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ORIGINAL ARTICLE

A qualitative research on the acculturation strategies, risk factors and health perceptions of Syrian asylum seekers

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Abstract

The internal turmoil, that broke out in Syria, started a mass migration movement towards Turkey in 2011. This migration movement, which proved to be an important social phenomenon, individuals from many different cultures have experienced coexistence for compulsory reasons. On top of that experience they were subjected to, the addition of a highly complicated process of acculturation, and the risk factors which immigrants and ethnic minority groups faced caused them to classify as vulnurable regarding health. The aim of this study is to assess how the preferred acculturation strategy of Syrian asylum seekers, who found themselves living along with different cultures, their negative or positive experiences and the risk factors they face affects their health, and health perceptions. The research was designed as a phenomenological research. In-depth interviews were conducted with 24 participants, who were included in the study, using the purposive sampling strategies, homogeneous case sampling and criterion sampling technique. In addition to the usage of code book obtained from the literary works related to the field using the deductive method, the data recorded by observing and the notes from interviews were reduced to themes, categories and codes using the inductive method. The study is grouped under three main themes, namely acculturation strategy of Syrian asylum seekers, risk factors affecting the healths of Syrian asylum seekers and health perception of Syrian asylum seekers. Statistical analysis of the data was carried out by using descriptive analysis and content analysis provided in the MAXQDA 2020 pro-package program. Although the participants heavily express their opinions in favor of seperationg strategy, which is one of the acculturation strategies, this is followed by an integration strategy. Furthermore, the participants were observed to have been subjected to discrimination and rejection, and in this process, facing risk factors mainly social, psychological, environmental, physical and barriers affecting healthcare procurement. Multiple relational analysis show that an intense relationship was found between the participants who preferred the separatist strategy and the risk factors affecting their health. It was observed that the participants who reported good health perception before migrating; due to the most reported social risk factor, economic barriers, reported negative health perception after migrating. The majority of participants who preferred the integration strategy reported good health perception both before and after migration.

Keywords: Immigration, nursing, acculturation strategy, perception of health, Syrian asylum seekers, risk factors

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Introduction

Migration, which affected all countries in the world, especially in the second half of the 20th century, appeared as mass migrations. And this situation caused a rapid acceleration of the increase in the immigrant population in the last half century. *"According to United Nations datas, if it continues with the speed which it has been going fort he last 20 years, the number of international immigrants in the world is expected to reach 405 million in 2050."* [1]. Despite being regarded as an event of displacement of individuals from one place to another, Migration is directly connected [2] with the social, cultural, economic and political structure of the society and is a concept that shapes social life and has a great impact on individuals [3]. Although the mass migration, occuring with or against people's wills, had an effect on individuals' lives at first, in later phases, it more than likely leads to them facing problems about nourishment, shelter and most importantly, health and education [2]. One of the fundamental reasons of this is the cultural differences between the host and the immigrant. This situation has revealed the importance of intercultural interactions [4]. It used to be possible to have societies consisting of only one culture; but, it is no longer possible to characterize a whole nation based on a single culture, language, religion, or identity [5,6]. Keeping in mind that almost all the countries have multicultural structure [7], both migration and culture are the subjects of many research papers [8].

Migration happens for the reasons like colonialism, war, seeking job etc. And as a result, countries become multicultural. Thus, people who have different cultural backgrounds come together on a different society and as a result of the interactions between those two cultures, comes a phenomenon that we call 'acculturation'. The definition of acculturation is, a binary cultural and psychological alteration process of two or more cultural groups and their individual members [5,9-11]. At group level; It includes changes in social structures, institutions, cultural practices while also including changes behavior at the individual level [11]. Acculturation; when it first came out with the respresentation of Gordon [12], had been known as 'assimilation model', its basic assumption was the immigrant inevitably getting assimilated by the host culture [13]. Afterwards, under Berry's guidance, 'bidimensional model of acculturation' came out [3]. According to Berry, every individual in a group experiences this process in different ways. The important factor in order to understand these individual differences is how the people direct themselves through this process. To understand these varying behaviors, 'acculturation strategies' are recommended. As they consist of attitudes and behaviors (meaning it includes both preference and the action) exhibited in daily intercultural encounters, they are called strategies rather than attitudes [14]. Eight acculturation strategies which are presented in Berry's model (1980), are now reduces to four by him [10]. Those are; assimilation, integration, separation and marginalization [9,13,15,16]. These strategies have different names depending on which group (dominant/host or non-dominant/immigrant) is being assessed. From the perspective of immigrant groups, individuals adopt the assimilation strategy when they are not interested in preserving their own cultural identities and are in search of daily interactions with other cultural groups [5,9,16]. On the other hand, individuals adopt separation strategy when they want to preserve their own culture and avoid interactions with others [5,9,10,13,16,17]. Integration strategy emerges if one is interested in maintaining their own culture as well as daily interactions with other groups [5,9,10,13,16,17]. Lastly, if the individual has little interest in protecting their culture (usually caused by cultural loss), and/or in interaction with others (usually caused by discrimination), marginalization happen [5,9,10,16]. Besides, both groups are affected by this process that alters not only the immigrant, but also the host [3].

Participants of this research who were forced to leave their country and seek asylum in Turkey were Syrian asylum seeker. At first, there were uncertainties about the status of Syrians who came to Turkey in result of mass migration [18], and temporary protection status was given with the Temporary Protection Regulation published

in the official newspaper No. 29153, carried out by the Foreigners and International Protection Law (YUKK) No. 6458, in 22 October 2014 [19]. It is regulated that foreigners be provided with education, access to the labor market, social assistance and services, interpreting and similar services, and especially health services [20].

In addition to these uncertainties, cultural issues and traumatic war experience they had since the beginning of the migration process, Syrian asylum seekers, who had to leave their place unwillingly and unprepared, are categorized as sensitive groups. These risk factors can very well cause drastic changes in their health as well as their perception of health.

Perception of health, being a subjective concept, nowadays has become the focal point of numerous studies and researchs. Especially health sociologists, epidemiologists and public health specialists are take up the subject in detail about the sociocultural aspects [22]. Perception of health, being an important criteria about the individual's assessment of their health and their quality of life [23], may also be defined as how the individual views their own health. It is known that health perception is a strong indicator of mortality rates [24,25], and it can be used to track risk groups and as a useful endpoint for clinical studies [24]. Perception of health is a very beneficial method as it can indicate some symptoms of diseases that can't be detected through examination or that are not considered to be part of examination [25].

To think of individuals as separate from the society they are a part of, is in conflicts with the acceptance of health being as a whole. Being healthy may vary from person to person, society to society and time period to time period [21]. Hence, traditions and the cultural structure of a society is affecting individual's perception of health [27,28]. For example; not being healthy. While one society may accept the seriousness of a disease, it can be different for societies that have different cultures. Culture is an important factor in determining of access to the health system by influencing individuals' perception and interpretation of disease symptoms, help-seeking behavior, decision-making, expectations from the role of the patient, their way of coping and communication with health providers [29]. Despite the prominence of cultural communication on its effects on health, the observation was that there were not enough qualitative researches on that field. Yet qualitative research; is crucial for nurses, whose field of study is people, to be able to understand and interpret human behavior with all its intricacies [30]. The main reason for phenomenological research in this field is that the acculturation process is specific to each individual and the results of most studies can't be generalized on the society that exhibits that culture. Every individual's experiences and the effects of those experiences are different in this process.

