important difficulties that Syrian women asylum-seekers face is unemployment. Until 2014, no official work permit was granted to them. However, according to Article 29 of the "Provisional Protection Regulation" published in the Official Newspaper dated 22 October, 2014 and numbered 29153, official work permits were granted (Regulation, 6883; Regulation, 8375). 42 But it appears that many Syrians have been employed at very low rates without a working permit. Because the Syrians who do not have a residence permit work as day workers and seasonal workers in the fields, and because employers want cheaper labor, they are not interested in working permission (Regulation, 6873). Local people are also disturbed because of the competition that this cheap labor gives them. Most people are worried about losing their jobs (Erdoğan, 2015). The Syrian asylum seekers, who do not know that they have a right to work, acquiesce to low wages in order to earn enough money to survive (Koyuncu, 2014).

The two groups (those working in the agriculture sector and those working elsewhere) with very different income levels have also different expectations. While people at a lower income level simply want a job to survive, people with higher income levels are more likely to live in better conditions and even settle in western countries after a while. Syrians who have started businesses usually prefer to employ Syrians (Lordoğlu & Aslan, 2016).

Child laborers are much preferred because they work at lower wages than adults. Children are mainly employed in textiles, workshops and in day work (Kaya & Kıraç, 2016). The low level of family income causes children to be employed if adults cannot find work. Children who lose their fathers in battle tend to work because they see themselves as the headman of the family (Harunoğulları, 2016).

Economically, asylum-seekers can be listed as cheap labor and illegal workers in agriculture, industry and small businesses. Most of those who lost their jobs believed that they "lost their jobs because they were Syrian (Ercoşkun, 2015). It may cause them to be reluctant to give rented houses or jobs because the Syrians are seen as threats to employment for local people. Because of such social, cultural, political, ethnic, religious reasons it is unavoidable that Syrian women aslum seekers are faced with neighborhood pressure. It is believed that such local women see them as competitors and a threat, seeing them as people who take their jobs from their hands. These factors lead to the social exclusion of Syrian women asylum-seekers, faced with neighborhood pressure, a constant sense of strangeness and most importantly facing the difficulties of being a woman.

As a result of Nasirova's work, conditional refugees chiefly expect not to be prejudiced by local people and for the locals to respect their culture. This serves as proof of their social exclusion (Nasirova, 2014).

Approaches against asylum-seekers should be based on the "rights-based approach", which is the most basic principle of social work in the occupational intervention with asylum-seekers. It is necessary to act with an approach based on the understanding that they are human before all else and that everything that is right for other people is also right for them. The range of social work interventions with refugees and asylum-seekers is varied and demands the application and acquisition of key knowledge and skills. Discrimination, stigma and disadvantage are rife when dealing with asylum-seekers, refugee groups and minority ethnic groups (Solomos & Beck, 1996; Gordon, 1992).

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3. METHODOLOGY

3.1. The Aim of Study

It is difficult to be an asylum-seeker or refugee, but it is more difficult to be a woman asylum-seeker or refugee. In addition to the difficulties of being a woman, the difficulties and troubles of asylants or refugees double their burden. In addition, half of the asylum-seekers in Turkey are women. The objective determination of the difficulties and troubles faced by women asylum-seekers carrying such heavy burdens is the aim of the study. Beyond this, the determination of their needs and the strategies they employ to cope with the difficultiees of their life may also serve as an objective resource for the support and assistance provided to them. The purpose of this study is to examine the difficulties faced by Syrian women asylum-seekers who are temporarily protected under the Provisional Protection Regulation in the case of Batman province located in the south east of Turkey. This study was carried out based on the general screening model in order to be able to determine the difficulties faced by women asylum-seekers.

3.2. Sample Design

The universe of the research consists of Syrian female asylum-seekers who live under temporary accommodation status in Batman province centre. The exact number of the universe is unknown. For this reason, sampling was used because it is difficult to reach the entire universe. In the snowball sampling method, one of the randomly chosen units is contacted first. With the aid of the contact unit it is passed to the second unit and the second unit is transferred to the third unit with the help of the second unit. In this way, as the size of a sample increases, the size of a sample expands (Yazıcıoğlu & Erdoğan, 2004; Yıldırım & Şimşek, 2005).

In this case, the researcher interviews several people who are eligible to enter the sample and collects information about other people who are deemed similarly appropriate. It was determined that the participation of 383 individuals would be sufficient to work according to the calculation of the sample size. Approximately 900 interviews were held with female asylum-seekers for the purpose of the research. However, interviews were held with 301 women who agreed to participate in the study. Some women who did not agree to participate in the study expressed fears such as their assistance being cut off and being embarrassed, and some did not specify any reason.

3.3. Data Collection Tools and Techniques

An interview form (questionnaire) was prepared which questioned the difficulties encountered by female participants in the survey. The prepared interview form consists of three parts. The first part asked participants for socio-demographic information (age, gender, marital status, languages, number of children, etc.). The second part elicited participants' opinions about education, health, housing, finances, social exclusion and communication difficulties. In the third part, they were asked open questions about other difficulties that they experienced. In addition, the participants' were encouraged to make general recommendations and their responses were classified.

3.4. Data Collection Process

After the approval of the ethics committee, the researchers reached out to the female participants within the universe, and the interview forms were completed by the interviewers via the interpreter. Translation assistance was obtained from a volunteer psychologist and social worker who speaks Arabic, Kurdish and English and who lives in Batman province. In order

to ensure healthy data collection during the process and that the participants gave more sincere responses, the purpose of the participant's investigation was clarified before the interview form was implemented and interviews were held after informed consent was obtained. Of the 900 participants interviewed in the direction of the survey, 301 agreed to accept the interview and fill in the interview form. The data of the study were collected between November 2017 and January 2018.

3.5. Analysis of Data

The interview form was used as a data collection tool in the research. After the data had been adjusted to suit the purpose, the database was created in the SPSS (Statistical Package for Social Sciences) 20.0 program which was used in the study and analyses were carried out by the academic advisor after the data were transferred. In the analysis of the data obtained within the scope of the research, some socio-demographic characteristics of the participants were taken into account and statistical analyses were made comparatively on the basis of chi- square, correlation analysis, frequency distributions, average, per cent, and cross tables.

4. FINDINGS

4.1. Socio-demographics Results

In this survey, 301 female asylum-seekers agreed to participate and 40.2 % of them were in the age range of 18-25 years, 27.6 % were in the age of 26-35, 15.6 % were in the age range of 36-45, 13.0 % of them 46-55, and 3.70 % in the age range 56 and over. The average age of the participants was 32; the youngest was 18 and the oldest 84. 47.2 % of asylum-seekers can speak Arabic, 40.2 % can speak Kurdish, 12.4 % can speak Turkish and 0.2 % can speak Farsi. Namely, Syrian women asylum-seekers can speak multiple languages and it is determined that the mother language of 73.8 % of the women is Kurdish, 25.9 % Arabic and 0.3 % Farsi.

39.5 % of female asylum-seekers graduated from secondary school, 18.3 % graduated from high school, 16.6 % graduated from primary school and 11.3 % graduated from university; however 13.3 % are not literate and 1 % of them are literate but have no diploma. In AFAD's (Disaster And Emergency Management Presidency) study (2014), it was established that 37 % of the Syrians living in the camps and 33 % of those living outside the camps were primary school graduates.

83.7% of married female asylum-seekers have had both official and religious marriages; however 16.3 % of them only have had a religious marriage, a practice which arises from the belief that both religious and official marriage must be together in Islamic societies. When the marriage pattern is compared with the education status, it can be seen that only those who have religious marriages and those who have both religious and official marriages are primary and secondary school graduates.

It is determined that 97.7 % of women asylum-seekers have a temporary protection document, 13 % of them are at some point in the process of obtaining the document, and 1 % of them do not have a temporary protection document. Almost all women who participated in this research study have temporary protection identity documents provided by the Republic of Turkey.

81.4 % of female asylum-seekers have relatives in Turkey, leaving 18.6 % with none. The reason for the high percentage of participants with relatives in Turkey is likely due to Syria's history of inclusion in the Ottoman sphere of influence and the simple fact that the majority of the people living in the geographical region of the Middle East are Muslim. Furthermore, the First World War led to relatives living separately in both countries by the Turkey-Syrian border. It is believed that the reason why there is such a high number of relatives in Syria is Batman province's proximity to the border of Syria.

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4.2. Economic Difficulties

76.7 % of women asylum-seekers do not receive cash aid from institutions such as the state or foundations, while 23.3 % of them are receiving aid. 83.1 % of asylum-seekers who do not receive aid from institutions such as state and foundation have relatives in Turkey, 16.9 % of them do not. 75.7 % of asylum-seekers who receive aid have relatives in Turkey, whereas 24.3 % of them do not have relatives. It is supposed that the reason that women do not get help can be that the majority of them have relatives from whom they can get aid.

88.4 % of women asylum-seekers face economic troubles, while 11.6 % of them do not report such a problem. In 61.1 % of asylum-seekers' families, 1 member Works; in 31.9 % of them 2 members work; in 5.6 %, 3 members work and in 1.3 % of them, 4 members work. According to these data, the majority of women face economic troubles. 92.6 % of them who do not get aid from institutions such as goverments and foundations (76.7 %) face economic troubles; however, 7.4 % of them do not face such economic troubles. Furthermore, 74.3 % of those who get aid from institutions such as governments and foundations have financial difficulties; however 25.7 % of them do not. Additionally, despite the fact that women receive help from relatives and institutions such as governments and foundations, it is believed that economic difficulties for women can arise from inadequate aid, insufficient to cover the requirements of families.

96.7 % of women have difficulties finding a job, and 3.3 % of them do not have one. Namely, almost all of the women have difficulties finding a job. It has been observed that 29.8 % of household livelihoods are provided by women, 29.1 % by the husband, 11.7 % by the mother, 11.5 % by the father, 5.3 % by a brother, 5 % by a son, 4.1 % by a sister and 2.5 % by a daughter. As written and visual media inform, the majority of women were not accompanied by their husband when they ran away from the civil war in Syria because he fought and died in the war. Therefore, supporting the family has become primarily the role of the woman, as reported by the study participants. Moreover, 58 % of the women were found to have trouble supporting the household because their rent was high, and 42 % were unable to live because their working fees were low.

4.3. Educational Difficulties

It is determined that 62.6 % women's children go to school; however 37.4 % of them do not go to school. It is believed that the reasons for their not attending school can be the need for the children to support the family income, the fact that children do not want to school, the lack of opportunity to go to school, language problems, or women's literacy problems in Turkish.

It is seen that 73.2 % of women asylum-seekers can benefit from educational opportunities efficiently in the area where they live; however 26.8 % of them cannot obtain easy access. Women indicated educational problems that they faced: 28.3 % of them said teachers do not pay much attention to children; 28.3 % of them said children have difficulties because of not knowing Turkish; 22.8 % of them indicate that they can not send their children to school because of financial difficulties and 20.7 % of them indicate that they cannot help their children because of their own low education level.

In addition, it is seen that the lack of interest of teachers is an another important education problem that Syrian women face. When Syrian children are thought to not be able to speak Turkish, teachers need to be more patient and concerned to avoid communication problems when children begin to school and they need time to learn Turkish.

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4.4. Health Difficulties

However, it is identified that 97.3 % of women asylum-seekers do not have social assurance, 2.7 % of them do; 78.7 % of women asylum-seekers and their families can not benefit effectively from health services in place where they live, 21.3 % of them do; as for the reasons why women themselves and their families could not benefit from health services, it is seen that 65.5 % of them can not benefit because of not knowing the language, 20.9 % of them can not benefit due to fear of discrimination, 6.8 % of them do not benefit because of needless, 4.5 % of them cannot benefit because of financial difficulties and 2.3 % of them cannot benefit because of access difficulty and distance; 79.4 % of them can make emergency health examinations, 20.6 % of them cannot.

4.5. Housing Difficulties

It is identified that 96.3 % of female asylum-seekers who participated in this research live in a rented house, 2 % live with their relatives, 1 % of them live in their own house and 0.7 % of them do not pay any fees as the landlord does not require it from the. It is reported that 91 % of houses where women live are heated with stove and 9 % of them are heated with central heating. Despite there being natural gas in Batman province centre, the great majority of asylum-seekers heat their houses with stoves. Likely as a consequence of economic troubles, they can not stay in houses with central heating, as rented houses with central heating have higher heating costs and higher rent. For these reasons, staying in a house that is heated with a stove arises from a compulsory choice for asylum-seekers.

Table 1. The other housing difficulties

The other housing difficulties	*n*	%
Heating problem	193	24.2
Facing diseases constantly related to warming	155	19.5
House where we live does not get sunlight inside (airless)	99	12.4
Cannot buy coal-wood	94	11.8
We have trouble with the landlord because we have difficulty in paying our rent	76	9.5
House smells of moisture and humidity	70	8.8
The house that we live in is very small and we cannot fit into it	47	5.9
We are struggling to find a home because we are Syrian	31	3.9
The place we're staying is not a place where a person can live	27	3.4
We cannot find a place to stay	3	0.4
We do not stay at home, we live in the street	1	0.1
Total	798	100.0

* More than one option marked.

They face major problems such as not being able to heat the house due to heating with stove, freezing and sickness due to an inability to warm the house, not being able to buy the wood and coal required for heating due to economic difficulties, the house being damp due to a lack of sunlight, the difficulties of having a small house and having problems with their landlord because of not being able to pay the house rent as well as coping with troubles caused by these problems (Table 1).

4.6. Social Exclusion Difficulties

It has been identified that 93 % of women who participate in the research and their families were not exposed to sexual abuse, 7 % of them were; 87.7 % of women who participated in the research and their families have not been exposed to any physical violence, 12.3 % of them have been. Out of 37 % women who were exposed to physical violence, 14 % of them are secondary school graduates, 13 % of them are primary school graduates, 5 % of them are not literate and 1 % person are postgraduates. It is determined that 69.8 % of women have not been exposed to verbal violence; however 30.2 % of them have.

It is reported that 39.5 % of women who were exposed to verbal violence are secondary school graduates, 18.3 % of them are high school graduates, 16.6 % of them are primary school graduates, 13.3 % of them are not literate, 11.3 % of them are postgraduate. and 1 % of them are literate but do not have a diploma. Namely, the majority of those who are exposed to violence are women with a low level of education. According to the correlation analysis, there was also a significant relationship between the groups. There is a linear relationship between the level of education and physical suffering in the positive direction. In other words, as the level of education increases, the level of violence decreases and as the level of education decreases, the level of violence increases.

Table 2. Some Opinion of women asylum-seekers about

Belonging to Turkey	***n***	**%**
No	187	62.1
Yes	114	37.9
Pressure from the community		
No	237	78.7
Yes	64	21.3
Facing with the challenges of being a woman		
Yes	288	96.0
No	12	4.0
Satisfaction status		
Not satisfied	153	50.8
Satisfied	148	49.2
Want to return		
Yes	167	55.5
No	134	44.5
Total	301	100.0

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It is identified that 62.1 % of women do not feel that they belong to Turkey; however 37.9 % of them feel they do (Table 2). 75.4 % of them who do not feel that they belong to Turkey have relatives in Turkey, and 24.6 % of them do not. 91.2 % of them who feel themselves belonging to Turkey have relatives in Turkey, 8.8 % of them do not. Although three-quarters of those who feel themselves belonging to Turkey have relatives in Turkey, they do not feel themselves belonging to this land. There is a Turkish proverb related to this: "They put a nightingale in a golden cage, nevertheless it said ouch my native shore ouch my home". Everyone feels free and peaceful in their own home. Outside one experiences social pressures and discomfort.

78.7 % of women asylum-seekers do not feel pressure from the community, however 21.3 % of them do (Table 2). Namely, one-fifth of women in this study feel pressure from the settlement and neighborhood where they live: however four out of five of them do not feel neighborhood pressure. This can result from their being foreign, asylum-seekers, or refugeees, their increasing unemployment rate, or their willingness to work in low paying jobs. Neighborhood pressure is a kind of social exclusion.

It has been identified that 96 % of women asylum-seekers face challenges related to being a women and only 4 % of them do not face challenges related to their womanness (Table 2). Almost all women who participated in this research encounter troubles, difficulties and distresses related to being a woman. It is considered that such gender inequality, being foreign, being poor, and living in deprivation lead to these distresses. In short, this conclusion emerges as the most concrete evidence of gender inequality against women. Otherwise, when one investigates instances of difficulty in renting a house among these women asylum-seekers, 99 % of them have difficulties, and 1 % do not. It has been identified that almost all of the women who participated in the research face difficulties because they are exposed to discrimination related to renting a house because they are female asylum-seekers.

When participants' satisfaction with being in Turkey are examined, 50.8 % of them are not satisfied, and 49.2 % of them are satisfied to be in Turkey (Table 2). It has been identified that 78.6 % of Syrian asylum-seekers who do not feel themselves belonging to Turkey are not satisfied in Turkey and 21.4 % of them are satisfied. Moreover, it is detected that 94.7 % of those who feel themselves belonging to Turkey are satisfied to stay in Turkey and 5.3 % of them are not satisfied. In other words, when the majority of asylum-seekers who are satisfied to be in Turkey feel themselves belonging to Turkey, four of five of those who are unsatisfied do not feel themselves belonging to Turkey. It has been identified that 59.4 % of women who feel neighborhood pressure are satisfied to stay in Turkey, and 40.6 % of them are unsatisfied. It was determined that 51.5 % of those who do not feel neighborhood pressure are satisfied to stay in Turkey, and 48.5 % of them are unsatisfied to stay in Turkey.

It has been identified that 55.5 % of Syrian women asylum-seekers would like to return to their country when the war ends, while 44.5 % of them would not (Table 2). More than half of the Syrian women asylum-seekers would like to return to their country if the civil war were over, whereas close to half of them would not. It may be that the reasons for the undesirability of returning home for nearly half of them arise from insecurities related to repatriation, anxiety of trial because of being a dissident, the possibility of not being able to find their homes in the conditions that they hope for, or their being destroyed or in unlivable conditions.

57 % of women asylum-seekers who do not feel pressure from their community would like to return to their country if the civil war were to finish in Syria, while 43 % of them would not. 50 % of those who feel such pressure would like to return and thee other 50 % would not. In other words, approximately three out of five women asylum-seekers who do not feel such pressure want to go back to their country when the war in Syria is over. The other two out of five do not want to go back. Half of those who feel neighborhood pressure want to go back as well as the other half who do not.

63.4 % of women asylum-seekers who are unsatisfied with life in Turkey would like to return to their country when the civil war is over in Syria, whereas 36.6 % of them would not. 47.3 % of women asylum-seekers who are satisfied staying in Turkey would like to return to their country and 52.2 % of them would not. In short, appoximately three of five women asylum-seekers who are unsatisfied staying in Turkey would like to return to their country when the war in Syria is over, and the remaining two out of five would not like to return.

5. CONCLUSION AND RECOMMENDATION

Legal status associated with different migrant groups might play an important role in integration processes. For example, Syrians in Turkey are not legally referred to as 'refugees'; they are foreigners under temporary protection. In this sense, their integration processes might differ from those of refugees (Şimşek, 2018; Sözer, 2019).

The level of education of Syrian female asylum-seekers who participated in this study is very low and mainly at the primary and secondary school level. The majority of those married are made up of official and religious marriages, and a few are only religious marriages.

It has been determined that the majority of women asylum-seekers covered by this study are young people. It is known that the majority of Syrians under temporary protection status are women, children, and the elderly. In this group, the responsibility of supporting the household and taking care of the children and the elderly are shouldered by young women. It is revealed by the results of the study that most of these women have difficulties supporting their households, cannot find a job, and most of them do not get in-kind and/or financial aid from institutions such as the government or foundations. In this context, research and projects aimed at providing women with job opportunities should be developed.

Syrians who lack economic resources and are less skilled might not be granted citizenship and remain under temporary protection for along time (Şimşek, 2018). Almost all of the women have difficulties in finding a job and they often cannot. It is suggested that politicians and managers in the struggle against this reality, which reinforces gender inequality and removes women from economic life, should contribute to this by making more employment-oriented arrangements for women.

An important finding is that four in five female asylum-seekers have relatives in Turkey. The majority of women receive help from their relatives; however they do not receive help from institutions such as the government and foundations. Nonetheless, the vast majority of women who are helped by institutions such as the government and foundations and their relatives still suffer from economic hardships. Women are both suffering from an ability to find work and from economic hardships when they receive help. To this end, women need to be strengthened. The development of projects that will create employment opportunities for women will contribute to the resolution of these problems.

Among the women who participated in this research, three out of five of their children go to school and two out of five cannot go to school. Going to school – in a word, basic education – is the most natural right of every child and in Turkey, where education is compulsory, should be given free of charge. For this reason, education policies and practices should be developed by the Ministry of National Education for the purpose of ensuring that children who cannot go to school do go to school and that financial support be provided to the families of the children who continue to study.

When the reasons for the inability of Syrian women asylum-seekers to benefit from the educational opportunities are examined, it has been identified that women are not able to help their children because their education level is low, they experieence financial difficulties and they are unable to send their children to school because of the difficulties arising from not knowing Turkish.

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Likewise, it is seen that the lack of interest among teachers is another important education problem that Syrian women face. When Syrian children are thought not to be able to speak Turkish, teachers need to be more patient and concerned to avoid communication problems, especially when children begin school. They need time to learn Turkish.

A new law to include Syrian children gradually as a part of the Turkish educational system was announced just at the beginning of the school year 2016/17 and the government decided to close temporary education centres (Sunata & Tosun. 2018).

It is an important determination that the vast majority of women do not benefit from health services and this arises from not knowing the language and anxiety about exposure to discrimination. It is seen that although there are no legal obstacles that prevent women from benefiting from health services, language problems, feeling like an outsider, and anxiety about exposure to discrimination hinder them. Studies should be carried out to resolve asylum-seekers' language problems and their anxiety about exposure to discrimination.

These women face major problems. They are often not able to heat their house because all they have is a stove, and report freezing and sickness due to the this. They aree often not able to buy the wood and coal required for heating due to a lack of economic resources, and their house is often damp because of lack of sunlight. They face the difficulty of having a small house and experiencing problems with their landlord because of not being able to pay the house rent as well as coping with troubles caused by these problems. These issues should be considered in aid to asylum-seekers. Nearly all women and their families live in rental houses. Besides, almost all of them have difficulty renting a house because they are asylum-seekers. Both unemployment and economic problems hinder their ability to provide for the household. To remedy this, in-kind and financial aid programs must be developed to cover their basic human needs.

Another important result that has been detected is that the majority of women and their relatives do not experience any sexual abuse. Despite this fact, some women do experience sexual abuse. Being a woman, being a child and being a refugee or asylum-seeker means being at risk.

