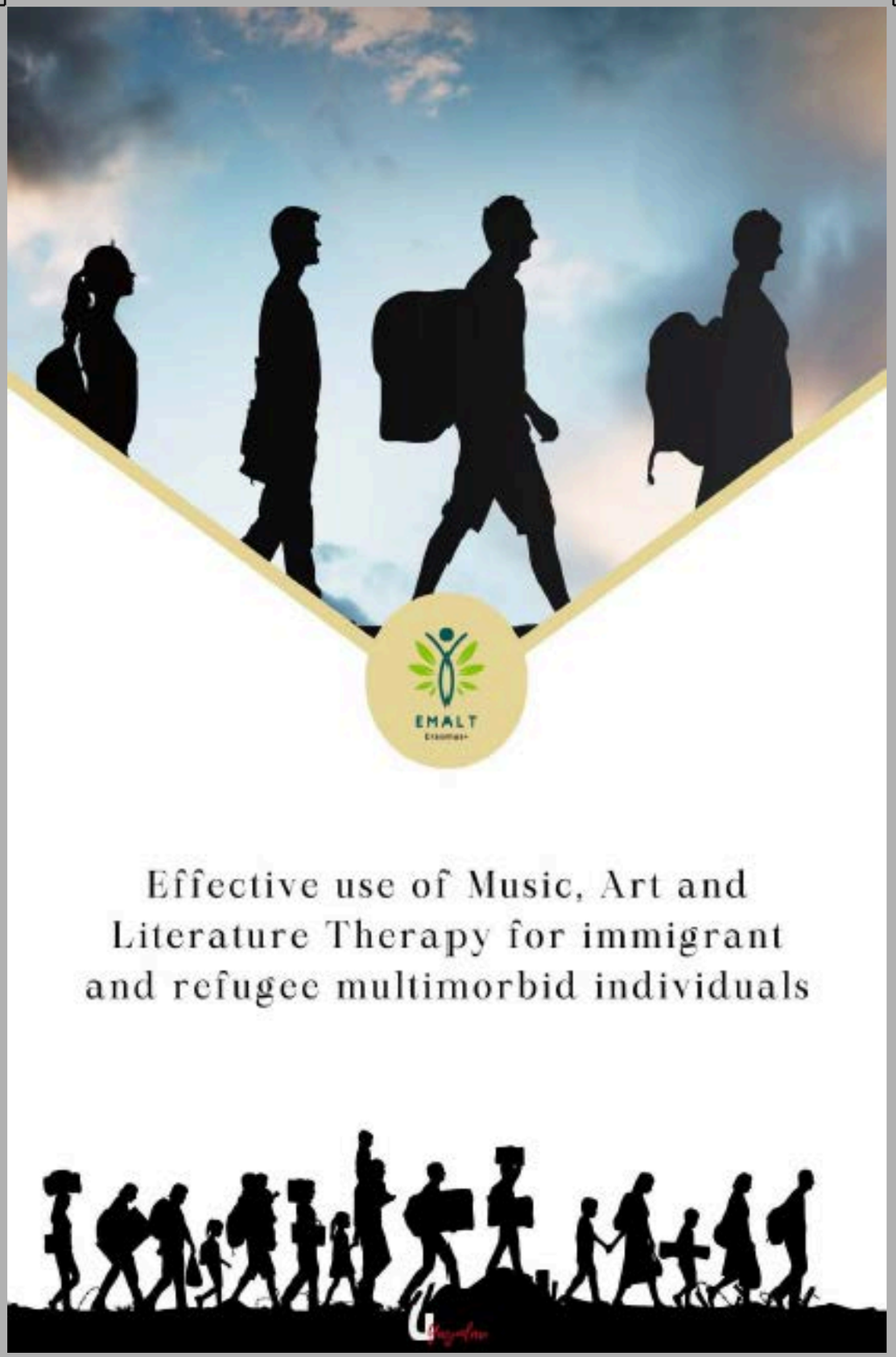


Effective use of Music, Art and Literature Therapy for immigrant and refugee multimorbid individuals

ART AND IMMIGRATION

U YAYINLARI
Certificate Number: 46736

ISBN: 9798398616255

Editor: Yasemin TUR
Cover Design: Umut HALLAC

Authors

Diyadin ALTUNTOP
Ahmet Emre YILKIRAN
Maria Giovanna ROMANIELLO
Umut HALLAÇ
Yasemin TUR

EMALT WORKING TEAM
22.418 words

©EMALT 2023

CONTENTS

PREFACE....3
INTRODUCTION.... 4
GENERAL FRAMEWORK....5
1. MIGRATION....8
2. PROBLEMS CAUSED BY MIGRATION....9
2.1.Integration Problem....11
2.2.Economic Problems....13
2.3.Psychological Problems....15
2.4. Alienation Problem....20
2.5. Social Exclusion Problem....21
2.6.Security Problem....23
3.NTERNATIONAL MIGRATION DATA and POLICIES....26
3.1.Netherlands....28
3.2.Turkey....30
3.3.Norway....32
3.4.taly....35
4. MIGRATION AND ART....38

5.ART THERAPY....40
5.1. What is Art Therapy?....40
5.2.History of Art Therapy....42
5.3.Art Therapy Applications....46
5.3.1.Objective....46
5.3.2.Justification....47
5.3.3.3.Compliance....50
6.EXPECTED EFFECT OF ART THERAPY....55
6.1.Short Term Expected Impact....55
6.2.Long Term Expected Impact....57
6.3. Multiplier Effects....58
7.EMALT GUIDE....60
7.1.EMALT Methodological Guide....60
7.2. Function and Role of the Therapist in EMALT Approach....61
7.3. Process to be applied in therapy....65
8.SAMPLE CASE STUDIES.... 68
9.RESEARCH METHOD.... 76
10.CONCLUSIONS....91
RECOMMENDATIONS....92
SOURCE.... 94
THANK YOU. 100

PREFACE

This book was prepared within the scope of the project "Effective use of Music, Art and Literature Therapy for immigrant and refugee multimorbid individuals" in partnership with Turkey, the Netherlands, Italy and Norway.

First of all, the phenomenon of migration, the problems created by the phenomenon of migration are discussed and analyses with case studies are included. In this context, findings have been reached that the most important psychological factors created by migration should be eliminated for social cohesion. Music, Literature and Art Therapy have been applied as a method, and the suitability and results have been supported by detailed studies. In the continuation of the book, the method applied is taken into a general framework and all studies are referred to as Arts Therapy.

This book is produced within the scope of ERASMUS+Programme by the financial support of the European Union. The contents of this book are the sole responsibility of EMALT TEAM and do not necessarily reflect the views of the European Union."

EMALT WORKING TEAM

INTRODUCTION

As a result of demographic changes, especially in developed countries, the post-migration change brings along social, health and economic phenomena. At this point, there is a significant increase in public health expenditures due to demographic increase. Today, the increasing costs of chronic diseases push humanity to new searches. Therefore, sustainable studies for a healthier, economic, social and community with EU values are important.The displacement of more and more people brings along structural problems as well as an increase in public expenditures. One of the problems that developed countries face and need to solve is crisis-oriented expenditure programmes.

Countries are developing new policy proposals in order to reduce public costs on the one hand and on the other hand to improve the quality of health and not to cause social security deficits. In order to develop service planning and social policies, it is important to create a data pool that brings together information on socio-economic characteristics and health status in the databases of different institutions and also reveals the profile of chronic patients.

Population planning, support needs of individuals in their daily activities, health, education, income conditions and expectations make it necessary to create a detailed system on the basis of regions compared to the rate of population growth. In this context, taking into account human rights, structural integration will be possible with the application of alternative methods. This book has been prepared to help refugees and immigrantswith chronic diseases before or after migration to integrate into the society through Arts Therapy.

GENERAL FRAMEWORK

People who move from one country to another in order to settle are called migrants (Faist, 2003:42). Migrant is the main element of migration movements. Those who stay in a country other than their own country of citizenship for at least 12 months are considered as migrants (Toksöz, 2006:109). A migrant is a person who voluntarily leaves his/her own country due to economic reasons or dissatisfaction with the social environment in which he/she lives and goes to another country legally or illegally and lives there (Olcay, 2012:232).

In general, migration, which is the act of going from one place to another for the purpose of settling, living and surviving (Crawley and Sklerapis 2018), is a complex and multidimensional phenomenon. It can be said that today's migration movements are much more complex than in the past in terms of the profiles of migrants, their personal reasons, the ways and processes of realisation (Roman 2015).

As a type of migration, refugee is "a person who, for reasons such as religious opinion, ethnic group or political opinion, believes that they are not safe in their country and therefore leaves or is forced to leave their country." (Sever, 2012:53) According to the 1951 UN Convention Relating to the Status of Refugees, a refugee is "a person who, having a well-founded

fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, has left his or her country and is unable or unwilling, owing to such fear, to return" (www.unhcr.org.tr).

Although health services for asylum-seekers and refugees vary from country to country, they are not at the desired level, including in developed countries. In the case of asylum-seekers and refugees, it is seen that the main means of benefiting from health and social services is related to the acquisition of citizenship or residence rights.

Refugees worldwide experience serious problems in terms of counselling, basic health services and preventive services, diagnosis, treatment opportunities and access to medication (Karadağ and Altınbaş, 2010:56). When analysed historically, human migration has progressed with different motivations in different periods but always on the same route - towards developed and prosperous countries.

In social terms, the negative dimension of migration is the anti-immigrant sentiment that emerges in society and can be labelled with different concepts such as 'anti-immigrant prejudice' (Quillian 1995), 'xenophobia' (Hjerm 2007), 'anti-immigrant sentiment' (Ceobanu and Escandell 2008, Hainmueller and Hiscox 2007), 'ethnic prejudice' (Hello et al. 2002), 'xenophobic sentiment' (Semyonov et al. 2006; Wilkes et al. 2007).

Most refugees are exposed to multiple pre-migration (such as traumatic experiences and past losses) and post-migration (such as difficulties encountered in the country of origin) traumas that negatively affect their

mental health (Table 1). Pre-migration risk factors include unfavourable economic, educational and occupational status in their home countries, political situations, social support, roles and disruption of the social network (Kirmayer et al. 2011). Accordingly, many refugees/asylum-seekers experience or witness traumatic events such as rape, torture, war, imprisonment, murder, physical injury and genocide before leaving their country (Nicholl and Thompson 2004). Risk factors during migration include the route travelled, duration, exposure to harsh living conditions (e.g. refugee camps), exposure to violence, disruption of family and social relations, uncertainty about the outcome of migration, and traumatic experiences during arrival to and escape from the country of asylum.

After migration, uncertainty about migration or refugee status, unemployment and unemployability, loss of social status, family and social support, anxiety about family members left behind as well as anxiety about reunification, language learning, cultural adaptation and adjustment difficulties (e.g. change in gender roles) are other risk factors that negatively affect mental health (Kirmayer 2011). As a matter of fact, it is reported that post-migration stress factors have a strong negative effect on mental health in asylum seekers/refugees more than pre-migration traumas (Teodorescu et al 2012).

1.MIGRATION

Migration is a very complex process. It is seen that many factors can have an impact. There is not only one reason for migration, but it is also possible to realise it voluntarily or forcibly. It is easier for individuals or communities to get used to where they go if they leave the place they are in for economic reasons, in line with their own wishes. However, it is possible to count forced migration as the most effective and difficult process in the migration of communities.

Migration, which corresponds to spatial change (Güvenç, 1996: 21), is a phenomenon that affects almost everything about the society, especially the psychological state of the individual.It is possible to see that migration generally flows from undeveloped or developing countries to developed countries or from undeveloped cities to developed cities.

The factor that makes migration so important is that it affects the social relations of national and international society in the context of social, political, security and economic relations. The phenomenon of migration is above all a sociological event that enables individuals or masses to open up to new sociology and identities. The multidimensional causes and consequences of migration are not only the agenda of the countries on the migration routes, but also a process that develops with the participation of all countries, non-governmental organisations and civil actors.(ADIGÜZEL 2019)

Immigrants see almost everything, especially the land, city and politics in the place they migrate to, as instruments or obstacles to power (Cengiz, 2010: 188). The fact that migrants have such an approach prepares the ground for the formation of large-scale changes in the natural and artificial environment in the new place where they settle.

However, the phenomenon of migration, which has different components and a multidimensional impact, is approached in many countries as a phenomenon related only to social policy (Borjas, 1994: 1714).

The most tragic issue of migration, the acceptance of refugees who have to relocate due to the pressures they face and the issue of which countries will bear the costs are among the issues that confront states in the international arena. The solution of humanitarian problems of refugees such as security, shelter, nutrition and health is often seen as a heavy burden for receiving countries (Akıncı et al., 2015: 77).

2. PROBLEMS CAUSED BY MIGRATION

Since 2011, conflicts in the Middle East and North Africa have triggered an influx of refugees from this geography towards neighbouring countries and the European continent. The Syrian civil war, which has entered its seventh year, has increased the security problems in the region and caused the refugee flow to turn into an international crisis.(KILIÇ 2019) The United Nations High Commissioner for Refugees (UNHCR) considers this crisis as "the biggest case since the Second World War" in terms of forced displacement.

Since 2004, The Migrant Integration Policy Index (MIPEX), prepared in cooperation with various international organisations, has been a useful resource in this sense. The index, which includes 167 variables, examines the migrant integration policies of 38 countries with large migrant populations such as the European Union (EU) countries, Australia, Canada and the USA through 8 themes (labour mobility, education, political participation, citizenship, family reunification, health, residence permit, anti-discrimination).

In the UN's "Global Trends in Forced Displacement 2022" report, it was announced that the number of people displaced last year due to war, persecution, discrimination, political repression, violence and human rights violations increased by 19 million 100 thousand people compared to 2021.

In the past, people had to migrate due to their powerlessness against natural events such as adverse climatic conditions, soil inefficiency, drought and earthquakes. However, today, migrations are caused by social, economic, cultural and political reasons between people and societies, and new migrations emerge in new forms (Abadan-Unat, 2002:252; Taş, Koçar and Çiçek, 2017:1371).

As a result of such migrations, many social, economic, cultural, political and psychological problems can be encountered and this situation creates new migration crises.

2.1.Integration Problem

Integration remains a controversial concept. Robinson (1998), like Castles et al. (2002), argues that integration is a chaotic term and is used by many people with different meanings. Rather than who defines the concept, the definition of the concept also varies according to different types of migrants. For example, the integration of refugees differs from the integration of migrant workers because the reasons for migration and their migrant status, as well as their conditions in the receiving society, are not similar. Some researchers emphasise that social networks and relationships have a significant impact on the integration of refugees and that these networks facilitate their access to rights (Cheung and Phillimore 2014; Bloch and McKay 2015; Danzer and Ulku 2011; Lamba and Krahn 2003; Williams 2006).

Sociologist Hofstede (2001) proposed to analyse cultures in 5 dimensions:

1. Individualism versus communalism: While Eastern societies organise their lives according to the values and judgements of the community, in Western societies the individual is at the forefront.

2. Masculinity; In some societies, masculine characteristics such as competition, power, materialism dominate, while in some cultures, kindness, compassion and mercy are at the forefront.

3. The distribution of power; to what extent are inequalities between the economic and social distribution of power in the culture tolerated?

4. Resistance to uncertainty; In societies with low resistance to uncertainty, anxiety is higher and individuals are expected to strictly follow decisions and norms.

5. Long-term orientation; long-term oriented communities prioritise investments and savings for the future, while short-term oriented communities are more concerned with the past and present.