Considering all these things, health care providers paying attention to these differences in health services, establishing effective and on point communication and planning health care accordingly, will reduce the difficulties faced in this regard [31]. For all the asylum seekers who experience this process intricately with all its dimensions, it is very important to plan nursing care with a multidisciplinary approach. This study will be a guide in revealing the effect of this multicultural environment, which deeply affects the health of the society and the individual, on physical and psychological health, how the individual perceives it and their experiences in the process. The intention is that this study will make a conceptual contribution to studies in different disciplines such as public health, nursing, psychology, and social work.

The aim of this study is to reveal the impact of the acculturation strategy preferred by Syrian asylum seekers who coexist among different cultures, and the risk factors they face from their positive or negative experiences in the process, on health and health perceptions.

Materials and Methods

Ethical aspect of the research

Ethical permission was obtained from Ege University Medical Research Ethics Committee (38-2009), and written permissions were obtained from the Provincial Immigration Administration and the Association for Solidarity with Asylum

Seekers and Immigrants in order to carry out the study. In addition, a written and verbal consent of the individuals included in the study was obtained for their participation.

Designing of the research

Study was carried out with one of the scientific research methods the qualitative research. The phenomenology design was chosen in order to reveal the opinions they expressed on this subject and the meanings they attributed to the events in detail.

Determination of participants

The research area consists of Syrian nationals between the ages of 18-65 living in İzmir and the working group, was chosen by purposive sampling method, from individuals who applied to the Association for Solidarity with Asylum Seekers and Migrants (ASAM) for health counseling and Syrian translators working in the institution.

In this study, from purposive sampling strategies, homogenous case sampling and criterion sampling were used. The process of data collection has ended in the research when the data was seen in the saturation point. Purposeful sampling criterias are to be living in Turkey for at least one year, to have no chronic disease, and to be between the ages of 18-65. A total of 24 participants were included in the study. Participants were numbered as K1-K24. Later, two of the participants haven't been able to be included in the study due to the having chronical diseases and being unfit to the measurement criteria.

17 of the participants are women and 7 of them are men. 2 between the ages of 18-25, 13 of them between 26-35, 7 between 36-45, and the remaining 2 of them are between 46-65. 1 of them is single while other 23 are married. 3 of the participants never finished any schools, 4 graduated primary school, 6 elementary school, 7 highschool, 3 university, and finally 1 of them is postgraduate. Among the participants, 5 of which are living with their extended family, while 19 of them are living with nuclear family. And, 1 is in the host country for 0-1 year, 16 of them are in for 2-5 years, and 7 between 6-10 years.

Process of data collection

To collect data in the research, demographic questions and semi-structured interview form, created by the researcher and included introductory information about the participants, were used. In-depth individual interviews were conducted with the participants within the framework of this interview form. While preparing the interview questions, studies and scales related to the subject were used. In addition, the form containing demographic information and questions in the interviews were translated into Arabic by an expert. After the translation, the interview questions were pre-tested with two participants in order to evaluate its intelligibility. After the arrangements made, the interview form took its final form and the negotiations started. The questions asked to the participants in the semi-structured interview forms were grouped under 3 subtitle. In order to question the acculturation experiences of Syrian asylum seekers in the process of migration and the acculturation strategies they prefer in the process; Some questions were asked, such as: "What does it feel like to be Syrian living in Turkey?", "Can you tell us about the migration and your experiences in this process?", "Can you tell us about the place and the conditions you are living in?", "Can you tell us a little about your family and close circle?", "Which language do you prefer to use the most at home and what are the reasons of this prefence?"

Some more questions were directed to them to find out if the status of Syrian asylum seekers are benefiting from health services in the acculturation process; "What do you think about Turkey's health services?", "What did you encounter in the health institutions you applied to?", "Can you explain your experiences about it with their positive and negative aspects?", "Can you talk about the importance of having healthcare professionals with a different culture?"

In the interviews in Arabic, one of the translators translated while the interview continued,

while another interpreter only took notes in detail about the statements of the participant's, thus, ensuring that no data was lost during the interview. The interviewer also took notes of his own and recorded her observations about the participants. After the interview, necessary notes were taken and summarized to the participants for approval. All these notes were included in the analysis as the primary data of the research.

The interviews were held between December 2019 and March 2020. With the choice of participants, 6 of the interviews started in Turkish, 17 in Arabic and one also in Turkish, but due to the participant having trouble whit the usage of language, it was continued in Arabic with the assistance of a translator. The notes taken in parallel with the interviews were studied alongside translators and completed. Then the data was arranged properly and saved as Word text. To be able to organize and obtain the raw data, the notes taken were examined in detail again, and the coding process started. A code book was created with the deductive method from similar studies and the inductive method from the data obtained. The codes obtained were combined under categories and themes according to their common characteristics.

Data analysis strategy

Descriptive (thematic) analysis and content analysis were used as research analysis methods. In the descriptive analysis, the data obtained as a result of the interviews and observations are reduced to the previously revealed themes, summarized and interpreted according to these themes [32]. One of the content analysis types, relational analysis, was also used. Qualitative content analysis involves breaking the data into small sections, coding these units according to the contents they represent, and grouping the coded materials according to the contents they represent [33]. Coding and data analysis of the study were carried out by the researchers using the MAXQDA 2020 package program. Frequency numbers (f) were used in the presentation of the findings. The obtained diversity and density of the themes were interpreted and reported along with various examples.

Validity and reliability

In order to establish convincibility, the interviewer working in the Association for Solidarity with Asylum Seekers and Migrants helped to eliminate biases as well as having better communication throughout the whole process. At the end of the interview, the data obtained regarding the contents of the interview were briefly summarized and the participant's consent was taken. In addition, at every stage of the study, support was received from experts who had minimum amount of contact with the participants (to eliminate bias) and had sufficient knowledge on qualitative research and the subject of research, and the data have been evaluated objectively from an unbiased point of view. In order to ensure transferability, all stages of the research were explained to the participants in detail and the research was carried out in accordance with every step of the process. It was emphasized that the findings of the research reflect the sample group and cannot be generalized to the population. To ensure reliability, the relevant literary works was scanned and the process was examined in similar studies. The obtained data was coded by a second researcher, and similar results came up. For the reassurance of confirmability, the raw data (opinions of the participants, observation by the researcher) were appropriately recorded, and frequent quotations from the participants' statements about each topic were included in the findings section.

Results

The research is grouped under 3 main themes as seen in Figure 1. Theme tags; Acculturation strategy of Syrian asylum seekers, risk factors affecting the health of Syrian asylum seekers, health perception of Syrian asylum seekers.

Acculturation strategies of Syrian asylum seekers

In line with the statements of the participants, the acculturation strategies theme of the Syrian asylum seekers was defined in 4 different categories. Those are; separation, integration, marginalization, assimilation strategies.