It has been identified that the majority of women and/or their relatives do not suffer any physical violence and more than one-tenth of them are exposed to physical violence. Measures to prevent violence need to be intensified.

It is an important result that half of the Syrian women asylum-seekers are not satisfied to be in Turkey and the other half is unsatisfied to be in Turkey. The reason why the dissatisfaction rate is at this level is considered to be that they are foreign, asylum-seekers, women, experience economic deprivation, difficulties in renting a house, social exclusion, general difficulties of being a woman, an the sensation of neighborhood pressure factors. Activities aimed at strengthening efforts to remedy this need to be initiated.

Even though they are provided with certain rights such as legal protection, health care and education, the refugees still have problems in accessing these rights due to the language barrier, registration problems, transportation costs (Sunata & Tosun, 2018), economic problems, stigmatiztion, exclusion, and access to health care systems, among others.

This study's results not only show us Syrian female asylum-seekers have a number of difficulties, but also that they are the most vulnerable, they need more help and empoverment, and they need jobs and integration into Turkish society.

One-fifth of women feel pressure from the community in which they live, four in five does not. In addition, more than half of them would like to return to their country when the civil war is over and close to half of them would not like to. In this regard, encouraging policies and programs for return should be constituted. Syrian asylum-seekers have been staying in Turkey for approximately 7 years. In this regard, almost all other related fields outside of the social work discipline are confronted with a large number of scientific research conducted in the literature (YÖK- Turkish Higher Education Institution, thesis screening and other related databases).

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In the field of social work, which is based on people and their fundamental value, different disciplines have become dominant and the need for social work has been replaced by other professional interventions because of not being able to show any demonstrable value in our work with refugees. In this regard, social service professionals and academics should strive to work urgently, engage in scientific work, and claim their rightful place.

This study has some important limitations. It does not represent all the Syrian women asylum-seekers in Batman and Turkey. The study provides only a partial snapshot of the whole picture of Syrian asylum-seekers women, and as the interviews were conducted in Arabic, Kurdish and Turkish and translated into English, it is possible that the original message may have lost its immediacy and/or full meaning via translation.

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Research Article

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THE ROLE OF CULTURE IN THE PERCEPTION OF PLANNED CHANGES IN THE EMERGENCY DEPARTMENT AND ITS INFLUENCE ON PATIENT SATISFACTION

ACİL SERVİSTE YAPILAN PLANLI DEĞİŞİMLERİN ALGILANMASINDA KÜLTÜRÜN ROLÜ VE HASTA MEMNUNIYETİNE ETKİSİ

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ABSTRACT

Thepaperaimstodeterminethe role of (sub)culture(s) in the perceptions of planned changes made todav ance health care quality and patientsatisfaction in a problematicemergencydepartment (ED) between 2006-2010 by comparing the findings of two-period of time. Both qualitative and quantitative designs were used. First qualitative data through observations and interviews were gathered in the Kocaeli State Hospital Emergency Department (KSHED), and then quantitative data through the two question naires we developed was collected. Fiv ehundred ED patients in 2006 and 366 in 2010 responded to th esurveys. Chi-square test for categorical data and paired samples t-test for ratiowere used to analyze the relationships and differences between demographic characteristics and dimensions of satisfaction and perceived cultural changes of health quality by years.

Several planned changes implemented in the ED between 2006 and 2010 were perceived positively by the patients and contributed significantly ($p<0.001$) too vear all patientsatisfaction and health care quality in 2010. Among the perceived cultural changes, human to human interactional dimension of improvements were most drastically moved up (from44.1% to 64.4%) and assessed satisfactorily.

KSHED hasa a unique culture consistingg of two subcultures, institutional and organizational, through which patients and health staff interpret the meanings in their perceptions and expectations, and interact, accordingly determines the degree of thei rsatisfaction and perceived health care quality, resulting in the successful management of organizational culture changes. The more thereciprocalexpectations are overlapped; the more organizational culture changes are positively perceived and the more their relations satisfactorily function.

Keywords: Emergency department culture, organizational culture, perception of change, patient satisfaction, healthcare quality

ÖZ

Bu makalenin amacı sorunlu bir acil servisde (AS) sağlık bakım kalitesini ve hasta memnuniyetini geliştirmek için, 2006-2010 yılları arasında yapılan planlı değişimlerin algılanmasında altkültür(ler)ün rolünü belirlemektir.

Araştırmada nicel ve nitel tasarım birlikette kullanıldı. İlk olarak Kcaeli Devlet Hastanesi Acil Servis'inde (KDHAS) gözlem ve mülükatlarla nitel veri toplandı, sonra iki anket uygulamasıyla nicel veri toplandı. Beş yüz AS hastası 2006'da ve 366 2010'da 366 katılımcı anket formu doldurdu. Değişkenler arasındaki ilişkiyi belirlemek amacıyla kategorik veriler için Ki-kare bağımsızlık testi ve iki yıl arasındaki değişim farklılığını belirlemek amacıyla eşleştrilmiş gruplar t testi kullanıldı.

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AS'de 2006-2010 yılları arasında yapılan planlı birçok kültürel değişim hastalarca olumlu algılandı ve 2010'da toplam hasta memnuniyetine ve sağlık bakım kalitesine anlamlı ölçüde ($p<0.001$) katkı sağladı. Algılanan kültürel değişimler arasında insanlar arasındaki etkileşim boyutu en keskin olarak artan (%44.1'den %64.4'e) iyileşme olup, memnuniyet verici olarak değerlendirildi.

KDHAS kurumsal ve örgütsel olmak üzere iki ayırt edici altkültüre sahiptir. Hastalar ve sağlık personeli algılarındaki anlamları ve beklentileri bu altkültürlere göre yorumlamaktadırlar ve buna göre etkileşimde bulunmaları memnuniyetlerinin ve algılanan sağlık bakım kalitesinin derecesini belirlemekte ve örgütsel kültür değişimlerinin başarılı yönetimiyle sonuçlanmaktadır. Karşılıklı beklentiler ne kadar çok örtüşürse örgütsel kültürel değişimler o kadar çok olumlu algılanmakta, hasta ve personelin ilişkileri memnuniyet verici olarak işlemektedir.

Anahtar Sözcükler: Acil servis kültürü, kurum kültürü, değişim algısı, hasta memnuniyeti, sağlık bakım kalitesi

INTRODUCTION

Understanding the nature of the patient–health staff interaction and its impact on patient healthcare has received increasingly more attention since the onset of managed healthcare in the late 1980s (Tasso and Behar-Horenstein, 2008). In the process of improving healthcare systems and policies, the patients' perspective and the management of organizational culture are becoming increasingly a necessary and integrated part of the health reforms (Tasso and Behar-Horenstein, 2008; Romanow, 2002) to deliver a proper health service. The Romanow Commission (Scott, Davies, and Marshall, 2003b) underlies the crucial importance for successful healthcare reform of working with core public cultural values since they shape our views, and play a central role in defining how we view the critical issues facing the future of healthcare, in deciding which problems should have the highest priority, and in shaping the solutions we choose to adopt or change, and in determining whether radical change or fine-tuning is necessary.

Turkey also, from the beginning of the 21st century, has engaged in considerable reform efforts to improve its healthcare and drive better and fairer health outcomes by making fundamental changes in the behavior of public hospitals. The regular implementation of measurements of quality performance and patient satisfaction in public hospitals are among the recent policies of change. Apart from regular surveys at hospitals, the Turkish Ministry of Health also carried out two patient satisfaction studies throughout Turkey. They found an overall 39.5% satisfaction in 2003 and 63.4% in 2008 (TUIK, 2015). This swift increase in patient satisfaction can be assessed as an indication of the well-planned organizational changes by the introduced policies.

A vast majority of literature on the organizational culture of hospitals has examined the United States or other high-income countries, and little is known about hospital culture in countries with different socio-cultural environments (Zhou et al, 2011; Helfrich, 2007) like Turkey. Previous studies often deal with how organizations shape, or shaped by, culture (Pedersen and Dobbin, 2006) or discuss how culture is spread and maintained in an organization (Oliver, 1992) or consider a perspective on deinstitutionalization to explore issues of resistance to subcultures, change and power within organizations (Kondra and Hurst, 2009). A few studies assume two different cultural forms can coexist in organizations (Greenwoods and Hinings, 1996). Specifically, past studies do not much consider deeply the role of embedded and collectively shared values, perceptions, expectations, beliefs and habits of a people in understanding what individuals and groups view as appropriate responses to illness (Olafsdottir and Pescosolido, 2009) in an environment of change and intensive social interactions like EDs, where the communicators are under high pressure and within a different state of mind (Seltzer, et al, 2012).

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This paper is a comparative analysis of the previous two studies we conducted in the KSHED. The first study was carried out in 2006 to determine the causes of the problems such as long waits, overcrowd, mistrust, and to measure the level of patient satisfaction and healthcare quality, and to introduce some suggestions to the Hospital Management (HM) for the implementation of planned strategic organizational changes in the ED culture. After obtaining from the HM information on what organizational changes in the ED culture they implemented between 2006 and 2010 we conducted the second study in 2010 in order to examine how the patients perceived the planned changes, and to compare findings of the two-period of time, and to determine the role of the culture in the perception of organizational changes, and its influence on patient satisfaction and healthcare quality. Some academics and many policymakers are showing renewed interest in the quantitative measurement of organizational culture to determine its relationship with satisfaction, performance and quality of care (Davies, Nutley and Mannion, 2000). The paper aspires some suggestions for further research and better healthcare policy and management, and thus to contribute further to the gap in the literature regarding the role of (sub)culture(s) in the perception of planned organizational changes in EDs (Zhou, et al, 2011).

The meanings individuals assign to illness and the meanings they assign to responses to illness provide important insight into the cultural beliefs individuals have about the social world (Fakhoury, 1998). Interaction and satisfaction depend on how role players perceive culturally predetermined-symbolic meanings and interpret them co other role players' expectations. The paper explores how meanings are derived from social interactions, and perceived and interpreted in a problematic ED. Thus, we have attempted to combine both applied and theoretical perspectives in one study. As Cockerham (2001) states there has been a general evolution of work in medical sociology that combines both applied and theoretical perspectives, and the utilization of theory has become increasingly common as a framework for explaining or predicting health-related social behavior.

The Role of Organizational Culture in the Perception of Changes and Its Influence on the Patient Satisfaction

Even though in the literature little consensus exists over precise definition of organizational culture, Cockerham (2001) and Schein (1990) define it as the pattern of shared basic presumptions and beliefs, invented, discovered, or developed by the members of an organization, as they learn to cope with its problems of external adaptation and internal integration, that have exerted sufficient influence to be considered valid and, therefore is to be taught to new members as the correct way to perceive, think, and feel in concern to those problems. It signifies a broad range of social phenomena, including an organization's shared signs, symbols, language, oral and written traditions (norms), artifacts, behavior patterns, practices, beliefs, values, assumptions, perceptions, expectations, rituals, and modes of deference; all of which serve to define an organization's identity and character (Brown, 1995; Scott, et al, 2003a; Scott, et al, 2003c), by which members of the group can differentiate themselves from other group (Hatch and Cunliffe, 2006).

Culture refers specifically to the deep structure of organizations, which is rooted in the values, beliefs, and assumptions held by organizational members (Denison, 1996), and complex health systems comprise a variety of coexisting cultures (mostly considered subcultures), some of which may share a common orientation and similar espoused values, and some of which may be disparate subcultures that clash or maintain an uneasy symbiosis (Martin and Seihl, 1983; Romanow, 2002).

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Complex health organizations made up of a large number of subgroups with which people identify and from which are derived distinctive values and norms for health behavior may be labeled organizational *subcultures* (Jandt, 2003). A subculture resembles a culture, however, subcultures have some important differences in that they coexist within dominant cultures and are often based on economic or social class, ethnicity, or geographic region (Jandt, 2003) or religious, occupational, departmental, ward, specialty, or other affiliations (Scott, 2003c).

The practice of patient care in an ED is fundamentally cultural due to the nature of its tasks and organization (Vosk and Milofsky, 2002). Each organization can create its own culture (Person, Spiva and Hart, 2013; Scott, 2003c) that goes beyond what is written down as organizational norms (Person, Spiva and Hart, 2013), rules and regulations.

In this paper, we assume that KSHED has a unique organizational culture consisting of two different subcultures, and that is sometimes in conflict due to ED's very nature. For a deeper understanding, we have distinguished the ED culture as*institutional (sub)culture*and *organizational (or enterprise) (sub)culture*. By *institutional culture* we mean patients and their families' persistent patterns of behavior, attitudes, values, assumptions, perceptions and expectations internalized and shared commonly in their social settings, and by *organizational culture*, we mean 'script' written policies, rules,[(Turner, 1982) held values, assumptions, patterns of thinking, perception and expectation represented by the ED staff, that arise from their specialized training and education, daily practice of work and interaction with peers and other occupational groups.

The planned cultural changes the HM implemented for the improvement of satisfaction and quality performance in the ED in the period 2006-2010 building up the suggestions of our first study concentrated on three basic types of interactions (i) *human to human* (like personnel's interactive training (coping with stress, and communication, empathy, and motivation, placement of reception staff, triage application, personnel's yearly professional training about emergency care), (ii)*human to equipment* (revised number system, establishment of an illuminated sign device for teaching the rules and regulations to the patients, preparation of the information placards and boards), and (iii) *human to physical structure* (like that the number of treatment rooms was doubled and extended, a tomography unit was established, tea-coffee automats were placed, and washrooms and toilets were renovated).

How these discernible cultural changes were perceived and the meanings attributed to them were interpreted by patients might influence their satisfaction in one way or other. It is believed that visible and tangible cultural elements such as buildings, policies, and written procedures, etc. are alterable, whereas sublimated and/or taken for granted elements of culture are not so easily changed (Kondra and Hurst, 2009). If managers wish to successfully manage to change the culture in their organizations, they must become aware of the many elements that can distort or create an incomplete understanding of culture and produce resistance (Kondra and Hurst, 2009). In this regard they should consider the view as much as patients perceive the changes as parallel to their expectations shaped by health organization culture, they will be satisfied, and patient-health staff interaction will improve (Linder-Pelz, 1982; Williams, 1994).

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The social contexts have their subcultures, and can potentially affect individual perceptions, attitudes, and behavior (Ulmer and Wilson, 2003) and as a result, while line and definition of *sick* ('who and how patient') do not pose great importance in other policlinics they are very critical in EDs. While interacting, many times patient-physician expectations –that are the fundamental determinants of ED culture- come into conflict with one other due to, first and utmost, its nature and their roles are not clearly described and sufficiently internalized. So, EDs are the places where people are the most sensitive, skeptical, egoist, anxious and stressful (Holm and Fitzmaurice, 2008). Organizational changes in the ED without changes in its cultural features would often fail (Umiker,1999).

METHOD

This is a longitudinal trend study. Trend studies are those that study essentially dynamic issues like performance and change within some general population over time and uncover *net* changes (Babbie, 1986).

Owing to the complex and dynamic nature of the health phenomena, comprehensive research in this area should soundly implement multi-method and multi-disciplinary, drawing on quantitative and qualitative designs (Young, 2004; Benzies and Allen, 2001). Therefore, the studies 2006 and 2010 based both on surveys via questionnaires (qualitative method), and on observations and interviews (qualitative method) to eliminate the contradiction of quantitative and qualitative research findings and their discrepancy and insufficiency when used alone (Mechanic, 1989).

Sample of the Study

KSH is situated in the city centre and is easy to reach. Approximately 500 patients visit it daily. After written permissions were obtained from the HM we conducted the studies. In the first study a sample of 500 and in the second a sample of 366 individuals, 18 years and over, visiting the ED within the 7/24 days were randomly selected. Since the physical and physiological health conditions of patients were not well, some of them did not take part in the study. And the questionnaire was not applied to the relatives of patients with too serious conditions. Semi-filled forms were extracted.

Data Collection Tools

In the study both unstructured observation form as qualitative method's data collection tool and questionnaire as quantitative method's tools were used. Since it is unlikely that any single instrument will ever provide a valid, reliable, and trustworthy assessment of an organization's culture, and so a multi-method approach will always be desirable (Scott, et al a) for complex social settings like emergency departments.

Data Collection and Analysis Process

After getting official permission from the KSH management, at first the relevant literature (KSH's newspaper archive inclusive) was reviewed and then direct observations were made unobtrusively in the ED by the researcher and two nursing students he

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trained. The observations of the first study took us a month (120 hours), the second study one week (18 hours) three times a day, mostly in intensive hours (19:00-23:00).

We focused mainly on three types of interactions (i) human to human, (ii) human to equipment, and (iii) human to the physical structure. We recorded verbal and nonverbal interactions of patient-staff. Such interactions included their talk, tone of voice, body language, complaints, medical treatment, prioritizing patients, acceptance to the triage room, sitting, standing, and giving them information, the volume of the waiting hall, hygiene etc. Thus we tried to determine meanings behind the verbal and nonverbal interactions, and certain points worthy of taking into the examination in the study.

Along with the observations, we interviewed with the patients, their relatives, the ED physicians and other staff to understand how they structure their external world in critical contexts by their perceptions and interpretations of what they conceive that world to be. These qualitative data revealed valuable information that aided the development of the study hypothesis, the preparation of the questionnaires and explanation of the quantitative findings that the quantitative measures could not highlight.

Finally, we traced the quantitative method by preparing questionnaires. There were 37 questions on the questionnaires. Both years' questions were almost the same, but we added some new questions to measure the direction of the perceived changes that the HM informed us to have implemented. We thus combined qualitative data with quantitative data through the structured questionnaires within the same study.

Patients were asked to rate specific issues concerning their perception of the changes resulting with satisfaction on a 3-point Likert-type scale (*improved/increased, stayed same, deteriorated/decreased*) and degree of satisfaction (quality) on a 5-point Likert-type scale (*very satisfactory to very unsatisfactory*) by years. The questionnaires were mostly filled out using a face-to-face interview technique by putting a tick on a box, and a small portion of them was self-administrated. The respondents were sufficiently instructed about the purpose of the study to give genuine answers, thus the confidentiality was tried to maintain.

The questionnaire included mainly three sets of the questions; (i) personal characteristics such as age, sex, education (Table 1) and waiting time (Table 2) as independent variables, and (ii) the dimensions of satisfaction with the perceived changes cover general service performance, staff's respect and concern, number of doctors, numbering system, physical structure, duration of waiting time, quarrel and disturbances (Table 2), and (iii) the dimensions of quality cover general health service efficiency, respect and concern, medical appliances, hall capacity, hygiene, and triage practice (Table 3).

Patient satisfaction questions to rate the perceived changes were asked in the survey of 2010 only to the participants who had previously visited the ED, and healthcare quality questions were asked to all of them to compare the differences between the two periods. Thus, we aimed at measuring the alteration in the perceptions of cultural changes and its influence on patient satisfaction and service quality. We used χ^2 test for the determination of the relations between the independent and dependent categorical variables, and paired-samples t-test for comparison of quantitative data analysis of the two years.

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RESULTS

As illustrated in Table 1 median age of the respondents was 32 in 2006 and 2010, and although gender difference was great in favor of females in both samples, since it did not pose a significant effect on the satisfaction, we did not attempt to equalize the gap by conducting more surveys. Their other features were also close to each other, not disrupting the overall performance score of the satisfaction measurement.

Table 1. Demographic features of the participants

Features	**2006**	**2010**
Age		
Mean	35.3	34.7
Median	32	32
Gender	**%**	**%**
Female	66.4	56.0
Male	33.6	44.0
Total	100.0	100.0
Education		
Illiterate or only literate	6.9	11.2
Elementary school	41.6	34.9
High school	33.8	29.4
University	17.7	24.4
Total	100.0	100.0

The survey data of 2010 showed that 279 out of 366 of the participants (76.4%) visited the ED before at least once. As illustrated in Table 2 nearly half of, or the majority of the participants perceived most of the dimensions of satisfaction with the planned cultural changes in a positive direction, an exception is a physical structure that is neutral.

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Table 2. Participants' satisfaction with perceived changes in 2010

Dimensions of satisfaction	***Perceived Changes %***			χ^2 P-Value				
	Improved	***Stayed Same***	***Deteriorated***	***Sex Male Female***	***Age* 18-35 36≥***	***Education* ≤12 13≥***	***Wait Time****	***Number of visits****
General service performance	***65.2***	***20.2***	***14.2***	0.348	0.004	0.006	0.008	0.816
Duration of wait time	*53.4*	*24.7*	*21.9*	0.526	0.100	0.038	0.027	0.455
Staff respect & concern	*49.4*	*28.5*	*22.1*	0.217	0.002	0.069	0.004	0.799
Number of doctors	*42.8*	*30.9*	*26.4*	0.173	0.057	0.057	0.001	0.337
Numbering system	*47.8*	*27.8*	*24.4*	0.932	0.253	0.554	0.268	0.049
Physical structure	*16.7*	*66.5*	*16.7*	0.016	0.303	0.298	0.756	0.077
Quarrel & disturbances	*47.5*	*37.6*	*14.8*	0.872	0.057	0.491	0.667	0.158

**Categories of participants' characteristics were split into two subcategories because of the rules of Chi-Squire test implication can be maintained more accurately.*

Majority of the participants (65.2%) believed that the general healthcare service performance increased and only a small portion (14.2%) believed it decreased. Nearly half of the participants (49.4%) perceived the changes concerning *concern and respect* improved as compared to previous years, 22.1% believed it decreased; during our observations a middle-aged frustrated patient suddenly shouted "May God give doctors a little bit (feeling of) mercy; they behave (us) as if they would not die a day" in order to express her dissatisfaction, as she could not achieve friendly or kind behavior as much as she expected to be. But that 42.8% declared that the number of physicians increased, although their number stayed same, assists a significant part of the participants perceived the changes satisfactory. Just as 53.4% perceived the examination duration reduced.

More than half of the participants (58.5%) evaluated the numbering system fair and proper, and 23.5% expressed dissatisfaction that underscores the lack of confidence and trust. We observed some patients were anxiously asking the guards when their turn would come, although the turn-indicator was on. One elderly (in his 65s) whose daughter was ill stood up, wondered a little in the hall and challenged by shouting: "I wished I were in my crazy (youth) days! For I do well know what to do!.." that was his expression of frustration.

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Of the participants, 53.4% perceived the waiting time for examination shortened and evaluated satisfactorily. Only 21.9% perceived it longer than before. During our observations, we encountered some undesired events such as quarrel or strife between patients and staff mostly in the waiting hall and rarely in the examination room as the waiting time longed and a crowd formed. Even though such inappropriate behaviors were significantly decreased from 47.5% to 14.8% there was still some lack. And though some physical changes such as the transformation of an empty room into a triage room, improvement of the examination rooms were realized in the ED, it seems that placement of a police cabin (we did not suggest it) and tea-coffee automat might reduce its functionality. Therefore, a great majority of the participants (66.5%) did not perceive any structural changes.