Dimensions of culture and acculturation are the main factors that determine the stress felt by individuals and the discrimination they perceive (Bhugra et al. 2014).Da Lomba (2010) argues that secure legal status is important for the integration of refugees because successful integration can only take place when refugees feel safe.While governments in developed countries are struggling to identify asylum seekers, the number of campaigns organised to deport asylum seekers is increasing (Bloch and Schuster, 2005; Willen, 2007). In Europe, refugees are seen as a threat to the nation-state and a problem that needs to be solved, and many laws have been passed and new policies implemented to control migration flows (Nyers, 2006; Penninx, Spencer and Van Hear, 2008; Waever et al., 1993).Some researchers have stated that people who have to leave their countries choose the country of refuge by taking into account factors such as the granting of basic rights such as labour, housing, health and education, the relationship between the sending and receiving countries, the political and economic situation of the destination country, geographical proximity, border controls and the presence of family members and social networks in the country of refuge (Boyd, 1989; Gilbert and Koser, 2006; Gurak and Caces, 1992; Havinga and Böcker, 1999; Koser, 1997).

2.2.Economic Problems

The most important issue created by economic problems is undoubtedly child labour. According to the 2017 report of the International Labour Organization, there are 152 million child workers worldwide. 73 million of 152 million children work in hazardous work. While 88 million (58%) of child labourers are boys, 64 million (42%) are girls. 77.9 per cent of children work in agriculture, 11.9 per cent in industry and 17.2 per cent in services (ILO, 2017: 9). According to ILO statistics updated every four years, child labour in the world shows a decreasing trend. While there were 246 million child labourers in 2000, this number decreased to 222 million in 2004, 215 million in 2008 and 168 million in 2012 (ILO, 2013: 13). In 2016, the number of child labourers in the world decreased to 151,622 (ILO, 2017: 9).

UNICEF's report published in 2017 reveals that the number of Syrian children of school age is 870,000 and an estimated 380,000 of them are out of school. According to the report, the Syrian crisis is the worst humanitarian crisis since World War II, and it is children who pay the highest price and bear the heaviest burden. The possible consequences of the risk environment in which Syrian refugee children live are defined by the organisation as "a generation of children becoming a 'lost generation'".

The economic inadequacies of refugees' families and the adversities they experience in accessing the labour market make refugee child labour "the most common way of coping with economic difficulties" (Soyalp, 2016: 13).

Canales and Pérez (2007) investigated the social exclusion of Latin American migrant workers in US labour markets. According to the results of the study,

well-educated and skilled Latin American migrant workers receive lower wages and are employed in lower positions than an American worker in the same occupational fields.

In the country of asylum, obstacles such as unemployment, inability to benefit from education and health opportunities to an adequate extent, exposure to discrimination, language and communication problems are serious risk factors in the mental world of refugee individuals. Garnett (Ünlü, Kızılhan, Elciyar: 2018),

Phillimore (2014) has shown that social networks have a positive impact on refugees' access to the labour market in the UK. Other researchers argue that refugee integration is possible through access to basic rights and secure legal status (McKeary and Newbold 2010; Valenta and Bunar 2010; Vrecer 2010). Da Lomba (2010) argues that secure legal status is important for refugee integration because successful integration can only take place when refugees feel safe.

The importance of access to the labour market for integration is also stated by Bloch (2004) through the example of refugees living in the UK. In addition to access to the labour market, refugees' feeling of security is also important for successful integration (Ager and Strang, 2004).

Economic approaches are predominantly based on labour-centred explanations (Karpestam and Andersson, 2013).

In addition to unequal value transfer, a reserve army of unemployed is strengthened under conditions where labour supply is abundant in central countries, wages are suppressed and profits are increased (Cope, 2019).

According to Saskia Sassen, one of the important world system theorists in the field of migration studies, "global cities" such as New York, Paris, London, Tokyo and Istanbul, which offer a variety of employment and high quality of life opportunities, are important centres of attraction for skilled and unskilled labour flowing from the periphery to the centre. Such cities are "strategic locations in the global economy due to their command functions and the concentration of high-level productive service firms for foreign markets" (Sassen, 1994: 54).

The biggest factor that leads to irregular migration is illegal labour activities. Since those without work permits accept precarious, uninsured and low-paid work, an informal informal labour market is formed for refugees. In this section, refugees working informally in sectors such as manufacturing industry, painting, whitewashing, construction work, clerking, restaurants and entertainment, which are generally expressed as marginal jobs and do not require much knowledge and skills, work without job security. (Irregular Migrations Sy.109-122)

Sweden, together with the Netherlands, has the highest unemployment rate for first generation migrants. Research by the OECD has shown that at the end of the two-year programme offered by SPES, many migrants are unable to join the labour market. Only 22% of men and 8% of women are employed in the first year after training (OECD, Working Together, 14).

2.3.Psychological Problems

There is no doubt that the biggest threat to the refugee who fails to succeed in problem areas is undoubtedly the threat to his/her mental health. It is

almost inevitable that refugees who cannot overcome their problems feel shame and guilt (Bilen and Kıran: 2020). Studies show that migration is an important risk factor both in the emergence of severe mental illnesses and in the exacerbation of existing illnesses (Cantor Graae & Selten, 2005; Eaton et al., 2011; Fazel et al., 2005).

As Demirbaş and Bekaroğlu (2013:12-13) found, most asylum-seekers are exposed to multiple traumas before migration (such as traumatic experiences and past losses) and after migration (such as difficulties encountered in the country of origin), which negatively affect their mental health (TABLE 1).

(TABLE 1).

Negatively Affecting Mental Health	Mental Health Healing
Pre-migration stress factors Traumatic experiences Losses in the family Exposure to or witnessing violence Stress factors during migration Traumatic experiences Physical/psychological	Acceptance of the asylum request Provision of work/occupat ion Social support Selective memories and dreams about their home, hometown and final return Longer stay in the country (average 3 years) Education in

According to research, the mental health needs of refugees are five times higher than the general population (Eaton, Ward, Womack, & Taylor, 2011). On the other hand, they apply to health services less than the general population and therefore receive less support (Aspinall & Watters, 2010).

Long-term detention in temporary accommodation centres has serious long-term negative effects on refugees' mental health (Louise Newman, 2013; Louise Newman et al., 2010). However, it has been reported that individuals residing as refugees in the host country for more than five years tend to show higher rates of depressive symptoms and anxiety disorders than other people in the country of stay, especially related to lack of social integration and unemployment (WHO, 2018).

In their study (2015), Hocking, Kennedy, and Sundram reported that the provision of job and health security led to a decrease in the symptoms of post-traumatic stress disorder in asylum seekers over time. In another study (Hocking et al., 2015), it is stated that the symptoms of mental illness in asylum seekers and refugees are reduced by sociodemographic characteristics and psychosocial factors rather than psychiatric intervention.

In a study comparing the risk of having psychotic disorder between refugees and asylum seekers and other immigrants in Sweden, it was reported that refugees and asylum seekers were at a higher risk compared to other immigrants (Heeren et al., 2014).

Similarly, in a study conducted by WHO with 10,019 Syrian refugees living outside temporary accommodation centres in Turkey, it was reported that

among the chronic diseases of refugees, the most common disease after hypertension in adults (15-69 years old, N= 7212) was severe mental illness (2.8%, approximately 200 people) and it was mostly seen in men between the ages of 60-69.

Severe mental illnesses are the most common illnesses in the 18-29 age group and in children (0-14 years, N=2807) (Mipatrini, Balcılar, Dembech, Ergüder, & Ursu, 2019).

It is known that factors such as language barriers, lack of knowledge about the health system of the host country, limited rights to receive free services, different mental illnesses and different attitudes towards medical and psychological treatments (cultural differences) are effective in refugees receiving less health support (WHO, 2018a). Depending on people's level of education and background, language barriers, their ability to interact with health professionals and express mental health problems can vary greatly (Giacco & Priebe, 2018). However, together with these factors, the inability of people to access the health services and support they need leads to much more visible and serious mental problems in people's lives in the future. In fact, studies show that asylum-seekers and refugees are highly likely to suffer from severe mental illnesses (schizophrenia and similar psychotic disorders and mood disorders) in the future (Eaton et al., 2011).

Migrants and refugees have to cope with the necessity of adapting to a new language, a different culture and a new environment in their country of origin. In particular, there is more uncertainty about how long they can stay in the host country until their status is determined, whether they will be

able to fulfil the bureaucratic requirements for obtaining the necessary permission to stay, and the risk of deportation or detention. This situation is known to cause asylum seekers to experience more stress than refugees (WHO, 2018a).

Chandra (2011) listed factors such as recent migration, low education level, a religion other than the religion of the country of origin, past psychiatric and physical illnesses, previous hospitalisation, inadequate social support and social networks, missing a specific geographical region, inability to learn a language as risk factors for the emergence of mental illness in women.

Schizophrenia is seen at a higher rate in Norwegians who immigrated to the USA compared to those living in their home country. The WPA, in its 'Guidelines for Mental Health and Mental Health Care in Immigrants', suggests that this disease emerges 10-12 years after immigration in relation to immigration (Bhugra et al. 2011). Kirkbride et al (2012),

In a study conducted by Steel et al. in Sweden in 2016, the rate of encountering a traumatic event among refugees was 89%. Clinically significant post-traumatic stress disorder was found in 47 per cent of refugees and major depression in 20 per cent.It is known that the frequency of mental illnesses is higher in migrants, refugees and asylum seekers (Bhugra et al. 2011, Bhugra et al. 2014)In 2015, when the health parameters of refugees, immigrants migrating for economic reasons and resident Danes in Denmark were compared, it was observed that serious mental illnesses were much more common in people who came to Denmark as refugees from countries such as Iraq, Yugoslavia and Afghanistan due to war and

conflict (Norredam 2015).Many studies have shown that the risk of mental illnesses, especially post-traumatic stress disorder and depression, increases in those who experience mental trauma in the early stages of migration and during migration, both in this period and throughout life (Steel et al. 2002, Marshall et al. 2005, Fortuna et al. 2008, Arevalo et al. 2015, Bogic et al. 2015, Li and Anderson 2016)

2.4. Alienation Problem

The concept of alienation is used in the literature of psychological science in the most general sense to express the loss of the individual's sense of self, his/her alienation from his/her own essence and the weakening of his/her inner world (Tolan: 2005).

According to Göhler (1990), one of the emotions experienced by migrated individuals is the feeling of foreignness. Migrants are first and foremost foreigners in the places where they live. Climate, environment, culture and language are different from the usual ones. This sense of foreignness, which is directly experienced in the external world, is also reflected in the inner world of the individual.According to Edward Said (Sayın: 2019), a refugee "has lost his home and language and is forced to live a solitary, irregular, decentralised life.

On the one hand, he/she tries to provide the physical conditions to sustain his/her life, on the other hand, he/she tries to enter another social sphere of values, to take root there, to acquire a new belonging, to adapt his/her values and lifestyle to the society he/she has just settled in. He tries to slow down the process of alienation by producing places of refuge with others

like himself in order to sustain his existence and recreate the climate where he came from."

Fromm (2006:156) explains the state of mind of the individual experiencing alienation as a situation in which he perceives and feels as if his actions and experiences do not belong to him.

According to the dimensions of alienation put forward by Seeman (Tolan: 2005), patients suffering from alienation have difficulty in the flow of life under the influence of feelings such as powerlessness, meaninglessness, normlessness, alienation, isolation, and often engage in a psychologically challenging struggle.

2.5. Social Exclusion Problem

While social exclusion is used to refer to the poor who work for low wages, it also refers to the inability of individuals to participate in various political, cultural and economic activities in the society in which they are geographically located (Peace, 1999: 397; Peace, 2001: 22-28).

"Social exclusion", a concept closely related to migration, was first discussed in France in the 1960s. Ren'e Lenoir, who used this concept in 1974 while serving as France's minister responsible for social affairs, described these excluded groups as "mentally and physically disabled people, criminals (offenders), the elderly in need of care, abused children, drug addicts, suicidal people, single parents, problematic families, marginal, asocial people and other people in 'social disharmony'" (Çakır, 2002).

According to Alan Walker and Carol Walker (1997), social exclusion, taken as the opposite of social integration, is defined as the state of being

deprived or denied civil, political, economic and social citizenship rights. According to Amartya Sen (1999), social exclusion is defined as the "deprivation of inadequacies" in employment, social insurance, education, health, nutrition, housing, financial markets, skills, politics, culture, etc. According to Duffy (1995), social exclusion is defined as a state of inability to participate effectively in political, cultural, social and economic life and being alienated from the pivot point of society and becoming increasingly distant from this point (Bölükbaşı, 2008, pp. 12-13).

Łodziński and Bartoszyńska (2009), in their research on the dimensions of ethnic exclusion of people seeking asylum in Poland, concluded that exclusion is not only due to ethno-cultural reasons, but also their legal status is important

According to the results of Dedeoğlu and Gökmen's (2011) research on migration and social exclusion in Turkey, Azerbaijani migrant women receive lower wages and are subjected to physical and verbal violence and exclusion. Exclusion from education and health services also confronts Azeri women migrants with poverty and social exclusion. On the other hand, the social exclusion of foreign brides who are Russian immigrants is also in the form of not being one of us due to their religious differences. In the words of Dedeoğlu, social exclusion for Azerbaijani migrant women is not as "foreign other" but as "other belonging to us". For women who migrated from Russia through marriage, social exclusion is made through the "foreign other"

Larsen (2011) evaluated social exclusion among Palestinian and Sudanese asylum-seeking families in rural areas of Denmark and found that a part of the Danish society has a socially positive view of asylum-seekers if they adapt to their country and culture.

Aasland (2002) evaluated his research in terms of the risk of social exclusion of non-citizens in Estonia and Latvia. In both countries, non-citizens are at higher risk of social exclusion. Their access to labour markets, participation in civil society and political life, degree of social exclusion and access to economic resources were analysed for the two groups. Non-citizens living in Estonia face a higher risk of social exclusion compared to Estonian citizens. In Latvia, no significant difference was found between citizens and non-citizens.

Bask (2015) analysed social exclusion among immigrants in Sweden. According to his research, problems with the accumulation of welfare are higher among immigrant groups. However, the relationships between the disadvantages of welfare are stronger among Swedes. However, even after controlling for various demographic variables and socio-economic class, social exclusion is more prevalent among immigrants in Sweden.

2.6.Security Problem

International migration is a dynamic and multidimensional phenomenon. The phenomenon of migration is affected and transformed by the conditions in which it exists (Şener, 2017: 4).

The concept of "global village" used by Marshall McLuhan to describe the post-Cold War world shows that the qualities and meanings attributed to migration have also changed (Arıboğan, 2019: 29).

Migration is one of the issues where the concepts of social security and securitisation are used the most in the literature (Rumelili and Karadağ, 2017: 3). In this process, migration has been securitised by the individual, state and society. It is seen that individuals migrate with security concerns but cause new security problems in the destination countries both for themselves and for the individuals in the society they are in. Migration is securitised by societies on the basis of the identity of the society for fear that their homogenous structure will be disrupted. States, on the other hand, securitise migration within the framework of problems such as border security, organised crime and terrorism (Telatar, 2019: 20).

The issue of migration, which has become a security problem, has started to be addressed with four approaches. Firstly, border controls and anti-terrorism measures and regulations that exclude migration have been the subject of research. Secondly, the human rights and fundamental freedoms of asylum seekers and migrants, which have been ignored by considering immigration policies as a security problem, have been analysed. Thirdly, the acceptance and integration of migrants who make a difference in society has been studied. Finally, the situation of migrants in the host country has started to be examined with an interdisciplinary approach (Özçelik, 2019: 257).

In addition to the security threats posed to countries, refugees also pose a threat to their own security through illegal means. As refugees and asylum seekers often arrive to escape the dramatic situation in their countries of origin and lack the necessary documents to legally leave the country, they are forced to resort to all means of escape and try to reach safe countries where they can seek protection. Many asylum seekers try to reach Italy by sea and face very dangerous journeys. In 2022, 2,406 migrants died in the Mediterranean Sea while trying to reach Europe by sea. Most migrants (1,417) died in the central Mediterranean, described by humanitarian organisations as the most dangerous route in the world. This number, which has increased compared to 2021, reaffirms the extremely high risk of desperation crossings. In the first seven months of 2023, around 1,900 migrants died or went missing while trying to reach Europe via the Mediterranean: the highest number since 2017. Many migrants are also trying to reach other European countries such as France and Germany from Italy. Even when trying to cross these borders and the walls erected by some European countries, asylum seekers face many dangers. Every year thousands of migrants are arrested or turned back at borders after their exhausting journey, often in south-eastern Europe.