It was observed that the participants expressed their views intensely in favor of separation strategy regarding the themes of acculturation strategies of Syrian asylum seekers. In this matter, most claim to prefer to maintain their own culture and habits (language, eating habits etc.), communicate with people from their own nation and use their own language. Participants stated their fear of their children forgetting their mother tongue, and that they feel more comfortable when they use Arabic in daily life, and as a consequence, had difficulty learning Turkish. Statements of K8 and K18;

> *"We are Syrians and we are guests in this country. We cannot do anything, we cannot speak. I cannot speak Turkish… I do not know how to speak Turkish with Turks … I don't know Turkish food, I do not know how to cook. Until now, we only cook syrian dishes. (K8), "I can get along with Syrians. They understand me, I understand them. But Turkish is difficult." (K18)*

After the separation strategy, integration strategy was the most preferred among the participants, and expressed their opinions in this direction. They mentioned that they communicated with the host society (neighbor, colleague, etc.) with this code, and their changes in behavior because of it. Yet those participants were observed not fully giving up on the characteristics of their own culture and continued to communicate with individuals close to their own culture. The participants expressed these views as belonging to both cultures; they explained it with behavioral changes such as consumption of food, use of media, and use of language. Opinions of K5 and K26;

> *"We are used to these since childhood, consuming them. There are some Turkish dishes that we have started to eat here… For example, chickpea soup is delicious. Also 'çiğköfte' and it is also delicious. On the contrary, we make* çiğköfte *as they are made here now..."(K5), "Our neighborhood is beautiful. Turks and Syrians live in our neighborhood." (K26)*

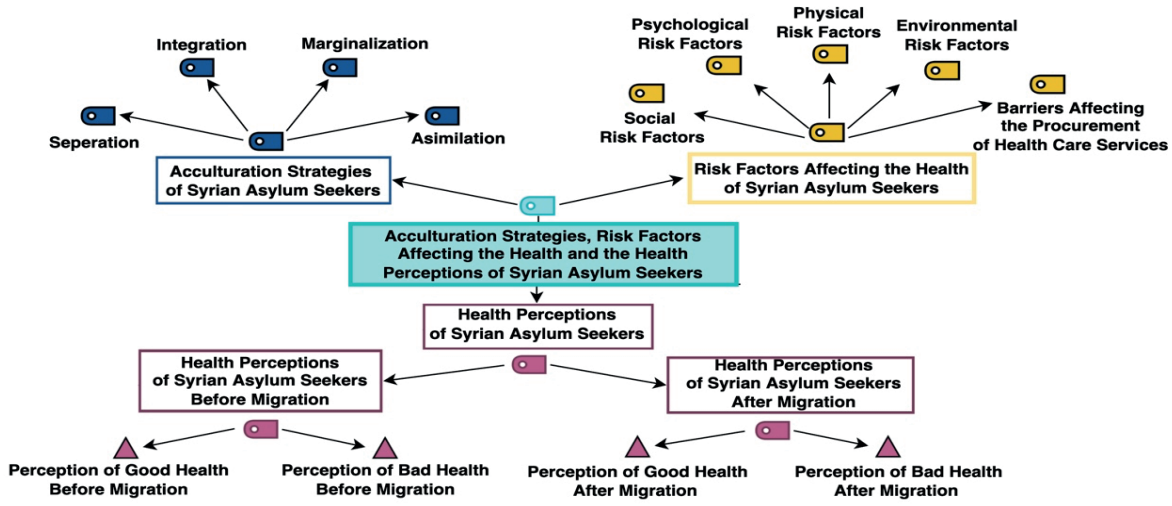

Figure 1. Representation of the themes and categories by the findings of the qualitative analysis regarding the risk factors which affect the healths of Syrian asylum seekers (Concept map)

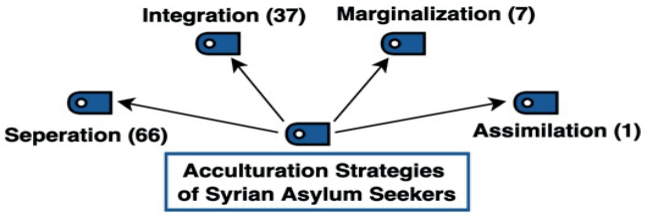

Figure 2. Acculturation strategies of Syrian asylum seekers

In parallel with the results of most studies, the marginalization strategy was not popular among the participants [6]. In this regard, the participants mentioned that they did not feel like they belonged to either culture and that they drifted away from both cultural groups. The thoughts K9;

> *"…I mean, if I could, I would like to speak English…Now we don't know who we can trust. We dont care Syrian or Turk." (K9)*

Only one of the participants was observed to have mentioned the category of the assimilation. Statements of K2 on the subject;

> *"I didn't feel very alienated. I came, shortly after my arrival, met my spouse (Turkish), and got married. I got married about 7-8 months later." (K2)*

Risk factors affecting the health of Syrian asylum seekers

The theme of risk factors affecting the health of individuals was examined under 5 different categories based on similar studies [3] and interview notes. These (Figure 3) are, according to the density of expressed views by the participants, ranked respectively as; social risk factors, barriers affecting the procurement of health care services, psychological risk factors, environmental risk factors and physical risk factors.

Social risk factors

Social risk factors are categorized as 6 different codes. Those being; economic barriers, language barrier, prejudices/ethnic prejudices, lack of social support, loss of social status, lack of education. About the language barrier code, The participants mentioned in 106 different places that they had difficulties in many areas such as finding a job and getting service because they did not know the language. This situation mostly led to not being able to receive salaries, not being able to sufficiently communicate with co-workers, poor neighbor/friendship relations, inadequate access to health services, and disruption in education. Regarding this issue, the participants stated that the language courses provided to them were unhelplful, and they mostly could not attend to it due to work/life conditions (having no one to look after the children, etc.). Statements of K15;

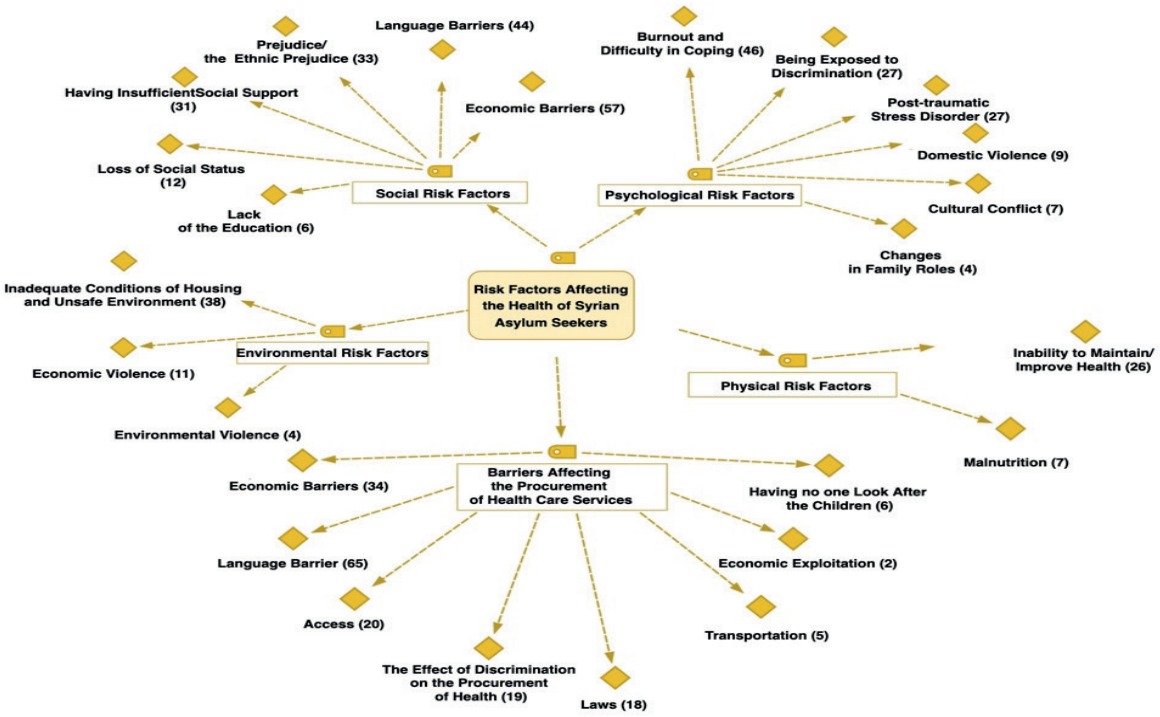

Figure 3. Model of hierarchical codes and sub codes section of risk factors affecting the health of Syrian asylum seekers