We investigated the statistical associations between the participants' characteristics and various dimensions of satisfaction and found them differ in the level of significance (shown in Table 2). Among the most significant characteristics associated with satisfaction were age, education and waiting time variables, and sex and number of visits were the least significant. Statistically significant associations were determined between general healthcare service performance satisfaction and age ($p=0.004$), education ($p=0.006$) and waiting time ($p=0.008$); between perceived waiting time and real waiting time ($p=0.027$) and education ($p=0.038$); between staff respect and concern and age ($p=0.002$) and waiting time ($p=0.004$); between number of doctors and waiting time ($p<0.001$) age ($p=0.057$) and education ($p=0.057$); between new numbering system and only number of visits ($p=0.049$); between physical structure and sex ($p=0.016$); between quarrel and disturbances and age ($p=0.057$). The general direction of associations was: satisfaction increases as the patients get older; the educational level increases satisfaction decreases; waiting time increases satisfaction decreases.

To determine the degree of satisfaction we compared the findings of the years 2006-2010, thus we aimed at measuring the role of culture in the perceptions of cultural changes in the ED.

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Table 3. Participants' evaluation of the degree of satisfaction (quality) by years

Dimensions of satisfaction	**Year 2006**						**Year 2010**					
	Very Satisfactory	Satisfactory	No Idea	Unsatisfactory	Very Unsatisfactory	Average Performance	Very Satisfactory	Satisfactory	No Idea	Unsatisfactory	Very Unsatisfactory	Average Performance
General service efficiency	3.5	38.1	23.1	28.1	7.2	*60.5*	15.7	48.4	10.8	18.1	7.0	*69.6*
Respect & concern	3.6	40.5	14.3	32.1	9.4	*59.3*	15.1	49.3	7.2	20.4	7.9	*68.7*
Medical appliances	2.7	30.0	35.8	27.3	4.2	*59.9*	8.0	29.9	42.2	15.6	4.3	*64.3*
Hall capacity	3.8	28.6	31.9	28.4	7.3	*58.6*	4.6	25.8	7.9	43.0	18.5	*51.0*
Hygiene	4.0	53.7	9.7	24.7	7.8	*64.2*	13.2	58.5	5.0	17.6	5.7	*71.2*
Duration of wait time*	27.4	7.1	-	9.4	38.3	*37.6*	69.9	15.8	-	7.1	3.3	*68.9*
Triage practice**							19.7	47.8	13.2	11.5	7.8	*72.0*

*Duration of taking a patient into examination was split into four categories: *at once, 1-5 minutes, 6-15 minute, 16-30, not yet examined, and we saw the placement of the categories fit as in Table 3.*

***Since triage practice was not practiced in 2006, it was asked only in 2010.*

An overview in Table 3 indicates that besides hall capacity all of the quality dimensions were evaluated more satisfactorily in 2010 than that in 2006. Among all of the dimensions general health service efficiency was rated most satisfactory (after triage system, which was not measured in 2006). While general health service sufficiency was 41.6% it strikingly rose to 64.1%. In the same direction, the quality of staff's respect and attention promoted from 44.1% to 69.5%, but despite a drastic improvement, still, the existence of 27.6% insufficiency should not be ignored in 2010 may reflect negatively on patients' credence to the ED. Improvement regarding the medical appliances was met satisfactorily, rising from 32.7% to 37.9%. We several times heard in 2006 some verbal complaints –usually by exclaiming- on broken-down of, or inexistence of, medical equipment. But, during our second study, we did not encounter such problems. Our qualitative data supported the survey findings.

We observed that the patients spent most of their times in the waiting hall, and most of the verbal and nonverbal interactions occurred there. Insufficiency in the hall capacity rose from 28.4% to 43.0%. The reason for such a negative perception has been explained above.

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Cleanliness sufficiency moved from 57.7% up to 71.7%. In 2006 we observed that when the toilets were not clean as much as the patients expected, they showed their reactions verbally since there was not any complaint box to write their complaints. During the second study, one box was placed.

After the revised numbering system and triage practice were implemented, the security was not calling patients anymore. As a result, 67.5% of the patients found the triage very satisfactory or satisfactory. According to our observational findings, the reason of insufficiency (19.3%) was that the triage unit sometimes remained empty or trainees performed this duty and failed to perform it satisfactorily.

Based on the satisfaction indicators, the average service satisfaction was calculated by 60.5% in 2006 and 69.6% in 2010. Using paired sample t-test, we found the difference meaningful ($t=4.67$, $p<0.001$). Such a high increase indicates that certain changes carried out in the direction of the findings and suggestions of the study in 2006 were positively perceived by the patients compared to their expectations, clearly reflecting on their satisfaction and more proper interaction with the health providers.

DISCUSSION

Most previous researches have taken into account only one or two aspects of satisfaction and quality, (Rahmqvist and Bara, 2010) while our paper focuses on several aspects of satisfaction and quality to obtain a broader perspective and discriminate between the influences of the different factors. The findings expand and deepen the role of the culture of the two groups of people, each of whom has own subculture, through which they construe the same event differently evaluated. It is for the same reason that although the sex distribution of patients officially is almost equal, in both studies the number of the women sampled appeared higher than that of the men. In Turkish society, women follow the tradition of becoming a patient companion and patient visitor more frequently than men (www.haber7, 2010).

In the previous studies, different outcomes were obtained as regard to the relationship between patient characteristics and patient satisfaction (Efe, 2007). The results of our analyses confirmed the findings of other studies that satisfaction is associated with the participants' age and education. Age was highly significantly related to satisfaction (χ^2 $p=0.004$). Many other studies have found that older patients are more satisfied than younger (Rahmqvist and Bara, 2010) almost regardless of culture, country, (Romanow, 2002) and as the level of education increases the level satisfaction decreases ($p=0.006$). Since the patients with high education level have higher standard expectations (Bostan,. Acuner and G. Yilmaz, 2007). But like us ($p=0.348$), they also could not determine any significant difference between men and women regarding the level of satisfaction (Yilmaz, 2000; Scott et al, 2003a).

Our observational findings go parallel with researches that argue EDs are overcrowded (Söyük and Kurtuluş, 2017), stressful and problematic areas, and health providers are under pressure (Söyük and Kurtuluş, 2017, Landau et al, 2018; Person, Spiva and Hart. 2013; Holm and Fitzmaurice, 2008). A correspondingly great deal of disturbances like quarrels and disputes occur there (Öztaş, 2018; Söyük and Kurtuluş, 2017). The paper suggests that while the explicit cause of overcrowding is that most patients visit the ED between 19:00-23:00 leads a longer waiting time and high density, its implicit reason is that people see in

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themselves a legitimate right to visit the ED however their health state is and whenever they wish. Their subculture sustains and provokes them. This result confirms Kondra and Hurst (2009): sublimated and/or taken for granted elements of culture are not so easily changed once gained. However, as the patients did not assess the changes functional, they did not feel enough satisfaction with the physical changes alone; so, degree of satisfaction with the hall capacity declined from 58.6% to 51.0%.

Our survey findings overlap with several studies that have suggested that as the waiting time, real or perceived, increases patient satisfaction decreases ($p=0.019$), and long waits beyond the expectations create unpredictable reactions, which rouse disorder and dissatisfaction in EDs (Öztaş, 2018; Landau et al, 2018; Söyük and Kurtuluş, 2017; Yildirim et al, 2005). Based on our qualitative findings and survey results we suggest that the more overcrowded is a social context, the longer the perceived waiting time, and the more problematic it is.

The paper supports prior survey results suggesting a high positive correlation between the physician respect and patient satisfaction (χ^2 $p<0.001$). [2,48] The perceived respect and attention drastically increased from 44.1% to 64.4%, and a relatively great part of the participants (42.8%) assessed the number of physicians increased although it remained the same. Some researchers argue that health staff's attention and respect is one of the most significant factors related to global patient satisfaction and the outcome in well-social relations (Franco, Bennett and Kanfer, 2002).

That approximately one-third of the patients did not know in what circumstances they must visit the ED is consistent with the previous studies where researchers found that those patients whose illness did not require emergency care applied to EDs (Kilic et al, 2011; Oktay et al, 2003). But this situation does not legitimate the ED physicians' opinion that 70-80% of the patients do not have symptoms requiring urgent care. For, when the patients' diseases, as written in the questionnaires, were reevaluated by a senior ED physician appointed by the HM, it appeared that the rate of those requiring urgent care was 48.6%, those not requiring was only 11.6% and those in question was 39.8%. That means the number of genuine ED patients is rather high contrary to the physicians' perception ($p<0.001$). Kilic et al. (2011) also found a similar result that 90.7% of the ED visitors were genuine patients. This is an implicit conflicting situation, many times resulting in an improper interaction between physician and patient. Skar, Bruce and Sheets (2015) similarly suggest that ED staff hold the underlying assumption and beliefs that the ED is not the place for older adults with non-urgent needs, and therefore their values impact the respect older adults are given and the care they receive. Here appears that as long as the role players' perceptions and expectations of each other differ, the problem seems to last. For the solution of the problem we recommend physicians should recognize an ill person as one of 'inferior quality, bad in condition, wretched, impolite, improper, incorrect, bad morally, evil in nature or character, malevolent, wicked, vicious, wrong' (Skidmore and Thackeray, 1976), and should accept anyone considering oneself genuinely ill, i.e. deserving emergency care. For any patient one's illness, even though it is unserious in reality, is the most critical illness (Fisek, 2015).

Despite certain deficiencies and impediments in its exercise as a newly introduced cultural item, the most remarkable process the HM put into practice for promoting the overall healthcare quality and patient satisfaction was the triage practice ($p<0.001$). This result supports the view that success in the triage is possible with the provision of optimal physical conditions and with the culturally trained and experienced paramedical staff (Saz, Ozen and Karapinar, 2009). The triage had a significant role to the rise of total service performance from 60.5% to 69.6% (t-test: $p<0.001$) by performing a filtering task and some patients attribute it to the examination period, and perceive the waiting time shortened and equity realized. It allowed for the majority of the patients perceive that they were instantly examined. Fry and Stainton (2005) also found that notions of timeliness, efficiency and equity are embedded in a culture of ED care. The paper reveals that the revised numbering system based on the triage was perceived as more fair and trustworthy (58.5%) as compared to before. But that there is still a considerable amount of dissatisfaction (23.5%) due to a perceived lack of trust and confidentiality proves the view of Seltzer et al.[13] cynical and skeptical attitudes stem from poorly managed internal relationships and interactions.

CONCLUSION

Various planned changes that the HM made in the ED were significantly perceived by patients as satisfactory. Among the corrective measures in the ED culture, the dimension of human to human interactional improvements was perceived more satisfactorily than the others. Health staff interactive training and triage practice played a more critical role in decreasing the problems and promoting satisfaction and service quality. As the perceived general performance of staff increases, their number is perceived positively increased although it remains the same in reality. It appears that high healthcare performance covers some lacks in intensive settings. When planned changes are managed by taking the EDs' subcultures into account implementation of these changes are perceived more satisfactorily since the subcultures influence the likelihood of success for change strategies.

Finally, the paper suggests that satisfaction and healthcare quality can be obtained in a problematic ED as a result of expected reciprocal relations, smooth interactions, depending on the degree of toleration of conflicting expectations, and obedience of the role players to the subcultures of each other. Otherwise organizational changes without changes in organizational culture would fail. However further research is needed for the impact of ED patient-health staff subcultures on the improvement of their relations leading individual satisfaction, organizational order and social equilibrium.

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THIS IS NOT ALL YOUR LIFE BUT THE PIECES YOU TALKED ABOUT YOUR LIFE: THE NARRATIVE THERAPY WITH THE ELDERLY

YAŞLILAR İLE ÇALIŞMADA ANLATI TERAPİSİ

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ABSTRACT

The population of the elderly is increasing both in Turkey and the whole world day by day. The present situation highly necessitates solving the problems of the elderly. According to narrative therapy, elderly individuals encountering many problems in terms of bio-psycho-social aspects transfer all these problems into their lives in the form of narratives. The personal narratives of elderly people often include the themes of “loss” and “deficiency”. These negative perceptions originate from the physical-mental health problems that increase with the old age and the narratives given to the elderly by the socio-cultural context. Narrative therapy provides an opportunity for elderly individuals to create an alternative narration to help them change their life stories. In this way, elderly individuals become aware of their existing narratives and collaborate with the therapist to build alternative narrations that will improve their well-being rather than being stuck in their existing stories.

In the current study, the contributions and applications of narrative therapy, which positively contributes to the individual’s bio-psycho-social well-being, are discussed. The first section of the study includes the introduction, which deals with the scientific and conceptual relationship between narrative therapy and the elderly. Following the introduction, the second section of the study focuses on the discussions about the fundamental philosophy and targets of narrative therapy. The next section is about the detailed presentation of narrative therapy practice, which has conducted with the elderly.

Key Words: The elderly, Narrative Therapy, Narrative

ÖZ

Yaşlı popülasyonu, dünyada ve Türkiye’de gittikçe artış gösteren bir nüfus grubudur. Bu durum yaşlı sorunlarının çözülmesini önemli hale getirmektedir. Anlatı terapisine göre biyo-psiko-sosyal anlamda birçok sorunla karşılaşan yaşlı bireyler, tüm bu sorunları anlatılar şeklinde yaşamlarına aktarmaktadırlar. Yaşlı bireylerin kendi anlatıları genellikle “kayıp” ve “eksiklik” temalarını içermektedir. Bu olumsuz algılar, yaşlılık dönemiyle gelişen fiziksel-ruhsal sağlık sorunlarından ve sosyo-kültürel bağlam tarafından yaşlı bireylere verilmiş anlatılardan kaynaklanmaktadır. Anlatı terapisi, yaşlı bireylere yaşam hikâyelerini değiştirmede yardımcı olmak için alternatif bir anlatı oluşturma fırsatı sunmaktadır. Böylece yaşlı bireyler, mevcut anlatılarının farkına varmakta ve bunların yerine kendilerinin iyilik halini arttıracak alternatif anlatılar inşa etmek için terapistle işbirliği yapmaktadırlar.

Bu çalışmada bilimsel olarak bireyin biyo-psiko-sosyal iyilik haline pozitif katkı sunan anlatı terapisinin yaşlılık alanındaki katkıları ve uygulamaları tartışılmaktadır. Çalışmanın ilk kısmında yaşlılar ve anlatı terapisinin bilimsel ve kavramsal ilişkisinin kurulduğu giriş kısmı bulunmaktadır. Bu bölümden sonra anlatı terapisinin temel felsefesinin ve hedeflerinin tartışıldığı ikinci bölüm gelmektedir. Bundan sonraki bölümde yaşlılarla gerçekleştirilen anlatı terapisi uygulamasına ayrıntılı olarak yer verilmiştir.

Anahtar Kelimler: Yaşlılık, Anlatı Terapisi, Anlatı

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INTRODUCTION

Elderliness is a complex issue, whose significance is increasing day by day, both in Turkish and international scientific literature. The essential reason behind the dramatic increase in the number of scientific studies about elderliness is the people who are gradually aging in all countries-including Turkey. According to UN's "2019 Revision of World Population Prospects", Turkey's elderly population rate is closer to 10% in 2020. However, the same report predicts that this rate will reach 25% in the 2060s, 30% in 2080, and 35% in 2100 (United Nations, 2019). According to "The Statistical Report of the Elderly in 2018" by Turkish Statistical Institute, it has foreseen that the rate of the elderly population in Turkey will be 10.2% in 2023, 12.9% in 2030, 16.3% in 2040, 22.6% in 2060 and 25.6% in 2080 (Turkish Statistical Institute, 2018). All these data reveal that elderliness will be one of the biggest problems of Turkey, just like the rest of the world.

The scientific studies conducted both at national and international level about ageing should be considered as significant investments for future societies. However, particularly in Turkey, the failure to diversify the studies about the elderly results in not being able to get prepared appropriately for the inevitable problem of the future. The fact that scientific studies with the elderly have often conducted from the perspective of medicine, theology, spiritual studies, and case studies reveals the lack of diversity in the related studies (Klein, 2008). The present study tries to make a contribution to this diversity by approaching the topic of elderliness from the perspective of psychotherapy.

The literature review in the field of aging shows that some drawbacks such as physical dysfunctions (inability to perform specific movements such as walking, running, etc.), sexual dysfunctions (infertility, hormonal changes, etc.), and intellectual dysfunctions (amnesia, dementia, Alzheimer), may occur in individuals as they get older (Duyan, Yolcuoğlu and Artan, 2014). All these physical and intellectual drawbacks, and the decrease in financial power together with the death of spouses, close relatives, close friends and etc. put the elderly individual into a disadvantageous position. In addition, the question of whether psychotherapy studies will be effective for an elderly person with such a complex and various problems is an important topic of discussion.

Kennedy and Tanenbaum (2000), who tried to answer the question above, looked for evidence in the literature regarding whether the old people would be positively affected by psychotherapy despite all the disadvantaged processes they experienced. The authors revealed that the elderly gained significant benefits as a result of the psychotherapy process (Kennedy and Tanenbaum, 2000). Another study presenting important scientific findings related to the above-mentioned question belongs to Roth and Fonagy (1996). In their study, Roth and Fonagy (1996) pointed out lots of researches about the positive effects of psychotherapy processes on the elderly to improve their well-being. The authors stated that although older individuals adapt to the therapy process more successfully compared to young people, these individuals need therapy for a longer period of time than young people. The main reason for long periods of the therapy process with older people was found to be related to more life experiences of older people than young ones with a more complex set of relationships in their lives.

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In their study, Smyer and Qualls (1999) went one step ahead of the idea that psychotherapy has positive effects on old individuals and stated that therapy is necessary for the solution of their problems. According to Smyer and Qualls, an individual experiences the following losses as he/she gets older:

1) Loss of strength and physical ability
2) Loss of youth and attraction in return
3) Loss of close relationships such as spouse, relatives, friends
4) Loss of power and prestige
5) Loss of intimacy and sexual opportunities
6) Loss of recognition
7) Loss of hope

According to the authors, all these losses generate some psychological difficulties that the person must cope with. Among these, the leading ones are: unhappiness, restlessness, depression, hopelessness, death anxiety and stress. The participation of the elderly individual in the therapy process can provide important benefits to solve all psychological problems (Smyer & Qualls, 1999). Hence, the academic studies reveal that psychotherapy has positive effects to ensure the well-being of the elderly. In the upcoming sections of the present study, narrative therapy, which is one of psychotherapy types that contributes to the well-being of the elderly, is discussed in detail.

Narrative therapy's "narrative" theme, which is based on conceptual processes, provides a suitable framework for the psychotherapy process of the elderly. Explaining this relationship through Erikson, who suggests that personality develops with social processes, will highlight the importance of narrative therapy for older individuals. Erikson categorized the period of elderliness as "the period of hopelessness against self-integrity". According to Erikson, as long as the individual considers he has a happy, virtuous, purposeful and ideal life, he feels himself fine/positive as a whole. However, if the individual considers that he lives his life in an unhappy, aimless, hopeless and non-ideal way, he feels bad / negative as a consequence of the problems such as death anxiety, unhappiness, hopelessness and depression (Erikson, 1950). As can be understood from the aforementioned statements, Erikson puts forward that the elderly individuals have certain moods by reviewing their past life experiences. When the elderly individual reviews his life in the first case, he reaches to the conclusion that he has reached an ideal narrative of himself. In the second case, the elderly person is unhappy by reviewing his life and concluding that he was unable to reach the ideal narrative that he accepted.

Robert Butler explained the above-mentioned self-review process, which is not clearly stated in Erikson's study, with the theory of "life review". According to Butler (1963), every individual is naturally inclined to review his own life in a detailed way towards the end of his life. Within this context, life review is a self-reflection process in which the individual can evaluate his past experiences, memories and narratives. As a result of the above-mentioned reflection process, the individual feels more positive as long as he reviews his life from a positive angle. However, if the individual evaluates his past negative as a result of life review, he feels more negative. From the angle of Butler, the negative evaluation of life review can lead to depression, anxiety of death and hopelessness (Butler, 1963).

Birren and Cochran (2001) asserted that the review of life experiences is the center of therapy in the therapeutic relationship with the elderly. According to the authors, when elderly individuals perform their own life review in a group environment, great therapeutic benefits are obtained for both the person and the group. Besides, the elderly individual's self-review with more than one person provides the opportunity to perform this review through different perspectives. Caldwell (2005) went a step further and suggested that the review of life experiences is the key to create new meanings in the life of the elderly.

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From the perspective of Caldwell, the review of life is an important opportunity to eliminate the problematic reviews of the elderly and develop more positive reviews for them. For this reason, Caldwell stated that the techniques such as bibliotherapy, diary, life maps, memory boxes and videography can contribute to the positive mood of the elderly. He also keynoted that working in cooperation with the relatives of the elderly individual is very important for the therapeutic relationship to reach its target.

Both the significance of transferring past experiences of older people in the therapy process and the possibility of these people to gain different perspectives while reviewing the past implied successful application of narrative therapy in the field of old age. In other words, "life review" theory has proved that narrative therapy can be applied to the elderly. The scientific studies in the literature support this argument. In the qualitative study of Gardner and Poole (2009), narrative therapy was conducted with 12 people who are aged between 55 and 70 years old and addicted to drugs or have mental disorders. The research concluded that narrative therapy has effects that reduce drug abuse and mental discomfort in elderly individuals. Also it was displayed that this therapy has contributed a lot to the psychological well-being of the elderly. In the case study carried out by Heidari et al. (2016), it was concluded that narrative therapy reduces death anxiety and increases the happiness rate in elderly individuals.

In the quantitative study conducted by Chow (2018), 192 people with an average age of 72 who had a palsy before received narrative therapy. The results of the study revealed that narrative therapy reduced depression level of the patients who had palsy before and increased their happiness, hope, self-review and the level of discovering the meaning of life. The qualitative study conducted by Klein (2008) reveals the experiences of the professionals who applied narrative therapy on the elderly. According to the obtained results, narrative therapy was found to be a very useful form of therapy for treating the problems of despair, depression, unhappiness, death anxiety and loneliness. In that case, it has become rather essential to fully understand what the narrative therapy, used functionally in the field of ageing, is and how it can be applied with the elderly individuals.

NARRATIVE THERAPY

Apart from the daily life, the following sentences can also be seen in literary works such as novels, stories and theater scripts: "I am a bad-tempered man", "I am a calm person", "People find me repulsive" and "Life is very boring". This situation is pretty naturally since art fictionalizes a copy of life from human mind. However there is always an important difference between art and everyday life, which is the phenomenon of reality. Raskolnikov might be a bad-tempered person. But the reader knows that if Dostoevsky had desired, he could have been a cheerful person. On the other hand, if one of your close relatives is a bad-tempered person, it is impossible for you to change him. Because your close relative is neither a story hero nor it is a fiction that your relative is a bad-tempered person. Well, is it really so?