Another security threat is human trafficking. Human trafficking is the illegal entry of a person into a country of which he or she is not a citizen in order to gain direct or indirect financial or material benefit. Illegal entry means crossing borders without complying with legal requirements. The fact that Turkey has the characteristics of a transit region in terms of transit migration has made Turkey more important in terms of migrant smuggling.

Turkey, as a country where irregular migration, more specifically migrant smuggling, is intensively observed, has a priority position for a large number of migrants. A significant number of Syrians in Turkey aimed to migrate illegally first to Greece and then to European countries. This situation has led to illegal migration, and many Syrian migrants have lost their lives on the way to Greece by sea, yet illegal crossings have continued. Illegal migration has created a sector of its own and this sector has a large number of illegal workers. Especially migrant smugglers have become the backbone of this sector. According to Stephen Castles and Mark J. Miller, in some cases, migrants accept the mediation of human smugglers in return for promises of good jobs and wages. Smugglers are mostly transit migrants who see Turkey as a transit country and want to migrate to the West. Interviews revealed that foreign refugees from countries bordering Turkey are more likely to accept smugglers

3.INTERNATIONAL MIGRATION DATA and POLICIES

At the beginning of 2023, there were 12.4 million refugees in Europe, including Turkey, more than a third (36 per cent) of all refugees worldwide. The distribution among European countries is far from homogenous. Turkey alone hosts 3.6 million refugees, more than 10 per cent of all refugees worldwide; Germany hosts around 2.1 million refugees, 6 per cent of all forced migrants worldwide. In 2022, around 1 million applications for international protection were made in the EU+ region (EU countries including Norway and Switzerland), mainly by migrants fleeing Syria, Afghanistan, Venezuela and Turkey. Asylum-seekers from Ukraine are increasing (361.2 per cent more than in 2021). Around 4 million people who

fled the country after the Russian invasion received temporary protection, an instrument created in 2001 after the conflicts in the former Yugoslavia and Kosovo. In 2022, there will be around 380,000 refugees and asylum seekers in Italy. They are from 30 different nationalities, mainly from the Horn of Africa, Sub-Saharan Africa and the Middle East, but also from Latin America. The number of arrivals by sea increased from 67,477 in 2021 to more than 105,000 in 2022.

In 1990, the Dublin Treaty was signed to establish the conditions for a common policy on asylum seekers. These conditions include that if an application to one Member State is not accepted, the right to asylum will not be granted in the case of applications to other Member States. Thus, the asylum application is collected in a single country. 1951 Geneva Convention on asylum seekers, it is understood that the Union has tried to establish its own principles, without prejudice to the provisions of the Geneva Convention on asylum seekers. In 1997, the 15 signatories to the Treaty of Amsterdam agreed to work towards the development of the Union as a "freedom, security and justice" area. At the 1999 meeting in Tampere, they agreed to develop a common EU action plan on asylum and migration.

These policies (Lönnback, 2002: 29): 1. to have a detailed perspective that can balance humanitarian objectives with economic concerns, 2. to realise a fair system that can provide third-country nationals with equality with the nationals of the country of origin, 3. to establish partnerships that can help source countries, 4. to establish a common asylum policy, adhering to the Geneva and other international treaties.

3.1.Netherlands

The Netherlands started to accept refugees in 1992. In 1994, legal arrangements were made by amending the Law on Foreigners on temporary protection. During the entry of refugees into the country, the authority was given to the Dutch Ministry of Justice. Within the framework of "Article 12 (a) and Article 12 (b) of the Aliens Act", the Ministry of Justice is authorised to control the regulation known as F Status, which is applied under the name of temporary residence permit for asylum seekers. Accordingly, asylum seekers can obtain a temporary residence permit for a maximum of three renewals within one year. However, they do not have access to family reunification rights during this three-year period (Van Selm-Thorburn, 1998: 224- 225-231). Later on, the Ministry of Welfare became the ministry in charge of their social and other urgent needs (Van & Thorburn, 1998, p. 225). According to TUNHCR's data, TUNHCR has accepted about 23,500 refugees to its borders. In this respect, it is the fifth country with the highest number of refugees in Europe (UNHCR, 1997). The Netherlands started to accept refugees in 1992. In 1994, legal arrangements were made by amending the Law on Foreigners regarding temporary protection. New regulations called "Temporary Arrangement for Displaced Persons" were introduced for persons fleeing from Yugoslavia. These arrangements were considered to provide temporary accommodation for those who fled (Humanitarian Issues Working Group, 1994, p. 42). In this respect, practices in Turkey and the Netherlands are similar (Ministry of Family and Social Policies, 2015, p. 78). The most important reason why Dutch practices differ from other countries is the implementation of a gradual integration system. Accordingly, those under

temporary protection gradually gain more rights with each passing year and their integration into the state system is ensured in parallel (Van & Thorburn, 1998, p. 225).

When the legal status and limitations of the Temporary Protection Policy in the Netherlands - Temporary Regulation for Displaced Persons - F status and TROO (Tijdelijke Regeling Opvang Ontheemden) policy are examined, it is seen that the policy gained legal ground in this field in accordance with the amendments to the Aliens Law of 1 January 1994. Not only Bosnians but also people from all former Yugoslavia benefited from TROO. The persons included in the scope of TROO were not granted rights such as the right to family reunification, the right to work or the right to education. An identity document was issued for the arrivals and some monthly financial assistance was provided (HIWG, 1994: 42).

In the Netherlands, access to the labour market for those included in the F status, which is known as temporary residence permit, is gradually increased, as in the field of education. However, asylum seekers are not allowed to work in any income-generating job or open their own workplaces during the first year of their residence permit in the country. (ECRE, 1999: 36).

According to estimates, 30.000 people live in the Netherlands without a residence permit. Many of them came here to work, others stayed in the Netherlands after a failed asylum procedure. Many of them are labour migrants, others are refugees who have exhausted all legal avenues, people smugglers or failed marriage migrants. (kerkinactie.nl)

The Dutch migration policy is based on the integrated migration approach, which is applied to prevent irregular migration and covers 6 basic principles.

1. Strengthen shelter and protection for refugees and displaced persons in the region
2. Solidarity and a robust asylum system in the European Union and the Netherlands
3. Less illegality, more returns
4. Promoting legal migration routes
5. Promoting integration and inclusion

3.2.Turkey

In 2011, due to the outbreak of civil war in Syria and the subsequent violence, mass migration to neighbouring countries started. In this sense, Turkey implemented the open door policy to prevent humanitarian rights violations in mass migration and allowed Syrians to enter by hosting them. Although asylum applications have been received since the beginning of the war in 2011, mass applications started in 2012-2013. In this case, the admission of those who do not have security of life to Turkey through the borders was regulated in accordance with "Article 91 of the Law on Foreigners and International Protection dated 2013" within the framework of the Temporary Protection Policy and the "Temporary Protection Regulation" was put into practice in 2014.

According to the 2021 data of the Directorate General of Migration Management; there is a continuous increase in the total number of Syrians entering Turkey. Moreover, according to the current data of the Directorate

General of Migration Management dated 28 October 2021, the total number of Syrians under Temporary Protection Status in Turkey has reached 3,726,206 people (Directorate General of Migration Management, 2021). Moreover, the Temporary Protection Policy is only recognised for those coming from Syria. One of the most important reasons facilitating Turkey's mass migration from Syria is the open door policy. Other reasons include Turkey's geographical neighbourhood, cultural affinity, common historical past and the attitudes of the two societies towards each other (Kaya, 2017). The implementation of the Temporary Protection Policy, according to Article 91 of the "Law on Foreigners and International Protection", is a method applied against mass migrants who cannot live under difficult conditions (war, crime against humanity, armed conflict, etc.) and who have to leave their country by force.

The temporary protection regulation was established to ensure the safety of people who are forced to leave their country of residence and to prevent human rights violations. According to this regulation; "Syrian citizens, stateless persons and refugees are under temporary protection even if they have applied for international protection (Directorate General of Migration Management, 2021)." These persons were given foreigner identification numbers and were given access to all basic rights within the country. These rights of Syrians have been protected by the state by giving them access to health rights, access to education rights, translation services, social aids and access to labour markets. In terms of access to health rights, "Article 27 of the Temporary Protection Regulation in Turkey" has been regulated and the rights of Syrians in urgent need of health and treatment have been

protected. In addition, medicines and treatments were provided free of charge through the activities carried out by the Ministry of Health (Directorate General of Migration Management, 2019).

It has been observed that the temporary protection policy implemented by Turkey in 2014 has serious similarities with the systems operating in Germany and the Netherlands and has emerged as a practice that offers more systematic and comprehensive rights within the framework of the Council of Europe directive (European Parliament, 2020).

Temporary Protection Policy in Turkey is regulated by the legal structure of temporary protection according to Article 91 of the "Law on Foreigners and International Protection" no. 6458 dated 1 April 2014. The Regulation was published in the Official Gazette with the decision dated 22/10/2014 and numbered 29153. In this sense, when the Temporary Protection Decision and related regulations are to be made, the President of the Republic can process or terminate the applications. The content of this decision is regulated by the Council of Ministers. A document called "Temporary Protection Identity Document" is issued to the beneficiaries of this policy. The Regulation also recognises the right to legal presence in Turkey (www.goc.gov.tr).

3.3.Norway

Norway's foreign-born population has tripled in the last 20 years, and the share of immigrants in the population has increased from 6.5 per cent in 2000 to 16 per cent in 2020. This is one of the largest increases in the OECD. Norway has a diverse immigrant population with different integration

needs. As a result of free movement arrangements, more than four in ten foreign nationals come from the EU, and more than half of them have arrived in the last decade, mainly to meet labour market needs.(oecd.org)

There is broad international co-operation on refugee and migration policy in Norway. The Ministry of Justice and Emergency Preparedness represents Norway in a number of international forums where issues in this field are discussed. UNHCR's guidelines, programmes and budget are adopted at meetings of the Executive Committee. Norway has been a member of the committee since 1955 (regjeringen.no)

The Nordic high-level advisory group on refugee issues (NSHF) is an information forum where countries informally discuss issues in the field of asylum, refugees and migration, including return and resettlement. The NSHF meets twice a year in the form of a formal meeting and a combined ministerial meeting/official meeting. The NSHF does not have a permanent secretariat. Meetings are organised by the country holding the chairmanship for the relevant year. The chairmanship negotiates between countries.

The Dublin Regulation forms an important part of the Common European Asylum System (CEAS). Together with the **European Dactyloscopy** (**Eurodac**) Regulation, which establishes a Europe-wide fingerprint database for unauthorised entrants to the EU, the Dublin Regulation aims to "quickly identify the Member State responsible for the [asylum claim]" and provides for the transfer of the asylum seeker to that Member State.

On 23 September 2020, the European Commission presented its proposal for a New Convention on Migration and Asylum (Convention). The proposal is based on 3 pillars;

1. Strengthened co-operation with third countries, Strengthened co-operation with third countries aims to prevent migratory pressure on the EU's external borders and facilitate the return of migrants without a right of residence.

2.Strengthening procedures at the EU's external borders: Strengthened procedures at the external borders are proposed partly as an extended registration, including a health and safety check, and to clarify how further case processing (screening) should take place. Some asylum seekers will be subjected to a border procedure for the fast processing of asylum applications and returns

3. Redistribute responsibility within Europe and create a new mechanism for solidarity: The new solidarity mechanism is proposed to be mandatory for member states but flexible. It is proposed to be triggered when a country experiences a major strain on its asylum system, enters a crisis situation and migrants rescued at sea are disembarked. In such cases, all other Member States should contribute by taking responsibility for asylum seekers (relocation), helping to repatriate rejected asylum seekers in the country under pressure or helping to strengthen migration management in the country under pressure. (regjeringen.no)

3.4.Italy

Most of the 2022 applicants for political asylum in Italy came from Bangladesh, Pakistan, Egypt and Tunisia. The applications examined by the Regional Commissions for the recognition of refugee status totalled 52,625: 6,161 were granted political asylum, 6,770 were granted subsidiary protection, 10,865 were granted special protection, while 27,385 applications (53 per cent) were rejected. The lack of a law organically regulating all aspects of asylum often makes life difficult for refugees in Italy. In fact, there are many bureaucratic hurdles and difficulties to overcome in order to start the path to reception and integration. Asylum seekers have the right to health care, while minors have the right to education. The right to work, on the other hand, is only recognised two months after the asylum application has been submitted. Once recognised, refugees can apply for Italian citizenship after five years of residence.

Martelli Law

In 1990, Law 39/90, commonly known as the Martelli Law in honour of its initiator, Claudio Martelli, was adopted. This law repealed the so-called 'geographical reservation' in the 1951 Geneva Convention, which limited the recognition of status to refugees from Europe. The law contained legislation that only partially regulated asylum.

Turco-Napolitano Law

In 1998, Italy revised its national legislation on immigration with Legislative Decree 286/98, known as the Turco-Napolitano Law after the names of the

then Minister of Social Solidarity, Livia Turco, and the Minister of the Interior, Giorgio Napolitano. The law replaced the Martelli law by making numerous changes to the rules on immigration to Italy, but did not make any significant changes to asylum.

Bossi-Fini Law

Immigration legislation changed significantly in September 2002 with the entry into force of Law 189-2002 (fully implemented only in 2005). In common usage this measure is called the Bossi-Fini Act after the names of its first two signatories, Umberto Bossi - then Minister of Institutional Reforms - and Gianfranco Fini - then Deputy Prime Minister. This law had a major impact on asylum: for example, it decentralised the asylum procedure, which had previously been carried out entirely by the National Commission for the Right to Asylum. Instead, the Bossi-Fini law established Regional Commissions whose task was to examine applications for the recognition of international protection within their geographical jurisdiction.

The Commissions are currently located in Milan, Gorizia, Rome, Foggia, Crotone, Syracuse, Trapani, Turin, Caserta and Bari and are managed and coordinated by the National Commission.Each Commission is composed of an official from the prefectural career as president, an official from the State Police, a representative of a regional authority (designated by the State-City and Local Self-Government Conference) and a representative of UNHCR.Together with the transposition of European asylum legislation, the

most important legal reform on asylum since the Martelli Law took shape in Italy between 2005 and 2008.

In 2005, EU Directive 2003/9 on 'minimum standards for the reception of asylum seekers in Member States' was transposed into domestic law. The legislative decree implementing the Directive laid down the rules for the reception of foreigners seeking refugee status on national territory, in line with European standards and international refugee law (in particular the 1951 Geneva Convention). Then it was the turn of Directive 2004/83, the so-called 'qualification directive', which was transposed into Italian law by Legislative Decree 251/2007. This directive sets out the criteria for Member States to use to decide whether an asylum seeker is entitled to international protection and what type of protection he or she should receive, whether refugee status or a form of subsidiary protection.

Finally, in 2008, EU Directive 2005/85, known as the 'Procedures Directive', was transposed into domestic law. Implemented by Legislative Decree No. 25/08, this directive sets minimum standards for procedures in Member States for the recognition and withdrawal of refugee status.

The last two decrees have significantly changed asylum rules. For example, they abolished the detention of asylum seekers, introduced the suspensive effect of appeals against the refusal of asylum applications and provided for family reunification for those granted subsidiary protection.

Despite the changes, Italy is increasingly in need of an organic law to regulate the whole asylum issue and to significantly improve the situation of refugees and asylum seekers. Italy is still unique among EU countries in

not having a unitary law that would provide asylum seekers with a functional system, assistance and integration and reduce operational difficulties for local authorities, volunteers, police forces and all operators on the ground.