"But the main problem is; I don't understand them. We couldn't adapt because of the language problem. The biggest problem for my daughter is… my daughter can't understand. For example, she has a stomachache. She feels like she's going to vomit, but she won't go (to hospital), because she is not able to explain it. I feel sorry for her not being able to explain it..." (K15)

Economic barriers is the code that almost all the participants expressed their views on. About this code; they often emphasized on unemployment, working in irregular jobs, or their income being insufficient to sustain their lives even when they are working. Some participants also stated that they could not pay their rent and got homeless as a result of the economic obstacles they experienced. Having faced economic barriers due to unemployment and temporary jobs, the opinions of participants with the codes of K7 and K10 are as follows:

"It's hard to be in need and being hungry anyway. So we started looking for a job from anywhere we can."(K7) "I have been unemployed for 2 months, I cannot work… We are used to hunger and poverty."(K10)

They talked about the prejudices/ethnic prejudices code, the contempt that syrians face and misconceptions about Syrians and their country. The views of the participant K1 on the subject are:

"…there is something like, everyone is treated the same way. It's as if everyone is the same, those who are educated and those who are not, there is no difference. When they mention a Syrian, people think of beggars." (K1)

The participants mentioned that they could not get enough social support, neither from their families or the people of the country they came from with code of lack of social support. The views of K11;

"No one helps anyone. As I said, isn't my family my life, my blood? I mean, there's no one to knock on your door and ask if you need anything." (K11)

Regarding the loss of social status code, they referred to the pre-war living conditions in their country, saying they were better than in Turkey and the jobs they were working in were more respectable there. The views of K9 about this are as follows:

"My job was good when I was in Syria. It was a profession where I could earn good money. I was a designer. Before I came here, I was not an employee, I was the boss. But i am an employee here."(K9)

Under the lack of education code, the participants stated that they had to take their children off the school due to economic difficulties and discrimination they faced, and they had to put them to work. They also mentioned that they could not send them to school due to the prejudices among the host society and the exclusion they go through. Opinions of K11 and K22;

"...Both (of my children) did not go to school because of discrimination… they never went to school..." (K11) "I'm thinking of taking the youngest sibling off the school now. Because life has become very difficult..." (K18)

Psychological risk factors

The category of psychological risk factors is defined with 6 different codes. Those being; burnout and coping difficulties, exposure to discrimination, post-traumatic stress disorder, domestic violence, cultural conflicts, change of roles family. As seen in Figure 3, in the category of psychological risk factors, the codes which participants expressed the most were burnout and difficulty in coping. The participants talked about the negative experiences they had due to the war in their home country, the discrimination and poverty they experience here, and that they felt burnout because they could no longer cope with them. The statement of K8 on the subject;

"As I said I'm not comfortable, I sleep with the same thoughts, the same exhaustment. So I wake up and hope that maybe I will begin a new life. But nothing changes… I do not want to listen to (music) while there are people who were cut off, people who were shot or died, while my mother, brother and family are far away…" (K8)

The second code on which the participants expressed their opinions intensively was exposure to discrimination. They mentioned that they are discriminated against in many areas and that they are treated differently from Turks. Particularly, the participants emphasized a lot about the discrimination they face in business life. K7's words about the topic:

> *"… 'You just left and fled'. This is what we go through all the time. Some places say 'we do not hire Syrians for employees'. When I work, my normal salary should be at least 3 thousand liras. They only pay 1800 liras at the moment. You have to accept it as a Syrian. If you do not accept, there is no job. They are squeezing this way and that is very difficult for me…"(K7)*

Regarding post-traumatic stress disorder code, the participants talked about the traumas they experienced because of the war in Syria and the negative effects of these traumas on their mental health. The views of the K7 on the subject are:

> *"Because i am depressed... What should I do. Because there was a bomb explosion I left my hometown… My face burned, my mental health got broken… I had a very hard time… While the bombs fell in my country, many of my close friends died. Many people I considered my brothers died. I mean innocent people. How many people died? I mean, children and so on." (K7)*

Under the code of domestic violence, the participants talked about the negative life experiences affected their family life, that there were frequent conflicts in the family and that these conflicts mostly resolved by violence. The statement of the participant K11 on the subject is as follows:

> *"I have never seen the things that I am seeing from my husband 6 years ago. I've been married to him for 15-16 years, I've never seen anything similar to this from him. After I came here, I was subjected to violence and torture. He humiliated me. Why all this? He doesn't work or he doesn't pay for our expenses… All this is happening." (K11)*

With the code; cultural conflict, the participants mentioned that they experience cultural differences, and that they get worse react from the host society as these differences (cultural distance) increase. The views of the participant K3 on the subject are as follows:

> *"... What we preferred in Syria is going to female doctor for pregnancy if you are not in a very difficult situation... But for example, when we go to doctor we say we prefer female doctor. When they say take off your clothes while being examined if there is no need for it, for example, if you are embarrassed and cover it up... they criticize it. They say 'why will the doctor look at you'..." (K3)*

About the code of change in family roles, the participants mentioned that their children also had to start working due to the financial difficulties they experienced here, because of this, there were changes in family roles, and this caused a negative impact on their physical and psychological health. The statements of the participant coded K2 on the subject are as follows:

> *"… When we first came with my brother, we started working. How old he was... Let's say I was 21 when we came. My brother was 4 years younger than me. The other one was 9 years younger than me. All three of us had to work somewhere in a textile shop." (K2)*

Physical risk factors

Physical risk factors are categorized with 2 different codes. These are; Inadequate protection/improvement of health and nutritional deficiency. As can be seen in Figure 3, the code that the participants expressed the most about was inadequacy in the protection/improvement of health. The participants complained that they could not receive health services or protect their health due to poverty, or due to not being able to procure an identity card. The statements of the participant K14 on the subject are as follows:

> *" …you are forced to do it here. We have to do things we cannot do, things that are forbidden for our health, because we have to work." (K14)*

With the code of nutritional deficiency, Participants claimed that they could not eat

adequately and healthily. K23 states that:

> *"…we went through such a time that I deprived my children of many things here. Even if I buy milk for my children from the market, I cannot buy it more than once a month, sometimes even once every two months;"(K23)*

Environmental risk factors

In the category of environmental risk factors, the most emphasized opinions of the participants were inadequate housing conditions and unsafe environment. They mentioned that they had to live in small, humid, old and cheap houses as a crowd due to poverty. The statements of the participant K11 on the subject are as follows:

> *"The house, is like… a small kitchen, It has 2 rooms, and a living room. It's a damp house. The bathroom and the toilet are not seperate. You can't stay in the bathroom without going out 2-3 times, you can't breathe."(K11)*

With the code of economic violence, participants claimed that they were abused economically with very high rents, low salaries among other things. K24 on the subject said:

> *"They wouldn't give us a house. The landlady was a woman with a child, she didn't have much money, she looked at us like we couldn't pay the rent. They started not giving us a house… They started asking for high rents because they knew we had to pay this rent and we had no other choice." (K24)*

Under the environmental violence code, the participants talked about the exclusion and violence they observed in their environment. The views of the K13 on this are as follows:

> *"For example, recently a boy and two girls looked at me laughing and said, "bomb, bomb" in Arabic, and they take an orange and threw it at me." (K13)*