The answer of White and Epston (1990) for the question above is definitely "No". According to the authors, a person forms his life and personality with dozens of "narratives" that he tells himself, the people around him or the narratives that other people tell him. Here, the concept of narrative refers to all judgements that the person make for himself and the people around him. For instance, the statement of "I am an introvert person" is a narrative that the person taught himself or learnt from his environment (White, 2007). As the person believes in this narrative, the situation of being introvert will preserve its reality in his life. So why should the judgment of the person be a narrative that is likely to change, not the real one?

The answer for the question above requires for a clear explanation of "postmodernism" and "social constructivism" concepts which constitute the root of narrative therapy. Social sciences have always been profoundly affected by the significant changes in natural sciences. This interaction played an important role in shaping the information set of social sciences (Fay, 1996).

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The statements of Newton clarifying the essential and unchangeable truths of the world and universe through "Principia" caused modernism, which aims to reach unchangeable truths, to be effective in social sciences. However, the falsification of Newton's ideas by Albert Einstein paved the way for questioning modernism in social sciences. By suggesting the theory of relativity, Einstein proved that there could be more than one reality that varies according to time and location rather than a fixed reality. As Newton suggested, time did not flow in the same way everywhere. The reflection of this situation on social sciences appeared with the concept of postmodernism (Freedman and Combs, 1996). If time is relative, why would not truths be relative as well? While there appears nothing that bases there is a fixed truth, what would be criteria to claim someone's statement wrong? In a more explicit statement, all concepts sanctified by modernism such as "universal truth, the unique reality, information that everyone must obey, universal goodness" have expired. There are now thousands of sets of information that are uttered from a particular perspective, being not more accurate than the other ones (Kropf and Tandy, 1998). According to postmodernism, no stable truths or realities exist in the universe that man is bound to discover. Modernism made a great mistake by looking for universal facts and truths. Since the universe we live in has a relative structure in which we can have more than one perspective on a subject. For instance, a woman can say "I think it is not an appropriate behavior for a woman to burst into laughter in the presence of other people" while another woman can say " I think it is usual for a woman to burst into laughter in the presence of other people". If the absolute truth was "It is a wrong behavior for a woman to burst into laughter in front of people", then it would be a wrong behavior for a woman to laugh loudly in front of people. However there is not such an absolute truth in postmodernism. Thus, both the woman who burst into laughter and the one who did not are evenly right and their opinions are evenly valuable. Neither of them says something wrong.

Social constructivism is regarded as a ring of postmodernism. According to social constructivism, the concepts are the most essential elements that an individual constructs himself, his environment and relations. An individual constructs his social world with the concepts he uses (Besley, 2002). These concepts take place in all thoughts and feelings of the individual. Through the concepts that he uses, the individual determines his subjective identity both cognitively and emotionally. Thus, changing concepts means that the individual completely rebuilds himself and his social environment. Because first the concepts then the sentences formed with these concepts change, and via these sentences, the person who feels himself as the subject changes emotionally and cognitively (White, 2004). Postmodernism and social constructivism ground narrative therapy at this point. By building therapies on the basic philosophy of postmodernism and social constructionism, narrative therapy aims to change the concepts, sentences and narratives based upon these sentences. The individualization of alternative narratives that will make the person feel better is one of the main targets of therapy (Goodcase and Love, 2017). However the individual possesses "dominant narratives" which prevent the person from individualizing these alternative narratives.

Dominant narrative is a kind of scenario that threatens bio-psycho-social well-being of the person and consists of narratives about his life and identity that his environment and he tells himself. This scenario is often produced by social culture as the ideal way of life that the person is expected to lead. It is observed that social culture is frequently manipulated by power holders owing to political and economic interests. As Foucault advocates that power holders put individuals into invisible pressures with the concepts of social culture, he underlines social concepts and narratives (Besley, 2002). For example, the scenario imposed to a heterosexual middle-class individual living in the Republic of Turkey through concepts and narratives are summarized as follows: Graduating from high school, studying at university at bachelor's or associate degrees, finding a job, getting married, having children, experiencing the roles of mothers and fathers, retiring and being active in life as much as possible while waiting death (Goodcase and Love, 2017). The narrators of these scenarios were the experiences of elderly individuals until the striking progress of media and technology.

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Nevertheless, technology and media have recently handled the task of imposing scenarios on what individuals in society should do (Mehlsen, 2011).

To illustrate the point, the image of happy shoppers is imposed to individuals through advertisements on television. The above-mentioned image converts into the narration of "The more shopping you do, the happier you are". With thousands of narrations like this, a person is imprisoned in an "ideal" scenario that is not owned by himself but the media and technology which are guided by the people with political, cultural and economic power. This scenario imposed on the person is experienced as a "dominant narrative". In other words, ideal personality of a given person constitutes dominant narratives. For sample, the postulate "A person deserves more respect as he earns money" is one of the dominant narratives of today's society. Nevertheless, the reason why this narrative is true is not questioned by the person or based on logical justification. This scenario is dictated to the individual by social culture, media, technology and his / her own desires. The unhappiness of the person comprises of the gap between dominant narratives and the completed behaviors of the individual (Berntsen & Rubin, 2002).

According to narrative therapy, the behaviors of the individual who failed to reach the goals of the dominant narrative are the main reasons of the psycho-social problems experienced by the person in the old age (White and Epston, 1990). To explain the situation through Erikson's theory, one feels self-integrity or hopelessness in old age. From the angle of narrative therapy, self-integrity means for a person to reach the targets of his dominant narrative at the end of his life. On the other hand, hopelessness refers to the failure of reaching the targets of a person's dominant narrative at the end of his life. Thus, changing the negative emotional state of an elderly person is conducted by thinking about his deep-rooted narratives (Goodcase and Love, 2017). To illustrate the point with a sample, an old person who has been unable to possess a house throughout his life is expected to evaluate himself as "idle" and "weak". The reason behind this evaluation is based on the following dominant narrative: "Possessing a house makes the person successful". However, there are no universal truths in a postmodern world. In the narrative therapy based on this philosophy, basic treatment model is established on the following hypothesis: The dominant narrative of an old person can be hindered by questioning. Instead of this dominant narrative, the alternative narratives which display strong sides of the individual, can be created.

NARRATIVE THERAPY METHOD FOR THE ELDERLY

White and Epston (1990) put forward that the following steps are available in psychotherapy process of narrative therapy:

1) Identifying the impact of the problem
2) Externalization and revealing the main structure
3) Designating unique results
4) Reconstituting the narrative and the members of the narrative from the beginning
5) Strengthening and clarifying the weak narrative
6) Identifying and consolidating the potential of the empowered weak narrative for future problems.

Each of these processes forming the treatment phase aims to eliminate dominant narratives in order to eliminate the person's despair. Instead of these dominant narratives, new narratives, which will be created with the person and contribute to the well-being of the person, are tried to be formed.

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1. Listening to the Elderly and Comprehending the Impact of the Problem (Identifying the impact of the problem)

As in all other therapies, the most significant role of a therapist in narrative therapy is to listen to the client effectively. The therapist's effective listening is very important in order to understand the concepts of the old person, the dominant narrative he embraces and where he sees himself in this dominant narrative. Besides, apprehending what the old person feels in each narrative is also essential so as to find out the clues of alternative narratives crushed in the dominant narrative (Rappaport, 1995). In addition, elderly individuals can provide a separate therapeutic benefit by explaining their past experiences. For many elderly people, telling a curious listener about his past experiences uninterruptedly provides a very beneficial psychological effect. Therefore, effective listening of the therapist while a person is reviewing his life is of great importance for other stages of narrative therapy to continue successfully (McLeod, 1996).

A clear understanding of the impact of the problem depends on comprehending the dominant narrative and the relationships of its members. In narrative therapy, " the members of the dominant narrative" refer to all people, living creatures and objects that the client is in relationship while telling his personal narrative. Thus, as the therapist understands the problem of the person, he must successfully analyze the dominant narratives dictated to the person by himself and his environment, the achievement degree of this dominant narrative and the emotional state of the elderly against this dominant narrative. Also, the following parameters are of great importance: the effect of the relationship of the elderly with the narrative members on the dominant narrative, the emotional outputs that these relationships create in the person and how the person makes sense of their relations with these members (Estes, 1993).

Another point to consider during listening and comprehension of the problem is that the narration of the person is perpetually changing. The main reason for this change is related to the constantly changing mood of the person; that is to say, the person can narrate the same event from various perspectives (i.e. from a negative perspective on a sad day and from a positive perspective on a happy day). This is a significant advantage for the therapist to show to the elderly that he has the power to create new narrations. On the other hand, this situation has a negative effect on the therapist's ability to successfully determine the dominant narrative, the members of this narrative and their relationship with the elderly, and the emotional state of the person in relation to this dominant narrative and relationships. Being aware of this negative effect, the therapist should keep his knowledge of the dominant story constantly updated on his agenda (Goodcase and Love, 2017).

2. Separating the Elderly from the Problem (Externalization and revealing the main structure)

In this phase of therapy process, it is initially set forth how the determined problem affects psychological problems such as depression, unhappiness, hopelessness, regret and guilty. Discussing the questions such as when the elderly individual first noticed the problem, how this problem affected the elderly, how the problem affected the person in the strongest and weakest moment will help to understand the impact of the problem on the psychological situation in all aspects (Polkinghorne, 1991). After the problem - psychological state relationship is analyzed successfully, the therapist tries to externalize the problem from the person. In this way, the therapist encourages the client to be an independent person far away from the problem. Furthermore, as the person considers the problem as a separate entity from him, he has the chance to obtain new narratives with more rational reasoning about the nature of the problem (Kelley, 1995). As an illustration, imagine that the elderly individual's spouse passed away a few months ago. He was unable to recover from the intensive bereavement period and drifted into a depressive mood. A therapist who wants to treat the client suffering from depression after his loss (problem) with narrative therapy can initially ask the following questions in order to detach the person from his "loss or bereavement": Now, let's suppose that we take away your sense of loss or bereavement that makes you feel unhappy.

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What would you like to say to this feeling, how do you think it affects you, how is your relationship with this feeling, do you think to keep it with you forever, what would you say to this feeling if you wanted it to leave you, do you think your spouse would want this feeling to stay with you? (Guterman and Rudes, 2005)

First of all, analyzing the relationship between the problem and psychological state clearly and then externalizing the problem from the person are important stages of narrative therapy. Because when the person externalizes the problem from himself, he automatically externalizes his psychological problem and the dominant narrative that he believes. Indeed, this externalization should be considered as a cognitive preparation for the fiction of a new narration in the later stages. Because in the therapy relationship, it is initially stated that the problem may affect the person only if the individual believes in the problem. This is the most basic point of all the remaining stages in therapy. Therefore, together with the stage of listening and understanding the problem, this stage prepares the person cognitively to fictionalize a new narrative (White, 2007).

It has been observed that the most difficult and long-lasting phase in the narrative therapy applications for the elderly is the externalization phase. Because the problems encountered in the elderly period are based on quite various and complex narrative patterns. In other words, the problem of the old person, who says that he is psychologically desperate, is based on his overall life experience. This situation makes it difficult for the elderly to externalize hopelessness. Because the elderly individual interprets this problem as his own character rather than being a separate entity that affects him. For instance, as the elderly person is told "Face the hopelessness", he has difficulty in following this instruction cognitively. Because, from the perspective of the elderly person, hopelessness is an innate characteristic feature of him. This situation causes an increase in the number of therapies conducted with the elderly (Goodcase and Love, 2017). As a result of all these time-consuming efforts, the fundamental question for the elderly who separates the problem from him is as follows: If the problem did not affect you negatively, how would your life be?

3. Designating Unique Situations to Reveal the Alternative Narrative of the Elderly

White (2004) notes that people do not have a lifestyle that is suitable only for dominant narratives in all periods of their lives. According to the author, individuals sometimes act contrary to their dominant narratives. However, these behaviors are often weakened and trivialized under the thumb of dominant narrative. The situations including the opposite behaviors of dominant narrative, consisting of few experiences compared to dominant narrative behavior in life, being weakened and trivialized by dominant narrative are called "unique situations".

At this stage of the therapy, other narratives that are against the dominant narrative in life span are shown to the client. Here, it is noteworthy for the therapist to ask the right questions. These questions and the review with the client are significant in order to show unique results to the elderly (Omer, 1997). For example, in the dominant narrative, an old person who feels unsuccessful because he was unable to buy a house for the rest of his life states that he has helped a poor person in some of his life story and enjoyed it. In the therapy process, the old person is inclined to return to the dominant narrative by addressing such small details. Therefore the therapist must try to further strengthen these small and unique situations, which are not suitable for the dominant narrative at this point, in the narrative of the person with questions (White and Epston, 1990). These unique situations are essential parts of the person's new narrative. Eventhough the person failed to buy a house with regard to the dominant narrative, he succeeded in helping a poor person. However, this success was overwhelmed by the failure of the dominant narrative. Therapist should try to cultivate the roots of the alternative narrative which becomes weaker under the dominant narrative with the following questions: "Do you think that the only way to be successful in life to buy a house? Don't you think that helping a poor person is a success?", "You told me that you helped a poor person. Let us focus on this issue. What exactly did you feel at that moment?" and "Well, did you have other events in your life that made you feel happy just

as the moment you helped a poor person?" (Kropf and Tandy, 1998). All these questions try to show the alternative narrative which the person is not aware of by himself via bringing unique results to the forefront.

At the end of this phase, the elderly person feels himself independent from the problem, and his psychological well-being gradually increases with the alternative narrative. Nevertheless, in order to eliminate the negative effects of the dominant narrative, it is not enough to lay the foundations of an alternative narrative with the elderly person. What needs to be done is to strengthen the alternative narrative created on the basis of unique situations and enable the elderly person to accept it to a large extent.

4. Re-evaluating the Relationship of the Elderly with the Members Constituting His Narrative (Reconstituting the narrative and the members of the narrative from the beginning)

As stated earlier, the personality / identity of an elderly person is closely related to the environmental factors that s/he lives in. Moreover, the environment in which the elderly person lived and grew is quite important in the formation of dominant narration. Cultural expectations, "ideal" narratives spread by media and technology, lifestyles of close friends and relatives, and other environmental factors are the main points so as to understand how elderly people consider their own narrations (White, 2007). The elderly individual forms his personality and ideal life style through the narrative which is constituted by these essential points. When the above-mentioned ideal narrative is not reached by the elderly person, psychological problems arise in the person. Thus the problem, identity and life story of the elderly individual are determined by his relationships with his environment. For this reason, the therapist should focus on the relationship of the elderly person with the people around him at this phase. The therapist must analyze how the old person transfers cultural values to his dominant narrative. The therapist must also determine to what extent this network of relations affects the old person's problem (Goodcase and Love, 2017).

As an illustration, an old person may label himself as a bad person since he divorced the spouse in early years of the marriage. The essential reasons behind the negative labelling can be stemmed from several environmental factors such as the expectation of married couples in the cultural system of the society that the elderly live, negative value judgement of close friends and relatives towards living out of marriage order and the failure of continuing marriage while close relatives and friends are good at marriage life. Thus, a therapist should focus on questioning the relations of the elderly individual with all the environmental members that constitute the dominant narration (Florio-Ruane, 1997). The main goal expected in this questioning is a rebellion. The mentioned rebellion is activated for the relationships which were accepted with no reason and formed between the person and members of narration. In this phase, the individual opposes the narratives of cultural expectations, relatives, the media, technology and business leaders. The above-mentioned opposing confirms the possibility of rewriting all narratives with the therapist (Rappaport, 1995). Cultural expectations, close friends and relatives may expect the elderly to continue marriage. However, it is the person, himself / herself, who is in an unhappy marriage life. Hence, creating personal narrative rather than being oppressed under the pressure of the aforementioned cultural narrative is very important in the provision of the person's well-being. At this point, the elderly individual is questioning, reviewing and finally reconstructing each environmental relationship with the therapist. All these efforts destroys the dominant narrative of the elderly to a large extent and strengthens the alternative narrative (White and Epston, 1990).

The investigation of the elderly individual's relationship with all the narrative members that make up the dominant narrative at this phase of therapy means the re-creation of each narrative membership. Since media, technology or culture has a different effect on the narrative that the person feels his own identity, which displays that membership has been re-fictionalized from the beginning. This situation undoubtedly enables the new narrative, which is created with unique results, to be clarified and strengthened by reconstructing the relationship of the narrative members. The elderly individual now has an alternative

narrative and a new network of relationships up to this phase of therapy. The brand new and solid perspective makes life review of the elderly more meaningful and happy for him.

5. Reinforcing and Clarifying the Weak Narrative

As the client begins to realize alternative-weak narratives, these narratives should be strengthened. The main reason for this situation is the actions of the old person that reinforced the dominant narrative for decades. All these actions cause the person to adopt the dominant narrative. However, with narrative therapy, the elderly individual realizes an alternative narrative, no matter how weak it is. What the therapist needs to do at this stage is to increase the number of the narratives in the consciousness containing feelings that the person feels strong and happy (White, 2004). To give an example, a person mentions about himself as being a helpful person while telling his dominant narrative. By making use of this statement, the therapist should increase the number of the narratives and reviews related to helpfulness in the mind of the person. Since helpfulness stands there as a source of self-confidence and happiness despite the dominant narrative of the person. However helpfulness did not adequately appear in the forefront of the dominant narrative. The therapist should use the theme of helpfulness to strengthen the alternative narrative by decreasing the power of the dominant narrative. For this, more life experience related to hopefulness should be brought to the forefront, the elderly person should be enable to review helpfulness more, and thus the alternative narrative should be strengthened (Goodcase and Love, 2017). In this phase, the main action is to put new and logical narratives against the dozens of actions that root the dominant narrative. As these new and logical narratives increase, there will be a positive contribution to the well-being of the person. In some cases, however, the client or therapist may have unrealistic expectations. These conditions appear especially in chronic conditions such as dementia, alzheimer's, heart problems and lung failure. Trying to empower the alternative narrative of the elderly in such situations is considered as unrealistic expectations. To speak generally, it is a must to understand that the change potential of these elderly people is quite limited (Tomm, 1989).

Another negative factor on the change of the elderly person's narrative is that the person experiences severe psychiatric problems. The therapist should focus on minor changes in negative experiences such as severe depression, trauma and history of abuse. White (2007) explains this situation via Vygotsky's (1986) scaffolding theory. In this regard, the therapist should work on more achievable goals depending on the mental and physical health of the elderly in such situations in narrative therapy. The sustainability of these minor changes indicates that the elderly can benefit positively from narrative therapy even under difficult conditions.

Putting effort to strengthen the alternative narrative of the elderly individual is an important phase for keeping the well-being of the person. However this is not the last phase of therapy. Because the alternative narrative, which is created and strengthened according to narrative therapy, is unlikely to be permanent in one's life without being integrated with the living space. Thus, alternative narrative should be integrated with real individuals in life, first with therapist, and then with reality itself in life.

6. Determining the Strengthened Weak Narrative of the Elderly Person for the Future Problems and the Process of Consolidation

The aim of this phase is to tackle with the remaining problems, such as family narratives and possible events in the future. In the last phase of narrative therapy, alternative narrative is reinforced by a broader uprising by questioning the narratives of political, economic and cultural powers. Indeed, this alternative narrative must unite with reality in order to integrate with one's self (personality). The therapist should consider inviting members of the narrative (the client's family, close friends, relatives, etc.) who have the potential to support the alternative narrative in this phase (White and Epston, 1990).

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It should be ensured that the alternative narrative of the old person is told to the members of the dominant narrative in company with the therapist. The support and approval of the alternative narrative of the old person by the members of the narrative is one of the most crucial phases in making this narrative permanent in the life of the old person. In these therapy sessions in which narrative members are invited, the old person and his relatives are required to discuss how the new / alternative narrative will affect future life relationships of the old person. Indeed this discussion constitutes the first experiences of the alternative narrative which the old person constructed outside of the dominant narrative after many years. In this way, the alternative narrative strengthened and supported in the area of consciousness will also be strengthened in the area of action (getting experienced by discussing with real people) accompanied by the therapist (White, 2007). In other words, for the first time, the person has the opportunity to discuss and implement the alternative narrative, which he has created with the therapist as a result of long sessions, with his relatives in the presence of the therapist. For this reason, the members of the narrative who do not care about the elderly person, support the dominant narrative of him, humiliate him and prevent his development should never be invited to the therapy sessions .The final target of narrative therapy in this phase is to explore how the old person will lead his future life with the alternative narrative. In the therapeutic relationship improved with the elderly, the essential problem that the person will frequently encounter in the future is the anxiety of death due to his age. This situation is explicitly set forth in Erikson's theory of psychosocial personality development. Erikson advocates that the elderly person will have low level of death anxiety as long as he evaluates his all life positively (self-integrity); on the contrary, if he evaluates his all life negatively, he will have high level of death anxiety (hopelessness) At this phase of the therapy, the elderly person is expected to evaluate himself and his past life positively by reconstructing his narrative. This is the main goal of narrative therapy for the elderly. Thus, the elderly person who reviews his life in a positive way should be suggested to share his knowledge with the younger generation. The therapist can ask the elderly person to carry out the above-mentioned action in the face of him by inviting young narrative member (the old person's grandson / daughter and etc.) to the sessions. Apart from this, the elderly individual is expected to share his achievements, knowledge and experiences by talking to the narrative members, writing letters or through digital media vehicles. This is of great importance for the elderly person to change his negative narrative throughout the therapeutic process and create a positive alternative narrative by overcoming the most rooted problem in the future, death anxiety, and having a peaceful old age (Goodcase and Love, 2017).

CONCLUSION

The present study reveals that negative or positive review of his own life is the determining factor for the elderly person in experiencing psychopathological conditions such as depression, death anxiety, loneliness, suicide and etc. Thus, "the review of life" is rather a determining process for the elderly individual's well-being. Also this study puts forward that the aforementioned review of life is composed of changeable narratives through narrative therapy. The narrative therapy, shaped by the influence of postmodern philosophy, agrees with the view that more than one truth should be accepted while opposing universal truths. Instead of a life story that makes the old person unhappy, narrative therapy builds the treatment model based on the question "Why do not we build a story that brings the old person's powerful features and increases his well-being?". Because if a person reviews his life positively, many psychopathologies that are common in old age will disappear. And the positive review of one's life depends on the notice that the narrative he believes consists of a fallacious and dictated narrative set.

Narrative therapy has a very simple argument for changing the dominant narratives that are shaped by the imposition of various power sets, which put the person at a disadvantage: identifying the alternative / new / weak narrative crushed under the dominant narrative in the old person's life and ensuring him to adopt the new narrative. Therefore, narrative therapy creates the treatment model by using six basic steps to ensure the well-being of the elderly individual.