4. MIGRATION AND ART

As migration has a positive and/or negative impact on many sociological, cultural, economic and political fields, it also has an important place in art that feeds on life. Generally, the issues addressed by artists who are directly affected by the effects of migration emerge as identity acquisition, identity conflicts and efforts to establish themselves in the new geography, which are the negative reflections of migration. These issues have been handled and studied in different ways with the artists' own artistic views and production practices.

Artists' handling of the problems brought about by migration, their determination of these problems and their proposals for their solutions make them visible in front of the society and contribute to the solution. Julia Kristeva deals with the relationship of the foreigner to a place through non-belonging; the foreigner "does not belong to any place, any time, any love. The space of the stranger is a train in motion, an aeroplane in flight, a passage that destroys the possibility of stopping" (Kristeva, 1996: 14).

Art is a phenomenon that is affected by life and all kinds of changes in life; the person who produces the work of art, the artist, is an individual who lives in society and develops and changes by feeding on society, and this individual reflects his/her own life and the characteristics of the society in

which he/she lives to the production of art. Therefore, changes in life are directly reflected on the artist and his/her work of art. For this reason, the work of art is a mirror of the sociological, psychological, economic and technological changes of the time it was produced. If the phenomenon of migration has taken a place in the life of the artist at the time when the work of art was produced, this may also be reflected in the work produced by the artist.In many parts of the world and in geographies where the great wars of history have taken place, forced migrations and the effects of these migrations have been felt. People who migrate generally have difficulty in being accepted by the existing society in their new geographies, and migrants are perceived as abnormal foreigners in the receiving societies;

The traces of the phenomenon of migration manifests itself in art in many different forms and expression styles, starting from the cave paintings of the first age people seeking fertile lands for themselves to today's art productions. In these artworks, the phenomenon of migration and the reflections of the difficulties and changes brought by migration to human life are quite evident. The issues related to migration in artistic productions are generally focused on the adaptation and identity problems experienced by individuals and communities in the new geography, alienation, efforts to gain a place and self-acceptance, deformation of culture, exclusion by the existing society and their effects on the individual. The artists discussed within the scope of the paper are selected from different geographies where the phenomenon of migration and its effects are experienced significantly

5.ART THERAPY

5.1.What is Art Therapy?

Although art therapy began to be investigated as a concept in the late 1900s, it became an official discipline in the 1940s with the belief that art could have a valuable place in psychiatric treatment by an increasing number of psychologists, psychiatrists and other health professionals. The term was first used by Adrian Hill in 1942 (Case & Dalley, 2006; Malchiodi, 2011). Hill, a graduate of art school, experienced that his drawing works contributed positively to his recovery during the tuberculosis treatment he received in the hospital after the war. He published his book "Art Versus Illness" (Adrian, 1945), realising that in cases of illness where physical resistance is low, the mental and emotional structure is damaged along with the body, and the need for psychological healing. However, art therapy has become a method used within the scope of the National Health Service (Hogan, 2001).

The American Art Therapy Association defines art therapy as a mental health profession that uses the creative process of making art to improve and enhance the mental, physical and emotional well-being of individuals of all ages. Accordingly, art therapy is based on the belief that this creative process, which includes artistic self-expression, helps people to solve their conflicts and problems, improve their interpersonal skills, reduce stress, manage their behaviour, increase their self-esteem and self-consciousness, and gain insight. In other words, it is the use of art-making as a therapeutic and developmental tool for people who are experiencing illness, trauma or life difficulties, or who simply want personal development.

It has been confirmed that creating art and doing so can cope with art and other traumatic experiences, improve cognitive skills and increase enjoyment of life (American Art Therapy Association AATA, 2009).

Art therapy works for the pre-verbal period. It tries to express what is not expressed verbally. At the centre of art therapy lies the translation of principle impulses and fantasies directed towards internalised self and object representation into concrete forms with artistic elements (Göktepe, 2015:23). From this point of view, activities such as drawing, scribbling and painting, which are non-verbal communication tools, are some of the important tools in reflecting the image in the mind. The relationship between art and therapy includes creating auditory and visual images with various art materials, turning visual images into concrete objects and working on these objects (Killick, 1993). Art therapy aims to increase cognitive, emotional, physical and spiritual subjective well-being by combining visual arts, creative process and psychotherapy (Göktepe, 2015:25).

Creative writing and poetry therapy, bibliotherapy, photography therapy are other art branches used in art therapy. In expressive art therapy, these fields are also very important in terms of diversity (Göktepe, 2015:68). Expression provides data and scale for both art and psychology.

In art therapy, various books, films and documentaries, music, museums, creative drama, games and dance are used extensively. The use of music, painting, marbling, traditional arts, bibliotherapy and workshops for therapeutic purposes not only provides ego satisfaction but also increases

the social functionality of the person. Art is actually a way of emotional expression. For children, play is both the most serious work and an art. The child reveals all his/her explorativeness. Play therapies are indispensable in child psychiatry. Likewise, the use of art, which is both a fun and disciplined method for adult patients, has a similar effect (Göktepe, 2015:12).

5.2.History of Art Therapy

Since the mid-20th century, it is seen that art elements have started to be used in the treatment process. In the 1940s, there was no formal art therapy education (Acar & Düzakın, 2017:9-10). Art therapy is defined as the use of various art materials in providing diagnosis and treatment to cause a positive development in individuals, resolve conflicts, reduce physical and mental problems, solve problems, help to cope with stress (Coşkun, Yıldız, & Yazıcı, 2010; Case & Dalley, 2006; Geue et al., 2010; Malchiodi, 2005; Demir, 2017:577). Although art therapy is the common child of psychology and art, it has evolved as a unique discipline with both of them (Vick, 2003). The art therapy approach includes all activities in the field of art practices such as painting, music, theatre, cinema, movement and dance (Malchiodi, 2003; Demir, 2017:577). Using all these artistic activities to evaluate individuals and groups and to intervene at the same time constitutes art therapy under the general title. Art therapy, which we accept as a very old form of therapy, is reuniting with its existentialist and phenomenological origins; in this age of criticism, psychotherapy is trying to establish its traditional relationship with other fields that have broken away from philosophy. With the work of Otto Rank, psychotherapy has been able to get rid of the narrow field of the factualist approach of the

analytical method and to expand into the cultural and symbolic field of the phenomenological method, which opens up with all the diversity of the postmodern approach with its spiritual and cultural richness. Psychotherapy has realised that a one-sided, analytical and positivist point of view is not enough by establishing a relationship with the cultural and symbolic sphere of existence with all its actions that can comprehend the human being holistically. Art, the most effective and inclusive activity of human culture, contributes to psychotherapy in this way (Filiz, 2016:180). The American Art Therapy Association defines art therapy as a mental health profession that uses the creative process of making art to improve and develop the mental, physical and emotional assets of individuals of all ages. Accordingly, art therapy is based on the belief that this creative process, which includes artistic self-expression, helps people to solve their conflicts and problems, improve their interpersonal skills, reduce stress, manage their behaviour, increase their self-esteem and self-consciousness, and gain insight. In other words, it is the use of art-making as a therapeutic and developmental tool for people who are experiencing illness, trauma or life difficulties, or who simply demand personal development. It has been confirmed that creating art and doing so can cope with art and other traumatic experiences, improve cognitive skills and increase enjoyment of life (American Art Therapy Association AATA, 2009).

Art became a part of a therapeutic process and art therapy gained an identity as an independent field with the art therapy practices of Adrian Hill in England and Margaret Naumburg in the USA, followed by the use of

Freud's personality theory in art therapy by Kramer (Kaplan, 2000; Hogan, 2001; Edwards, 2004).

In the history of art therapy, there are three main periods of development: The first of these periods is the period between the late 1930s and the early 1950s, when the idea of using art as a therapy in a hospital setting first began to develop and expressionism came to the fore. The approach known as art therapy in Europe emerged from the needs arising after the Second World War. Both psychotherapy and art therapy were used in attempts to rehabilitate people traumatised in the war (mainly armed forces personnel). World War 2 was a period in which many new and influential ideas emerged in psychiatric practice. As a result of the war experiences, a number of future-orientated rehabilitation initiatives were launched. These included shifting psychiatric care to the community, or at least to outpatient general hospitals. Art therapy in mental hospitals was also initiated as an extension of this. At this time, the increased sensitivity of the post-war society to suffering and the tendency to change everything that belonged to the past may have encouraged interest and admiration for psychotic art, which expressed the pain of the inner world with a striking indifference. In this period, the aim of art therapy was the patient's relaxation through self-expression. A space large enough for the patients to work without drawing attention to themselves and a sufficient area was allocated for each patient, painting materials and a table were provided, and the patient was directed to paint without any intervention under the silent observation of the therapists (Killick, 1993; Yazıcı, 2006). The second is the period from the early 1960s to the late 1970s. This is the period when many art therapists

supported the antipsychiatry movement and humanistic schools of therapeutic thought with the establishment of the British Association of Art Therapists. It was during this period that accepted ideas about what constituted madness began to be challenged. In this phase, art therapy came under the influence of psychoanalysis, especially Jungien approaches. Jung himself was a sculptor and artist. Unlike the Freudian schools that emphasised language, he emphasised the image, which he saw as a primitive form in which the psyche manifested itself. In this sense, he saw madness not only as a psychological destruction but also as a process that reveals the inner nature by lifting the veil on the layers of the mind (Gilliam, 1990; Killick, 1993; Yazıcı, 2006). Finally, in the third period after 1980, i.e. today, art therapists have experienced many legal changes in the public sector and their work has become increasingly professionalised. The first two periods left art therapists the legacy of having the same careful approach in every therapeutic work. Art therapists tried to take part in various psychotherapy approaches by saying that what they were doing was not a distraction or occupational therapy, but a method of discharge, communication and interpretation that worked through free association. In this period, technical problems came to the fore. In the second half of the 1980s and early 1990s, severe economic conditions coincided with a reactionary step back in psychiatric practice. The problem of how to integrate a therapeutic approach with a general philosophy of treatment began to occupy art therapists. In the period between 1991 and 1995, art therapists, like other professionals working in the public sector, found themselves confronted with a protracted reorganisation of the public

service. It was now necessary for those working in the therapeutic field in public service units to turn their attention to understanding the political and economic conditions of their work as well as the therapeutic relationship (Killick, 1993; Killick & Schaveiren, 2003; Yazıcı, 2006).

5.3.Art Therapy Applications

5.3.1.Objective

Art therapy is a method that aims to benefit from the positive power of art in the treatment of physical disorders caused by negative psychological conditions by using fields such as human development, creative process, counselling and psychotherapy models, and has two main objectives: The first of these is to bring to light the emotions and thoughts sent to the unconscious and to gain insight into negative behaviours and thoughts associated with the subconscious. According to Naumberg (1966:1), in art therapy, people use verbal expressions to explain the work they have produced by overcoming the situations in which speaking is initially prevented by using graphics or similar forms of expression of the internal conflicts they have uncovered from the subconscious. Daily (1984: 14) supports the notion that art therapy, which involves the creation of individual art as a therapeutic17 tool, focuses on discussion, analysis and personal evaluation. Art therapists integrate artistic forms of expression with human helping techniques to provide a creative 'helping' environment for their beneficiaries. (Henderson, 1998: 184) Human development is based on psychosocial theories that utilise therapeutic tools to help resolve psychodynamic, cognitive, personal and interpersonal emotional conflicts

Professionals who carry out many studies in this field work on the healing power of art therapy.

5.3.2.Justification

What makes art therapy stronger than many other methods is that it can address even the most painful issues without disturbing the person (Steele & Kuban, 2003). The hidden feelings, wishes or fears of the client are seen as products that emerge in a non-verbal and symbolic language. In this respect, psychological problems of different severity and diagnosis can be treated using this method.

Kreapelin and Bruer suggested that the paintings made by patients can be important clues in making a diagnosis (Rubin, 2016; Acar & Düzakın, 2017:8). In individuals who have difficulty in verbally expressing their feelings and thoughts, it is recommended to use other options such as art therapy to facilitate expression (Scharff, 1996:257).

Art is not far from the relationships we have mentioned for reasons such as guiding, relaxing, making meaningful and facilitating human life. Being a human being means organising, shaping and using the data of nature for new production actions. Because as long as there is production, man expands his field and finds the opportunity to understand his environment better (Kandinsky, 1993:64).

Art, not on its own but according to us, will be considered good or bad to the extent that it eliminates our weaknesses, for example, our forgetfulness, despair, our search for greatness, the difficulties we experience in understanding ourselves or our longing for love (Armstrong

& Botton, 2013:72). For this reason, the work we create with art therapy will remind us of ourselves and reflect our inner world. The essence of art therapy will be to provide clients with the opportunity to organise their emotional experiences and expressions through artistic means (Öz, 2015:824). If we consider art as a tool, the tool is an extension of the body, it enables the fulfilment of a desire and is needed due to a deficiency in our physical structure. Art also mediates psychological weaknesses.

Farokhi (2011) concluded in his study that art therapy is applied with various patient populations in individual, couples, family and group therapy formats in mental health, rehabilitation, medical, educational and forensic settings. Art therapy is an effective treatment for people experiencing developmental, medical, educational, and social or psychological impairment. The aim of art therapy is to improve the patient's sense of personal well-being. Cristina and Aneta (2012) found that art therapy had no effect on the treatment of patients with diagnoses such as traumatic stress, schizophrenia and depression. Khadar et al. (2013) concluded that art therapy can improve people's lives by helping them improve their mental, emotional and even physical conditions. Petruta-Maria (2015) examined the areas of use of music therapy, one of the sub-branches of art therapy, in health. The study concluded that music therapy can improve cardiac disorders and affective and neurological disorders (such as schizophrenia, amnesia, depression, aphasia and speech disorders). According to Mousavi and Sohrabi (2014), art therapy is an important intervention tool that reduces aggressive children's anger and increases self-esteem. According to Haeyen et al. (2015), using art therapy methods,

disorders in emotions such as emotional awareness, constructive emotion regulation, a stable self-image, contact with self and others, psychological perspective and sense of control, integration of emotions and possible insight can be eliminated. Dain et al. (2015) concluded that art therapy used as traditional and complementary medicine has the potential to improve pain, symptoms and other quality of life measures for patients and families. According to Walker et al. (2016), there is not enough information about art therapy applications for co-morbid traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). Especially for people with symptoms of PTSD and TBI, the inclusion of these techniques in a broader interdisciplinary team assessment and treatment strategy holds great promise to identify the disease faster and return it to its former functions. Wang and Li (2016) proved in their study that art therapy has some effects on improving the attention and orientation of dementia. In addition, it has been proven that it has many benefits such as reducing behavioural and psychological symptoms, improving the social skills of patients and alleviating the burden of dementia caregivers. According to Holmqvist et al. (2017), art therapy has proven that there are situations in which an internal change can be observed in patients by affecting consciousness, self-awareness and ego-power in the therapeutic process. Blomdahl et al. (2018), in their study, reveal that the patient contributes to more knowledge by deepening the understanding of the importance of talking to the patient's self in an internal dialogue that occurs when the patient participates in the image, art materials and the art-making process. The external dialogue with the therapist illuminates and deepens the internal

dialogue. Both the processes of making art and describing experience broaden and change understanding through internal dialogue, making the self and the situation visible.

5.3.3.3.Compliance

When the problems that occur after migration are analysed, it is seen that the most important problem is psychological aspects. Improving the factors that are at the basis of chronic diseases with alternative methods will make serious contributions to societies and the future. Migrants and asylum seekers are among the population groups considered disadvantaged in the field of social work. In the field of mental health, working with refugees is considered in the context of trauma and post-traumatic stress disorder (PTSD) (Kalmanowitz & Ho, 2016, p. 57). Art therapy journals spanning the years 1985-2014 reveal a widespread approach to creative expression as a mix of approaches to trauma in general (Appleton, 2001; Baker, 2006; Chilcotte, 2007; Kalmanowitz & Ho, 2016) In 2015, in a comprehensive meta-analysis (Bogic et al. 2015), which evaluated the mental effects of war on refugees and evaluated the results of studies conducted at least 5 years after settlement in the new country, it was shown that mental illnesses seen in refugees showed significant differences from study to study, and that the country of origin, the country of settlement, traumas exposed during the war, and stressful situations that emerged after settlement were related to mental health. In this study, unemployment, not knowing the language of the country of settlement and inadequacy of the social support system after migration were found to be related with anxiety disorders that cannot be otherwise named in women.

