LIFE SYTLES AND HEALTH PROBLEMS OF TURKISH YOUTH STUDYING IN SECONDARY SCHOOLS OF ROTTERDAM

Fahri Çakı*

Kadir Canatan**

Abstract: By benefitting from the general stand point of sociology of the body, in this article, we try to shed light on health problems of immigrants. More specifically, the relationship between life styles and health problems of Turkish youth studying in Netherlands is the main subject of this article. The major research question can be expressed as the following: to what extent do the life styles of Turkish youth influence their health conditions? In this regard, we aim to test 5 hypotheses:

1. Gender difference among Turkish youth is a significant factor affecting their health problems and life styles.
2. As age and level of education get higher, so do internal group differences.
3. Turkish youth is no different from other ethnic groups in terms of their life styles and health problems.
4. Turkish youth is similar to Moroccan youth in regard to their life styles.
5. Disregarding group membership, young people involved in sports are better off than all others in living a healthier life.

We try to test those hypotheses by using the data set of a research project called "Jeugdmonitor Rotterdam" (Rotterdam Youth Survey) carried out by Rotterdam Municipality Health Services (GGD) in secondary schools. Main findings can be summarized as the following: First, the findings show that there is *not* a great difference between boys and girls in terms of health experiences. There seems to be no gender difference among those who describe their health as "bad." Second, the findings show no significant pattern of difference among age groups. It is not right to claim for the youth that health problems get increased as they get older. However, when it comes to life styles, age seems to be a source of differentiation. In other words, as young people get older, parallel to this as they get more level of education, we start observing a negative effect on life styles. Third hypothesis (ethnic differences have an effect on neither life styles nor health experiences, thus, Turkish youth is no different from other ethnic groups in terms of their life styles and health problems) was confirmed in regard to neither of them. The fourth hypothesis (Turkish youth is similar to Moroccan youth in regard to their life styles) was confirmed by many indicators of life styles. The last hypothesis (disregarding group membership, young people involved in sports are better off than all others in living a healthier life) was confirmed by all groups.

The most important conclusion of this article is that there is a correlation between life styles and health experiences of Turkish youth. Put it differently, all factors that we used as indicators of life styles (weight, consumption of fruits and vegetables, breakfast habit, spending time before TV and computers, smoking and use of cannabis and alcohol), with the exceptions of cold drinks (sodas/sweet beverages) and mobility, seem to be related to health experiences. This conclusion is quite important from the sociology of the body point of view. Although apparently and directly seem be related to the products that we consume, body health and well-being experiences are closely related to our socio-cultural habits if we look at them from a broader perspective.

Key Words: Lifestyles, Health problems, Turkish immigrants, youth

Tüm hakları BEYDER'e aittir ***All rights reserved by the JKEM***

1. Introduction

After immigration movements from previously colonized societies and from international labor corresponding with social immigration movements of family unification and formation, Netherlands became a typical immigration country in the second half of the last century. Today a multicultural society is been obviously felt all over the country, primarily in larger cities. According to the data from the Statistics Institution of Netherlands, the number of immigrants and of their children has increased to the level of over 3 millions in 2010. This institution divides the immigrants living in the country into two groups: "western immigrants" and "non-western immigrants". The number of the latter reaches almost two third of the whole immigrant population. Out of those, Turkish immigrants consist of the largest group. Then comes respectively Moroccans, Surinamese, Antilles, and Arubans (see Table 1).

Table 1. Estimation of Immigrant Population in Netherlands (2010-2020)

Ethnic Groups	**2010**	**2020**
Turks	381.001	419.668
Moroccans	345.418	405.816
Surinamese	340.570	366.849
Netherlands Antilles and Arubans	137.049	170.252
Western Immigrants	1.496.146	1.627.711
Non-western immigrants	1.833.282	2.163.636
Total	3.329.437	3.791.349

Resource: CBS, 2010.

The majority of the immigrant population lives in four biggest cities of the country: Amsterdam, Rotterdam, Den Haag ve Utrecht. In all those cities but Utrecht, the immigrant population reaches at almost half of city population (see table 2). Although main immigrant groups in those cities consist of a significant mass, ethnic and cultural mosaic is not limited with them. Many small groups coming from all over the world contribute to the flavoring of life in those metropolitan areas.

 All rights reserved by the JKEM

Table 2. The Ratio of Immigrant Population to the General Population in 4 Larger Cities (2009)	
Amsterdam	49.4
Den Haag	47.3
Rotterdam	46.9
Utrecht	31.5
Resource: CBS, 2010.	

Rotterdam, being an old port, well reflects multiethnic and multicultural social life of Netherlands. According to a research carried out by Rotterdam Statistics and Research Institution, small immigrant groups who are recorded as “others” originate in 150 ethnic groups (Bik, 1998). This means, taking the main immigrant groups into consideration too, that around 155 ethnic groups live together in this city.

Turks have become a major group in Rotterdam due to increasingly growing number of family unifications and formations since the mid-70’s. Today the number of Turks living in and around Rotterdam is about 66 thousands. One of the main characteristics of the Turkish population is that it shows a youthful structure. Those who are younger than 24 is over % 50 of the whole Turkish population (ISEO-COS, 2002:14-15). Turks are concentrated primarily at Feijenoord and Delfshaven but also at Noord, Charlois and Kralingen-Crooswijk districts of Rotterdam (COS, 1998:19). Concentration at those districts provides both advantages and disadvantages. On the one hand, it helps for solidarity and organization among those immigrant Turks but, on the other hand, it also corresponds with a risk of isolation from the larger society.