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The first of these steps is to identify the impact of the problem. In this phase, the main aim is to understand the elderly person's dominant life story and how he was affected by this story via listening to him effectively. Besides, in this phase, it is of great significance to determine the relationship clearly between the old person and the dominant narrative, together with the problem stated by the old person. The second stage of the treatment includes externalization and revealing the main structure. The main purpose at this stage is to ask effective questions to ensure that the old person is a separate entity from the problem. The fact that the person describes himself as a separate entity from the problem increases the potential of creating an alternative narrative. The third phase of the treatment is to determine unique results. At this stage, the therapist tries to lay the base of the alternative narrative by identifying the experiences and values against the dominant narrative of the elderly person. These unique situations are the fundamental parts of the alternative narrative that will be strengthened in the next phase of therapy. The fourth phase of the treatment is related to the reconstruction of the narrative and the memberships of the narrative completely. At this stage, each individual, with whom the elderly person has a relationship, is subjected to a new formatting by getting rid of the relationship with the object and the living being in the dominant narrative. The reconstruction of previous relationships has a reinforcing effect on the alternative narrative. In the fifth phase of the treatment, it is tried to strengthen and clarify the weak narrative. In order for the alternative narratives, which were grounded and put into pieces, to take place on the mind of the old person, it is aimed to focus on the reviews and experiences related to these narratives. The last phase of the treatment aims at strengthening the weak narrative and identifying its potential for future problems. The alternative narrative, which is tried to be empowered on the old person's mind, is converted into experiences with the reviews conducted by the relatives of the old person who make contribution to support the new narrative. In order for the old person to overcome the death anxiety which he will experience in the rest of his life, it is highly emphasized that the old person shares the alternative narrative with young generation.

In an era when the world is aging continuously, the efforts to ensure the well-being of the elderly should be considered as important investments to be made for today and future. Therefore, it is not sufficient for the studies related to old age to remain only in the context of medical and social policy. The academic studies about old age need to be handled from a much more diverse and wider perspectives. The current study was carried out to ensure psychological well-being of the elderly. It should be propounded by clinical-scientific studies that narrative therapy contributes to the well-being of the elderly. Hence the applied scientific studies about the relationship between narrative therapy and the field of ageing gain importance. Filling this gap sufficiently in the related literature is very important in terms of strengthening the practices.

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THE EFFECT OF WELL-BEING ON LIFE SATISFACTION: A STUDY ON STUDENTS

İYİLİK HALİNİN YAŞAM DOYUMUNA ETKİSİ: ÖĞRENCİLERE YÖNELİK BİR ARAŞTIRMA

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ABSTRACT

Well-being and life satisfaction are concepts that are frequently emphasized in today's world. The individuals' desire to maximize the satisfaction they get from their lives has been effective in increasing the importance of these concepts. Universities are major factors in individuals having maximum life satisfaction. This study aimed to identify the effects of well-being on the life satisfaction of vocational school of higher education students and the relationship between these two factors. The study was conducted in December 2018, in Yalova. At the end of the study, it was determined that the level of well-being of the participants was high and their life satisfaction was medium level. It was determined that there was a positive and moderate relationship between well-being and life satisfaction. Moreover, it was determined that well-being had a positive effect on life satisfaction. These results show that well-being is a determinant of life satisfaction. In the frame of these results, some suggestions were made for promoting the well-being and life satisfaction.

Keywords: Well-being, Life Satisfaction, Students.

ÖZ

İyilik hali ve yaşam doyumu günümüz dünyasında üzerinde sıkça durulan kavramlardır. Bireylerin hayatlarından aldıkları tatmini maksimum seviyeye çıkarmak istemeleri kavramların öneminin artmasında etkili olmuştur. Bireylerin azami hayat tatmini yaşamalarında üniversiteler büyük bir etkendir. Bu çalışma ile meslek yüksek okulu öğrencilerinin iyilik hallerinin yaşam doyumlarına etkisinin ve bu iki değişken arasındaki ilişkinin tespit edilmesi amaçlanmıştır. Araştırma Aralık 2018 tarihinde Yalova'da gerçekleştirilmiştir. Araştırma sonucunda araştırmaya katılanların iyilik halinin yüksek, yaşam doyumunun ise orta düzeyde olduğu belirlenmiştir. İyilik hali ile yaşam doyumu arasında pozitif yönlü ve orta düzeyde bir ilişki olduğu belirlenmiştir. Ayrıca iyilik halinin yaşam doyumunu pozitif yönde etkilediği belirlenmiştir. Bu sonuçlar iyilik halinin, yaşam doyumunun bir belirleyicisi olduğunu göstermektedir. Bu sonuçlar çerçevesinde öğrencilerin iyilik halinin ve yaşam doyumunun artırılmasına yönelik bazı önerilerde bulunulmuştur.

Anahtar Kelimeler: İyilik Hali, Yaşam Doyumu, Öğrenci.

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INTRODUCTION

Universities are of great importance in the development of societies. In universities, students do not only receive education and training activities related to their chosen professions. In addition to this, the school environment offers great opportunities for them to socialize. The students who complete their education process contentedly show up as individuals who are more active in their lives, more satisfied in their professional lives and have better socio-economic status. In the opposite situation, it is inevitable that the students who had problems during their university education, will have a decrease in their quality of life; they will take a break or withdraw from education, become unhappy in their professions or turn to another profession. Therefore, for the benefit of students, universities and the future of the society, it is essential for students to have a high level of life satisfaction during their university education and to identify and solve them if they face any problems.

LITERATURE REVIEW

Well-being

Well-being is an active process which allows individuals to be aware of their own existence and provides an opportunity for them to make their own choices (National Wellness Institute). Well-being is defined as the cognitive and affective evaluations of the individual as a whole. These assessments include cognitive satisfaction and satisfaction judgments, as well as emotional responses to events. Therefore, well-being is a very broad concept that includes a high level of positive emotion and mood, and life satisfaction, and a low level of negative emotion and mood (Diener et al., 2011: 187).

People define the state of well-being differently according to their own set of beliefs and values. The family structures of people, the societies in which they live, and their social positions determine their well-being (Bolsoy and Sevil, 2006: 79). The state of well-being is a holistic lifestyle with many dimensions, which needs to be evaluated as an active process that varies from person to person. In this respect, individuals with high perceptions of well-being, besides having accomplished their goals in their lives, should make constant efforts to maintain and improve their current situation and shape their lives accordingly (Kayiş, 2017: 27-28).

Although the state of well-being is included in World Health Organization (WHO) definition of health as “not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being” (quoted from WHO by Tengilimoğlu et al., 2012: 69), this definition puts more emphasis on the health of individuals. However, the concept of “well-being” carries much more dimension within itself. There are many dimensions of well-being (Foster et al., 2007: 15-16; Korkut Oven et al., 2017: 1462). These dimensions are briefly described below:

- **Physical well-being:** This dimension, which emphasizes the physical aspect of well-being, requires active and continuous effort. In general, it includes activities such as proper nutrition, regular sleep, avoiding substance addictions, engaging in physical activity, self-care, and adopting a healthy lifestyle.
- **Emotional well-being:** This is the dimension of the state of well-being related to the inner world of the individual. It includes the ability of individuals to realize their emotions, to control them, to cope with stress, to have self-esteem, and to develop positive emotions about themselves and their future.
- **Social well-being:** This dimension, which puts an emphasis on the social, environmental and natural dimension of the state of well-being, includes social support provided to individuals through their relationships with their families, friends and others.
- **Intellectual well-being:** This dimension, which constitutes the cognitive aspect of the state of well-being, is defined

by the active intellectual life of individuals. It involves the development and improvement of individuals and society by acquiring, using, sharing and applying information.

- **Spiritual well-being:** This dimension, which involves the individuals' search for the purpose and meaning of their lives and setting goals for themselves, expresses a process that is innate and continuous. Spiritual well-being is about individuals' connection with other individuals, society, nature, the universe, and supernatural forces.
- **Professional well-being:** This dimension is related to the individuals' personal satisfactions and their work in paid or unpaid jobs to contribute to society.
- **Environmental well-being:** This dimension, which is based on reciprocity (balance, effect, control), is related to the much wider environment (home, work, society, nature, world, universe) of the individual.

Life Satisfaction

The concept of life satisfaction, which explains the satisfaction of people in their lives in general, is a concept with an emotional background and it's very important for individuals. The broad meaning and the complex structure of the concept of life makes it difficult to make a definition about life satisfaction and to reveal what affects life satisfaction. Therefore, there is no consensus on the concept of life satisfaction (Polatcı, 2015: 30). Life satisfaction is the extent to which individuals evaluate the general quality of their lives in a positive way. In other words, it is about how much people enjoy the life they lead. This concept describes positive emotions associated with life (Kaba et al., 2017: 2).

Life satisfaction is one of the concepts related to the happiness of individuals, and it represents the cognitive side of individual well-being (Dost, 2007: 133). Life satisfaction is a very important concept in terms of mental health of people (Kaya, 2011: 174). Being happy in daily life, finding a meaning in life, being consistent in achieving your goals, having positive personal traits, feeling good physically, feeling secure financially and etc. are among the factors that affect the life satisfaction (Keser, 2003, cited by Kaya, 2011: 173-174). In positive psychology, happiness is conceptually used as "subjective well-being" in general. Subjective well-being has three interrelated elements. The first one is positive effect, the second one is negative effect and the third one is life satisfaction. While the first two affects explain the likes and dislike of the individuals, life satisfaction includes cognitive assessments of individuals related to their lives. The definition of life satisfaction is the general judgments and evaluations of individuals about their lives (Çivitci, 2012: 322).

Individuals feeling satisfied with their lives by evaluating their lives according to their own criteria and having more positive emotions and less negative emotions are indications that their subjective well-being is positively high (Demolished and Demir Güdül, 2015: 299). Subjective well-being alone is an important concept. Besides, since it provides satisfactory relations, increases productivity and it has positive effects on psychological and physical health, it should be handled with care both in terms of individual and social sense (Gündoğar et al., 2007: 15).

Relationship between Well-being and Life Satisfaction

The concepts of life satisfaction and well-being encompass all lives of individuals. They also have both individual and social consequences. We can say there is a relational interaction between these two concepts. The hypotheses of the research that is made in the light of this information are identified as follows:

H1: There is a positive relationship between well-being and life satisfaction.

H2: Well-being has a positive effect on life satisfaction.

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METHOD

The research was conducted in December 2018 with 414 associate students studying at Yalova University, Thermal Vocational School. The data were collected by using survey method. The required permission was obtained from the institution for the research.

Data Collection Tools

The survey form used to collect the data in the research consists of three sections. The first part consists of demographic questions including information about the gender, age and departments of the students.

In the second part, the "Well-being Scale" was used. It was developed by Diener et al. (2009) and Fidan and Usta (2013) performed a Turkish validity and reliability study on it and adapted it to Turkish. The scale consists of 8 items.

In the third chapter, "Life Satisfaction Scale" was used. It was developed by Diener et al. (1985) and Dağlı ve Baysal (2016) performed a Turkish validity and reliability study on it and adapted it to Turkish. The scale consists of 5 items.

Expressions in the well-being scale and life satisfaction scale were measured using the 5-point Likert-type scale with the options "1 = strongly disagree", "2 = disagree", "3 = partially agree", "4 = agree" and "5 = strongly agree".

Data Analysis

SPSS Statistics 23.0 software package was used for data analysis. Descriptive statistics (frequency, percentage distributions, mean deviation, standard deviation) were calculated in the data analysis. Since Kolmogorov-Smirnov test revealed that the data did not come from normal distribution ($p < 0.05$), Spearman's correlation and linear regression analysis was performed to determine the relationship between well-being and life satisfaction. The findings were evaluated at 95% confidence interval and 5% significance level.

Limitations of the Study

The fact that the study was carried out on a vocational school and that all students could not be reached due to absenteeism, internship, etc. renders this study limited. At the same time, in such a study that directly measures the relationship and effect between well-being and life satisfaction, the limited number of subjects both limited the study and made it difficult to make comparisons.

RESULTS AND COMMENTS

130 students (31.4%) who participated in the study were male and 284 (68.6%) were female. 81 of them (19.6%) were in the department of Health Care Management, 102 (24.6%) were in the department of Elderly Care, 103 (24.9%) were in the department of Physiotherapy, 128 (30.9%) were in the department of First and Emergency Aid.

Table 1: Descriptive Statistics of Variables

Variables	n	Avg.	Std. Dev	Min.	Max.
Well-being	414	3,48	0,72	1,00	5,00
Life Satisfaction	414	3,06	0,86	1,00	5,00

According to Table 1, the well-being of the participants was high and life satisfaction was moderate.

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Table 2: Correlation Analysis of Relationship between Well-being and Life Satisfaction

		Life Satisfaction
Well-being	**r**	0,62
	p	0,00
	n	414

According to the correlation analysis results in Table 2, there is a statistically significant relationship between well-being and life satisfaction ($p < 0.05$). According to the correlation coefficient ($r = 0.62$), there is a positive and moderate relationship between well-being and life satisfaction.

Table 3: Effects of Well-being on Life Satisfaction

	β	**t**	**p**
Invariant	0,44	2,77	0,01
Well-being	0,75	16,71	0,00
	R^2= 0,404		
	F= 279,25		
	p= 0,00		

Dependent Variable: Life Satisfaction

According to the results of regression analysis in Table 3, it was determined that well-being had a positive effect on life satisfaction ($\beta = 0.75$, $t = 16.71$, $p < 0.05$). It is seen that 40.4% of the changes in life satisfaction are explained by well-being ($R2 = 0.4404$). These results show that well-being is a determinant of life satisfaction.

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DISCUSSION AND CONCLUSION

This study aimed to determine the effects of well-being of the students of vocational schools on their life satisfaction and the relationship between these two variables. Two hypotheses have been developed for these purposes. As a result of the analyses conducted to test these hypotheses, a positive and moderate relationship was identified between well-being and life satisfaction. According to this result, H1 hypothesis was accepted. Again, as a result of the analysis, it was determined that well-being had a positive effect on life satisfaction. According to this result, H2 hypothesis was also accepted. The results of the research conducted by Argan et al. (2018: 55-56) also support the results of this research.

Another result obtained from the study is that the participants' well-being was high, and their life satisfaction was moderate. It is desirable for the students to have a high level of well-being. The students who have high levels of well-being grow up as individuals who can make their own choices in their lives and improve themselves in cognitive and affective terms. Such individuals are more advantageous in achieving their goals than individuals with low well-being. It is not desirable that life satisfaction is medium level. Students, who cannot provide enough life satisfaction, are more likely to be unhappy, to not enjoy life, to not expect much from the future, and to see their lives as meaningless compared to the students with high life satisfaction. Köksal's (2015: 31-33) and Tuzgöl Dost's (2007: 140) research results support the results of this research.

SUGGESTIONS

Based on the results of the study, the following suggestions may be presented:

- In the vocational school in question, it is necessary to carry out the required studies in order to ensure the continuity of the well-being of the students with high level of well-being and to increase their medium-level life satisfaction. Therefore, it may be suggested to conduct in-depth interviews with the students in order to reveal the reasons that decrease their life satisfaction in particular and to take necessary steps to eliminate the identified reasons.
- Another suggestion is conducting and evaluating this study with more participants from universities in Turkey, and by comparing them, doing new researches to determine what kind of studies can be carried out to maximize students' well-being and life satisfaction.
- Necessary regulations can be made in universities for these two concepts which are important for students. For example, it may be suggested to expand the social spaces within the university, to create platforms where students can express themselves freely, and to establish student wellness centers where social workers, psychologists and sociologists are employed, and students should always be able to access them and receive counseling services.
- In order to increase the well-being and life satisfaction of the students, the activities that can be carried out by the local government of the region in which the university is located are also important. For example, opportunities like student clubs, social activity centers, social activities, etc. will positively affect students' well-being and life satisfaction.
- The work of non-governmental organizations is also important to increase the well-being and life satisfaction of students. Projects with students, voluntary social activities, lobbying activities, etc. it will serve this purpose.
- It is also important to rally the political institutions in order to increase students' well-being and life satisfaction. The projects that will be developed by considering the students' feedback to increase their well-being and life satisfaction can be given as an example in this regard.

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A QUALITATIVE RESEARCH ON THE ANXIETY AND STRESS CONDITIONS OF FAMILIES WITH SPECIAL NEEDS CHILDREN

ÖZEL GEREKSİNİMLİ ÇOCUĞA SAHİP AİLELERİN KAYGI VE STRES DURUMLARINA DAİR NİTEL BİR ARAŞTIRMA

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ABSTRACT

In this study, based on the experiences of mothers with special needs children between the ages of 3-6, it is aimed to reveal the anxiety and stress conditions concerning their children, which are formed by individual, familial and environmental conditions. Mothers of thirteen individuals residing in Sakarya province and having different disability types were included in the study. A working group in accordance with the purposive sampling method was formed. The study is a descriptive research created in a qualitative design. The semi-structured interview technique was employed in the data collecting process. In consideration of the reliability of the study, the statements of the participants were included in the form of "direct quotation" without any change in terms of spelling and grammar. The participating parents in the research were informed by the authors about the purpose and content of the research. No limitation was applied to the age of mothers. A parenthetical coding technique was used. In the study, the anxiety and stress situations that parents experienced when they learned that the families would have special needs children in the themes of uncertainty and exclusion were revealed. The anxiety and stress conditions that families suffer vary as per their experiences and differ from each other. The first moment of confrontation and the ambiguous process afterwards seemed to create more stress and anxiety in families. On the other side, it was demonstrated that, in some cases, the exclusion is due to the family and in some cases, is from the outside. The fact that stress and anxiety experienced in cases where psychological health and well-being deteriorates can lead a person to suicide is another finding of the research.

Keywords: Family, special needs, anxiety, stress.

ÖZ

Bu çalışmada 3-6 yaş aralığında olan özel gereksinimli çocuğa sahip annelerin yaşantılarından yola çıkarak çocukları ile ilgili bireysel, ailesel ve çevresel koşullarla şekillenen kaygı ve stres durumlarını ortaya koymak amaçlanmıştır. Çalışmaya Sakarya ilinde ikamet etmekte olan ve farklı engel türlerine sahip on üç bireyin annesi dahil edilmiştir. Amaçlı örnekleme yöntemine uygun çalışma grubu oluşturulmuştur. Çalışma nitel desende oluşturulmuş betimsel bir araştırmadır. Verilerin toplanmasında yarı yapılandırılmış görüşme tekniğinden faydalanılmıştır. Çalışmanın güvenirliği de dikkate alınarak katılımcıların söyledikleri "doğrudan alıntı" şeklinde imla ve dil bilgisi açısından değişikliğe gidilmeden aynen aktarılmıştır. Araştırmaya katılan ebeveynlere araştırmanın amacı ve içeriği hakkında yazarlar tarafından bilgi verilmiştir. Annelerin yaşları belirlenirken herhangi bir sınırlamaya gidilmemiştir. Parantez içi kodlama tekniği kullanılmıştır. Çalışmada ailelerin özel gereksinimli çocuklarıyla birlikte ilk yüzleşme anı ve sonrası, belirsizlik ile dışlanma temalarında yaşadıkları kaygı ve stres durumları ortaya konmuştur. Ailelerin yaşadıkları kaygı ve stres durumları, yaşantının özelinde çeşitlenmekte olup birbirinden farklılık göstermektedir. İlk yüzleşme anı ve sonrasındaki muğlak sürecin ailelerde daha çok stres ve kaygı oluşturduğu görülmüştür. Dışlanmanın ise bazı durumlarda aile içi, bazı durumlarda aile dışından kaynaklandığı tespit edilmiştir. Psikolojik sağlık ve iyi oluş halinin bozulduğu durumlarda ise yaşanan stres ve kaygı durumlarının kişiyi intihara kadar götürebileceği araştırmanın başka bir bulgusudur.

Keywords: Aile, özel gereksinim, kaygı, stres.

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INTRODUCTION

Being a family and walking to the future with healthy steps hand in hand are the basic values that have a unique significance in each individual's world and make life meaningful. The family, which is the core institution of society, has many qualities that it provides to its members. Functions such as love-to be loved, taking responsibility, fulfilling social roles, and being active in decision mechanisms are just some of them (Kaytes et al., 2015). The complementary element of the marriage of every parent is having a child (Varol, 2005). The family's expectation in this process is to have a healthy child. Notwithstanding every family has dreams about their child, the accompanier of this process is anxiety. Nobody dreams of a child with a disability or inability in his/her dreams about their child. In fact, even thinking over this generally discomforts parents (Arı et al., 2012). When parents come to know that they have children with disabilities, they experience different moods (Yates, 2012). This is an unexpected situation and the confrontation process begins when parents fall in despair of a normal child. Similar and common stages that begin with the rejection response are afterward accompanied by understanding and controlling the situation (Howard et al., 2010; Featherstone, 1980; Turnbull and Turnbull, 1985). According to Kübler-Ross (1997), the mourning process, which consists of five stages of denial, anger, bargaining, depression and acceptance, are similar processes experienced by families with children with special needs (Luterman, 1979; Gören, 2016). When families face their special situation for the first time, many stages such as shock, guilt, embarrassment, hovering door to door in hopes of finding a cure, miracle search, bargaining, refusal, wrapping logic accompany this process. In these experiences, the depth and length of the stages differ according to the anxiety and stress situations of the families (Seligman, 1989; Varol, 2005; Guerin and Fay, 1988; Sardohan Yıldırım and Akçamete, 2014).

Children with special needs take place below or above norms in terms of both physical and learning abilities. Therefore, they need individualized training programs in their educational processes (Hallahan and Kauffman, 1997; Özsoy et al., 2000). Although specially talented individuals fall within the scope of this term, in practice, individuals with insufficiency in this term come to the fore (Heward, 1996; Akkök, 2000). Therefore, individuals with special needs phrase was used for individuals under the norms that differ significantly from their peers as individual characteristics and competencies in the study.

Stress and anxiety are the two main facts reflecting the emotional state of families in these differences seen below the norms. Stress can be defined as the state of reaction that creates both social and psychological effects on the person as a result of threats or strains of the organism (Baltaş and Baltaş, 1984). In the event of this strain, many differences and changes occur with the individual and environmental farters in order to overcome the threat perceived by the individual (Mason, 1980; Parker and Decotiis, 1983). Anxiety is the mental and physical reactions of the body when the person experiences fear and tension (Morgan, 1991). In addition to being a chronic and complex emotional process, it also includes negative experiences of social processes. It is a universal life situation that can affect a person in such a way that he / she cannot see and work in private life situations where serious tension is experienced (Drever, 1969; Spielberger, 1976; Nemiah, 1975). Studies on families with children with special needs reveal that stress and anxiety are higher in these parents than in other parents (Dyson, 1993; Hallahan and Kauffman, 1997; Aydoğan, 1996; Kavak, 2007; Akkök, 1989).