3.3.2.1. Music Therapy Compliance

Treatment through music is known as music therapy. "The music therapist can use rhythm, melody, tempo, pitches and poems to develop a language that enables the child to follow what is said, to understand what the other person says (perceptive) and to express his/her senses to the other person (expressive)" (Çoban, 2005, pp. 101-102). Even if singing cannot be reduced to mere communication, it is "a basic form of existential communication. It can also express thoughts and feelings that cannot be expressed through speech. Being able to sing words accompanied by melody can comfort such patients by showing that they have not irreversibly lost their linguistic capacities completely, and that the words are still somewhere inside them,

even if music is required for them to come out of the mouth" (Sacks, 2016, p. 221).

Chlan and Tracy defined music therapy as "a reliable and effective treatment for patients with serious illnesses due to its effect on reducing suffering and anxiety". In their experimental studies to prove the effectiveness of music therapy, Sacks (1992) found that it was useful in the treatment compliance and development of patients with Parkinson's disease; Priestley found that analytically orientated music therapy facilitated the disclosure of the inner experiences of patients, providing greater awareness and personal development; Wrangsjö (1995) found that music therapy was effective in the treatment of depression, McDonald (cited in Bony, 1997) found that music therapy was effective in the treatment of hypertension.Bony, 1997) found that it caused a decrease in

hypertension, Jacobi and Eisenberg (cited in Bonny, 1997) found that it improved the quality of life of rheumatic patients.

Traditional and Complementary and Alternative Medicine (CAM) is defined by the European consortium of European researchers funded by the European Commission as follows: "CAM, as used by European citizens, represents a variety of medical systems and treatments based on the knowledge of practices and skills derived from experience and philosophy and used for the alleviation, treatment, diagnosis and prevention of physical and mental illnesses as well as for the maintenance and improvement of health. CAM treatments are generally used outside the conventional health care system, but in many countries some treatments have been accepted or adapted by the conventional health care system.

3.3.2.2. Literature Therapy Suitability

Storytelling, one of the oldest practices of humanity, is "a medicine that strengthens the individual and society and directs them towards the truth" (Estes, 2013, p. 33). While storytelling facilitates the discovery of one's own solutions as a subject away from a didactic structure, it also supports the self-efficacy of individuals. Nossrat Peseschkian (Pereschkian, 1998) emphasises the therapeutic uses of the mirror, model, repository and mediator functions of stories; the mirror function facilitates the identification of the ego with the richness of images in stories. The person reflects his/her needs in the story and ceases to be a victim of his/her conflicts by providing distance from the subject's own conflicts (Pereschkian, 1998, pp. 35-36). The storage function states that a story can be interpreted differently by adapting it to different situations, and that the

memory of the story reduces dependence on the therapist (p. 38). It is an intermediary between reality and the feeling of pleasure (p. 40). In the method called Narrative Therapy, opinions and studies such as opening ways for the person to express their own problems and reducing the destructiveness of the problem by externalising the problem are included (Denborough, 2016).

Freud was the first to say that poetry can be used to explore the unconscious (Freud, 1981). Hedberg (1997), a poetry therapist, sees poetry as an enormous path to the unconscious. According to him, poetry is a therapy, a magic, sometimes ordinary, a mirror of the struggle for life and the deepest human secrets, the music of the soul, something that enchants and renews even the hardest hearts.

Art Therapy Eligibility

One of the many strategies for balancing emotions is drawing (Larsen, Billings, & Cutler, 1996), and it has been found that drawing relieves unhappiness and anger (Diliberto-Macaluso & Stubblefield, 2015) (Drake & Winner, 2012). "In the exercise called 'Cleansing', participants write the names of the people they are angry with and draw them and the reasons why they resent them. Afterwards, in order to resolve the trapped energy between them, the people whose pictures were drawn are forgiven and the papers are torn" (Sabah, 2011, p. 209). "Works done in an expressionist manner first help to understand the interior and then to reveal the personality. Nature figure paintings make it easier to understand life. In this way, we admire life and the life system. We are happy to feel ourselves a part of this system and we care about being one with it. We begin to take

part in our personal journey" (Sabah, 2011, pp. 67-68). Colouring provides the client with a spontaneous free-flowing method to depict their thoughts and feelings (Buchalter, 2004, p. 75). In a study conducted by considering that drawing requires higher cognitive demand and painting requires lower cognitive demand, it was found that in both occupations, the depiction of the situation was more fun with drawing, and only the painting activity provided an impressive 'flow' state (Forkosh & Drake, 2017, p. 75). In the therapeutic use of painting, the 'action painting' movement argues that with the technique discovered by Pollock, "people create a combination of primitive desires and the contemporary period and transfer it to their painting" (Kamışoğlu, 2012, p. 69). This technique allows the client to express their problems, feelings, fears, wishes and concerns in a non-threatening way through spontaneous drawing. It provides the client with a wealth of symbolism and imagery that they can relate to and learn from. Images serve as tools that facilitate communication, growth and insight (Buchalter, 2004, p. 26).

Visual arts / Painting Art Therapy, which contributes to the regulation of emotions and thoughts of the person, helps the individual to organise and strengthen his/her perceptions by strengthening his/her emotions and attention through art materials.

Art enables the person to discover himself/herself and try some thoughts by activating the creativity process of the person, and on the other hand, the process of descending and discovering the subconscious mind is facilitated by the artistic work of the expert.(Beykoz Academy Journal, 2017; 5(2), 150-162)

6.EXPECTED EFFECT OF ART THERAPY

6.1.Short Term Expected Impact

Therapies involving group work help to improve socialisation and communication skills (Buchalter, 2004, p. 123). Psychodrama, which is a group work, is a treatment method in which interpersonal relationship, conflict and emotional problems are explored with special dramatic methods (Subaşı, 2016, p. 137). Participants become aware of their suppressed emotions through pairing, take risks, move towards lower level conflicts, observe mimics and gestures through role reversal, and shed light on their own lives through mirror technique (Altınay, 2016, p. 52). Kellermann and Hudgins describe the contribution of psychodrama to the emotional coherence of human beings as follows; "Psychodrama aims to give the protogonist, who is stuck in the trauma resolution process, an opportunity to remind, repeat and work on painful events in the past. Such re-enactment is assumed to be therapeutic by helping the protogonist to emotionally reintegrate and cognitively process the loss that has devastated him/her, thus creating a spontaneity that will alleviate the psychological impact of the trauma" (Kellermann, Hudgins, 2013, p. 26).

It involves creating expressions using visual and plastic art language under the guidance of an art psychotherapist. Creating awareness through these expressions and the process of discovering the meanings within them; developing cognitive skills; coping with difficulties such as stress, grief, depression, loss, traumatic experiences and symptoms of chronic illness and is an art psychotherapy that forms the basis for the development of self-confidence. Art Psychotherapy is based on the understanding that the

creative process itself is healing and enhancing. In Art Psychotherapy, coloured pencils, dry paints such as pastels; wet media such as marbling, gouache, acrylic, oil paint; sculptural materials such as clay, play dough, wire and similar; coloured papers, magazines and even art materials that can be used for collage and assemblage, which can be diversified with recyclable waste collected from nature or from the street, the individual transforms their inner spiritual experiences into external representations. Your expressions should find and provide meaning in one's own art in order to create a supportive relationship between the art psychotherapist and the client.Artistic work carried out in the company of an art therapist;

•Expressing emotions

• Acting as a container for intense emotions

• Communication tool

• Clarification about orientations

• Socialisation

• Spending meaningful time

•Flexibility in case of uniformisation

•Enriching everyday life

•Acquiring new skills

•Purposefulness

•Mood control

6.2.Long Term Expected Impact

The use of multiple medications increases the risk of side effects, increases the number of hospitalisations and consequently adds additional burden to health costs. Art therapy is a powerful tool for communicating emotions. Because the resulting image is a symbolic and visible representation. During the impressive creation process, the patient's emotions, impressions and body awareness are very intense. The product of creation gives some feedback to the patient. One of the basic principles of art and other therapeutic disciplines is to comment on oneself. In addition, therapy has an important mission to overcome psychological states and in this context, long-term expected effects:

- Social adaptation
- Increasing problem solving, focus and attention skills
- Having an awareness that can affect all life processes
- Recognising stress factors in their lives and developing coping skills
- To be able to express their fears and anxieties in the process of creative action
- To be able to express deep and painful emotions trapped inside as a symbol
- Learning new skills that increase self-esteem and help memory and thinking
- Enabling unconscious emotions to be brought to consciousness (such as dream symbols)
- Having control over their concerns and problems

- Creating a safe environment for reflecting on their lives and sharing their experiences
- Taking more responsibility for their behaviour, attitudes and actions
- To be able to control their emotional world
- Coping with psychological states
- Minimising fear of future anxiety
- Reducing health costs
- Facilitating the healthy functioning of the nervous system
- Repair and reconstruction of the inner world
- Conflict and problem solving
- Self-esteem
- Reducing feelings of guilt
- Increasing focus and attention skills
- Increased sense of responsibility
- Finding release from heavy emotions or traumas
- Regulation of impulses through sublimation
- Maturation of defences
- Therapeutic alignment

6.3. Multiplier Effects

As a result of demographic changes, especially in developed countries, post-migration change brings social, health and economic phenomena. At this point, there are serious increases in public health expenditures due to the demographic increase. The dissemination and sampling of the findings

obtained at the end of the study will contribute to the reduction of public expenditures.

The relocation of more and more people brings along structural problems as well as an increase in public expenditures. One of the problems that developed countries face and need to solve is crisis-oriented expenditure programmes. Countries are developing new policy proposals in order to reduce public costs on the one hand and on the other hand to improve the quality of health and not to cause social security deficits. In order to develop service planning and social policies, it is important to create a data pool that brings together information on socio-economic characteristics and health status in the databases of different institutions and also reveals the profile of chronic patients. Population planning, support needs of individuals in their daily activities, health, education, income conditions and expectations make it necessary to create a detailed system on the basis of regions in proportion to the rate of population growth. In this context, as a result of the dissemination of the project results:

1-Multimorbid individuals will motivate themselves positively by transferring their gains after therapy in a way that will encourage their peers.

2- Sharing the successes of multimorbid individuals after this process with other multimorbid individuals will encourage their peers to be involved in the process.

3- Multimorbid individuals will enable them to live independently by realising their own potential and participating in activities in line with their

needs and wishes. This process will improve their quality of life and facilitate adaptation.

4- The health costs of states will be reduced.

5-The principles on which their actions reflect their system of thought and feeling will change.

6-The therapist witnessing this process will gain experience by helping the person to increase his/her awareness, to create new perceptions of movement and thus to develop new communication mechanisms in his/her emotional and verbal communication.

7- By supporting personal development and social communication; communities that start to live a happier and more peaceful life will increase.

7. EMALT GUIDE

7.1. EMALT Methodological Guide.

The EMALT approach aims for the client to achieve greater independence and integration. The focus is not on the person's current problem, but on the person. PABSEM does not believe that the aim of therapy is only to solve problems. Therefore, the main goal of therapy is to create an environment that helps the individual to strive for self-realisation. Clients realise that by using masks they lose contact with themselves.

In a therapeutic session in a safe environment, they realise that they also have more authentic ways of being. For this reason, EMALT focuses on five characteristics in the therapy process.

These are;

i) Self-actualisation

ii) Taking responsibility

iii) Self-confidence

iv) Internal evaluation

v) Acceptance

Developing these qualities is the main aim of EMALT therapy. These five characteristics provide a general framework for understanding the direction of therapeutic action. The therapist does not choose specific goals for the client. The cornerstone of EMALT theory is the view that clients in a relationship with a facilitating therapist have the capacity to define and clarify their own goals.

7.2. Function and Role of the Therapist in EMALT Approach

The role of the therapist lies in their way of being and their attitudes, not in techniques designed to 'make the client do something'. Research on EMALT during the project showed that therapists' attitudes (multimorbid) rather than their knowledge, theories or techniques facilitate personality change in the client.Basically, therapists use themselves as an instrument of change. When they meet people with multiple illnesses on a one-to-one level, their 'role' is to be self-independent. They do not get lost in a professional role. It is the therapist's attitude and the client's belief in their own inner resources that create the therapeutic climate for growth. EMALT theory argues that the therapist's role is to be present and accessible to the

client and to focus on their immediate experience. Above all, the therapist must be willing to be realistic in a multi-disordered relationship. The therapist is a catalyst for change by being sensitive, accepting and empathic. Instead of seeing clients in predetermined diagnostic categories, the therapist meets them on a moment-by-moment experiential basis and enters their world. Through the therapist's attitudes of genuine concern, respect, acceptance, support and understanding, clients can release their defences and rigid perceptions and move to a higher level of personal functioning. When these therapist attitudes are present, clients have the freedom to explore areas of their lives that have been denied or distorted in their consciousness. To do this, the therapist uses the EMALT approach in the following steps.

1. Psychological contact: The client and the therapist (called psychologist, art therapist, music therapist, etc.) are in psychological contact.

2. Client: (Multimorbid people are called clients.) The client may be maladaptive, vulnerable or anxious.

3. Therapist: The therapist is harmonious, realistic and formal in the relationship with the client.

4. The therapist shows unconditional positive respect for the client.

5. The therapist experiences the client's internal frame of reference with empathic understanding and tries to transfer this experience to the client.

6. Communication about the therapist's empathic understanding and unconditional positive approach towards the client is provided at a minimum level.

These essential qualities of the therapist, together with the therapist's presence, work holistically to create a safe environment for learning. Regardless of their theoretical orientation, most therapists make an effort to listen to the client fully and empathically, especially in the early stages of therapy. According to the EMALT approach, constructive personality change will occur if the therapeutic core conditions are present for a certain period of time. The basic conditions do not change according to the client type. Moreover, they are both necessary and sufficient for therapeutic change to occur. As clients experience that the therapist listens to them in an accepting way, they gradually learn to listen to themselves in an accepting way. Seeing that the therapist cares and values them (even the hidden and negative aspects), clients begin to see the value and worth in themselves. As they experience the therapist's authenticity, clients give up many roles and become real to themselves and to the therapist. This EMALT approach can best be described as a way of being and a shared journey in which therapist and client reveal their humanity and participate in an experience of growth. The therapist can be a relational guide on this journey because he/she is usually more experienced and psychologically mature in this role than the client. Therapists who adopt EMALT theory are able to reconcile their own inner experience with the external expression of that experience and to articulate the feelings, thoughts, reactions and

attitudes that exist in the relationship with the client. This communication is done with careful thought and judgement on the part of the therapist.

The transfer of the therapist's empathic understanding and unconditional positive regard for the client is ensured. If the therapeutic basic conditions are present for a certain period of time, constructive personality change will occur. The basic conditions do not change according to the individual. Moreover, they are both necessary and sufficient for therapeutic change to occur. From the EMALT perspective, the client-therapist relationship is one of equality. Therapists do not keep their information confidential or try to mystify the therapeutic process. The process of change in the client depends to a large extent on the quality of this equal relationship. As clients experience that the therapist listens to them in an accepting way, they gradually learn to listen to themselves in an accepting way. Seeing that the therapist is interested in and values them (even the hidden and negative aspects), clients begin to see the value and worth in themselves. Therapists are committed to expanding their own life experience and are ready to do whatever it takes to deepen their self-awareness. EMALT therapy emphasises that therapists must adapt to the emerging needs of the client and respond in the best interests of the individual. If therapists keep this in mind, they are likely to make the right clinical decisions most of the time. EMALT therapists value their clients with multiple disorders and warmly accept them without conditioning them into acceptance. This is the attitude of "I accept you as you are". Through their behaviour, therapists express that they value their clients with multiple illnesses for who they are and that clients are free to have feelings and experiences. The higher the degree of

valuing, accepting and caring for the client with multiple illnesses, the greater the chances of successful therapy.