As in the whole Dutch society, the most important problems of Turkish youth in Rotterdam are the shortcomings of education and unemployment. When “integration” is mentioned in this country, those are the first issues coming to the mind. Even though second-generation Turks are better –compared to their parents called as “guest workers” (“gastarbeiders”) –in Dutch language and even though they definitely see their future in this country, they are still not in a well-enough position, compared to their Dutch peers, in the sector of education and job markets.

The “Jaarrapport Integratie 2009” report prepared by Dutch Social and Cultural Plan Bureau compares Moroccan and Turkish youth and indicates that Turkish youth have a greater difficulty in education. Because of their criminal and disturbing behaviors, the Dutch public thinks of Moroccan youth as less integrated in society.

According to Plan Bureau this is not exactly true in all areas. Moroccan youth show better improvements in education. “Turkish-origin Dutch youth face serious problems in different stages of their educational career. This is most probably due to inward-oriented characteristics of the Turkish group, which also prevents learning Dutch language. The backwardness of Turkish youth in language prevents them from improvements in education. When they reach at the end of their primary education, Turkish youth are more backward in language compared

Tüm hakları BEYDER’e aittir All rights reserved by the JKEM

to their peers in the Moroccan community. Moroccan youth surely show a success of language abilities during their primary education. Reflections of Turkish youth's backwardness in language can be observed even in their low level of participation in secondary education. Additionally, Turkish youth more often fail at schools and show poorer performances in examinations." (Gijsberts & Dagevos, 2009:16).

Above-mentioned report indicates that Turks recently make more progress in the job market despite their poorer performances in education. Among all other immigrant communities, the Turkish one has a less level of unemployment (% 10). On the other hand, the number of Turks receiving payments from unemployment compensation is getting smaller and, due to a strength gathered from solidarity among themselves, Turks are getting more entrepreneurial in society. The most significant indicator for their entrepreneurial character is the facts that they are more often building their own businesses and that they tend to have less criminal behaviors compared to other communities (Gijsberts&Dagevos, 2009:17).

Even though Dutch public and official institutions emphasize the internal dynamics of immigrant communities in the process of their integration, in reality this integration process is a more complex phenomenon. In the efforts of explaining this phenomenon, one has to keep in mind that many factors –like immigrant-related factors (such as histories of immigrant communities, their intra-group relationships and potentials) as well as factors behind the control of the immigrants (such as host country's attitudes towards immigrants, institutional arrangements, practiced policies and conjectural developments) –play important roles. According to the "Jaarrapport Integratie 2009" report, compared to other immigrant communities, Turks have a lower level of perception of Netherlands as a hospital country and a lower level of security feeling in this country. The traces of why Turks are so pessimistic can be found in the negative political and social conjecture in Netherlands that appeared, and that still goes on, in the 2000's. This downbeat climate caused recently many Turks moving back to their homeland. Among them, even the number of Netherlands-born Turkish youth is significantly large.

Discussions with immigrants and minorities in Netherlands usually exclude the issues and problems on health. It is a new development that the latest annual national report of integration touches on this issue, which used to be a concern of only local authorities and specific health institutions until recently (See 2009:302-313).

According to this report, Turkish, Moroccan, Surinamese and Antilles children and youth, compared to their Dutch peers, appear to be less happy with their health. This still remains so even after family unifications and improvements based on socio-economic conditions of families. One of the main reasons of unhappiness regarding health is being overweight. According to measurements based on length and weight rates, immigrant youth tend to have more problems of overweight. In all groups, but Turks, especially girls have this problem. Among likely reasons behind those problems, changing habits of nutrition and physical inactivity come to mind first. Having the problem of overweight is common especially among those children who come from backgrounds of single parenthood and poor family. Another aspect of this problem among immigrants is cultural perceptions. As among Turks, some immigrant communities perceive meals as a symbol of abundance while, at the same time, having lunch/dinner possesses a social function.

It is known that psychic problems are more common among families of lower socio-economic status. Such problems show themselves as either inward (muse, depression and fear) or outward (aggression, boundless behaviors, and troubles with peers) behavioral issues. According to measurements, while inward behavioral problems can be seen equally distributed among all groups, outward psychic problems are detected more commonly among

 All rights reserved by the JKEM

Turkish, Surinamese and Moroccan youth. Those problems are partly related with immigration history and socio-economic status of the family.

It is observed that not only physical (overweight) and psychic (outward) problems but also psychosomatic problems are highly seen among young people. Especially girls report non-physical complaints. Part of those complaints is related to their social statues. When those are excluded, then the difference between immigrants and the Dutch gets decreased. However, it is thought that the other part of those complaints has more social and cultural aspects. No matter what the reasons of complaints are, it should be expected that those complaints will negatively affect later stages of young people's lives and their socio-economic statuses.