Disability is not solely a process with emotional or psychological impacts such as stress, anxiety, social exclusion and isolation. In addition to these, it is a very complex process that involves long health care services according to the type of disability, and also with an economic aspect in so far as families with children who need intense care through special education and rehabilitation processes face a reality like impoverishment (Ali et al., 1994; Veisson, 1999). Besides the material needs, information needs are among the needs of families. When these needs are not met, it is observed that

children lock themselves in the house and repeated routines result in problematic behaviors over time (Toker et al., 2019). The emotional confusion that emerges due to learning of the baby's condition brings along the changes in expectations (Yıldırım-Doğru and Arslan, 2016). These changes vary after the child joins the family. When it is considered within the context of system theory, these changes are observed in the structural and functional dimensions of the family as well as in their developmental dimensions (Duyan, 2005). Cases such as self-accusation due to the situation of the child, feeling inadequate in dealing with the type of disability, being dependent on professional services arising from feeling compelled more than necessary for specialist guidance, excessively protecting the child and in this way making child dependent on the parent, rejecting child's inability affect all these structural and functional dimensions (Özgür, 2000). Supporting families in these emotionally complex circumstances and bringing down the unfavorable situations experienced by them is the main target of determining the needs of families (Durualp et al., 2011).

The responses and approaches of parents towards children with disabilities may differ (Danış, 2006). Researches put forth that the mother traditionally plays the role of protection while the father is not so sensitive in meeting the special needs of the child with disability, and his interest is less than the mother's (Alptekin, 2004; Lillie, 1993). The selection of mothers as participants in the research has provided access to healthier and various data regarding the realities, anxiety and stress levels experienced by families. In addition to determining the needs, revealing the ambiguities, inadequacies, and hence anxiety and stress situations that families feel and experience concerning the future will also diversify and qualify the services to be provided. These qualitative data, which are needed and making a contribution to the development of sustainable services, make the research more meaningful and demonstrates its importance.

In the study, based on the experiences of mothers with special needs children between the ages of 3-6, it is aimed to determine the individual, familial and environmental anxiety and stress situations that mothers experience due to their disabled children. The anxiety and stress situations that families experience vary according to their lives and differ from each other. Only the quantitative revealing of the problems experienced by families with children with special needs leads to the missing of the subjective parties regarding the problem and the sensitivity of the developed solution proposals decreases. In this context, in the research conducted on mothers, answers to the following questions are sought.

- What are the anxiety and stress situations felt during the first confrontation and afterwards?
- What are the anxiety and stress situations about uncertainties?
- What are the anxiety and stress situations on exclusion?

METHODOLOGY

Research Model

The research was carried out as a case study in the qualitative research design in order to reveal the future concerns of parents with children aged 3-6 with special education needs. The semi-structured interview technique was employed in collecting the data. Thanks to the qualitative studies performed in order to examine the sample thoroughly, the depth of the inner feelings regarding the subject has been reached. (Bogdan and Biklen, 2003; Yıldırım and Şimşek, 2006). The interviews were performed bearing these dynamics in mind.

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Sample Group

Mothers of thirteen individuals residing in Sakarya province and having different disability types were included in the study. A working group suitable for snowball and chain sampling, which is one of the purposeful sampling methods, was formed. Purposive sampling is the process of evaluating the rich information situations in detail, remaining loyal to the aim of the study (Yıldırım and Şimşek, 2006).

The participating parents in the research were informed by the authors about the purpose and content of the research. No limitation during determining the ages of mothers was applied. The average age of mothers is 35.5. Children with special needs suffer from a delayed milestone (mental deficiency), autism spectrum disorder and Down syndrome. Only 1 parent works, the remaining 12 participants are housewives.

Table 1. Demographic Information of Children and Mothers in the Study

Child's Codes	Child's Gender	Date of Birth	Child's Diagnosis	Mother's Age	Number of Children	Education Status	Occupation
MD	M	21.06.2016	Autism	31	2	Secondary School	Housewife
TG	M	28.07.2016	Autism	29	1	High school	Housewife
ZK	F	13.02.2016	Down Syndrome	40	3	Primary school	Housewife
SH	M	08.02.2016	Mental Deficiency	28	1	High school	Housewife
YMO	M		Autism	28	1	High school	Housewife
AÇÜ	M	27.05.2015	Down Syndrome	27	1	Secondary School	Housewife
ÖD	M	04.01.2014	Mental Deficiency	36	1	Secondary School	Housewife
DD	F	04.01.2015	Autism	46	4	Primary school	Housewife
BB	F	27.09.2016	Physical and Mental Deficiency	37	2	Secondary School	Housewife
AA	F	20.10.2014	Physical and Mental Deficiency	39	1	High school	Housewife
ABV	F	12.07.2016	Down Syndrome	49	2	Secondary School	Housewife
KD	M	12.02.2016	Autism	35	2	Secondary School	Factory Laborer
YEK	M	05.06.2014	Down Syndrome	37	3	Primary school	Housewife

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Data Collection Tools

In the study, in order to determine the views of mothers with special needs children regarding their anxiety and stress conditions and their diversities, the semi-structured interview form created by researchers, to which field specialists also contributed, was used. Open-ended questions were asked to the mothers, such as when they learned about the special situation of their children, what they experienced first, the reactions they received from the environment, and the emotions they felt in their uncertainty. According to Stewart and Cash (2014), the interview is "A mutual and interactive communication process based on the form of asking and answering questions, performed for a predetermined and serious purpose." According to Karasar (2015), interview technique is the quickest way to learn about possible underlying reasons for information, thoughts, attitudes and behaviors of people on various topics.

Data Collection

Study data were obtained from thirteen mothers of special needs children. The semi-structured interview questions were determined in order to reveal their views on the anxiety conditions they faced. A voice recorder was used to ensure a detailed quotation of the interviews. All the mothers participating in the research were informed about the purpose and scope of the research prior to the interview, and interviews were conducted on a voluntary basis with the permission from the mothers. Since the subject is special and sensitive, researchers always considered the ethical principles regarding unconditional respect and acceptance so that the mothers participating in the study could be comfortable. In addition, during the meeting, care was taken to ensure that the mothers were relieved and that the interviews were carried out spontaneously. The interviews ranged from approximately 15 to 50 minutes and were held in a quiet classroom environment at the school where their children get educated. When an answer given by the mother was also an answer to another question, the question was not addressed again. The interviews were ended by thanking the mothers.

Data Analysis

Interviews performed with the semi-structured questions were carried out on a voluntary basis. Descriptive analysis technique was used in the analysis of the data obtained. The obtained data were coded line by line in a special form. The main concepts were generated from the coded pages one by one and then transferred to the analysis pages. Interview transcripts were presented under the themes and categories related to the problem with direct quotations (Cohen and Manion, 2007; Yıldırım and Şimşek, 2006).

As Creswell (2016) emphasized on the validity and reliability of the study, the interview transcriptions were checked by comparing them with the recording. In qualitative research, validity and reliability are the most basic feature that is sought for the impartiality of the research and accurate measurement of the case (Yıldırım and Şimşek, 2006). For this purpose, the interview transcripts were both confirmed by the participants and checked separately by two separate experts who are field experts. The general framework in the analysis of the research consisted of three components (*reduction, presentation, inference*) and three operations (*coding, note-taking and suggestion development*) that were hold in the Qualitative Analysis Model of Miles and Huberman (1994).

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A parenthetical coding technique was used. As in the example of "AA, 39, H, HS", the initials of the names and surnames of the children are in the first space, the age of the mothers is in the second space, the first letters of their jobs (H: Housewife, FL: Factory Laborer) in the third space, their graduation level (PS: Primary School Graduate, SS: Secondary School Graduate, HS: High School Graduate) is coded in the last space. Following the analysis of the data, the findings were described, interpreted and evaluated on three main themes as inadequacy, ambiguity and sense of exclusion. In the theme of inadequacy, the sense of inadequacy that the mothers felt when they first learned that their children were disabled and later was considered. In the theme of ambiguity, the inability to predict the disability and the future of the disabled children was addressed. The theme of exclusion focused on the social acceptance and social support.

FINDINGS

The data obtained from the analysis performed were presented by directly quoting the contents of the interviews with the mothers, and divided into codes, themes and categories. The study focused on three themes experienced by mothers with special needs children between the ages of 3 and 6. These themes are sense of inadequacy, ambiguity and sense of exclusion.

Findings Regarding the Anxiety and Stress After the First Confrontation

The anxiety, stress levels and reactions of mothers to disabilities they faced regarding their children differ from each other. While some consider the situation, she experienced as the whole world collapsed her ears, some stated that she was very unfair in her reactions to her husband and thus she would first change this situation if she had a chance to return those days. Some mothers, on the other hand, stated that they felt anxious and fearful in so far as the financial impossibilities concerning the education life of their children. All these stress conditions faced are diversified specific to the experiences of families:

> *"What am I going to do now?" I said. When I learned that I was living something that would last a lifetime while I was waiting to end at 3 years old, I said, "What am I going to do? How do we live this life?" I got stuck. I couldn't find a queue, I went directly to the psychiatrist's door and started to cry, I said, "There is a danger for my child to have autism and I cannot get an appointment." They said okay, they scheduled an appointment for after 1 month. I said, "I have not slept for two nights, how I will wait for a month" (TG, 29, H, HS).*
>
> *"We caved in, you are looking at the child and, helplessly, you are able to do nothing, we did not want to eat and drink. Our sleep is disturbed"(BB, 37, H, SS).*
>
> *"I was extremely bad when I first heard it. The psychology at that moment is inexpressible that the whole world collapsed on my ears. I couldn't go into the hospital" (AA, 39, H, HS).*
>
> *"D.'s father has already left us. I had to struggle against the situation alone with my children. I don't have a family here. I have no one I can get support from" (DD, 46, H, PS).*
>
> *"When we were in the hospital in Sakarya, there was constant sleepiness in Ö. We asked for a referral from the doctor. They did not allow. So, my husband took us out of the hospital by force. On the way to Umut Tepe, Izmit, he opened his eyes. When the doctors there saw that we came with our own means, they were very angry that we did not come via an*

ambulance. Then they started examinations. They suspected that there was something syndromic. Then we took it to Istanbul Çapa. We were always in search for 2 years" (ÖD, 36, *H, SS).*

"It was said that it was innate in the family, he resembled his grandfather, and the child was naughty. He would cry until we arrived home. While everyone was living a happy and beautiful motherhood, I had long sleep problems. Crying, not going anywhere, not getting out of the house, I had a hard time" (TG, 29, H, HS).

"Frankly, I am so worried financially. Schools are very limited. How the families suffering from financial impossibilities will afford the education of their children". (AÇÜ, 27, H, SS).

"It's not blame, but I expected so many things from my husband, materiality has a limit and spirituality too. Until we learned about Ö's illness, we said to each other not even once to get up and sit there. But I wore away my husband too much, asking for more than my husband could do. My husband tried to provide my child and me with all the support he could. However, I have never found it enough. Despite all this, I usually prefer my husband when I go to the hospital. Because I have difficulty in experiencing my feelings among others, I cry if I have to cry when I am together with him, stop if I have to stop. If I could go back to those days, I wouldn't have put the squeeze on my husband" (ÖD, 36, H, SS).

"I can't cope with it anymore. When he cries, when he asks for something from me, and if I cannot do it, I feel very bad" (TG, 29, H, HS).

"Early on, I thought that if I make him had private lessons in addition to rehabilitation, I supposed he would get better promptly. But despite all the intense lessons, it was not what I expected. Yet we still continue the lessons. It is not easy but rather costly. Both my husband and I are working overtime for this. I scheduled my shift to the time that K. came from school. Only my manager and chief know the condition of my child. I did not share it with my other colleagues. I see him as a normal child. I explain to him everything at home as if I explain a normal child" (KD, 35, FL, SS).

"Sometimes I think he seems like learning something right away, I say okay, but such a thing is happening that even though I say something very simple over and over again, he is giving a blank stare, I think that he will not learn anything at that moment, I feel that my effort is meaningless. All my energy is run out of, I feel my hands are tied, I always cry. It sounds like he will never get better. I think I still couldn't accept my child's special condition. I do not know what I will do. Will he be able to learn like his friends when he starts school? What if he can't learn and fall behind? What if he can't go to school together with his friends? My brain is occupied by these questions constantly. I can't sleep at night, I have severe headaches. I had an anxiety disorder. I do not want to use pills given by psychiatry for life, they stupefy me. When my husband comes home, I want him to take care of T. a little, teach him something, but it is useless, he is playing a little and he gets tired and lies on the sofa. From time to time, I storm at my husband. But I am aware that my husband has to work too, thus he gets tired. I have to do something all the time, so I get very tired because I think it can't be recovered if I don't. Sometimes I maltreat both the child and myself. I don't know what to do" (TG, 29, H, HS).

Findings on Anxiety and Stress about Ambiguity

According to the information obtained from the mothers who constitute the sample group, anxiety and stress conditions stemming from ambiguities vary significantly. At this point, where ambiguities regarding their past and upcoming experiences form a concern for the future, it is observed that issues such as the education process, marriage and social life of their children with special needs come to the fore as a source of stress. On the other hand, not every family feels the same concern. Families who accepted the situation have less anxiety for the future. The presence of mothers who had fainting and

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crying fits in so far as their fear and anxiety and even suicide thoughts shows how important psychological health and well-being are. When the ambiguity experienced by the families is resolved and becomes more predictable in this extraordinary process they face, it is observed that the families feel better and even use the expressions that those days are not as bad as they expected later on. In fact, there were families who emphasized that this special situation of their children had a special place in their own family relationships and that they became a family thanks to it:

"Our minds were always occupied by thoughts as, god forbid, if something bad will happen in the future. This ambiguity of the child has worn us out so much as to what will happen in the future" (BB, 37, H, SS).

"We raised my first child with my mother-in-law. So I did not figure out much. It was the first time I was raising a child on my own. Doctors in Izmit sent us to Istanbul for a test or something. After the results, I cried a lot, I was very scared. Since the time was limited, we couldn't talk to the doctor. I entered into the internet on the phone and searched. When I read horrible things, fear haunted me. I was sorry, how it will progress, what will happen. The examples I saw on the internet frightened me a lot. I thought the worst. I wondered if there will be a death" (BB, 37, H, SS).

"When the doctor in Eskişehir said so, I jumped out of my skin. I searched afterward. She can't speak but thank God, she is not bedridden. It was very difficult to accept, I even thought about suicide sometimes. I had a psychological treatment then" (DD, 46, H, PS).

"I did everything said. I think a lot about whether I had a lot of stress during pregnancy. Or something happened after the baby was born, and the idea that I couldn't notice it hit me a lot. Did something happen during pregnancy? Or did I have eclampsia, and but I was not aware of? Is it my fault that this happens? I questioned a lot. When I think about it, I become sad" (BB, 37, H, SS).

"I took care of Y.M for the first 9 months he was a very normal baby. When he was 9 months old, I turned back to work, whatever happened took place after that. I wish I hadn't started work, maybe it wouldn't be like this" (YMO, 28, H, HS).

"I was constantly thinking that will my child be able to love someone? Get married? Study? Will he be able to make friends? I started having fainting fits then" (KD, 35, FL, SS).

"He is three years old today. Every time when I went to control for nine months; they said 'we can terminate it if you want, you have such a right. That is, nothing happens legally. I refused it at every examination. They showed that paper to me. At that time I had many psychological problems" (MD, 31, H, SS).

"They performed progeny testing or something. They examined everything. Yes, there was retardation. Test results as to whether there is a chromosomal disorder or not in terms of having syndrome come after 3 months. Three months became like a prison to me. You know, always, I cried, I thought about what will happen, how it will go, how it will be, how this child will read, how to marry. I was always sad, crying" (SH, 28, H, HS).

"I talked to my brother's wife, she asked about my child's problem. As far as I understand, I said that my child does not look in my eyes, if it does, I will understand the problem but my child does not see me. She said, well, I don't want you to scare, but she said it's a symptom of autism. I said what autism is. Then I started searching on the internet. Then I figured out that this is one of the autism symptoms. The phone fell from my hand, I started to cry. I went into the crying fit, called my husband, I said come home urgently" (TG, 29, H, HS).

"In that period of time, whenever I entered the internet, I always came across articles about autism providentially. I think a few signs fit my child. Then I talked to my husband. I searched on the internet for what autism is, but one is very afraid when not know what it is. What will happen and what will be done" (YMO, 28, H, HS).

"Now my daughter is 3.5 years old, I still haven't searched for it on the internet. Because, there were some rumors

regarding earlier die of these children. I also asked these rumors when I went to the doctor in Izmit. The doctor said to me 'Only God knows when and who will die, no one can tell when anyone will die. These children need love, raise her with your love", at that moment I relaxed" (ZK, 40, H, PS).

"You get away from it all, you just engaged in the child. You have no connection with the house anymore. There was only A. in our lives; we were thinking about 'what we can do' but we were not worried about the future" (AA, 39, H, HS).

"Without it, we wouldn't be a family. It is the basis of our home. We would not be without him" (AÇÜ, 27, H, SS).

"I just want it to be with me, be healthy, be recovered. At the moment, I don't care 'will he be able to join the army for military service?', rather, 'will he be able to outgrow the diaper, say mother?' I think of them" (ÖD, 36, H, SS).

"He went to kindergarten for 6-7 months. They, from Serdivan Guidance and Research Center, said this school. We took a lot of tests. Finally, it was said atypical autism. Then we came to this school. It was not as I scared" (TG, 29, H, HS).

"M. wouldn't hold my hand. Now, he is holding my hand for 2-3 days. We've been traveling outside constantly for two days. He never held my hand, just with his fingertip. Even this made me very happy. Its communication is in that way. He makes eye contact for close to 1 minute. He stares when someone says something" (MD, 31, H, SS).

Findings on Anxiety and Stress about Exclusion

Considering the anxiety and stress conditions of the participating mothers in the research, it is observed that most of them mainly have anxiety about "what if they don't like my child, if they exclude him". In addition, the unfavorable situations experienced in public transportation, the insistence about the termination of pregnancy, the acceptance of the siblings each other, being more proud of the other grandchildren, the fears as to what will happen in my absence, come to the forefront as general sources of stress in exclusion. Differently from this, some mothers particularly stated that they can take away their children anywhere, they do not hide their children from anyone, and the power in so far as their husbands give them a back and support them. It can be observed from the statements that the anxiety and stress conditions that these families have about their children are less than other families:

"My husband's family is at an advanced age. They are obviously not very knowledgeable, but we haven't benefited from anyone, its aunts, etc., all of them are far away and also my husband is always on the roads, thus I care for my child. I am very lonely in this regard and the child should get support from everyone. People should not hesitate to get help from around, and we should explain this to our around and ask for support. Particularly in public transportation vehicles, people should be more sensitive, etc. Negative looks shouldn't be given on us, please" (ABV, 49, H, SS).

"While I was talking to my children about the special situation of their siblings, I opened an autism video on television. The children were surprised. But my 13-year-old daughter figured out, she said mom did something happen. My other daughter and son found it hard to accept. I explained to them later therefore the relations are good now" (DD, 46, H, PS).

"You see, you know, why they are doing this all the time. Let's terminate it, let's get it out. I was always sad about that. I was stuck in this hospital environment. They said let's terminate even when there were last three days. They said let's make a needle. We also visited pediatric surgery. Those three days passed to me as if it was 9 months" (MD, 31, H, SS).

"You get reactions from outside. For example, when I went to a hospital and sat down, a mother looked at us and said "very strange child", "why this child is so different". But I do not know, perhaps I am a mother of a disabled, I have never

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said "this is so strange" to any child ... You cannot call a child "what a pity". It's his specialty. Everyone has their own skills and abilities. They shouldn't call my child a pity either. When a normal child shouts, I cannot say pity as well" (ÖD, 36, H, SS).

"My family, my sisters-in-law are all sweet on my child, yet I am anxious that, in my absence, what will happen to my child, worried about the future" (YEK, 37, H, PS).

"There are a few, you know, in the neighborhood. But they are disabled, not autism or anything. I wonder will it be like that. They came to my mind. I wonder if they were like that. I thought of them. If so, what are we going to do then? I said. As you know, things are a bit excluded in this way in society. I was very afraid that he will be excluded" (YMO, 28, H, HS).

"My mother-in-law, for example, shows her other grandchildren proudly because they are healthy. They kiss when you say "kiss my hand son", and you know, they say welcome when you say "say welcome my daughter". When you look at Ö. and say him say welcome, in fact, he shows his love in another way. But another eye is needed to figure out this" (ÖD, 36, H, SS).

"I never hid my child. It is too sad that there were those who did not even come to say congrats" (ABV, 49, H, SS). "My husband was constantly afraid that if they don't like our child and exclude when he goes to school one day" (AÇÜ, 27, H, SS).

"By saying that we have nothing to do, my husband was both supporting and giving me a back. That was good to me. God forbid, what if he thought negatively too! I don't know what would have happened if he said why it came to this" (BB, 37, H, SS).

"Her older sister is protecting him by usually speaking to her cousins like don't shout at him, he is sick already. Say something 2-3 times. He doesn't understand. You will be more to him" She is only 8 years old. Her brother is the same. They try not to batter while loving in order to protect him. While we think as to whether she will be jealous, since she was also our daughter, she does more than we do. Asks his mood, likes and takes care. When she goes home, she asks, "What are you doing M.? For example, he cried a lot in the evening. His older sister said to him 'Why are you crying? I can't understand you, my brother. His father is in shock. She also cares about his school. She is far beyond our expectations" (MD, 31, H, SS).

"There are some who ask about Ö. without hurt. Without mentioning his illness 'how is Ö.?" The circle of friends made me relax. It made me socialize. Socialize absolutely" (ÖD, 36, H, SS). "I have never got strange reactions. Everyone came near us and loved him, I react if I get strange reactions, I guess I'll walk away from that place. I behave a little hard, maybe I can't help myself saying something" (AÇÜ, 27, H, SS).

"People generally love him. There are not so many people we have already met outside. But if we are going to go somewhere, a wedding, an association, etc. I take him too. We take him wherever we go. We go to dinner together with my husband and children. Z. is whatever our other children are for us" (ZK, 40, H, PS).

"My grandmother takes care of my son because I work. She brings it to school every day and waits at school" (KD, 35, FL, SS).