7.3. Process to be applied in therapy

The therapist seeks to understand the function of the client's behaviour, including how particular behaviours emerge and how they are maintained. In the EMALT approach, the therapist sets initial treatment goals and designs and implements a treatment plan to achieve these goals. In this context

- The multimorbid client defines specific treatment goals at the beginning of the therapeutic process with the help of the therapist. An assessment is carried out before treatment to identify the behaviours targeted for change.

- Ongoing assessment throughout the therapy determines the extent to which the goals set have been achieved.

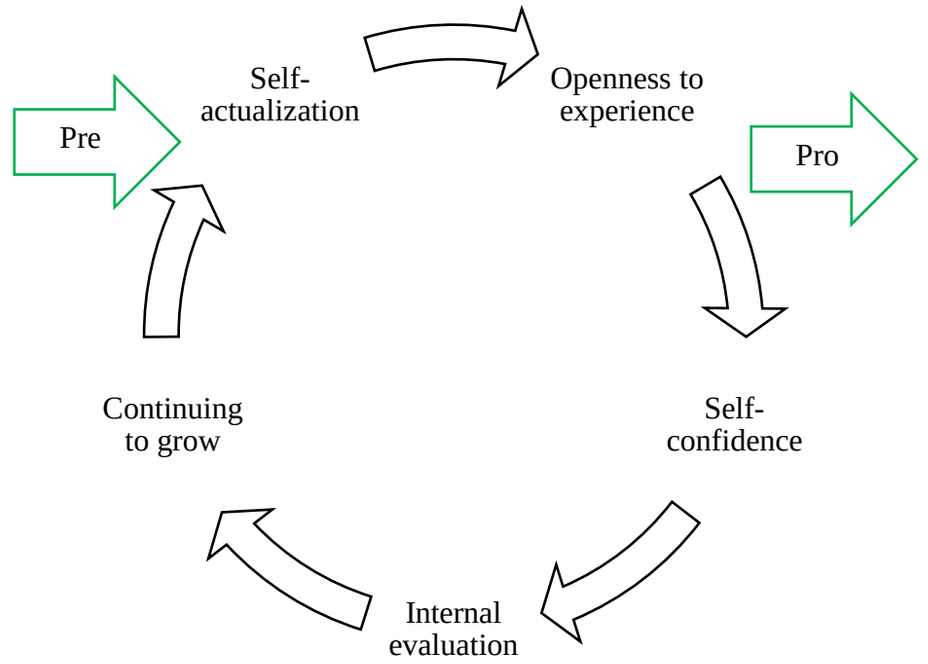
- A way to measure progress towards the goals was developed based on empirical verification.

- Multiple disease patients play an active role in making decisions about their treatment.

- The therapist helps the client to set specific and measurable goals.

Goals should be clear, concrete and understandable. These goals should be accepted by the client with multiple disorders and the therapist. The dimensions of the problem behaviour are determined.

- The success of the change plan is assessed by measuring progress towards goals during the therapy period. Outcome measures are given to the patient at the beginning of treatment and are collected periodically during and after treatment to determine whether the strategy and treatment plan are working (pre-test - post-test results).



8.SAMPLE CASE STUDIES

ARTTHERAPY
THEORETİCAL BASES: A CASE STUDY

DIAGNOSIS	: Anxiety
NUMBER OF SESSIONS	: 6
MATERIALS	:Paper, paint, pencil
CLIENT	:SA.K, 47

In the art therapy study diagnosed with Anxiety personality disorder, the client's feelings, thoughts and traumas were observed.

A 47-year-old woman named S.A.K applied to the hospital's psychiatrist service due to persistent stomach pain. We started working with the client to help her express her feelings and thoughts more easily due to her mood instability. In the study, the pictures made by the client in each therapy session and the session details are as follows.

Session 1: The client was asked to describe a very painful event in the past through a picture.

"This is a dead fish, it died of hunger and its bones are visible. My brother was as small as this fish when he died."

It is seen that the lines are broken and irregular in this study. After the work was finished, she needed to draw a topper on the edges of the work again. This shows her insecurity towards her environment and her need for self-protection (Figure 1).

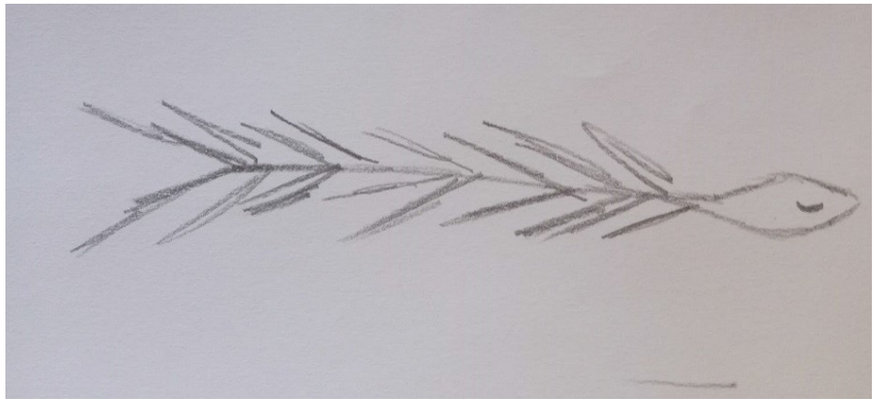


Figure.1

Session 2: "I will draw a shoe. A shoe that is worn out from constant walking, but kind." The lines are one-way. The fact that he has no shoes and that they are high up shows that she has internalied the situation of loneliness and being alone. It shows his distrust of the environment and the need to protect himself. (Figure 2)

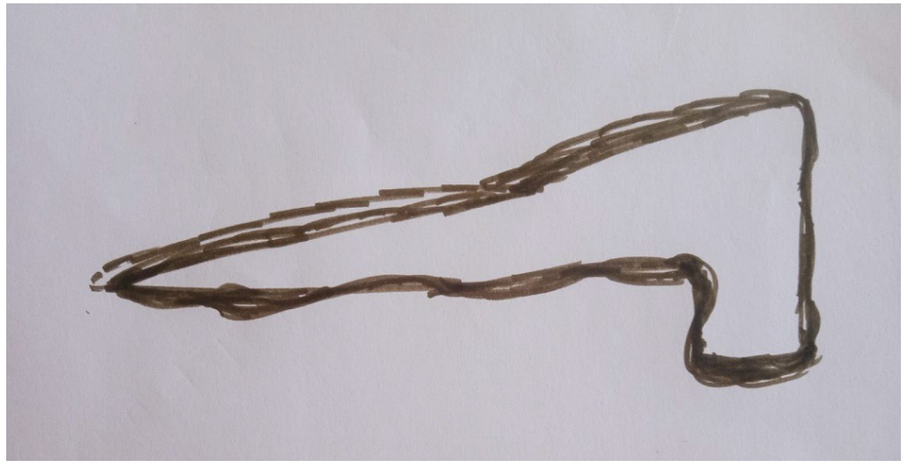
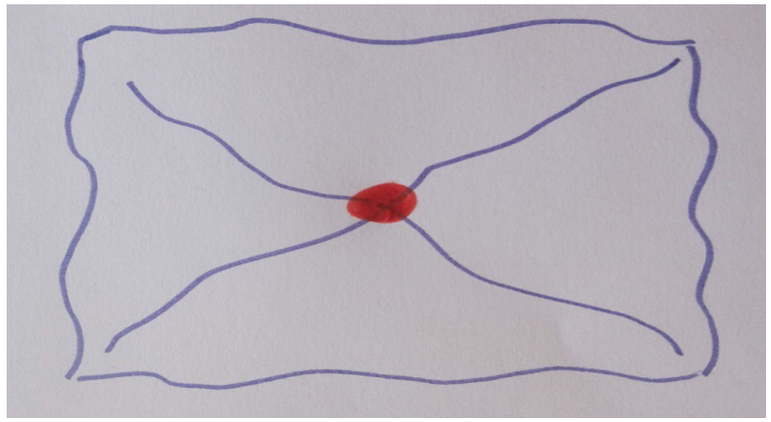


Figure.2.

Session 3: I want to collect my experiences in this envelope. It would be nice to keep them all together and look at them whenever I want.

This work is a reflection of the unconscious. Some of the lines are wavy, some are regular. . Order, disorder, symmetry, asymmetry all together. In the drawing, it can be seen that she is trying to restrain his dreams. (Figure 3)



Session 4: No one attended the session.

Session 5: "Thoughts were discussed through pictures. It feels good to do this, I usually don't have time. "I have to take all the responsibility, in fact I always feel tired."

Session 6: She was asked to draw the house she lived in during her childhood. She was angry while drawing the picture.

"It doesn't even look like my home. It's so bad, I don't want to remember my home, there is pain in every room that I remember. It was seen that she relaxed towards the end of the session."

In this session, the problems of her mother came up. Childhood traumas were revealed.

He stated that he constantly argued with his mother during his childhood, that his mother excluded him, and that his mother loved his other siblings more. It was observed that she had a subconscious coding of perfectionism to gain her mother's love.

The picture could not be photographed because the person tore it up.

After the Session: After the last session, it was suggested to the client that it would be useful to think of a calming subject that she could draw after the sessions.

For people diagnosed with anxiety, the most important way to recover is by resolving the accumulated stress and tension in the nervous system.

Resolving accumulated stress and tension in the nervous system allows the mind to get rid of sorrows, worries and fears. Naturally, when negative emotions such as fear and anxiety disappear, life becomes more satisfying and our body begins to regain its health.

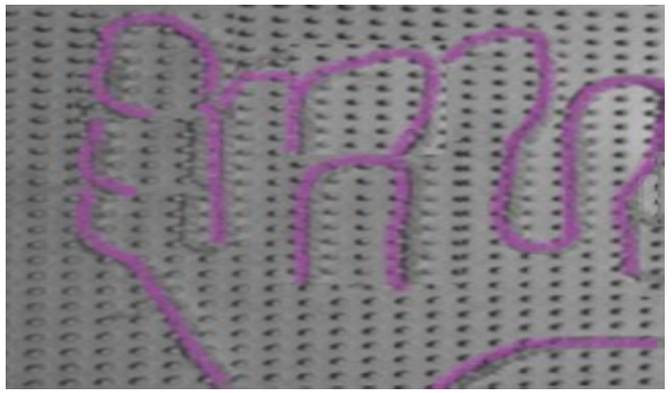
ARTS THERAPY
THEORETİCAL BASES: A CASE STUDY

DIAGNOSIS	**Major Depression**
NUMBER OF SESSIONS	7
MATERIALS	Table, rope, finger paint, crochet
CLIENT	M.H., 36

In a short-term art therapy study conducted with M.H (1986), the emotions, thoughts, traumas and consequences of a person diagnosed with Major Depression and exhibiting self-harming behavior were observed. A 36-year-old male patient committed suicide by overdosing on the 10th day after using different doses of medication. The following year, he sought asylum with the help of a person he met on the internet. The client's past story includes a recent trauma. . The patient had been previously hospitalized with symptoms of mood disorder, increased suicidal ideation, self-harming behaviors, and paranoid thoughts. A short-term art therapy session was started so that the client, who had difficulty communicating with the treatment team, could express his feelings and thoughts more easily. In the research, the work done by the client in each therapy session and the notes taken by the therapist regarding that session are given as follows:

SESSION 1: The trauma experienced in the past was relived by drawing with a rope on the table and the fear, anger and loneliness experienced at that moment were expressed.

The painting was described with the following words: “This is a big cactus. It pains me to see everyone judging my choices, the thorns on the cactus prick my entire body. I chose the purple thread for everyone to see.” **(Figure a.1)**



(Figure a.1)

SESSION 2: The reason for self-harm was discussed over the picture of a cactus knitted with string on the table.

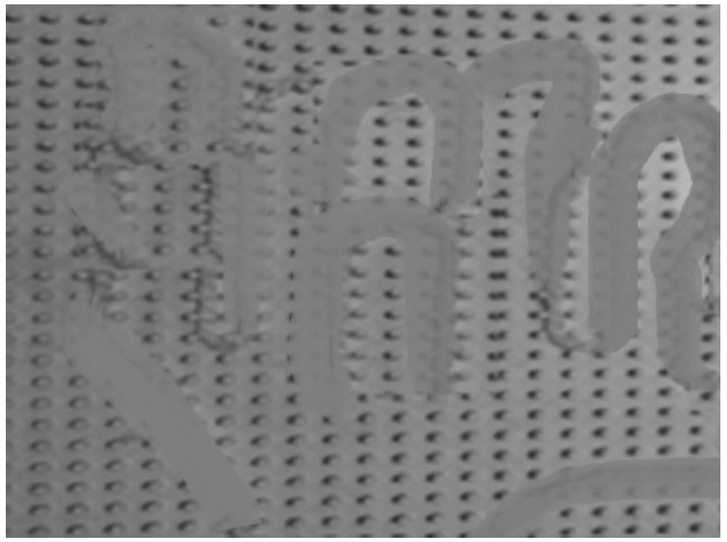
While painting he said: “I had to do something, I had to show it! "I have no one to understand me, everything is meaningless"

SESSION 3: What is it like to express yourself freely without trying to set limits? Do you feel comfortable in this way or do you have a strong desire to control and direct yourself?

"It's nice to sit here and do this. It's so hard to be alone, maybe I should do this to express what's inside me."

SESSION 4: Suicidal thoughts were discussed with the help of the art therapist and under a heading in the gray color chosen by the client.

"I covered the thorns on the cactus with paint, maybe I shouldn't have covered them, but I still don't know, I'm scared."**(Figure a.2)**



(Figure a.2.)

SESSION 5: What emotions did you experience during the process?

“This desire to shut down everything I wish to be… a black, faded dark me.”**(Figure a.3)**

(Figure a.3)

SESSION 6: This session was much more peaceful and nothing disturbing was mentioned. Commented on the bpaint:

“I loved doing this maybe I should always try it”

SESSION 7 : The person's traumatic experience was conveyed through painting.

While this; The phrase “I experienced uncertainty” was used. “It's been a great experience. Thank you for helping me to let me think." said

AFTER SESSION SHARING: After the last session, the client was shown a picture made recently. It was suggested that it would be helpful for the client to think of a calming topic that he could draw when he needed to get away from the sessions. The birds picture was shown by the client.

The pastel drawing was explained as follows: “I actually know what I like, what makes me happy, and for that I want to be as free as the birds.”

In the study, it was observed that the client externalized his traumas, feelings and thoughts through the pictures and colorings he made in each therapy session. As a result of the study, the client has gained the experience of expressing his feelings by taking time for himself and has gained the ability to focus on activities that make him happy and calming. When the client's post-study process was followed, it was observed that he used painting through handicrafts as suggested to help relaxation. In this framework, permanent, calming and sustainable effects have been revealed.The person shared his thoughts that he could gain the courage to face his fears by painting

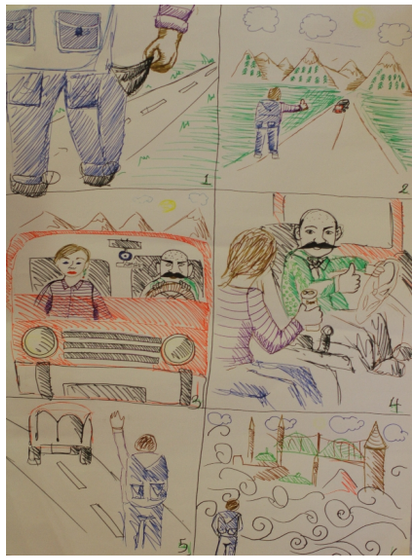
EXEMPLARY PICTURES

EXAMPLE 1.