Barriers affecting health care procurement

The category of barriers affecting health care procurement is categorized with 8 different codes: language barrier, economic barriers, access barrier, impact of discrimination on the procurement of services, laws, no one to take care of children, transportation, and economic exploitation. As can be seen in Figure 3, about the category of barriers affecting healthcare procurement, the most common barrier they encountered was their lack of knowledge about the language and the translations being insufficient. The statement of the participant K16 on the subject is as follows:

> *"I don't understand the language here… I don't go to the doctor most of the times. If there is no one to translate for me, if I can't find an interpreter, I don't go. I mean i would be always late for treatment." K16*

With the code of economic barriers, the participants mentioned that they had financial problems due to unemployment, irregular jobs and that they could not procure health services because of those. The views of the participant K12 are:

> *"Most of the time it doesn't compensate. My wife works irregularly and my daughter's physical therapy needs to be paid for. Since we are not Turkish citizens, and we can't afford it in private, my daughter's treatment is disrupted most of the time." (K12)*

Under the access barriers code, the participants mentioned systemic problems such as problems taking appointments, and that they could not access health services because they had difficulty in the hospital processes; especially in the first time, due to having no knowledge about how it works and not getting any help. K12 has put it this way saying:

> *"I don't know anything here; the hospital, or where the right and left of this place are? My daughter was delayed a lot. At first, we didn't know. We learned later but we were late. Because I started my daughter's treatment after 5 years. I had some difficult moments." (K12)*

About the effects of discrimination on service procurement, the participants mentioned that the discrimination they suffered from health care workers as well as other patients negatively affected their health service procurement. The statements of the participant K2 on the subject are as follows:

" …the reactions we got from the doctors… You came to Turkey and you want to choose the hospital and you don't even know how to make an appointment… You came to Turkey and you get paid. Look, these are the doctor's words. You make lots of children… These things affect me too…(K2)

Regarding the code of laws, the participants talked about the systemic problems and unfair laws they encountered. They stated that not having an identity card, being Syrian and their lack of legal rights create obstacles for some treatments. On this topic, participant K21 mentioned:

"It went on like this for 5 years. I couldn't do anything. Because the doctors asked for physical therapy. It's not surgery or anything, it's just physical therapy. The reports we had did not matter. They didn't accept it for physical therapy. Why is it invalid? because we are Syrian citizens..." (K21)

Also, the participants mentioned that there is no one to look after the children when they go to the hospital or when they are hospitalized, because their families are mostly in Syria and social service networks here are insufficient. This situation severely affected their work life and health. Participant K9 expressed:

"…for example, I sometimes stay in the hospital for arouns 2 months, or my wife stays in the hospital for ourchild, my other children stay elsewhere. Go to the hospital, take medicine, go to the other children, I cannot continue to work. I have great difficulties in these matters." (K9)

With the transportation code, the participants mentioned that it is difficult and costly to reach the hospitals.

"Hospitals, go, visits are giving me hard times. Transportation costs are putting me in trouble too much. When we first came here, our child was just born. I did not know any place… " (K21)

Health perceptions of Syrian asylum seekers

The category of health perception of asylum seekers before migration is also defined with 2 different codes (Figure 4): The perception of good health before migration and the perception of bad health before migration. About good health perception; the participants stated that they lived in better conditions in their own country before the migration, that they were in better health, they were able to maintain their health easier, and they ate well. The statements of the participants with the code K14 on the subject are as follows:

"When I was in Syria, I did not complain about anything. My mother and I would wake up in the morning. There is a place close to us in Damascus… It had clean water. We would walk early in the morning, take fresh air, fill some water from there. I had no complaints." (K14)

Under the code of bad health perception, three of the participants mentioned that their health was also bad in their own country before migration. These participants mentioned that they perceived bad health before migration due to the chalky water there and due to weight problems. The views of K4 are:

"The water of the place where we lived in Syria before was chalky. We have been drinking it since we were little, and now I have dental problems because of it." (K4)

Two different codes have been defined regarding the health perception after migration category. These are; The perception of good health after

Figure 4. Health perceptions of Syrian asylum seekers before and after migration

migration and the perception of bad health after migration. The participants who expressed their negative opinions about the perception of bad health after migration mentioned that their health started to deteriorate due to their new life conditions after they migrated. Those conditions are; living in poor houses, terrible work conditions for health, and an abundance of stress. The statements of the participant K3 on the subject are as follows:

> *"Very bad… If I talk about my own health… My heart beat is unstable, my head hurts, my body hurts, I go to the hospital, they say everything is normal. But my body feels like, i am sick-abed who lies in bed for 6-7 days..." (K3)*

Contrary to the participants who claimed to perceived bad health after the migration, few of the participants mentioned that there were no changes in their health after the migration, and some even claimed to have gotten better. The statement of the participant K4 on the subject is:

> *"Thank god I'm in good health. I mean I don't have any problems." (K4)*

Relational analysis

When we examine Figure 5, while individuals who prefer the separation strategy have a good health perception before migration, they stated to have perceived bad health perception after migration. The thickness of the connecting lines indicate the strength of the relationships. Participants who preferred the marginalization strategy also perceived bad health after migration, and good health before it, same with the ones who opt for seperation strategy. Despite some of the participants, who preferred the integration strategy, reporting bad health perception before and after migration, the majority of them had good health perception in both cases. On the other hand, among the individuals who preferred integration reporting good health perception before, some stated to have bad health condition after migration. Participant K4 stated that he preferred the integration strategy. In addition, he made opinions about the perception of good health after migration, which was expressed most commonly. The statements of the participant K4 are as follows:

> *"We mostly speak Arabic at home… My family doesn't speak Turkish very well. They know very little. Our Turkish neighbors and landlords visit us frequently. My wife has learned a little from this. However, it's usually difficult when we talk about something. She can't understand me.", "My health is well thankfully." (K4)*

Participants who preferred the separation strategy mostly stated that they faced economic obstacles, intense burnout and difficulties in coping, lack of social support, prejudice/ethnic prejudice and discrimination. At the same time, same aforementioned participants have bad health perception after migration. The lines marked with red show the relationship between

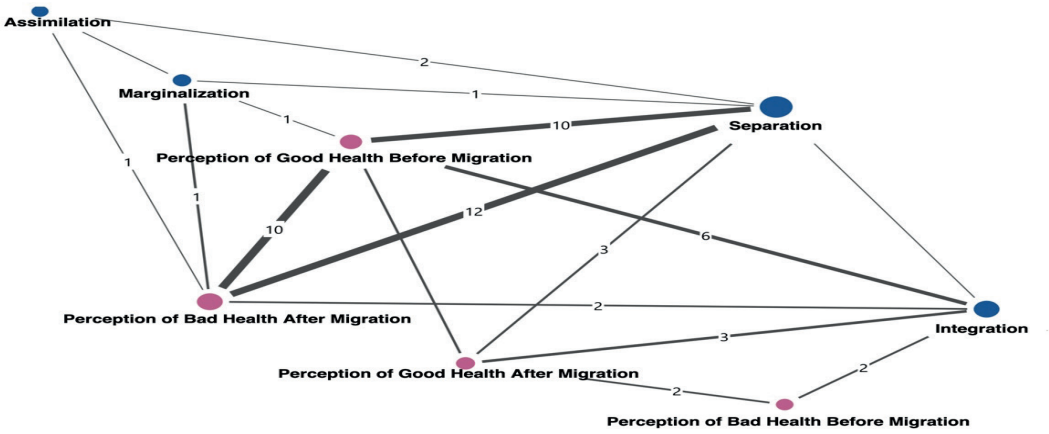

Figure 5. Concept map showing the relationship between the acculturation strategies and the health perceptions of asylum seekers

these codes. In addition, yellow lines indicate the strong connection between the risk factors affecting the health of asylum seekers who prefer the separation strategy, and the relationship between the perception of good health before migration and the perception of bad health after migration. It was observed that the participants who reported good health perception before migration mostly reported bad health perception after migration mainly because of economic barriers they faced. Economic and language barriers under the category of social risk factors, are observed to prevent participants having access to health care services. The turquoise lines on the map show these relationships. The relationship between integration and the good and bad health perception after migration is shown in the previous map. Figure 6 also shows that integration is associated with language barrier as a risk factor. It is suspected that language barrier will affect access to health care and indirectly the perception of health for individuals who had bad health perception and preferred integration. The opinions of the participant K14, who talked about economic barriers, burnout and coping difficulties, and the perception of bad health after migration (dotted lines marked with red on the map) are as follows:

"I am without the majority of my teeth for about a year. I can not eat. Here in Turkey, treatment is paid, public hospitals require an ID card. Also, my wife and I feel psychologically in a dead end. I'm so bored with everything in life. I want to go back to Syria, i mean there is a war and my family is there. We were displaced from where we used to live. Health, income, sadness and grief make a person grow older, he becomes older than his age. Especially what happened to us. Normally i am not allowed to smoke. But lately, I smoke too much…" (K14)

Discussion

In this study, "Berry's Acculturation Model", developed by Berry and his colleagues, was used to interpret the data [34] and the acculturation strategies after migration chosen by the participants were deducted based on experiences. In a study conducted with Syrians migrated to Canada, their access to freedom, equal treatment and immagrant rights by the Canadian system positively affected their cultural integration processes after migration [35], and integration is the most popular acculturation strategy among them [6,36-38]. According to Kılıç, Syrian women are more likely to adopt the integration strategy than the acculturation strategies in Berry's model [39]. However, while in this study, the most preferred acculturation strategy was the

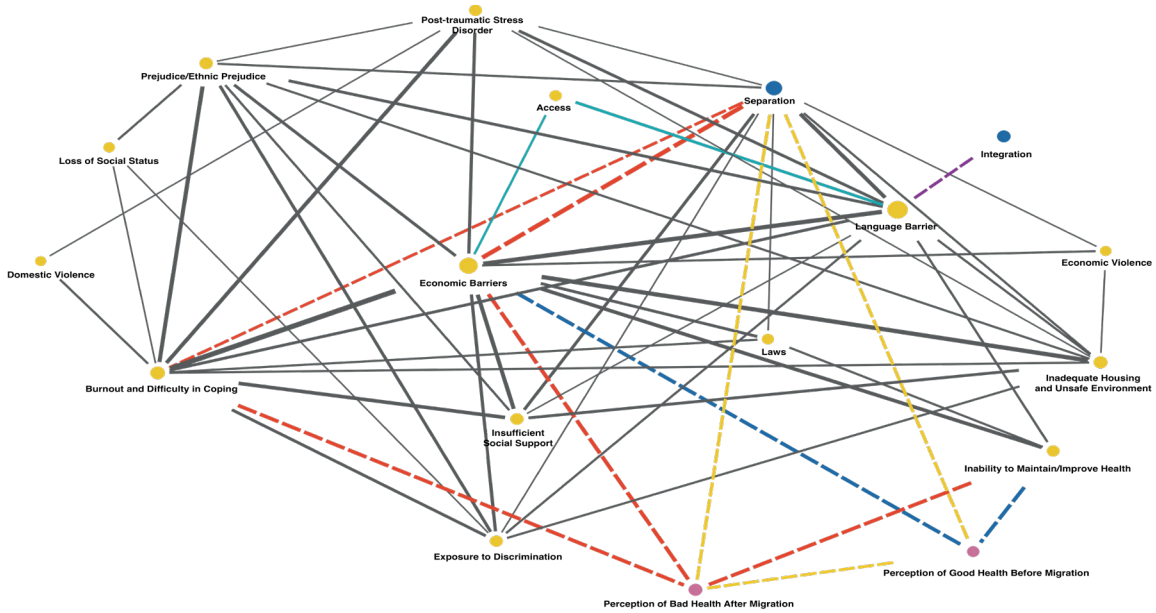

Figure 6. Concept map showing the relationship between health perception of Syrian asylum seekers, risk factors affecting their health and acculturation strategies

separation strategy, it was followed closely by integration. The least preferred strategy among the participants was assimilation, and followed by marginalization.

Migration experience can cause many physical, mental, socioeconomic and cultural problems [40]. The majority of immigrants face traumatic and challenging issues such as unemployment, insufficient support, prejudice, discrimination and abuse [29]. In addition, situations such as very low income, the lack of adequate health institutions in the region, lack of health insurance, language problems, and the multiple families living in the same household negatively affect the health of Syrians [41]. It has also become very difficult to find housing, because of high demand and increasing house rents [18]. It was observed that the employment situation of immigrants has serious effects on the individual and his family, as well as the effects on the economy and social life. This situation proved to be a source stress for both the society and the individuals. Asylum Seekers, who are working in unfair environments, who do not know their rights in cases such as work hazards, who do not want to lose their jobs or be sent back to their country, are unable to pursue their legal rights [42]. Another issue frequently mentioned by the participants in this study is the high rate of discrimination in workplaces, especially in work distribution and salaries. This negatively affects the socio-economic status of individuals. Since socio-economic status creates certain images and obligations on individuals, and in parallel to this, loss of social status makes it that much difficult to maintain a good image and take on important responsibilities [43]. For this reason, it is very important to support vocational education, language education, education programs teaching rights, finding jobs suitable to their abilities and skills, and similar practices in the employment of the individual [42].

Asylum seekers who experience forced migration have difficulties in various dimensions in different areas, and these difficulties can negatively affect their psychological well-being [44]. Immigrants develop mental disorders, especially due to the extraordinary situations and the violence they experience, and it is also one of the things affecting their health negatively [41]. Prejudices and exposure to discrimination have been a source of serious stress. In a study conducted with Syrian and Yemeni immigrants, it was claimed that there were changes in the family structure of the participants, their family roles, their relations with the family and the environment and so on [45]. In another study conducted with military personnel who served during the Gulf War, post-traumatic stress disorder was found to negatively affect physical health [46]. Also in this study, it was observed that the negative experiences in the war affected both mental and physical health negatively.

Not having Access to enough healthy food to meet the daily needs of individuals has been another issue that is insufficient for asylum seekers [41]. Factors such as nutrition and hygiene problems, the inability to provide clean drinking water and the inability to remove wastes properly affect the health conditions negatively in the regions where the asylum seekers mostly migrated. At the same time, immigrants also face problems such as inadequate and unbalanced eating, and infectious diseases due to nutritional problems during the migration process [41]. The most common difficulties that the asylum seekers face in receiving health care are language, cultural barriers, fear of prejudice, and lack of enough knowledge of the health system [29]. Most of the immigrants cannot speak the language of the country; They do not know where and how to look for solutions for the problems they encounter [18] and they have serious communication problems because of speaking different languages [31]. This situation leads to an increase of discrimination. In parallel with the effect of discrimination on health care procurement, Syrians experience social exclusions such as economic, regional, city-based, educational and health [47].

In this study, the participants stated that they perceived their health well before migration. In the study conducted by Kallas with Syrian immigrants in Canada, he mentioned that the majority of women who immigrated to Canada perceived an improvement in their health status and their health perceptions were generally

more positive in Canada, and mentioned that these developments were generally related to physical health [35]. However, in this study, it was observed that especially social, psychological, environmental and physical risk factors are frequently encountered and these factors are associated with the perception of poor health after migration. Social risk factors; individual unemployment [43], social relations [48] are significantly related to the perception of health, and it was observed that the participants talked about the economic barriers they faced due to unemployment, the inadequacy of their social support, and the same participants mostly reported the perception of bad health.