2. Research Question and Hypotheses

While, during the 80's, socio-economic differences were emphasized the most as the basis of immigrant problems, the emphasis changed during the later years. This time it was socio-cultural differences. No matter what the qualities of the problem are, the attitudes and especially cultural backgrounds of the immigrants are used as an explanatory framework. When societal problems are correlated with cultural factors, this usually takes one to the following conclusion: Insomuch as it is their culture that lies at the basis of immigrants' problems, then their cultures are nonfunctional and one should consider such cultures as obstacles for their integration. This is a culture-essentialist approach since it stigmatizes and criminalizes immigrant cultures. Essentialist approach presupposes some unchangeable characteristics in every culture while it also denies the abilities of ethnical members to change it over time.

On the opposite site of this approach, there is the materialist approach which is based on socio-economic foundations. According to this approach, cultural structures work as depended on socio-economic structures. If socio-economic structures change then economic structures do so as well. As long as socio-economic structures of immigrants remain unchanged, then they will keep having their problems, from this point. Thus, culture is just a reflection of socio-economic structures.

By benefitting from the general stand point of sociology of the body, in this article, we will try to shed light on health problems of immigrants. The most important aspect of this stand point is that it elaborates the relationship between society and the body from an interactionist perspective without getting at any reductionism. Particularly in dealing with health issues, sociology of the body admits that, on the one hand, genetic and internal factors and on the other hand, socio-cultural and external factors play roles at the same time. Whereas genetic-internal factors are stable and hard to be changed, socio-cultural and external factors are more available to be affected and changed. Sociology of the body has no reductionist attitude towards the latter type of factors. The relationship between society and the body is a complex and mutual relationship. Not only socio-economic but also socio-cultural factors can be equally influential. Sociology of the body is not reductionist in regard to the relationships between the group and the individual either because internalization of socio-cultural data by the individual takes place in different forms. Claiming that every individual internalizes the group's cultural elements in the same way and degree cannot be true. Thus, excessive emphasis on group characteristics cannot often explain individual problems.

Within the framework of those general approaches, the relationship between life styles and health problems of Turkish youth studying in Netherlands is the main subject of this article. The major research question can be expressed as the following: to what extent do the life

Tüm hakları BEYDER'e aittir *All rights reserved by the JKEM*

styles of Turkish youth influence their health conditions? In order to operationalize this question we need to make some definitions on a few concepts. First of all, by "Turkish youth" we mean mostly Netherlands-born 10-19 year old youth who have a father and/or mother in Turkish-origin. This group of youth lives in Rotterdam and studies in secondary schools together with other ethnic peer groups. Their environment for interaction and socialization consists of family, street, school and metropolitan youth cultures. "The life styles" and "health conditions or problems" of those youth are the products of such environmental conditions. By the concept of "life styles" we mean the youth's actions and habits of their own choice. Those actions and habits may contain a large set of actions such as involvement in sports, watching TV, usage of the Internet, consumption of alcoholic drinks, smoking, etc. Naturally those actions and habits have some effects on the health of the youth. By "health problems" we do not mean problems diagnosed by health authorities; instead, we mean the youth's own descriptions and perceptions of health problems. Therefore, we embrace a subjective description of health.

We believe in the benefits of a comparative analysis for a better understanding of Turkish youth's status. For this reason, we will make several comparisons among the youths of important ethnic groups in Rotterdam, including the Dutch youth. Those comparisons will allow us to realize inter-group differences as well as the forms of interactions. Within this framework, we think that it is important to test the following hypotheses:

- Gender difference among Turkish youth is a significant factor affecting their health problems and life styles.
- As age and level of education get higher, so does internal group differences.
- Turkish youth is no different from other ethnic groups in terms of their life styles and health problems.
- It is fair to claim that Turkish youth is similar to Moroccan youth in regard to their life styles.
- Disregarding group membership, young people involved in sports are better off than all others in living a healthier life.

We will try to test those hypotheses by using the data set of a research project called "Jeugdmonitor Rotterdam" (Rotterdam Youth Survey) carried out by Rotterdam Municipality Health Services (GGD) in secondary schools. This project was implemented during the 2007-2008 academic year and it collected data in many life areas such as health, school, peer groups, residential environment, etc. of students in different majors. It aimed at helping young people to have both a healthier life and a more successful academic carrier as well as at lessening school drop-outs.

As it can be realized from the table below, a total of 13 thousands of youth all over Rotterdam participated in the survey. The majority of those young people were first and third-grade students. Among the whole groups of participants, the Dutch youth is the largest ethnic group with over a rate of % 55. The numbers of Turks and Surinamese are represented with equal rates.

Table 3. Youth by ethnic Origins (2007-2008)		
	Absolute number	%
The Dutch	7137	55,8
Surinamese	1124	8,8
Antilles/Arubans	442	3,5
Moroccan	995	7,8
Turks	1121	8,8
Kaapverdiler	351	2,7
Others	1611	12,6
Total	12781	100,0

Although Rotterdam Youth Survey (Jeugdmonitor 2008) is the main source of data in this study, we will use data also from Health Survey (Gezondheidsenquette 2008), which was carried out among all ethnic groups in four larger cities. This way, it will be possible to see a picture of the general situation.

3. Health Experiences of Turkish Youth

In order to measure health situation of the participants, Rotterdam Youth Survey asked the youth how they felt about themselves in general. Experienced health indicates subjective judgments of people on their own health and this is a good indicator reflecting one's total health condition in general. Possessing 5 options, young people responded to this question as "very well", "good", "not bad", "not well" and "bad". Before dealing with the responses of the youth, we wish to draw a general view by presenting some interesting results of "Health Survey" carried out, in 2008, in 4 larger cities (Amsterdam, Utrecht, Rotterdam and Den Haag).