Age:42
Study owner : Ali D.
Topic: Darkness
Material Charcoal
Genre : Abstract

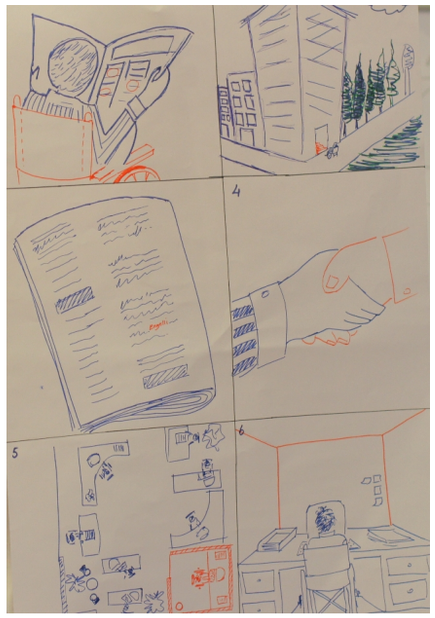
EXAMPLE 2.

Age:35
Study owner Armin E.D.
Subject: Traces from the past
Material :Watercolour
Genre : Abstract Painting



EXAMPLE 3.

Age:32
Study owner:Reza G
Topic: Beginning
Material Pastel
Genre : Figurative



EXAMPLE 4.

Age:28
Study owner Arash B.
Subject: Traces from the Past
Material :Charcoal
Genre : Concrete

9.RESEARCH METHOD

PRELIMINARY REPORT

Abstract

This report is a preliminary report analysis compiled for the "Effective use of Music, Art and Literature Therapy for immigrant and refugee multimorbid individuals" project, which was accepted by the Norway National Agency to conduct some studies on the effects of Therapy, which we call the integrity of the body, soul and mind. In the preliminary report studies of the project with reference number 2021-1-NO01-KA220-ADU000030237, whose short name is EMALT, two groups formed by neutral assignment were selected, one as the experimental group and the other as the control group.Understanding the epidemiology of multimorbidity; Improving intervention opportunities is very important in terms of reducing the burden of disease, prioritizing health services and arranging them in line with the needs of the patient. The designs of studies in this area and patient data sources significantly affect the results of the research. Only hospitalized and elderly patients are considered, as few diseases are usually considered based on individual reports; prevalence information is very variable. The prevalence of multimorbidity occurs at an early age, particularly in socioeconomically deprived areas; It is known that mulimorbidity due to physical and mental disorders is more common. For this reason, research has been started with the project group formed by Turkey, Netherlands, Italy, Poland and Norway in order to evaluate the existing problems on a sample basis.

Model of the Research

The method of taking measurements before and after the experiment will be determined from both groups, and the tests will be carried out in two stages as preliminary and final. In case of significant differences between pre-experimental measurements, measures added to the risk analysis plan for the studies will be taken. The research, which was carried out to evaluate the effect of therapy applied to people living alone, staying with a family or multimorbidities, on the level of Loneliness Syndrome and Psychological Well-being, will be conducted in a pre-designed quasi-experimental design. The research type consists of two groups as experimental and control group. SPSS 25.0 statistical package program was used in the analysis of the quantitative data of the research, and Kolmogorov Smirnov test was used to decide on the statistical technique. Whether chronic diseases such as diabetes, blood pressure, panic attacks, respiratory problems will remain constant in artistic studies on the

mental activities of multimorbids will be observed during the working period. A comparison will be made by evaluating the pre-study and post-study situations of those who voluntarily participated in the studies. In studies, ıt will measure whether mental activities are stable and change due to whether anxiety with EEG recordings in some areas. It will observe whether the studies and art have important physiological, psychological, social and behavioral effects on some chronic diseases.

Sample

The research sample consists of immigrant and refugee multimorbids living in the Netherlands, Italy, Norway, Poland and Turkey. The data obtained within the scope of the Protection of Personal Data will be kept confidential and the names of the volunteers will be known only by the project group, and nicknames will be used instead of names. The sample of the study was created with a paired design. Thirty multimorbid individuals meeting the inclusion criteria were assigned to the experimental and control groups. The experimental group consisted of 15 volunteers from multimorbid individuals, and the control group consisted of 15 other volunteers. The reason for choosing the experimental and control groups from different areas is to prevent the rate of influence on each other when they stay in the same place. For this reason, 30 of the 41 samples from each country were randomly selected and assigned to the experimental and control groups.

Inclusion criteria for the study: Being able to communicate, being willing to practice, not having dementia, mental retardation or any mental health disease such as Alzheimer's or schizophrenia.

Exclusion criteria from the study: Volunteers whose compliance with the inclusion criteria deteriorated during the study period and who want to leave the study will be excluded from the study. Data analyzes of 30 volunteers determined in this context were collected by other countries and sent to the Netherlands .

General Perspective

A significant part of the people participating in the study work in labor-intensive and predominantly unskilled jobs, depending on the characteristics of the city they live in.

The sectors in which the work is concentrated are construction, textile and service, especially seasonal works.

As refugees migrate mostly for security reasons,in general their skills are incompatible with the host country, which reveals that their access to the labor market is more limited. The incoming data also supports this situation. In line with the data received, the information regarding gender, marital status, educational status and occupation of the individuals participating in the research is shown in Table 2.

Demographic sample information on volunteers

			Group		
			Experiment	Control	Total
Gender	Woman	N	5	4	9
		%	33,33	26,66	30,00
	Man	N	10	11	21
		%	66,67	73,34	70,00
Marital	Single	N	10	10	20
		%	66,67	66,67	66,67
	Divor/Widow	N	1	-	1
		%	6,67	-	3,33
	Maried	N	4	5	9
		%	26,66	33,33	30,00
Edication	Primary	N	-	1	1
		%	-	3,34	3,34
	Middle	N	1	-	1
		%	6,67	-	3,34
	High School	N	9	12	21
		%	60,00	80,00	70,00
	University	N	5	2	7
		%	33,33	13,33	23,32
Profession	Esthetician	N	3	1	4
		%	20,00	6,67	13,32
	Temp employee	N	7	10	17
		%	46,67	66,67	56,67
	Student	N	-	1	1
		%	-	6,67	3,34
	Bottle-washer	N	1	1	2
		%	6,67	6,67	6,67
	Caretaker	N	4	2	6
		%	26,66	13,32	20,00
Total		N	15	15	30
		%	100,0	100,0	100,0

Table. 2

According to the findings in the table, 9 of the volunteers participating in the research were female and 21 were male. 5 females and 10 males in the experimental group, 4 females and 11 males in the control group. 30% of the volunteers are married, 3,33% are divorced or widowed, 66,67 % are single. Most of the volunteers are high school graduates , and the rate of university graduates is 23,32%. 56.67% of the volunteers are temp employee, 13.32% are esthetician, 20% are caretaker, 6.67% are bottle-washer and 3,34 % is student. Most of the experimental group and control group are temp employee

Data Collection Tools

The data in the study were obtained from Information Form (Annex-1), Informed Consent Form (Annex-2), Personal Information Form (Annex-3), Voluntary Feedback Form for Therapy Practices (Annex-4), Psychological Well-Being Scale (PWBS) (Annex) -5) and Loneliness Scale (LOSS) (Annex-6).

Personal Information Form

A personal information form was prepared in order to reach information about the multimorbidities participating in the study, including their family structure, age and gender, and whether they have health problems that would prevent them from taking an active role in participation, and their participation in social activities.

Feedback Form for Therapy Applications

In order to better understand the mood of multimorbidities, a form with open-ended questions was prepared.

Psychological Well-Being Scale (PWBS)

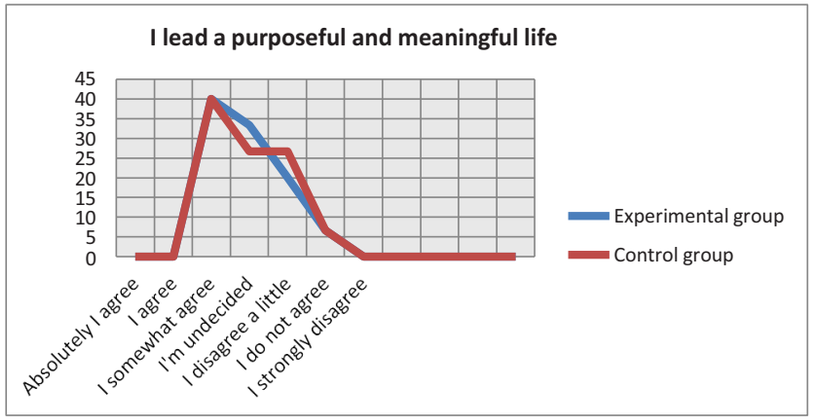
Psychological well-being has been defined as managing existential challenges in life (such as maintaining meaningful goals, personal development, and establishing quality relationships with others) (Keyes, Shmotkin, & Ryff, 2002). There are six dimensions in the psychological well-being model proposed by Ryff (1989). These; self-acceptance, positive relationships with others, autonomy, environmental control, life purpose, and personal growth.

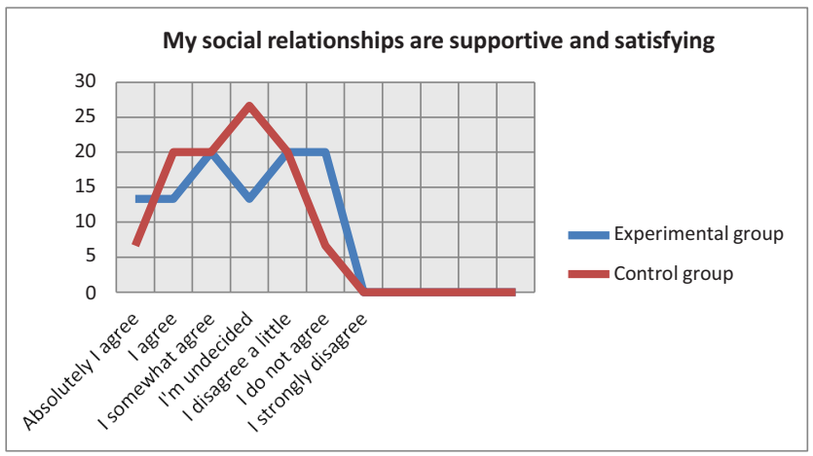
Key concepts related to psychological well-being, developmental theories that reveal the tasks and challenges in human development; It was obtained from clinical explanations revealing what self-actualization, maturation, full functionality or individualization are, and determinants of positive criteria of mental health (Ryff, Magee, Kling, & Wing, 1999). Psychological well-being theory is a combination of theories that examine the characteristics of people with positive functions (Özen, 2010). Roothman, Kirsten, and Wissing (2003) stated that psychological well-being can be conceptualized in relation to emotional, physical, cognitive, spiritual, personal and social processes. When the literature is examined, it is seen that there are a limited number of measurement tools related to psychological well-being. Although there are Psychological Well-Being Scales developed by Ryff (1989), Diener et al. (2009, 2010) explained the reasons for developing a new scale as follows: First, the scale they developed is shorter than the Psychological Well-Being Scales. Secondly, the scale includes some items that are not available in the existing Psychological Well-Being Scales, such as "connectedness and concern" and "optimism". The Psychological Well-Being Scale was developed by Diener et al. (2010) to measure socio-psychological well-being as a complement to existing measures of well-being. The items of the scale were created by taking into account the basic components of various well-being theories. The Psychological Well-Being Scale includes some items based on social relations such as having supportive and rewarding relationships, contributing to the happiness of others, and being respected by others. The scale also includes items based on having a purposeful and meaningful life, being interested in daily activities, and being busy with a job. The items are associated with self-esteem and optimism. Finally, there are items on the scale based on feeling capable and competent in activities that are important to the individual. The scale evaluates important elements of socio-psychological functions from one's own perspective. The aim of this study is to perform the adaptation, validity and reliability study of the Psychological Well-Being Scale developed by Diener et al. (2009, 2010) in a sample of university students. Psychological Well-Being Scale (PWBS) (PIO) was developed for the measurement of socio-Psychological Well-being as a complement to the existing well-being measurement tools with the studies of Diener et al. between 2009-2010.

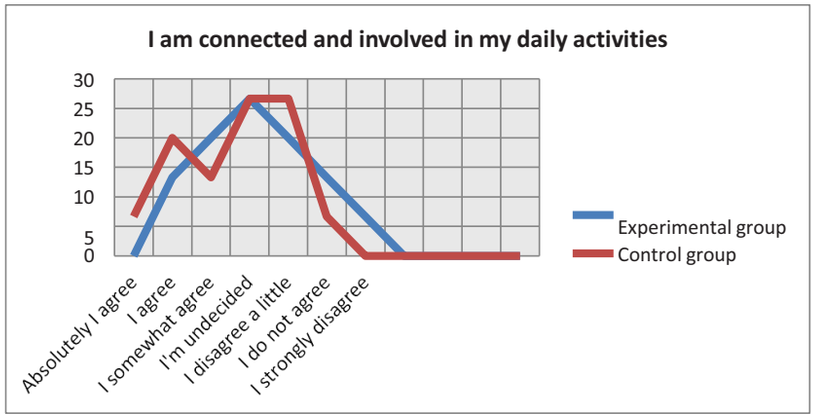
Psychological Well-Being Scale (PWBS) items are answered in the range of 1-7, with the form of strongly disagree (1) to strongly agree (7). All items that make up the scale contain positive statements. The scores range from 8 points when answered as I strongly disagree with all items, and 56 points when answered as I strongly agree with all items. A high score

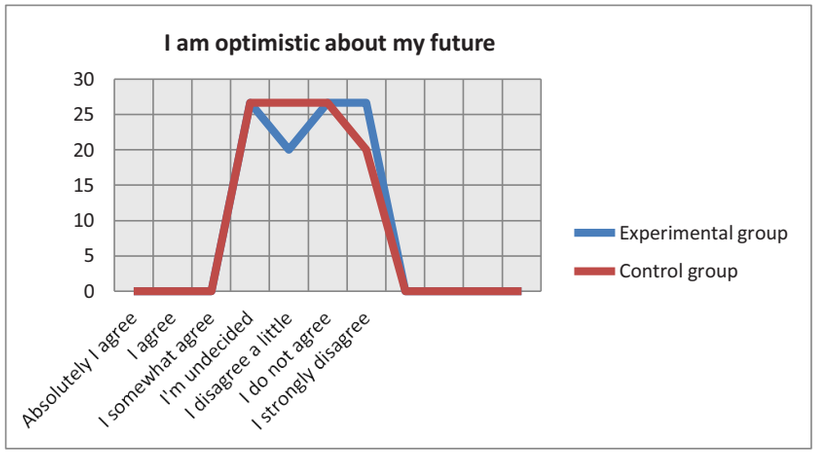
indicates that the person has many psychological resources and strengths. As a result of the validity study carried out by Telef with the participation of university students, it was found that the PWBS contained a single factor and the total variance explained was 53%. The factor loads of the items of the scale vary between 0.65 and 0.77. The Cronbach alpha internal consistency coefficient of the PWBS was found to be 0.87. Although the scale does not provide different measures for each of the elements of Psychological Well-being, it provides a general perspective in terms of positive functions in areas related to different elements that we believe are important (Diener et al., 2010).