While it is obvious that the assimilationist policies and practices do not lead to the welfare of immigrants, it is also known that marginalization also causes the most negative consequences [14]. Since the participants did not talk much about the assimilation and marginalization code, there was no significant relationship found between these codes and the health perception code in this study. Discrimination is undoubtedly playing a role in resulting worse health perceptions [49] and observed health results [50]. Lastly, it was observed that the participants who preferred the separation strategy over integration, reported more about bad health perception, and there was a significant relationship between them in relational analysis.

Conclusion

As a result of the traumas and negative experiences they had before migrating, during the war process, Syrian asylum seekers faced a number of risk factors and were evaluated as vulnerable groups in health. In this process, being forced to leave their country, leaving their financial resources, jobs, families and social circles behind are all effective in the emergence of these risk factors. The participants had to work for low wages and without any social security in jobs that are not suitable for health and require physical strength, because of the poverty they face after those losses. The majority of the participants stated that they lived in unsanitary, damp, windowless, and crowded houses. All these can cause many psychological and physiological problems and negatively affect health perceptions. Along with these, priorities of individuals had changed and they put their health after basic necessities to survive such as food, shelter and sustaining life. Participants who encountered a brand new culture had difficulty in learning the characteristics of the new culture, and they had difficulties expressing themselves in many areas, especially due to the language barrier. Besides, some of the participants with the health services, experienced discrimination from employees, patients and their relatives, and it has been observed that this situation has become a source of concern for individuals and causes disruptions in healthcare procurement. Participants have been observed to mostly prefer the separation strategy more than other acculturation strategies. Traumas and negative experiences throughout the migration process; situations such as cultural conflict with the host society in the process of acculturation, mutual prejudices, insufficient social support, loss of social status; Caused the immigrants to face with psychological risk factors like post-traumatic stress disorder, difficulties with coping and burnout. These risk factors have caused changes in the family dynamics of individuals and resulted in violence within the family. It has been faced with situations such as children who need education have to work at an early age and children have to be in the role of parents due to the losses they experience. Participants who claim to have encountered these experiences, especially the ones who preferred seperation strategy, reported perception of good health before migration. Yet, due to the fact that they encountered many of these risk factors after migration, it became increasingly hard to sustain good health and it turned into perception of bad health.

This study may contribute to the completion of gaps in studies in the field of migration and health and also when it comes to planning of different studies. It can strengthen scientific data with qualitative and quantitative approaches carried out in the field of nursing. The main factor in the failure of Syrian asylum seekers communicating with other cultures and the decrease in their communication is the language barrier. The

language barrier, which is not a risk factor to neglect, is negatively affecting social life and access to services such as health and education. With the language courses organized by experts in the field and trained translators working in those services (health institutions, etc.), the negative effects on the physical and mental health of the individuals would be eliminated. Programs built for better mutual communication of ethnic groups, provision of better Access to information and/or programs alleviating the pressure on individuals and making the life easier for them, will undoubtedly maket he acculturation process go smoother. With health service providers, the role of nurses is especially important, who are in contact with people all the time. Awareness of different cultures for nurses should be increased, studies should be carried out on this subject and nursing care suitable for different cultures should be provided. For this reason, it is necessary to revize the education and consultancy services in the field of health. In order to plan appropriate trainings, it is important to enrich the literature on the field and to increase the competencies of health workers in this regard. In nursing, which is the group that has the most direct contact with asylum seekers in health institutions, it should be a priority to include these issues in the education program in university regarding intercultural nursing care as well as planning in-service training on the subject.

Limitations: Although the researcher knew the language well, the interviews in Arabic were conducted with the help of a translator in order to understand the concepts specific to culture correctly. Because of the prohibition to take voice recording by the order of İzmir Provincial Directorate of Migration Management, no voice was recorded in the interviews conducted inside the institution and they were carried out with the presence of two translators, as well as taking notes in detail. Because of the limited conditions in the office, (telephone, traffic of consulters etc.) the interview was done in an available time in terms of intensity.

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References

1. T.C. İç İşleri Bakanlığı Göç İdaresi Genel Müdürlüğü (2016). Türkiye Göç Raporu-2016 (in Turkish). https://www.goc.gov.tr/kurumlar/goc.gov.tr/files/2016_yiik_goc_raporu_haziran.pdf

1. Bozan İ, Kaştan Y. Views of the migrant students on problems they confront: A case study (in Turkish). IJOSES. 2018;5(10):225-48. doi: 10.20860/ijoses.447898.
3. Zafer AB. 1878-1914 yıllarında Balkanlar ve Kafkasya'dan gelen ikinci kuşak göçmen kadınların kültürleşme süreci (Bursa vilayeti İnegöl kazası örneği) (in Turkish). [PhD Dissertation] Bursa Uludağ University Institute of Social Sciences. 2015.
4. Kızıltaş Ş. Kültürleşmenin tüketici etnosentrizmi üzerine. Etkisini belirlemeye yönelik bir araştırma. (in Turkish). [PhD Dissertation]. Atatürk University Institute of Social Sciences. 2014.
5. Berry JW, Poortinga YH, Segall MH, Dasen PR. Cross-cultural psychology: Research and applications. Cambridge University Press; 2002.
6. Berry JW, Sam DL. The Cambridge handbook of acculturation psychology: Cambridge University Press Cambridge; 2006.
7. Berry JW, Kalin R. Multicultural policy and social psychology: The Canadian experience. In Political Psychology. London: Palgrave Macmillan; 2000. 263-84 p.
8. Güler A. The effects of ethnic identity in acculturation and psychological well-being among Turkish immigrants in the united states. Hacetepe University Institute of Social Sciences 2016.
9. Berry JW. Immigration, acculturation, and adaptation. Appl Psychol. 1997;46(1):5-34. doi:

10.1111/j.1464-0597.1997.tb01087.x.