The most shocking result of this Health Survey, which involved all people aged 16 and over, is the following: Among 4 cities, it is the people of Den Haag and Rotterdam who have the most negative feeling about their health conditions while it is the Turkish group that have such negative feelings at most. While, in 4 larger cities, the population rate of those who do not feel well is % 17, the same rate for the people of Den Haag is %20 and for that of Rotterdam it is % 19. On the other hand, surprisingly % 41 of the Turks responded as feeling "not good" or "bad". Then, the Moroccans follow them with a rate of %33.

As the table below shows, the second attractive finding is the fact that the least complaining group on general health conditions is the Dutch. All other ethnic groups perceive their health worse than the Dutch.

Tüm hakları BEYDER'e aittir *All rights reserved by the JKEM*

Table 4. Health experiences by ethnic groups in 4 larger cities (2008)	
	%
The Dutch	14
Surinamese	24
Antilles/Arubans	20
Moroccan	33
Turks	**41**
Other Westerners	15
Other non-Westerners	20
General Average	**24**
Resource: Van Veelen vd., G4 Op Gezondheid Uitgemeten, Den Haag 2009.	

The relationships among cities and groups seem to be related to background characteristics of individuals, which are also related to city population compositions. The most complaining groups about their health are the followings: elderly people, immigrants, people with lower level of education, unemployed people, people with no partners, people with no or little income, and people residing in undeveloped neighborhoods (Van Veelen vd., 2008:22). In the following sections we will deal also with the influences of life styles on health.

Table 5. Health Experiences by Youth coming from Different Ethnic Groups (2007-2008)			
	Experienced Health (%)		
	Bad	**Not bad**	**(very) good**
The Dutch	1,0	11,5	87,4
Surinamese	1,8	18,8	79,4
Antilles/Arubans	3,8	19	77,1
Moroccan	3,1	16,1	80,7
Turks	**3,2**	**23,5**	**73,3**
Kaapverdiler	1,7	15,4	82,9
Others	2,8	15,1	82,1
Total	**1,8**	**14,4**	**83,8**

 All rights reserved by the JKEM

When we compare table 4 and 5, we realize two important facts. First, while we see quite high rates of people feeling bad about their health, now we notice that the same rates are getting down in table 5. This is in fact an understandable situation because there is an inevitable positive correlation between youth and being healthy. As people get older, health problems gradually start to increase and vice versa. In terms of the general average, %2 of the youth feels bad about their own health. In another words, 229 out of 12.757 people feel this way.

Secondly, while Turks has the highest rate of people indicating health problems in table 4, it becomes Moroccans in Table 5. They have a rate of % 4.8 with health problems. Moroccan youth is followed respectively by Antilles/Arubans, Turks, and Kaapverdiler. The common point in both tables is the fact that the Dutch has the lowest rate of health complaints.

Before dealing with how inter-group differences can be accounted for, we wish to point out that it will be useful to look at the above tables from a relativist perspective. Those who respond, in table 5, as "not bad" for their health situation are in fact a group of people with some complaints in regard to their health. If not, they could choose responding as "well" or "very well". Thinking in this way, we can conclude that young people do have a considerable amount of health problems.

Some differences in health experiences are noticeable among Turkish youth not only in terms of their ethnic origin but also in terms of their internal group dynamics. For instance, while %21 of boys describe their health as "bad" (%3) and "not bad" (%18), this rate goes up to % 32 among girls. Particularly the rate of girls who describe their health as "not bad" is quite high (%28).

While the differences among those age groups only who describe their health as "bad" do not demonstrate a significant pattern, the rates tend to significantly increase when they are taken together with those groups who describe their health as "not bad". Furthermore, particularly the group of 13 year-old-youngsters tends to have more complaints about their health.

4. Life Styles of Turkish Youth

The concept of "life styles" is operationalized, by different researches, with different measurements and indicators although it covers a quite large area. In the Health Survey carried out in 4 cities of Netherlands, this concept was operationalized by 4 main indicators. As it can be noticed from the table below (table 6), those indicators are the followings: smoking, use of alcohol and cannabis sativa, and body movements. Of course many others can be added to those indicators but still they will give us some ideas about the life styles of young people.

It is obvious from table 6 that, after Surinamese, Turks are the second group smoking the most. The survey asked the informants if they smoked or not but the frequency of smoking was not questioned. In terms of smoking habits, the Dutch, Antilles and Arubans stand on one side whereas Turks and Surinamese stand on the other. Moroccans are separated from all other groups due to the fact that smoking habit is infrequent among them.

Contrary to smoking, consumption of alcohol is seen more common among the Dutch and other westerners. Turks and Moroccans, probably due to their Muslim identity, appear to be the least alcohol consuming groups. When asked if they used cannabis sativa within the last 4 weeks, it is the groups of Antilles and Arubans together with other westerners who responded "yes" the most (around %10-11). Cannabis sativa ‒ or "marihuana" as it is commonly known ‒ is a kind of drug also called "grass" or "spice" in many countries. Although infrequent in

Tüm hakları BEYDER'e aittir *All rights reserved by the JKEM*

the other groups, it cannot be claimed that this plant as a drug is not known or consumed by them.