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DISCUSSION AND CONCLUSION

The study was designed in order to determine the stress and anxiety conditions based on the disabilities, and the feelings and thoughts, causing to these feelings, of the thirteen mothers who have special needs children from different disability groups between the ages of 3-6. According to the results of the study, it was found that almost all mothers experienced great sadness and depression when they learned that their child would be/was disabled, they gave stress responses due to grief process such as severe crying fits, insomnia, eating disorder, thinking constantly about the situation in their mind, etc. It is understood from the expressions and the intensity of their stress responses that two of the mothers of special needs children diagnosed with autism spectrum disorder are still unable to accept their disability. Regardless of whether the disability in a child occurs due to congenital causes or at any time of the development period causes families to experience intense sorrow and grieving (Fışlıoğlu and Fışlıoğlu, 1997). The fact that child has disability while waiting for a healthy baby causes families to experience a process in which they are confronted with situations such as shock, denial, anger, fury, anxiety, embarrassment, chaffer, from pillar to post, waiting for a miracle, rejecting child, and rationalization (Deniz et al., 2009; Varol, 2005; Ataman, 1997; Özdoğan, 1997; Seligman, 1989). Researches carried out with parents of a disabled child are to be such as to reveal that the type and degree of disability of the child is an important factor predicting the stress of families. For instance, some studies have demonstrated that having autistic children instead of educable children is a factor that increases stress (Akkök et al., 1992; Şengül and Baykan, 2013). In studies performed on stress perceived by mothers and fathers of disabled children, it was recorded that parents with children in the preschool period had higher stress levels (Yurdakul et al., 2000; Kaner, 2004).

Some of the participating mothers in the study also expressed stress factors in relation to family functionality. It is understood that the mothers who mentioned that they devoted all their energy to their disabled children with the thought that they had more duties in taking care of their children, therefore they could not allocate private time for themselves, also stated that they could not be supported by their spouses at the desired level. Within this context, it was recorded that mothers constantly used expressions of fatigue, low energy, burnout, and helplessness during the interview. Deformation of family functionality in families with children with disabilities is another cause of stress. In the care of children with disabilities, more duties fall to mothers mostly therefore it causes mothers to fully devote themselves to their disabled children. Due to being continuous characteristics of the needs of disabled children such as constant care, attention etc., and mothers cannot allocate time for themselves, and the fatigue of the process and the excessive responsibilities of mothers cause them to have conflicts with their spouses (Doğan, 2001). A few of the participating mothers in the study stated that they received emotional support from their spouses in the process of accepting their child's disability and that this support had a positive impact on coming through the grieving process. It was predicted from the sentences of the mothers participating in the study who stated that they received adequate spouse support that they were more acceptive for their children's disability and their anxiety and stress levels were lower by comparison with those who stated they couldn't get that support. In studies performed for the families with mental disabilities, it is revealed that helping spouses each other reduce stress and this leads to healthier family functioning (Kaytez et al., 2015).

It was determined that the anxiety and stress conditions of the mothers, who participated in the study, arising from their children's disabilities, were concentrated under three main headings. The first of these was the anxiety and stress situation that developed due to the feeling of inadequacy that the mothers felt when the first moment of confrontation and after they found out that their children were disabled. It was determined that the sense of inadequacy due to disability grows out of

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the mothers' lack of/unable to have the knowledge regarding the disability, the thought that their efforts are not sufficient for their child, that they did not find the educational opportunities in their place adequate, that the financial opportunities are not sufficient for the intensive special education of their children and the poor support from the spouse. Parents' inability to have sufficient information about the child's disability and/or lack of adequate information support from the field specialists following the diagnosis process has commenced can lead families to stress. Mothers with disabled children show negative psychological indications and may be more sensitive to stress, particularly when they do not get support from fathers in the care of their children (Özokçu and Canpolat, 2013). Families with disabled children confront emotional disorders as well as stress. Efforts to find a proper educational institution for children with disabilities, needing more money for special education, difficulties in explaining their child's condition to their family or other individuals in the society, engaging in different searches for their children, needing more time and energy for their children's care and emotional disturbances in families can be the causes of emotional weaknesses, tension and conflicts as well as social deterioration (Kavak, 2007; Aydoğan, 1999; Aslan, 2010; Lusting, 1999; Sarısoy, 2000; Özokçu and Canpolat, 2013).

It can be suggested that the second important factor regarding the anxiety and stress conditions of the mothers who participated in the study, arising from their children's disabilities, is ambiguities. These ambiguities are rather composed of inability to predict the course of the child's disability and anxiety and stress conditions stemming from concerns about the future of the disabled child. Having a disabled child not only increases the stress, anxiety and concern levels of the parents but also unfavorably affects their future expectations (Cin and Kılıç, 2005; Uguz et al., 2004). It was recorded that some of the participating mothers in the study had concerns about the future care of their disabled children, while others experienced anxiety and stress on matters such as whether their child's future education life, friendship and emotional relationships could be, whether they could get married. Ambiguity as to what children with disabilities will encounter in the future, and ambiguities as to how their disabled children will continue their lives, especially after their parents aged or their death, can cause mothers to experience constant anxiety (Coşkun and Aktaş, 2009). Some of the participating mothers in the study expressed that they experienced a positive change in their family dynamics after the disabled child became a member of the family. It can also be stated that the stress arising from the change in the family has positive impacts on some families. In some studies conducted, the spouses mentioned that after having a disabled child, their marriage gained strength, they constantly made a "collective effort" for the development of their children, and this effort further united them and strengthened their relationship (Kazak and Marvin, 1984). In another study, it was recorded that with the participation of the disabled child to the family, a kind of mother-father-child triangulation was formed, and the spouses construe other family problems as more insignificant thanks to directing all their interests to the disabled child. In other words, disabled children act as the "walking stick of the relationship" in the family (Doğan, 2010; Yıldırım and Akçemete, 2014).

A few of the participating mothers in the study expressed that they initially questioned/blamed themselves for their child's disability. Several of the mothers stated that they questioned whether they had a part in their children's disability for a long time and still they felt bad when they remembered this situation from time to time.

It can be suggested that the third important factor regarding the anxiety and stress conditions of the mothers who participated in the study, arising from their children's disabilities, is the sense of exclusion that the disabled child may confront. It can be stated that the underlying thought at most that worry the great majority of the mothers participating in the study is the feeling that their disabled children cannot be accepted and supported by the social circle. Social support is identified as a concept of how much the individual is loved and respected by others (Sarason et al., 1983; Kaner, 2003; Yamaç, 2009; Kaner, 2010; Aksel, 2018). Most of the participating mothers in the study expressed that after the birth of

their disabled child and/or the diagnosis of the disability, at the first level, they got social support from the nuclear family members, their close relatives and friends, and at the second level, that they did not get adequate social support from neighbors, distant relatives, and friends. Most of the mothers, on the other hand, stated that they took social support from social institutions. Social support points out to the emotional, instrumental, or informational assistance provided by the family members, relatives, friends, and other relationships existing in the society (Şahin, 1999; Sungur Bozdoğan, 2011). In the study of Karadağ (2009), it was demonstrated that there was a negative relationship between the despair levels and social support factors of mothers with children with disabilities, and as the level of social support perceived by the mothers increased, their despair levels decreased. Again in the same study, it was also recorded that the social support levels of the mothers are low, who always feel uncomfortable from the perspective of society to the disabled and always have problems within the family, anxious about the future of their children, feel disappointed and guilty, have difficulties in the treatment process and express that their child brings an additional economic burden to the family. In their research, Altuğ et al. (2006) revealed that families with children with mental disabilities do not get adequate social support, families who find social support from the environment unsatisfactory express more living drawbacks and experience intense anxiety about the future of their children. In other studies conducted with mothers, it has been revealed that mothers with children with disabilities have more financial and moral difficulties and need more support when compared to other mothers, that mothers who get support are emotionally more engaged in their children, mothers who perceive high levels of social support have high self-esteem and low levels of stress and depression (Deveci and Ahmetoğlu, 2018; Kaytez et al., 2015; Şentürk and Varol Saraçoğlu, 2013; Boyd, 2002; Yıldırım-Doğru and Arslan, 2016; Deniz et al., 2009; Canaslan, 2014; Weis, 2002; Karakuş and Kırlıoğlu, 2019).

Suggestions

- The couples who are at risk of having a child according to the tests carried out pursuant to the procedures of marriage should be informed about the disability conditions that may occur as a result of possible pregnancy, as well as a follow-up system should be developed for these couples,
- The personnel of primary health care institutions should provide adequate information to the expectant mothers who have a risky pregnancy about possible risks and refer them to the relevant units,
- Field specialist health personnel should inform families about the disability adequately,
- Prenatal parenting education should be planned in order to increase the prenatal level of knowledge for the purpose of developing the strategies of parents with disabled children to cope with the problems of the disabled child.
- Long-term parental education should be provided by specialist staff, including the post-natal care of children with disabilities, developmental characteristics, possible risks, etc.
- Families, especially mothers and baby-minders, should be educated on the education and care of disabled children.
- Education programs should be prepared in order to enable parents with disabled children to cope with their psychological and educational problems.
- Social support should be provided to families with disabilities by means of informing the close relatives and friends of parents with disabled children by specialists.
- Social network systems should be developed in order to enable families with disabilities to communicate with other families of children with disabilities, and families should be supported in accepting their disabled children.

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- Families should be informed about the functions of special educational institutions around them and be encouraged to start special education in early childhood.
- Early childhood units and special education kindergartens should be opened for children with disabilities across the country,
- Social sensitivity should be improved by means of preparing public service announcements, publications etc. that will inform the society about disability,
- In order for families with a disabled child to cope with the difficulties they encountered in matters such as childcare, education, treatment and raising, the necessary support should be given to the families by the social institutions.
- Units providing services to families should be generalized in order to reduce the family burden of families with disabilities,
- Families with children with special needs should be provided with lifelong guidance and psychological counseling, covering family education, directing families to the services they need, providing them with the necessary information, providing them with various problem-solving skills when necessary.
- Ensuring that families with disabilities create value, gain social skills and awareness with the help of getting group guidance services, works should be carried out through local governments and schools in order to provide assistance to families in other learning areas.
- Government assistance for children with disabilities should be enhanced and education, rehabilitation, and medical services should be as accessible and sustainable as possible,
- Solutions and activities that provide psycho-social relief for families of children with disabilities should be taken into account by local and central governments.
- Public and non-governmental organizations should take a more active role in social work processes with the society on disability and its continuity should be ensured,
- Measures should be taken in order to implement social support projects that will enable the development of family members with disabilities,
- In order to get benefit from their guidance, empowering and counseling roles in terms of approaching families with children with disabilities, employment of specialists who communicate with families with disabilities such as social workers, psychologists, psychological counselors, doctors and nurses should be intensified.

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THE ELIZABETHAN POOR LAW OF 1601 AS A RESULT OF SOCIO-POLITICAL AND ECONOMIC CONDITIONS OF THE SIXTEENTH CENTURY ENGLAND

ONALTINCI YÜZYILDA İNGILTERE'DE YAŞANAN SOSYO-POLITIK VE EKONOMIK DURUMUN BIR SONUCU OLARAK 1601 ELIZABETH YOKSUL YASASI

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ABSTRACT

Miscellaneous economic, political, military and social events that took place in England during the sixteenth century caused poverty and hard times in England. The dissolution of the Catholic Church, the emergence of mercantilism as the early stage of capitalism, plague epidemics, ongoing wars and migration of Protestants from the continental Europe to England changed the structure of social life profoundly in the sixteenth century and caused poverty. As a result of this, the number of people who vagabond and beg across England grew. King Henry VIII, King Edward VI and Queen Elizabeth I promulgated various laws to alleviate poverty and to finalize begging across the country. 1601 Act for the Relief of the Poor was the final and revised version of a series of poor law legislated in the sixteenth century. This study aims at understanding the reasons and functions of the Old Poor Law of 1601 in the light of former acts and socio-political developments of the sixteenth century. Therefore, the focus of this study is on the Poor Law of 1601 and the socio-political and economic developments of the sixteenth century.

Keywords: Elizabethan Poor Law, Poor Law of 1601, Henry VIII, The 1601 Act for the Relief of the Poor

ÖZ

On altıncı yüzyıl boyunca İngiltere'de yaşanan çeşitli ekonomik, siyasi, askeri ve toplumsal olaylar halkın yoksullaşmasına ve zor günler geçirmesine neden olmuştur. Katolik Kilisesi'nin dağılması, kapitalizmin ilk aşaması olarak merkantilizmin ortaya çıkışı, veba salgınları, devam eden savaşlar ve kıta Avrupa'sından İngiltere'ye gerçekleşen Protestan göçü bu yüzyılda İngiltere'de sosyal yaşamın yapısının derinden değişmesine yol açan olayların en önemlileriydi. Özellikle, Kral VIII. Henry'nin Katolik Kilisesi ile ipleri koparması sonrasında yaşanan çözülme fakirlerin zaten zor olan yaşamını dahada zor bir hale getirmiştir. Çünkü o döneme kadar İngiltere'de hayırseverlik ve fakirlere yardım görevini ağırlıklı olarak Katolik Kilisesi yerine getirmekteydi. Anglikan Kilisesi'ni kuran VIII. Henry, büyük bir zenginliğe sahip olan bu manastırların malvarlığına da el koymuştu. Ortaya çıkan bu boşluk nedeniyle yoksullar zarar görmüştür. İşte bu nedenle, Kral VIII. Henry 1530, 1531 ve 1536 yıllarında çeşitli yasalar çıkararak yoksullukla mücadele etmeye çalışmış ve bir taraftan da 1601 Elizabeth Yoksul Yasası'nın temelini atmıştır. Artan yoksulluğa bağlı olarak sokaklarda dilenen insan sayısında yaşanan artış, on altıncı yüzyıl boyunca ülke genelinde dilenmeyi yasaklayan çeşitli yasaların çıkmasına neden olmuştur. Katolik Kilisesi'nin dağılmasından sonra oluşan bu yeni ortamda, Henry yoksullara yardım etme işinde kiliseleri etkin bir şekilde kullanmıştır. Parish adı verilen kiliseler en küçük idari birim olarak yapılandırılmış ve yoksullara yardım etme işlerindeki tüm organizasyonlar bu parish adı verilen kiliseler tarafından yürütülmüştür. Halkın yaşadığı yoksulluğu gidermek için sırasıyla Kral VIII. Henry, Kral VI. Edward ve Kraliçe I. Elizabeth tarafından çeşitli aralıklarla yoksulluk ve dilencilikle mücadele kanunları yürürlüğe sokuldu. Bunlardan bazıları

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dilencilikle ve başıboş gezmeyle mücadele etmek adı altında vücudu kanlar içinde kalana kadar kırbaçlanma ve idam etmek gibi oldukça ağır cezalar da içeriyordu. Öyle ki, bazı yasalar çıraklık eğitimi almayı reddeden 14 – 18 yaş arasındaki çocukların bile kanlar içinde kalana kadar kırbaçlandırılarak cezalandırılmalarını emrediyordu. Şüphesiz, bu kanunlar içinde en acımasızı, belki de, VI. Edward'ın çıkarmış olduğu yasaydı. Çıkardığı 1552 tarihli yoksul yasasıyla İngiltere'de yoksulların kayıtlarının tutulmasını ilk defa sağlayan kişi Kral VI. Edward olmuştur. Ancak yine aynı kanunda başıboş gezen yoksulların köleleştirilebilmesine dair acımasız hükümler de yürürlüğe girmişti. Edward'ın getirdiği sert hükümleri kaldıran Elizabeth sırasıyla 1563, 1572, 1576, 1597, 1598 ve 1601 yıllarında değişik kanunları yürürlüğe koyarak, İngiltere'nin sosyal refah seviyesinin yükselmesine çok önemli katkı sağlamıştır. 1601 Tarihli Yoksullara Yardım Yasası, aslında, on altıncı yüzyılda yasalaşan bir dizi yasanın nihai ve gözden geçirilmiş en son versiyonuydu. Bu çalışmada bugün bile çok önemli olduğu kabul edilen 1601 Yoksul Yasası ve bu yasanın bir ihtiyaç olarak ortaya çıkmasına vesile olan sosyo-politik ve ekonomik olaylar ele alınmıştır.

Anahtar Kelimeler: I. Elizabeth, Yoksul Yasası, VIII. Henry

The Elizabethan Poor Law of 1601 as a Result of Socio-Political and Economic Conditions of the Sixteenth Century England

The 1601 Act for the Relief of the Poor, which came into force more than four centuries before our time, is considered an important cornerstone in the history of social policy and welfare in England. Today, many social workers regard 1601 Elizabethan Poor Law as the onset of the welfare state. The sixteenth century was a very difficult period for England as well as for all of Europe. Unlike the fifteenth century, which was economically abundant and rich, the sixteenth century was a century of poverty. There were a lot of poor people and most of the time "the English poor relied – when family support was lacking – on a shifting combination of philanthropy, municipal regulation, and the Church" (Kelly & Gráda, 2011, p. 343). For this reason, The Poor Law of 1601 was one of the greatest achievements of Elizabeth and it is still considered one of the most important laws in the history of social work. Beier (2004) argues that it was probably the first national poor-law system in Europe (p. 4). This fact makes this act unique and unprecedented. Nevertheless, some authors argue that one of the aims of this old poor law was to create a cheap labor force for competition in foreign trade. All things considered, it seems that understanding the quintessential of some social problems leading to social crisis and poverty in Early Modern England would be highly significant for appreciating the value of the old poor law and its contribution to modern social work.

So, what were the reasons for the poverty that prepared the conditions of the 1601 Poor Law? There were many reasons for this in the sixteenth century. The dissolution of the Catholic Church, epidemics of plague, wars and the emergence of mercantilism were among the most important ones.

Social, Political and Economic Reasons of Poverty in the Sixteenth Century

Almost all of Europe, including England, lost one-third to one-half of its population during the plague epidemic in 1347-1350 (Champion, Frassetto, & others, 2020). Bubonic plague struck England in 1348 for the first time, and until the famous Great Plague of 1665 it "struck roughly every 20-30 years, killing around 20% of London's population each time" (Museum of London, 2011). In addition to Black Death, ongoing wars, such as The Hundred Years' War and The Wars of the Roses, caused a dramatic decrease in the human population of England during the fourteenth and fifteenth centuries. Owing to this decrease in the English population, it can be said that the amount of food was relatively abundant and the prices were affordable in the fifteenth century. By contrast, the growing population in the sixteenth century had to tackle rising food prices. In his study, Harry A. Miskimin (1977) reported that the greatest price rise in the sixteenth century was in the agricultural sector. Prices of agricultural products increased fourfold in the early seventeenth century compared to the late fifteenth century. However, the price increase in manufactured goods was much lower in the same period (pp. 44,45).

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Having a higher birth rate than the mortality rate and the emigration of Protestants, fleeing from France, Holland, and Belgium, were two major factors in the increase of the population in the sixteenth century. These emigrants contributed a lot to the English economy and trade in the upcoming years. When they arrived in the country for the first time, however, they were poor and in need of help. Under these circumstances, the total population of England and Wales increased from 2.500.000 in 1520 to 4.100.000 in 1600, and the rate of urban population increased from 6.2 % in 1520 to 8.4 % in 1600 (Grigg, 1980, p. 95). In those days agricultural production was not more profitable than trading. Between the years 1500-60, for example, any kind of money invested in agricultural products was bringing 1.50 -3.00 per cent per year (Blanchard, 2005, p. 115). Wool and different kinds of cloth trade were the most important items of British exports in the sixteenth century. For this reason, some feudal lords started to own a large number of sheep herds and commenced to shift their business interest from the agricultural sector to the wool and cloth trading. There was a negative correlation between the increase of population and the decrease in agricultural production. In all respects, working-class had to struggle with increasing population, high inflation, low wages and labor costs in Early Modern England.

Mercantilism and Sailing to the High Seas

As the early stage of capitalism, mercantilism was relentless to the poor. "In a context that considered population growth to be equal to wealth, society adopted two measures: on the one hand, to take the poor into care and, on the other, to use them as cheap labor" (Gómez Díaz, 2006, p. 706). Two sides of the coin had two different viewpoints. The ruling class was the adamant defender of mercantilism and low wage policy for the prosperity and development of England. They believed that low labor cost was extremely crucial for competing with rival countries in foreign trade. In this respect, Gregory (1921), Tawney (1922), Heckscher (1935) and Buck (1942) suggested that keeping wages low for the sake of economic growth and international competitiveness meant that mercantilism was a way of the brutal exploitation of the poor in English society (Qtd. in Orsi, 2013, p. 11). Therefore, while trying to understand the poor law, it is possible to draw a conclusion both about the relief and exploitation of the poor. It is a fact that mercantilism had a negative effect on the poor in the sixteenth and early seventeenth centuries.

Dissolution of the Catholic Church

It is a fact that after Henry VIII had established the Anglican Church in 1534, the Catholic Church, its Archbishops and their subordinates, who used to provide help with the poor, commenced losing their control over English society. When Elizabeth I ascended to the throne of England in 1558, she took over a country with a profound social, economic and political turbulence. During her reign, which lasted nearly half a century, she had to take some precautions to relieve the pains of the growing number of the poor. The dissolution of the Catholic Church, between 1536 and 1540 (The National Archives), caused an increase in the number of poor and beggars on the streets of England. Given that the Catholic Church was an important organization to alleviate poverty, it would not be wrong to claim that the dissolution of the monasteries influenced poor people negatively. The year 1534 in which Henry VIII announced the independence of the English Church was the beginning of the English Reformation movement. Since the Pope did not allow Henry VIII to divorce Catherine of Aragon, Henry VIII declared himself as the Head of the English Church. After this date, the Roman Catholic Church began to its disintegration. In those days, living conditions of the poor were hard and the Catholic Church had a crucial function for taking care of the poor. Briefly stated, the dissolution of the Catholic Church made the life of the poor people even more difficult. Another key fact to remember is that the year 1534 opened the doors of England to Protestantism. Since 1534 till the beginning of the Seventeenth Century England experienced a transition period of the Protestant Reformation. During this period, some monarchs were Catholic and some others were Protestant. Controversial issues between the Catholics and Protestants caused worsening of the welfare

system in the country which had so far gained power from the Catholic Church. The Catholic Church was providing relief services in England until then. Due to the dissolution of the Roman Catholic Church, there was a gap in the collection and distribution of charity and alms. Therefore, starting with Henry VIII, all governments attempted to administer and regulate the poor relief through a series of acts. In the wake of the enforcement of various poor laws in the sixteenth century, Elizabeth enacted her famous poor law of 1601, which stayed unaltered until the year 1834.