10. Berry JW. A psychology of immigration. J Soc Issues. 2001;57(3):615-31. doi:10.1111/0022-4537.00231.
11. Berry JW. Acculturation: Living successfully in two cultures. IJIR. 2005;29(6):697-712. doi: 10.1016/j.ijintrel.2005.07.013.
12. Saygın S, Hasta D. Migration, acculturation and adaptation (in Turkish). Current Approaches in Psychiatry. 2018;10(3):302-23. doi: 10.18863/pgy.364115.
13. Berry JW, Phinney JS, Sam DL, Vedder P. Immigrant youth: Acculturation, identity, and adaptation. Appl Psychol. 2006;55(3):303-32. doi: 10.1111/j.1464-0597.2006.00256.x.
14. Berry JW. Integration and multiculturalism: Ways towards social solidarity. Papers on social representations. 2011;20(1);1-21.
15. Berry JW, Kim U, Minde T, Mok D. Comparative studies of acculturative stress. Int Migr Rev. 1987;21(3):491-511. doi: 10.1177/019791838702100303.
16. Berry JW, Kim U, Power S, Young M, Bujaki M. Acculturation attitudes in plural societies. Appl Psychol. 1989;38(2):185-206. doi: 10.1111/j.1464-0597.1989.tb01208.x.
17. Berry JW, Sabatier C. The acculturation and adaptation of second-generation immigrant youth in Toronto and Montreal. Immigrant children: Change, adaptation, and cultural transformation. 2011:125-48.
18. Mazlumlar İçin Dayanışma Derneği (Mazlumder). Kamp dışında yaşayan Suriyeli kadın sığınmacılar raporu (in Turkish). 2014:45.
19. Akıllı S, Akıllı H, Dirikoç A, Ravanoğlu Yılmaz, S. Geçici koruma altındakiler, sığınmacılar, göçmenler ve mülteciler raporu. TC. Nevşehir Valiliği İl İnsan Hakları Kurulu Komisyon Raporu – 2016 (in Turkish).
20. Altun U, Görel Ö. Sığınmacılar ve mülteciler raporu. 2016 (in Turkish).
21. Akpınar B. "Ocak" culture and folk medicine in the axis of the health and culture relationship: Sample the Eskil-Aksara. 2020. https://hdl.handle.net/11492/5401
22. Aydın, K. Living condition, self perceived health and illness. JSR. 2019;22(1):32-68. doi: 10.18490/sosars.559087.
23. Temel AB, Çimen Z. Kronik hastalığı olan yaşlı bireylerde sağlık okuryazarlığı, sağlık algısı ve ilişkili faktörler (in Turkish). Ege Üniversitesi Hemşirelik Fakültesi Dergisi. 2017;33(3):105-25. https://dergipark.org.tr/en/pub/egehemsire/issue/33737/332345
24. Fayers PM, Sprangers M. Understanding self-rated health. Lancet (London, England) 2002;359(9302):187-8. doi: 10.1016/S0140-6736(02)07466-4.
25. Idler EL, Angel RJ. Self-rated health and mortality in the NHANES-I epidemiologic follow-up study. Am J Public Health. 1990;80(4):446-52. doi: 10.2105/ajph.80.4.446.
26. Eriksson I, Undén AL, Elofsson S. Self-rated health. Comparisons between three different measures. Results from a population study. Int J Epidemiol. 2001;30(2):326-33. doi: 10.1093/ije/30.2.326.
27. Ekti ZA. Aile sağlığı merkezine kayıtlı kişilerin sağlık okuryazarlığı düzeyinin genel sağlık taramaları ve sağlık algısı üzerine etkisinin değerlendirilmesi (in Turkish). 2020.
28. Torsheim T, Ravens-sieberer U, Hetland J, Välimaa R, Danielson M, Overpeck M. Cross-national variation of gender differences in adolescent subjective health in Europe and North America. Soc Sci Med. 2006;62(4):815-27. doi: 10.1016/j.socscimed.2005.06.047.
29. Hacıhasanoğlu Aşılar R, Yıldırım A. Göçün sosyal ve ruhsal etkileri ve hemşirelik. göç ve göçmen sağlığı (in Turkish). 1st ed. Ankara: Türkiye Klinikleri; 2018. 10-20 p.
30. Çetinkaya A, Özsoy S. (Ed.) Nitel araştırma, hemşirelik alanından örnekler (in Turkish). Çukurova Nobel Medical Bookstore; 2021.
31. Zengin M, Yayan EH, Düken ME, Yeliz S. Suriyeli sığınmacıların sosyo-kültürel farkındalıklarının sağlık hizmetlerine yansıması (in Turkish). Bandırma Onyedi Eylül Üniversitesi Sağlık Bilimleri ve Araştırmaları Dergisi. 2021;3(1):11-7.
32. Karataş Z. Karataş. Paradigm transformation in social sciences research: Rise of qualitative approach (in Turkish). TJSWR. 2017;1(1):68-86.
33. Polit DF, Beck CT. Nursing research: Generating and assessing evidence for nursing practice. Lippincott Williams & Wilkins. 2008.
34. Horenczyk G, Munayer SJ. Acculturation orientations toward two majority groups: The case of Palestinian Arab Christian adolescents in Israel. J Cross Cult Psychol. 2007;38(1):76-86. doi: 10.1177/0022022106295444.
35. Kallas N. Understanding the perspectives of Syrian refugee women toward their health and physical activity needs as they become integrated into Canadian society. University of British Columbia. 2017. doi: 10.14288/1.0355832.
36. Jasinskaja-Lahti I, Horenczyk G, Kinunen T.

Time and context in the relationship between acculturation attitudes and adaptation among Russian-speaking immigrants in Finland and Israel. J Ethn Migr Stud. 2011;37(9):1423-40. doi: 10.1080/1369183X.2011.623617.

37. Jasinskaja-Lahti I, Liebkind K, Horenczyk G, Schmitz P. The interactive nature of acculturation: Perceived discrimination, acculturation attitudes and stress among young ethnic repatriates in Finland, Israel and Germany. IJIR. 2003;27(1):79-97. doi: 10.1016/S0147-1767(02)00061-5.
38. Sam DL, Berry JW. Acculturation: When individuals and groups of different cultural backgrounds meet. Perspect Psychol Sci. 2010;5(4):472-81. doi: 10.1177/1745691610373075.
39. Canbaz Kılıç B. Suriyeli mülteci kadınların fiziksel aktivite deneyimlerinin kültürleşme bağlamında incelenmesi. [master thesis in Turkish] Health Sciences Institute. 2020.
40. Söğüt K, Bilge Ç. Protecting and improving health for refugee women: A nursing approach. JOHASS. 2021;4(1):192-206. doi: 10.53048/johass.879451.
41. Aydoğan S, Metintas S. Türkiye'ye gelen dış göç ve sağlığa etkileri (in Turkish). Türk Dünyası Uygulama ve Araştırma Merkezi Halk Sağlığı Dergisi. 2017;2(2):37-45.
42. Uslu Ak B. Türkiye'de farklı koruma statüsündeki göçmenlerin istihdam deneyimleri. [PhD Dissertation in Turkish] Hacettepe Üniversitesi, Social Work Department 2021.
43. Beland F, Birch S, Stoddart G. Unemployment and health: Contextual-level influences on the production of health in populations. Soc Sci Med. 2002;55(11):2033-52. doi: 10.1016/S0277-9536(01)00344-6.
44. Buz S, Dikmen A. Psychosocial well-being of forced migrants. Journal of Society & Social Work. 2021;32(1):227-50. doi: 10.33417/tsh.728689.
45. Ekmen E, Koçak O. Göçün Suriyeli ve Yemenli göçmenlerin aile yapıları üzerine etkileri. Sosyal Siyaset Konferansları Dergisi. 2020;79:167-205. doi: 10.26650/jspc.2020.79.0002.
46. Barrett DH, Doebbeling CC, Schwartz DA, Voelker MD, Falter KH, Woolson RF, et al. Posttraumatic stress disorder and self-reported physical health status among US Military personnel serving during the Gulf War Period: A population-based study. Psychosomatics. 2002;43(3):195-205. doi: 10.1176/appi.psy.43.3.195.
47. Gül M, Şaşman Kaylı D. Türkiye'deki Suriyeli üniversite öğrencilerinde sosyal dışlanma algısı üzerine nitel bir araştırma: Uşak üniversitesi örneği (in Turkish). Journal of Society & Social Work. 2020;31(3). http://hdl.handle.net/11655/23311
48. Fuhrer R, Stansfeld SA. How gender affects patterns of social relations and their impact on health: A comparison of one or multiple sources of support from "close persons". Soc Sci Med. 2002;54(5):811-25. doi: 10.1016/S0277-9536(01)00111-3.
49. Gee GC. A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. Am J Public Health. 2008;98(Supplement_1):S48-S56. doi: 10.2105/ajph.98.supplement_1.s48.
50. Karlsen S, Nazroo JY. Relation between racial discrimination, social class, and health among ethnic minority groups. Am J Public Health. 2002;92(4):624-31. doi: 10.2105/ajph.92.4.624.