Table 6. Life Styles by Ethnic Groups (2008)				
	Life Styles (%)			
	Smoking	**Alcohol**	**Cannabis**	**Lack of body movements**
The Dutch	27	14	7	35
Surinamese	39	5	7	53
Antilles/Arubans	26	7	11	52
Moroccan	15	0	4	55
Turks	**36**	**3**	**5**	**65**
Other westerners	31	13	10	40
Other non-westerners	22	5	5	50
RESOURCE: Van Veelen vd., G4 Op Gezondheid Uitgemeten, Den Haag 2009.				

The fourth indicator of life style, mobility, was measured with what is called Healthier Mobility Norm in Netherlands. Those with no or little mobility in their daily life have a considerable rate in every group. The highest rate in this sense belongs to Turks (% 65). Other groups with a rate over % 50 are Moroccans, Surinamese, Antilles, and Arubans. The Dutch and other westerners seem to be more active and awake in this respect. If generalized, it can be claimed that immobility tends to be a problem of non-westerners rather than western groups.

When the distribution of indicators/rates regarding life styles and its relationship with some variables are taken into consideration, it becomes clear that life styles are determined not only by cultural elements but also by socio-economic factors. Due to the fact that it is forbidden by their religion, Turks and Moroccans are less interested in consumption of alcohol and drugs. Westerners, on the other hand, tend to consume such things much more than the other groups. Inversely, Turks and Moroccans less adjust to the norms of mobility and particularly Turks smoke more. Some general trends arise out of an evaluation taking socio-economic factors into consideration over all groups.

 All rights reserved by the JKEM

Within the framework of those trends, the followings are particularly noticeable: consuming alcohol, cannabis, and tobacco and having less mobility are more common among people with lower level of education compared to those with higher ones; among people with no employment and income (or people dependent on compensation) compared to people with a regular job and income; among unmarried or divorced people compared to married couples; among men compared to women; and among people of undeveloped districts compared to people of developed districts. So it means that not only cultural or socio-economic factors but both influence life styles.

A more detailed analysis by age groups will determine whether, or to what extent, generation-gap is influential on life styles. The Health Survey in 4 larger cities gives a chance, from age-groups point of view, to make generalizations similar to the ones made above in regard to life styles. Smoking culture is seen the most (%33) among the age group of 45-54 year-olds. Then, it gets rapidly decreased among older age groups. Behind this slump lies the act of quitting smoking most likely due to health problems. On the other hand, while the rate of smoking is % 25 among the age group of 16-24, it gradually increases among later age groups and it reaches up to % 28.

Although with different rates, there is a similar pattern in regard to consuming alcohol, which is seen the most among the age group of 55-64. Again it gets rapidly decreased among later age groups. On the other hand, whereas alcohol consumption rate during younger ages (between 16 and 44) is around % 10-11, it increases among the age group of 45-54. So it means that alcohol consumption has a trend of increase towards middle ages, and then it tends to decrease during later periods.

On the contrary to smoking and alcohol habits, consumption of cannabis seems to be a fashion peculiar to young people rather than middle and older ages. While the rate of cannabis consumption among the age group of 16-24 is % 10, it tends to decrease gradually among later age groups. Contrary to smoking and alcohol, cannabis appears to be a habit that is experienced at younger ages and that is quitted at older ages. What is more, it looks like it has an ethnic character as well. Among all ethnic groups, it is Antilles and Arubans who are most interested in this object.

Lack of mobility seems to be a problem concerning all age groups and a large portion of public. While a large group (around %40) of people, since younger ages, make no effort of adjusting to prescribed mobility norms for health, this rate rapidly decreases down to % 25 among the 55-65 age group. Here we can foresee an effort emerging after problems of immobility are experienced. This effort disappears again at later ages.

In sum, first two indicators show that smoking and use of alcohol are most commonly used particularly among the middle-age group and that use of cannabis is a passing youth fad while, on the other hand, problems of immobility concern a large group of people who look for solutions after they start noticing the importance of such problems during their middle ages. Life experiences rather than getting informed seem to be more influential on this as a Turkish proverb says: “a nuisance is worth more than thousands of good advice”.

After all those given evaluations, we can now get back to life styles of Turkish youth in Rotterdam and to the comparison of them with the youth of other ethnic groups. We can examine life styles of the given youth in three categories of habit as addictive substances, nutrition, and mobility. To start with addictive substance habits, we will use a set of habits based on 4 main indicators: smoking, use of alcohol, use of cannabis, and use of hard drugs. As it is clearly seen in the table (7) below, the most common habit of smoking among all the

Tüm hakları BEYDER’e aittir All rights reserved by the JKEM

youth is the Dutch youth (% 10), who are followed by Surinamese and Moroccan youth (% 8).

Compared to smoking, consumption of alcohol has a higher rate among the youth. However, when reading the given rates, here a special attention should be paid on how the survey questions were verbalized. Those rates are the rates of the youth who responded as “yes” for the question of “have you ever had alcohol?” This does not mean that they regularly consumed alcohol as they could regularly smoke in their daily lives. Within this group, it is seen that Turks and Moroccans are the ones who have this habit the least. It might be asserted that they probably just tried it a few times in their lives.