A Glimpse into the Legislative History of the Poor Law in the 16th Century

During her reign, Queen Elizabeth I pursued a peaceful policy and her country experienced a golden age. 1601 Poor Law was one of the most notable accomplishments of Elizabeth. She established a system for the relief of the poor and brought the responsibility to the society itself. 1601 Poor Law imposed strict sanctions on the poor who did not want to work even though they were healthy. People who were healthy but refused to work would go into the jail. In other words, contribution to the economy was mandatory and everyone healthy had to work. By this provision, begging was banned throughout the country. Elizabeth built a great number of almshouses. Parishes had to look after the poor people. Charlesworth (2010) claims that Elizabeth established "the oldest continuous surviving legal system of welfare relief in Europe; a 400-year-old common law (later public law) locally funded and administered system of relieving poverty" (p. 16). Indeed, Elizabeth was not the first ruler who banned begging in England. Her father Henry VIII enforced the vagabonds act in 1530 and banned vagabonding and begging in England. However, as Quigley (1998) put it, the Statutes of Labourers of 1349-1350 were probably the first of the poor laws and there were two reasons for its enforcement: "the large number of poor people [who emerged after the breaking down of feudalism and] who were roaming England begging" in search of a better paid work; "and the Black Plague and famine of 1348-1349." (p. 102). Chapter 1 of the 1349 Statute of Labourers orders: "Every person able in body under the age of sixty years, not having to live on, being required, shall be bound to serve him that doth require him, or else committed to the goal, until he find surety to serve" (qtd. in Quigley, 1998, p. 103). In this regard, it is important to review prior poor laws of the sixteenth century in England.

The Vagabonds Act of 1530

The full name of the 1530 act was *An Act Directing How Aged, Poor and Impotent Persons, Compelled to Live by Alms, Shall Be Ordered, and How Vagabonds and Beggars Shall Be Punished*. As Quigley (1998) put it, the vagabonds act of 1530 categorized the poor into two groups as "(1) the aged and the impotent poor who were worthy of help, and (2) the able-bodied poor, the vagabonds and beggars, who were unworthy of help and who were punished if they refused to work" (p. 102). It is clear that when able-bodied poor did not work, they were not welcomed in those days. Yet the living conditions were really hard and thousands of people were wandering from one town to the other with the hope of finding a better-paid job. There was a great number of able-bodied beggars whom Henry VIII considered a big problem for England. The vagabonds act of 1530 ensued as a result of such poverty. The able-bodied poor and the beggars had to work for a limited amount of money. The wage that they got was below the minimum living standards. The circumstances of the poor were getting even worse day by day. Thus, Henry VIII had to introduce two poor laws successively in 1531 and in 1536. According to Quigley (1996) these two laws of 1531 and 1536 "developed the first comprehensive system of poor relief" (p. 92).

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The Act of 1531

On the grounds that the act of 1531 "made a distinction between the impotent poor who needed relief and the able-bodied poor who refused to seek work" (Kunze, 1971, p. 10) for the first time, it is possible to suggest that it had an important role in the formation of the 1601 Elizabethan Poor Law. The impotent poor had the right of getting a special license to be able to beg in permitted regions. It was the legalization of begging by law. Kunze (1971) argues that 1531 Act tried to "alleviate the giving of indiscriminate charity" and foresaw "the future role of the parish as the unit of local government responsible for levying rates and administering poor relief" (p. 11).

The Statute of 1536 (Henrician Poor Law)

The full name of the statute of 1536 was *An Act for the Punishement of Sturdy Vagaboundes and Beggars.* Because of the fact that Henry VIII established the Anglican Church and separated England from the Papal authority, it is possible to see the influence of this monastery reform in the act of 1536. "The selection of the Church parish as the unit of poor relief revealed the continued close relationship that existed between religion and charity. The statute ordered that the clergy during sermons. confessions, and last wills and testaments" (Kunze, 1971, p. 11). Similarly, Paul Slack (1995) advocates that recognition of the parishes as the smallest administrative units was a normal process, and he stresses a fact that 1536 act emphasized the establishment of the civil parish (p. 10).

In his noteworthy study, Kunze underlines the importance of the Henrician Poor Law of 1536 in terms of a provision as regards the paid public welfare workers. (1971, p. 12) He points to the revolutionary provision in section VIII, in the Henrician Poor Law of 1536. There was a section about the paid welfare workers. In section VIII, it says that welfare workers "shall have and take for his and their so doyng suche competente wages of the money of the said common colleccions as by the discrecions of the Maier Aldermen Govemor Bailiffe or Justices of peace and others of the parisshe shalbe thought good and reasonable..." (The House of Commons of Great Britain, 1536). What makes this provision even more important is the fact that succeeding Elizabethan Laws abolished this tenet. "The framers of the 1536 statute also recognized the existence of financial inequities among the parishes. The act provided for the transfer of the "overplus" from wealthy parishes to poorer parishes for the maintenance of the poor" (Kunze, 1971, p. 12). Kunze (1971) advocates the statute of 1536 for five reasons. Firstly, it appointed the parish as the smallest administrative unit of poor law. Secondly, it tried to finish the unorganized haphazard distribution of charity. Thirdly, it set down alms picking procedure. Fourthly, it specified system of proper registration of relief funds. Finally, it foresaw the prospective "development of paid public welfare workers" (p. 13). However, the statute of 1536 was highly severe for the idle vagabonds. Section 24 in the statute of 1536 says: "to suffer peyne and execucion of dethe as a felon & as enmies of the Common Welthe, and to losse and forfaite all thir landes and goodes as felons do in all other causes within this Realme" (The House of Commons of Great Britain, 1536, p. 560). Although the number of vagabonds and thieves were hanged during the reign of Henry VIII is a controversial issue, some historians like Charles Knight suggested it as a loose estimate, "the generally accepted statement that during the reign of Henry VIII there were seventy-two thousand thieves and vagabonds hanged" (Knight, 1868, p. 471). Despite its severe clauses, Miles (1949) argues that "The Elizabethan Poor Law was based, in large part, upon the constructive measures of the Act of 1536" (p. 26).

The statute of 1536 specified the situation of vagrant children between the ages of five and fourteen. It ordered the begging or idle children between the aforesaid ages to be put to masters in husbandry, other crafts or labours: "under the age of xiiij yeres and above the age of fyve yeres in begging or idelnes, and to appoynte them to maisters of Husbondrie or other craftes or labours to be taughte, by the whiche they may gette their livinges whan they shall come to age" and the children who rejected such service and who were over the twelve years old and under the age of sixteen would be whipped publicly:

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> ...And if any above the age of twelve yeres and under the age of syxtene yeres refuce suche service or departe frome the same without cause resonable...that he or they have refuced to serve or have departed frome thir service without cause resonable, he shall then in the parisshe where he was apprehended be openly whipped with roddes...(The House of Commons of Great Britain, 1536, p. 559).

The Poor Law of 1547 (Edwardian Poor Law)

Today it is thought that the Statute of 1536 was immensely severe. However, *The Statute of Legal Settlement Act* or the Poor Law of 1547 was more merciless as it brought slavery for the vagabond who rejected to work. Davies (1966) describes this law as: "the most savage act in the grim history of English vagrancy legislation, imposing slavery as a punishment for the refusal to work" (p. 533). Although the law had remained in force for two years before it was annulled immediately in the wake of the death of Edward VI, it is possible to consider this law as an inauspicious omen or mentality of the pro-slavery approach of England in her colonies. According to the law, the "vagabonds who were found without work were to be enslaved to a master for two years. If the vagabond attempted to escape, he became the master's slave for life; a second attempt to escape resulted in his classification as a felon" (Kunze, 1971, p. 13). It is not hard to guess how hard the conditions of the enslaved vagabonds were. To be poor in England in the early sixteenth century was extremely hard, especially during the reign of Edward VI. Some authors argue that the Poor Law of 1547 was an indicator of the need for a cheap labourship: "The extraordinary provisions of the first statute of Edward VI., for making Slaves of unwilling labourers, offers a distinct proof that there was a demand for labour" (Knight, 1868, p. 470). However, it was doubtful that these peasants who had worked independently on agricultural lands for a long time would meet the labour force needs.

The Poor Law of 1552

The Poor Law of 1552 ordered the official records of the poor by parishes for the first time. Keeping the records of the poor was very important for systematic and evenly distribution of help. Due to the success of the task that they undertook, the parishes sustained their role in the poor law of 1601. Without the records of the poor, it would probably be difficult to control the poverty. Besides, 1552 poor law adopted the appointment of the collector of alms. This law ordered Collectors to "gather money from those who could afford to pay in order to assist people unable to work for their own support" (Mcintosh, 2014, p. 332). "Increasingly Collectors used much of the money they gained from rates to deliver regular payments to a selected subset of the poor, a practice that would become common in the seventeenth and eighteenth centuries" (Mcintosh, 2014, pp. 333,335). The Poor Law of 1552 ordered a regular payment for the poor for the first time.

The Statute of Artificers of 1563

An Act Containing Divers Orders for Artificers, Labourers, Servants of Husbandry and Apprentices is usually called The Statute of Artificers of 1563 or The Statute of Apprentices of 1563 and it was entirely different from the earlier poor enactments which had adopted brutal approaches including slavery towards the vagabond and the poor. With the enforcement of the Statute of Artificers of 1563, Elizabeth targeted to stop competition and organize life to reach a regular and stable society in which everyone could share by status (Encyclopædia Britannica, Inc., 2020). This act founded a system to fix local wages, to check the working conditions of the workers involving apprentices, and to take mobility of the workers under control (Woodward, 1980, p. 32). It remained valid until 1819 and simply categorized the poor into different groups for the first time: able-bodied deserving poor who would work but could not, idle poor who were healthy but did not prefer to work; and impotent poor who were unable to work owing to some health problems, being old, too young and disabled. "It assumed the moral obligation of all men to work, the existence of divinely ordered social distinctions, and the need for the state to define

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and control all occupations in terms of their utility to society" (Encyclopædia Britannica, Inc., 2020). It ordered seven years of mandatory apprenticeship and confined the movement of the poor.

The Poor Law of 1572

On the grounds that the *Codifying Act of 1572* (14 Eliz., C. 5) ordered the statutory appointment of the overseers in lieu of the collectors in each parish for the first time, it is important to underline its significance (Emmison, 1931, p. 103). Besides the appointment of the overseers, the introduction of the taxation to fund the poor was the other important step of this legislation. It ordered a mandatory poor rate so as to help the impotent poor. In order to beg and wander freely, people had to own a license from A Justice of the Peace. Begging or wandering without that license was forbidden and resulted in severe punishments. Children who were under the age of 14 and soldiers on their way home were exempted from this prohibition. Penalty of wandering or begging for the second time was death as a felon. Although there were severe punishments, there were not enough solutions to tackle the vagabonding and begging. The Poor Law of 1572 paved the way to the Poor Law of 1601.

The Poor Law of 1576

An Act for Setting of the Poor on Work, and for the Avoiding of Idleness was an act ordering to set the poor on work and prohibiting vagabonding. The Poor Law of 1576 ordered to set the vagabonds and beggars on work. According to the order of this Act each parish would provide iron, wool or similar stocks for the sturdy vagabonds and beggars to work on. Secondly, the Poor Law of 1576 ordered the erection of the houses of correction in each county. According to Frank Aydelotte (1913) "The famous poor law of 1597 was nothing but a modification" (p. 63) of the Poor Law of 1576.

The Poor Law of 1597

In 1597, Elizabeth I promulgated a series of statutes including *An Act for Maintenance of Husbandry and Tillage; An Act for Relief of the Poor; An Act for Punishment of Rogues, Vagabonds, and Sturdy Beggars; An Act for Erecting Hospitals, or Abiding and Working Houses for the Poor; An Act to reform deceits and breaches of trust touching lands given to charitable uses* and *An Act for the Explanation of the Statute made the Fifth Year of Her Majesty's Reign Concerning Labourers.* According to Sidney and Beatrice Webb (1963) it was "an important series of "Orders for the Relief of the Poor"" (pp. 72,73) which aimed at providing relief for the elderly, disabled, the ill and infants through parishes and ordered the vagabonds and beggars to be sent back to their hometowns. Each parish would look after its own poor. It is possible to maintain that the Poor Law of 1597 was more humanistic than prior acts which ordered severe punishments such as slavery or the execution of the vagabonds. The Poor Law of 1597 ordered parishes to provide work for the able-bodied poor in workhouses. However, severe punishments were ordered for those who continue to vagabonding and begging: "Any justice of the Peace, may appoint any person to be openly whipped naked, until his or her body be bloody, that shall be taken begging wandring or misordering him or her self, as is declared by statutes, 39 *Eliz.* 4. § N. and I Jac. 7. § N. to be a Rogue Vagabond or Sturdy Begger" (The House of Commons, 1597, p. 510). The Poor Law of 1576 and 1597 were the final draft of the 1601 Act for the Relief of the Poor.

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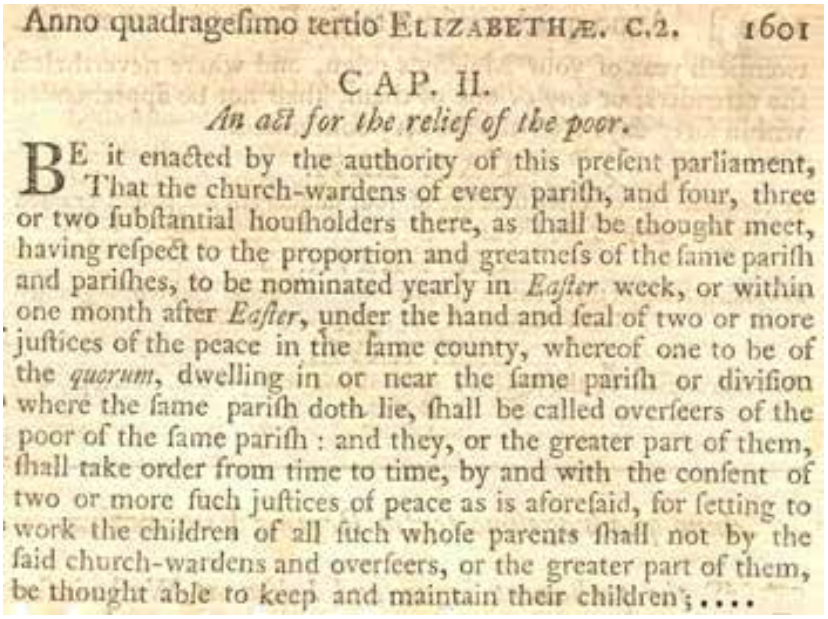
The Elizabethan Poor Law of 1601

[43 Eliz. c. 2. s. 1. 4.]



Anno quadrageſimo tertio ELIZABETHÆ. C. 2. 1601

CAP. II.

An act for the relief of the poor.

BE it enacted by the authority of this preſent parliament, That the church-wardens of every pariſh, and four, three or two ſubſtantial houſholders there, as ſhall be thought meet, having reſpect to the proportion and greatneſs of the ſame pariſh and pariſhes, to be nominated yearly in *Eaſter* week, or within one month after *Eaſter*, under the hand and ſeal of two or more juſtices of the peace in the ſame county, whereof one to be of the *quorum*, dwelling in or near the ſame pariſh or diviſion where the ſame pariſh doth lie, ſhall be called overſeers of the poor of the ſame pariſh: and they, or the greater part of them, ſhall take order from time to time, by and with the conſent of two or more ſuch juſtices of peace as is aforeſaid, for ſetting to work the children of all ſuch whoſe parents ſhall not by the ſaid church-wardens and overſeers, or the greater part of them, be thought able to keep and maintain their children; ....

"An Act for the Relief of the Poor"

Briefly stated, the 1601 *Act for the Relief of the Poor* was an inevitable and final stage of previously enforced poor laws throughout the sixteenth century. It was a revised and compiled version of former acts.

For instance, Henry VIII started to use the parishes as the smallest administrative unit to organize and distribute the charity and alms to the poor in 1531. Elizabeth did not change this system. Moreover, she gave more responsibility to parishes in poor relief work.

In 1552, Edward VI ordered to keep records of the poor for the first time. It was the first known statistics of the poor in the sixteenth century. Succeeding government of Elizabeth sustained keeping records of the poor in the following years. Again, the Poor Law of 1552 ordered the appointment of collectors for the first time. Twenty years later, in 1572, Elizabeth replaced collectors with overseers and she explained the responsibilities of the overseers in the same year for the first time. By the same token, the Poor Law of 1572 ordered the taxation to fund the poor for the first time.

That is to say, the 1601 Act for the Relief of the Poor maintained the humanitarian provisions of the prior acts and annulled the inhuman ones. It is important to keep in mind that the poor laws of the sixteenth century were not only designed to find a solution to poverty but also defend the rights of the ruling class and landowners, too. As aforementioned above, some of the poor laws in the sixteenth century involved inhumane and severe provisions.

The Poor Law of 1601 categorized the poor into four different classes as impotent poor, able-bodied poor, idle poor and poor children. Thus, it became possible to make the potential workforce of the poor contribute to the economy of the country. In the end of the sixteenth century England had a lot of experience to struggle with poverty. Numerous poor laws and statutes that aimed at keeping balance between the poor and the landowners were put into force. Finally, Elizabeth introduced the revised version of the poor law in 1601. Contrary to the name of the Poor Law of 1536, *An Act for the Punishement of Sturdy Vagaboundes and Beggars*, the name of the poor law enforced in 1601 was *An Act for the Relief of the Poor*. This change in the

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name of the poor law proves that there was also an alteration and development in the mentality and sense of human rights.

Important Provisions of the Poor Law of 1601

I. Description of the Overseers for the Poor; Their Office, Duty and Account

In the beginning of the statute, along with the functions of the parishes, the duties and qualifications of overseers are described. According to the first clause of the statute, parishes, being the smallest administrative units, were entirely responsible for taking care of the poor in their region. In order to combat with the poverty churchwardens and two, three or four substantial householders, in proportion to the greatness of the parish, would be appointed as overseers of the poor in that parish.

> BE it enacted by the authority of this present parliament, That the churchwardens of every parish, and four, three, or two substantial householders there, as shall be thought meet, having respect to the proportion and greatness of the same parish and parishes, to be nominated yearly in Easter week, or within one month after Easter, under the hand and seal of two or more justices of the peace in the same county, whereof one to be of the quorum, dwelling in or near the same parish or division where the same parish doth lie, shall be called overseers of the poor of the same parish: (The House of Commons of Great Britain, 1601, p. 130)

In other words, it was a system in which central government distributed the responsibility of taking care of the poor to the parishes. In this system, overseers administered both almshouses and workhouses. They tried to alleviate the poverty in their region. Their duties were as follows:

II. The Setting to Work and Apprenticeship of Children

It was churchwarden and overseers' responsibility to take care of the children whose family were not able to look after them or not thought able to keep and maintain their children. The churchwarden and overseers were authorized to decide about the children who were in need of help and not. They would set the needy children to work. By doing so, the aim was that these poor children would learn a profession to maintain their life: "... setting to work the children of all such whose parents shall not by the said church wardens and overseers, or the greater part of them, be thought able to keep and maintain their children" (The House of Commons of Great Britain, 1601, p. 130).

III. To Provide Work for the Able-bodied Poor

Able-bodied poor adults were another big problem for the country. It was thought that recruiting the able-bodied poor was important in combating poverty. Therefore, churchwarden and overseers were ordered to set the able-bodied poor on various works. "...and also for setting to work all such persons, married, or unmarried, having no means to maintain them, and use no ordinary and daily trade of life to get their living by" (The House of Commons of Great Britain, 1601, p. 130). Here, the erection of workhouses was remarkable.

IV. Taxation and Set the Poor on Work

Everybody who was not poor was to pay tax periodically for the relief of the poor. The parishes worked as both recruiter and tax collector.

> ...and also to raise weekly or otherwise (by taxation of every inhabitant, parson, vicar and other, and of every occupier of lands, houses, tithes impropriate, propriations of tithes, coal-mines, or saleable underwoods in the said parish, in such competent sum and sums of money as they shall think fit,) a convenient stock of flax, hemp, wool, thread, iron, and other necessary ware and stuff, to set the poor on work: (The House of Commons of Great Britain, 1601, p. 130).

However, An Act for the Relief of the Poor of 1597/98 had promulgated this tax for the first time before the release of the Poor Law of 1601.

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V. The Relief of the Impotent Poor

Overseers had the right of paying sums of money for the relief of the disabled and impotent poor. They had the authority of distributing alms and aid as much as they thought fit.

> ...and also competent sums of money for and towards the necessary relief of the lame, impotent, old, blind, and such other among them, being poor and not able to work, and also for the putting out of such children to be apprentices, to be gathered out of the same parish, according to the ability of the same parish, and to do and execute all other things, as well for the dis posing of the said stock as otherwise concerning the premises as to them shall seem convenient. (The House of Commons of Great Britain, 1601, p. 130)

VI. Erection of Workhouses

The 1601 Act for the Relief of the Poor made it possible to build poorhouses for the accommodation of the vagabonds and paupers. These poorhouses later came to be called workhouses. The aim of these workhouses was to offer accommodation and work for those who cannot look after themselves. Most parishes erected workhouses as it was one of the most effective ways of combating with the poverty.

Conclusion

The 1500s were difficult years for ordinary people due to profound alterations in the social, economic and political structure of England. The dissolution of the monastery, the emergence of mercantilism, changing nature of trade and agriculture, plague epidemics, migration and ongoing wars were some of those remarkable events of the sixteenth century. These social changes brought new habits and lifestyle, as well as poverty. Therefore, The English Parliament enforced various poor law.

Indeed the 1601 Act for the Relief of the Poor was the codified and revised version of a series of former poor laws. It systematized the existing law by borrowing and maintaining the humanistic clauses of former laws and eliminating the inhumane ones. It can be said that the Poor Law of 1601 introduced some new rules, but the foundation of it was laid much earlier during the reign of Henry VIII.

It simply released the fact that parishes had the responsibility of keeping the records of the poor, orphaned, widowed, sick and injured people in their regions, and looking after those poor people. It categorized the poor into different groups such as able-bodied poor who were healthy but did not prefer working and impotent poor who were disabled, ill or old and cannot look after themselves. It ordered apprenticeship for the children of the poor families who were between the ages of 12 and 18 to teach them a job. Taxation of income, erection of workhouses and almshouses were other clauses of the Elizabethan Poor Law of 1601.

All in all, the efforts of Queen Elizabeth to alleviate poverty and unemployment were highly successful. Today, the 1601 Act for the Relief of the Poor is considered as the beginning of the welfare state.

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Sample Reference Types:

1.Collins, M. (1986). Sampling, Consumer Market Research Handbook. London: McGraw-Hill Press. **(Show Book Resource)**

2.Durak, A. (1993). A Study on Validity of Beck Hopelessness Scale. Unpublished Master Thesis, Ankara University Institute of Social Sciences, Ankara. **(Unpublished Thesis Welding)**

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4.Official Gazette (1961). Law on Migration. Number: 106, Date: 5th June 1961. **(Official Newspaper)**

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Please refer to the APA 6 guide resource guide for the detailed resource formats.

In-Text Resource Representation Examples:

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