Table 7. Use of Addictive Substances by Ethnic Origins of the Youth (2008)

	Life Styles			
	Smoking	**Alcohol**	**Cannabis**	**Hard Drugs**
The Dutch	10	49.5	4	0.5
Surinamese	8	43.5	4	1
Antilles/Arubans	6	51.5	5	1
Moroccan	3.5	4.5	2	1
Turks	**8**	**13**	**2**	**0**
Kaap Verdiler	3.5	36.5	2	0.5
Others	7.5	63	3.5	0.5

Besides alcohol and smoking habits, the youth was asked whether they used cannabis and hard drugs. The rate of young people responding “once” or “more than once” for the question of “how often have you used cannabis within last 4 weeks?” varies between % 2 and % 5. While the least (around %2) cannabis using groups are Turks, Moroccans and Kaap verdiler, the rate goes up to % 4 and % 5 among the groups of Antilles/Arubans, the Dutch, and Surinamese. From the survey data, it is not possible to know whether the informant actions within the last 4 weeks are also a constant act in their usual lives.

In respect to hard drugs, it is understood that the youth of all groups has no or very occasional experience in this field. It can be suggested that hard drugs are a taboo especially among Turkish youth. Unlike smoking and use of alcohol, Turkish community tends to have less tolerance for hard drugs.

The second field for the measurement of life styles concerns food habits. It was questioned whether the youth of different ethnic groups have a breakfast in the mornings, whether they consume fruits and vegetables (plants that has antioxidant functions), how much cold drinks they drink.

Tüm hakları BEYDER’e aittir *All rights reserved by the JKEM*

In the first column of the table (8) below, the rates of the youth who start the day without breakfast is given. As it can be noticed from there, the highest scores for starting the day without breakfast belong to the groups of Surinamese and Antilles/Arubans. For the Turkish group, this rate has the lowest score (even less than % 8).

Table 8. Food Habits by Ethnic Origins of the Youth (2008)

	Life Styles			
	Breakfast	**Fruites**	**Vegtables**	**Cold Drinks**
The Dutch	4.7	8.6	1	80
Surinamese	18.8	9.7	1.8	85
Antilles/Arubans	17.5	12.7	7	87
Moroccan	11	6.7	5	85
Turks	**7.6**	**6**	**5.5**	**81**
Kaap Verdiler	13	7	7	88
Others	10	7	4.7	75

The rate of those who never consume fruits or vegetables varies between % 1 and % 7. While the lowest rate in this sense belongs to the Dutch and Surinamese youth, the highest rate belong to the groups of Kap Verdiler and Antilles/Arubans. Turkish and Moroccan youth, on the other hand, tend to have mostly a mid-level rate.

In addition to breakfast, and consumption of fruits and vegetables, the youth was asked whether, or how much, they drunk cold drinks containing sugar. From this point o view, the rate of those who drink no or little cold drinks varies between % 12 and % 25. It means that almost every group has a high rate of drinking cold drinks. As table 8 suggests, the inter-group differences are not too big.

The third questioning area of life styles concerns habits of sports and mobility. In this context, the informants were asked how much they had mobility, how long they stayed before computers and TV, and additionally if they had weight problems. The youth responding "never" for the question of "how many days do you have mobility?" are those who never have any mobility and sportive activities, not even having a walk. As it is clear in table (9) below, the rate of such youth is % 1,5 among the Dutch while it is % 3 or above among the groups of Surinamese, Turkish, Moroccans and Kaap Verdiler .

Tüm hakları BEYDER'e aittir *All rights reserved by the JKEM*

Table 9. Habits of Mobility by Ethnic Origins of the Youth (2008)				
	Life Styles			
	Mobility	**TV**	**Computer**	**Weight**
The Dutch	1.5	28.5	32	8
Surinamese	3.7	58	48	15
Antilles/Arubans	2.5	59.5	55	17
Moroccan	3.3	51.5	30.5	15
Turks	**3.5**	**54**	**52.5**	**27**
Kaap Verdiler	3.7	69	48	18
Others	2.9	52.5	40	11.5

Spending too much time before TV and computers too cause lack of mobility; thus, measurements on this will provide some information for us to evaluate mobility of the youth. Table 9 shows us the rates of watching TV one hour or more per day. It looks like Kaap Verdiler, Antilles/Arubans, and Surinamese are the ones watching TV at the most rate. They are followed by Turks and Moroccans. The Dutch youth, among all, seems to be the least TV-watching group with a rate of % 28,5. We can interpret this data as the Dutch group possesses more opportunities and options of leisure activities.

We see a similar pattern in regard to spending time before computers. It is the immigrant groups of youth who spend one hour or more in front of computers every day. Again the Dutch youth is the least-computer using group in their daily life.

It is well known that malnutrition and immobility cause some weight and health problems. The last column in table 9 gives us some ideas on this matter. According to the measurements based on the relationship between length and weight, Turkish youth seems to be the group experiencing weight problem at the greatest rate while the Dutch youth, on the other hand, seems to be experiencing the problem at the lowest rate. The rates of the other ethnic groups seem to be more or less equal.

As a general interpretation based on the indicators of life styles, we can suggest that Turkish youth do not have more problems from eating and addictive substances points of view with the exception, however, that they tend to have less mobility and more weigh problems compared to the other ethnic groups.

5. The Relationships Between Life Styles and Health Perceptions

After describing health experiences and life styles of Turks in general and Turkish youth in particular, now we can attempt exploring the relationship between those two variables. The general view in public opinion is that life styles have serious effects on health conditions and, that particularly habits of smoking, alcoholic drinks, and malnutrition harm health. If

Tüm hakları BEYDER'e aittir

All rights reserved by the JKEM

immobility and weight problems are added to this list, the public image that the new generations maintain an unhealthy life gets further strengthen. Now we will discuss whether, or to what extent, this public image of the relationship between life styles and health conditions do really reflect the reality. But before starting this, it is necessary to underline an important point.

As we have seen in previous sections, the great majority of the youth have a good health (% 80). Moreover, it cannot be claimed that they have a serious problem in regard to their life styles (see table 5). In other words, the above-mentioned public image cannot be said to be true. Generalizations based on observed problems in a small group are a source of prejudices about the youth as it is so for all kinds of groups. Prejudices about some groups exist usually because of extreme simplifications, categorizations, and generalizations.

The second source of the introduction, in the Dutch public opinion, of immigrant youth in general and Turks and Moroccans in particular as problematic groups is the fact that the circles of the media and politics are focused too much on those groups. This is a result of what psychologists and social psychologists call "selective perception". In the recent past of Netherlands, sometimes Surinamese and sometimes Antilles youth attracted public attention but Turkish and Moroccan youths, since a long time, have been at the center of the media and political agenda. This focus on Turkish and Moroccan youths is sometimes related to the real problems of some young groups but mostly it is a product and part of the conjecture.

Although, possessing a magical association, the concept of social integration of immigrant youth is an important issue, that concept itself was never considered as problematic by the Dutch public. For us, it is reasonable to think that this concept in fact holds an ethnocentric character. This is so because, when one talks about the integration of immigrant youth, indigenous-white-Dutch-youth (IWDY) is taken as the main norm or model. Thus, the immigrant youth are considered to be sufficiently integrated as long as immigrant youth resembles to IWDY or, on the contrary, they are considered to be failing in integration as long as they show somehow different characteristics than IWDY. Needless to say that indigenous youth cannot be presented as a model. Just to give an example, interest and participation in politics among the Dutch youth are usually quite low. Immigrant youth develop an apolitical attitude and get alienated from political life, if and as long as they resemble to the Dutch youth. In such a case it is clear who should be presented as a model for the others. It is known that first generation-Turkish community used to be, and still are, more interested and active in political life compared to the second and third-generation Turkish youth. By looking at this picture one should conclude that second and third-generation Turkish youth are better integrated. But who can say that this is a desirable integration?

We set such prejudiced and ethnocentric approaches aside and we claim that our correlation analysis points out a correlation between the life styles and health conditions of Turkish youth. To put it in another way, all of the life style indicators (weight, fruits, vegetables, breakfasts, watching TV, attitudes towards use of computers, smoking and consumption of cannabis and alcohol), with the exceptions of cold drinks (sodas) and mobility indicators, seem to be related to health experiences. This relation of course is sometimes positive and other times negative. While fruits, vegetables, and breakfasts have positive influence on health, other types of habits and behaviors have negative influence on it.

It cannot be argued, when altogether compared, that there is a great difference between the youths of the Dutch and other ethnic groups. While eating and mobility habits have positive effects on health, there is a negative relationship among all others.

Tüm hakları BEYDER'e aittir *All rights reserved by the JKEM*

At this stage, we have to admit that life styles often times have negative effects on the situation of the young people who describe their health experiences as "bad" and "not bad". Moreover, this situation should be understood as an ethnicity- irrelevant problem. In other words, eating habits and various behaviors harming health are more or less seen among all groups. Such habits and behaviors are responsible also for negative health experiences. However, as we pointed out before, some parts of negative health experiences are based on socio-economic factors; they cannot be explained solely by life styles possessing socio-cultural character. Any reductionist approaches on this matter must be avoided. Besides, we can think off even a positive role of socio-cultural factors when the subject is Turks and Moroccans due to the fact that Islamic beliefs save them from the use of alcohol and drugs and thus help them keep their health.

Investigating internal group differentiation of Turkish youth, by gender and age, will give us some ideas on internal group dynamics. We do not come across great differences among girls and boys from lifestyles point of view. The difference between girls and boys are far away from being significant in terms of both eating habits and addictive substance habits. When it comes to weight and mobility problems, girls seem to have a little bit more problems of immobility. However, even this does not mean that they have more weight problems. On the contrary, boys have more weight problems (% 31,5) than girls (% 23,5).

We made a comparison between the lowest age group (13), which was the mostly represented age group in the research, and the highest age group (15) in order to see if age variable has any effects on life styles. We found out that there appear some changes in life styles as age increases and that those changes show a negative character. Young people gradually start, as their ages get higher, to develop more habits of addictive substances use like alcohol, cannabis and smoking. Eating and mobility habits tend to change less. We can interpret those facts as young people try to prove themselves with the use of such addictive substances, which are seen as indications of social status. At the background of such habits, of course we should admit the role of peer groups as well.

6. Conclusions and Evaluation

In the sociology of the body, health is considered to be an area affected by both socio-economic and socio-cultural factors. In this article we tried, through the concept of "life styles," to determine the role of socio-cultural factors in addition to well known socio-economic factors. In this process, we tried to operationalize the concept of "life styles" by using several indicators. By summarizing the main findings in the light of our hypotheses, now it is time to go back to our original research question and formulate an appropriate answer.

Our first hypothesis was that gender differences affect both health experiences and life styles. The assumption behind this hypothesis was the idea that boys and girls, in Turkish culture, get grown up with different role expectations and that they fallow different paths of socialization. However, the findings show that there is *not* a great difference between boys and girls in terms of health experiences. Although the rate of those who describe their health as "not bad" is relatively higher among girls than boys, there seems t be no gender difference among those who describe their health as "bad."

As for life styles too, there seems to be no significant gender difference. We found out that girls have relatively lesser rate of mobility but this does not mean that they have more weight problems compared to boys. Considering all those, we can conclude that our first hypothesis

is falsified. Additionally we can conclude that gender differences should not be exaggerated for the new-generation-Turks.

The second hypothesis was that internal group differences get increased depending on the variables of age and level of education ("As age and level of education get higher, so does internal group differences"). The findings show no significant pattern of difference among age groups of those who describe their health as "bad," whereas especially the youth of 13 year-old age group tends to have more complaints on their health when they are evaluated together with those age groups describing their health as "not bad." In this case, it is not right to claim for the youth that health problems get increased as they get older.

When it comes to life styles, age seems to be a source of differentiation. In other words, as young people get older, parallel to this as they get more level of education, we start observing a negative effect on life styles. This means that age is more influential than gender as variables of internal group dynamics. Thus, the second hypothesis should be considered partly confirmed because it was confirmed in regard to life styles though not in regard to health experiences.

The third hypothesis was that ethnic differences have an effect on neither life styles nor health experiences (thus, "Turkish youth is no different from other ethnic groups in terms of their life styles and health problems"). This hypothesis was confirmed in regard to neither of them. First of all, the youths of Turkish, Antilles and Aruban groups are getting worse health experiences compared to other ethnic groups. The rate of those Turkish youngsters who describe their health as "bad" is not too different from that of other ethnic groups. However, the rate of those Turkish youngsters who describe their health as "not bad" is much higher than that of other ethnic groups.

Ethnicity seems to play a role from the stand point of life styles as well. Turkish youth, compared to other ethnic groups, has lower rates of alcohol and especially drug use while they tend to smoke more than the others but the Dutch. As Turkish youth is not too different from the others in terms of their eating habits, they are not too different in terms of mobility and spending time before TV and computers either. Nonetheless, Turkish youth seems to have more weight problems than all other groups. In short, Turkish youth has some distinctive characteristics on certain issues while they are not so different from other ethnic groups in regard to some other issues.

The fourth hypothesis was that, due to their Islamic backgrounds, "Turkish youth is similar to Moroccan youth in regard to their life styles." This hypothesis was confirmed by many indicators of life styles. For instance, those two groups show similar trends in regard to their habits of eating, mobility and spending time before TV and computers while, at the same time, they seem to hold similar attitudes towards alcohol and drugs.

The similarities between Turkish and Moroccan youths cannot be explained only by their religious backgrounds. We have to take it into consideration also that those two groups have more social interactions with each other in Netherlands. Thus, similarity starts with the common ground of religious background and gets further solidified with social interactions.

The last hypothesis proposed that, disregarding group membership, young people involved in sports are better off than all others in living a healthier life. This hypothesis was confirmed by all groups. In other words, those who get involved in sports one hour or more in a week seem to be happy with their health. Whereas the correlation among the Dutch and other groups is high, it is low among Turkish youth. The reason behind this is the fact that the rate of mobility among Turks is low anyway.

Tüm hakları BEYDER'e aittir ***All rights reserved by the JKEM***

Besides the hypotheses and their tests, the most important conclusion of this article is that there is a correlation between life styles and health experiences of Turkish youth. Put it differently, all factors that we used as indicators of life styles (weight, consumption of fruits and vegetables, breakfast habit, spending time before TV and computers, smoking and use of cannabis and alcohol), with the exceptions of cold drinks (sodas/sweet beverages) and mobility, seem to be related to health experiences. This relationship, needless to say, is sometimes positive and other times negative. While factors like having breakfast and consuming fruits and vegetables have positive effects on health, some other factors like spending too much time before TV and computers, smoking and use of cannabis and alcohol have negative effects on it.

This conclusion is quite important from the sociology of the body point of view. Although apparently and directly seem be related to the products that we consume, body health and well-being experiences are closely related, in fact, to our socio-cultural habits if we look at them from a broader perspective. In addition to socio-economic variables, the role of socio-cultural habits on our health is a truth that cannot be denied. This finding not only shows the limited explanatory strength of socio-economic factors on health problems, but it also informs us why health policies cannot be determined only with the manipulation of those factors. If health is a phenomenon based on socio-cultural factors, then they should be taken into consideration as well and some additional appropriate measurements regarding socio-cultural factors must be incorporated into health policies. In regard to life styles generating risks for health, it is vital to develop some preventive measures not only by health institutions but also by many others such as the family, NGO'S, religious and educational institutions.

REFERENCES

Bik, M, 1998, **De bevolkingsgroep 'overige arme landen' in Rotterdam**, COS, Rotterdam.

COS, 1998, **Demografische gegevens 1998**, Rotterdam.

Gijsberts, M. & Dagevos, J. (2009), Jaarrapport integratie 2009, Sociaal en Cultureel Planbureau, Den Haag

ISEO-COS, 2002, **Minderhedenmonitor 2001**, Rotterdam.

 All rights reserved by the JKEM