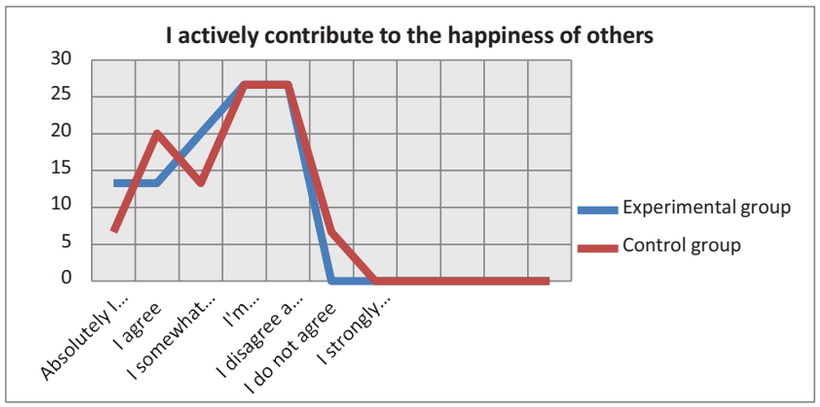
Psychological Well-Being Scale (PWBS) Pretest Results



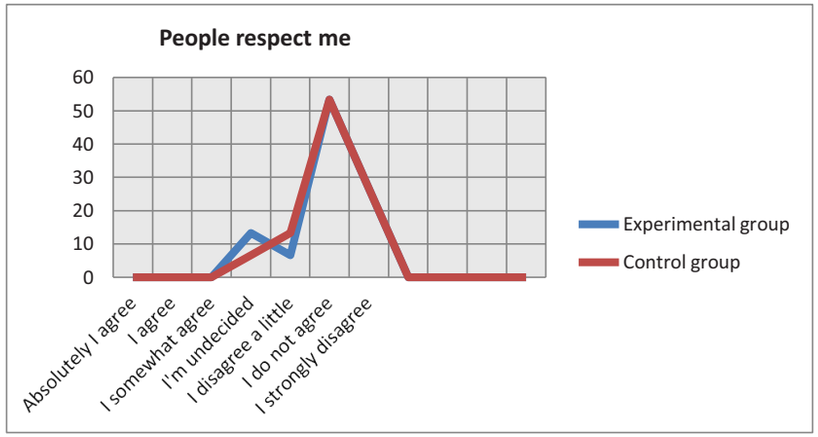


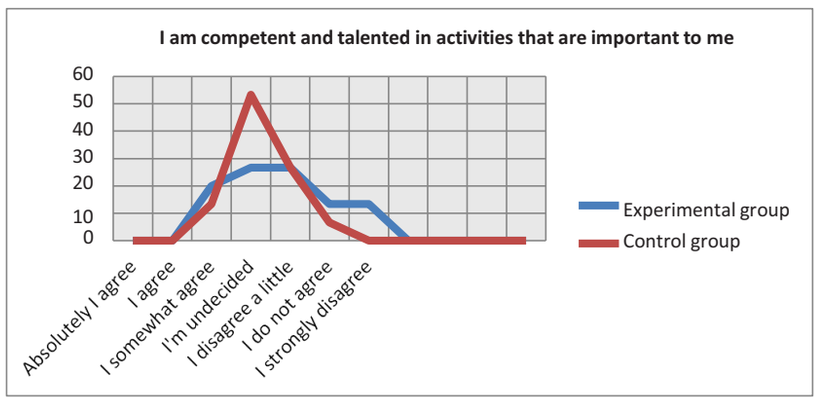

I am connected and involved in my daily activities
30
25
20
15
10
5
0
Absolutely I agree
I agree
I somewhat agree
I'm undecided
I disagree a little
I do not agree
I strongly disagree
Experimental group
Control group


I am optimistic about my future
30
25
20
15
10
5
0
Absolutely I agree
I agree
I somewhat agree
I'm undecided
I disagree a little
I do not agree
I strongly disagree
Experimental group
Control group


I actively contribute to the happiness of others
30
25
20
15
10
5
0
Absolutely I...
I agree
I somewhat...
I'm...
I disagree a...
I do not agree
I strongly...
Experimental group
Control group

I'm a good person and I live a good life
60
50
40
30
20
10
0
Absolutely I agree
I agree
I somewhat agree
I'm undecided
I disagree a little
I do not agree
I strongly disagree
Experimental group
Control group


People respect me
60
50
40
30
20
10
0
Absolutely I agree
I agree
I somewhat agree
I'm undecided
I disagree a little
I do not agree
I strongly disagree
Experimental group
Control group


I am competent and talented in activities that are important to me
60
50
40
30
20
10
0
Absolutely I agree
I agree
I somewhat agree
I'm undecided
I disagree a little
I do not agree
I strongly disagree
Experimental group
Control group

Loneliness Scale (LOSS)

The Loneliness Scale (LOSS) was developed by Russell, Peplau, and Ferguson in 1978, and was later revised by Russell, Peplau, and Cutrona in 1980. This developed scale was developed in order to determine how lonely people are. The scale consists of 20 items in total, 10 of which are reverse coded. Scale items are answered on a four-point Likert scale (1 = I have never experienced this situation; 4 = I experience this situation often).

10 items (1,4,5,6,9,10,15,16,19,20) indicate positive expressions showing satisfaction with social relationships, 10 items (2,3,7,8,11,12,13,14,17) ,18) include negative expressions showing dissatisfaction with social relations. The highest score obtained from the scale is 80, and the lowest score is 20. As the scores obtained from the scale increase, the Loneliness Syndrome levels of the individuals also increase.

In the reliability study of the original form of the scale, 0.89 correlation was found between the first form and the revised form. It was determined that the reliability coefficients of the scale's internal consistency and score invariance were sufficient.

Findings regarding the validity of the scale show that the scale significantly distinguishes between lonely and non-lonely subjects.

Data Collection

Multimorbid individuals forming the research area were informed about the purpose and requirements of the application and the criteria for inclusion in the research. An Informing Form (Annex-1) about the purpose of the research was given to 30 multimorbid individuals who met the research criteria and were willing to participate in the group work, and their written consent was obtained for their participation in study (Information Consent Annex 2). A total of 21 people selected as the experimental group volunteered for the application. Among these volunteers, 15 multimorbid individuals who could regularly participate in weekly group therapy activities were included in the experimental group. Then, Personal Information Form (Annex-3), Loneliness Scale (LOSS) (Annex-6), Psychological Well-Being Scale (PWBS) (Annex-5) were applied to this group.

Psychological Well-Being and Loneliness Syndrome scores were obtained before participating in the therapy group practices of the multimorbid individuals in the experimental

group. In the group selected as the control group, the scales and personal information form were filled by 20 volunteers who met the research criteria. Among these individuals, 15 individuals with homogeneous characteristics with the experimental group characteristics were evaluated within the scope of the control group. Therapy group activities will be planned in line with the data obtained. The activities planned and organized according to the needs of the group will be implemented in 24 sessions, 2 sessions of 180 minutes per week. During the therapy practices with the experimental group, no intervention will be made on the control group. After the 3-month study, the Psychological Well-Being (Annex-5), and Loneliness Syndrome (Annex-6) scales will be administered to the experimental and control groups as a post-test. The data obtained will be evaluated through the quantitative SPSS analysis program. In addition, written feedback will be received from the experimental group volunteers at the end of the Therapy sessions.

Analysis of Data

SPSS 25.0 statistical package program will be used in the analysis of the quantitative data of the research. The significance level will be taken as 0.05 in all analyzes. Before proceeding to the analysis, the normality of the data was tested with the Kolmogorov Smirnov test in order to decide on the statistical technique. In the analyzes performed separately on the data of the experimental and control groups, it was concluded that the data showed a normal distribution, since the p value was greater than 0.05 (See Table 2).

Kolmogorov Smirnov Test Results

Practise	Group	Value	Sd	p
LOSS Pre Test	**Experiment**	0,158	1	0,105
	Control	0,172	1	0,174
LOSS PostTest	**Experiment**	-	-	-
	Control	-	-	-
PWBS Pre Test	**Experiment**	0,114	1	0,193
	Control	0,128	1	0,192
PWBS Post Test	**Experiment**	-	-	-
	Control	-	-	-

Table 3

The **"independent groups t-test"** will be used to compare the pre-test and post-test mean scores of the experimental and control groups. In the comparison of the pretest and posttest

mean scores of the experimental and control groups separately.

The **"dependent groups t-test"** will be used. Apart from these, the mean standard deviation, frequency and percentage distributions will also be included in the calculation when describing the data.

FINDINGS

Under this heading, there is information about the quantitative findings on the determination of the effect of the therapy group activity prepared for immigrants and refugees participating in the research on Loneliness Syndrome and Psychological Well-Being and the evaluation of the demographic characteristics of the volunteers.

Evaluation of Demographic Characteristics Between Groups

Statistical significance is the probability that the relationship between two or more variables is due to something other than chance. Comparison of measurements of the same sample at two different times can be done with the paired t-test.

First of all, a chi-square analysis was used to determine whether a total of 30 multimorbid individuals in the therapy (15) and control (15) groups, who did not receive any intervention, differed in terms of some socio-demographic variables.

According to the analysis made;

Ho: There is a statistically significant difference between the experimental and control groups. **H_1:**There isn't statistically significant difference between the experimental control groups. Gender ($X2=0.051$, $Sd=1$, $p>.05$)

Marital status ($X2=0.06$, $Sd=1$, $p>.05$)

Education level ($X2=0.085$, $Sd=1$, $p>.05$)

Age ($t=-1.809$, $p>.05$)

No statistically significant difference was found between the experimental and control groups. (H1) Therefore, it can be said that the groups show a similar distribution in terms of some socio-demographic variables.

Comparison of the Pre-Test Scores of the Groups from the Scales

It was evaluated whether the multimorbid individuals in the experimental group participating in the therapy applications and the control group that received no intervention differed from each other in terms of the measurements evaluated in the research before the therapy group applications started. According to the analysis, the comparison of the Loneliness Syndrome level pretest scores of the experimental and control groups is presented in Table 3, and the comparison of the Psychological Well-Being level pretest scores is presented in Table 4.

Comparison of the mean scores of the experimental and control groups from the pre-test application of the Loneliness Scale

Pre-Test	Group	N	Avarage	SS	t	p	Va
LOSS	**Experiment**	15	52,66	9,611	0,377	0,709	86,22
	Control	15	54,01	9,856			90,66

Table 4.

According to the findings in the table, there is no significant difference between the experimental and control groups in terms of Loneliness Scale (LOSS) pre-test mean scores ($t=0.377$, $p>0.05$). According to this result, it can be said that the Loneliness Syndrome levels of the experimental and control groups before the Therapy group activity were similar.

Comparison of the scores of the experimental and control groups from the pre-test application of the Psychological Well-Being Scale (PWBS)

Pre-Test	*Group*	*N*	*Avarage*	*SS*	*t*	*p*	*Va*
PWBS	**Experiment**	15	59,33	9,611	0,840	0,203	85,23
	Control	15	60,01	8,4515			66,67

Table 5.

According to the findings, there was no significant difference between the experimental and control groups in terms of the Psychological Well-Being Scale (PWBS) pre-test mean scores (t=-0,840, p>0.05). According to this result, it can be said that the psychological well-being levels of the experimental and control groups before the Therapy group activity were similar.

Findings Regarding Inter-Group and In-Group Comparisons

Findings Related to Loneliness Syndrome

Under this heading, there are the findings of the statistical analyzes made to determine the effect of the therapy group activity with immigrants and refugees on the Loneliness Syndrome. Loneliness Syndrome multimorbidity levels were determined by the Loneliness Scale (LOSS). Findings under this title of the research;

- Is there a significant difference between the pretest and posttest total scores of the Loneliness Scale (LOSS) of the multimorbids in the experimental group participating in therapy practices?
- Is there a significant difference between the Loneliness Scale (LOSS) pre-test and post-test total scores of the multimorbids in the control group that did not receive any treatment?
- Is there a significant difference between the post-test total scores of the Loneliness Scale (LOSS) applied to the multimorbidity constituting the control and experimental group after therapy applications? It is an answer to the questions expressed in the form.

Next Loneliness Scale Post-Test (LOSS) Applied to the Experimental Group

In this section, the comparison of the scores of the experimental group from the pre-test and post-test application of the Loneliness Scale (LOSS) will take place. According to the findings, it will be compared whether there is a significant difference between the average scores of the experimental group's Loneliness Scale (LOSS) pre-test (X=60.01) and post-test. According to this result, it will be measured whether the therapy group effectiveness has a significant effect on reducing the level of Loneliness Syndrome in the experimental group.

Next Loneliness Scale Posttest (LOSS) to be Applied to the Control Group

In this section, the comparison of the Loneliness Scale (LOSS) pre-test and post-test scores of the control group will take place. According to the findings, it will be compared whether there is a significant difference between the average scores of the experimental group's Loneliness Scale (LOSS) pre-test (X=59.33) and post-test. Accordingly, the change in the Loneliness Syndrome levels of the control group will be determined in the three-month period.

Findings Related to Psychological Well-Being

Under this heading, there will be findings to determine the effect of the Therapy group activity prepared for the volunteers participating in the research on Psychological Well-being. Psychological Well-being levels of multimorbids will be determined by Psychological Well-Being Scale (PWBS). The findings under this title of the research;

- Is there a significant difference between the Psychological Well-Being Scale (PWBS) pre-test and post-test total scores of the multimorbids in the experimental group participating in therapy practices?
- Is there a significant difference between the Psychological Well-Being Scale (PWBS) pre-test and post-test total scores of the multimorbids in the control group that did not receive any treatment?
- Is there a significant difference between the total scores of the Psychological Well-Being Scale (PWBS) post-test applied to the multimorbidity constituting the control and experimental groups before the therapy applications? It will be an answer to the questions expressed in the form of.

Comparison of the Scores of the Experimental Group from the Psychological Well-Being Scale (PWBS) Pretest and Posttest Application

In this section, the comparison of the scores of the experimental group from the pre-test and post-test of the Psychological Well-Being Scale (PWBS) will take place. According to the findings, it will be checked whether there is a significant difference between the psychological well-being scale (PWBS) pre-test (X =54.01) and post-test mean scores of the

experimental group. According to this result, it will be determined whether the therapy group activity has a significant effect on increasing the level of Psychological Well-being in the experimental group.

Comparison of the Control Group's Scores from the Psychological Well-Being Scale (PWBS) Pre-test and Post-Test Application

In this section, the comparison of the scores of the control group from the pre-test and post-test of the Psychological Well-Being Scale (PWBS) will take place. According to the findings, it will be checked whether there is a significant difference between the mean scores of the Psychological Well-Being Scale (PWBS) pre-test (X=52.66) and post-test applications in the control group. The change in the level of well-being of the control group in the last three months will be observed.

Comparison of Experimental and Control Groups Scores from Psychological Well-Being Scale (PWBS) Post-Test Application

In this section, the comparison of the scores of the experimental and control groups from the Psychological Well-Being Scale (PWBS) post-test application will take place.According to the findings, it will be checked whether there is a significant difference between the experimental and control groups in terms of the Psychological Well-Being Scale (PWBS) post-test mean scores. According to this result, it will be analyzed whether therapy group activity has a significant effect on increasing the level of Psychological Well-being.

10.CONCLUSIONS

According to the findings obtained from the statistical analyses applied as a result of the research ;

- The scores of the experimental group from the pre-test and post-test of the UCLA Loneliness Scale differed significantly. According to this result, it was observed that art therapy group activity had a significant effect on reducing burnout syndrome in the experimental group.
- The scores of the control group from the pre-test and post-test of the UCLA Loneliness Scale differed significantly. Accordingly, it was observed that the burnout syndrome of the control group increased throughout the research.
- The scores of the experimental and control groups in the post-test of the UCLA Loneliness Scale differed significantly. This result, it can be said that art therapy group activity has a significant effect on reducing the level of loneliness.
- The scores of the experimental group from the pre-test and post-test of the Psychological Well-Being Scale (PWBS) differed significantly. According to this result, it can be said that art therapy group activity had a significant effect on increasing the level of psychological well-being in the experimental group.
- The scores of the control group obtained from the pre-test and post-test of the Psychological Well-Being Scale (PWBS) differed significantly. It is seen that the well-being levels of the control group decreased throughout the research.

- The scores of the experimental and control groups from the post-test application of the Psychological Well-Being Scale (PBI) differed significantly. According to this result, it can be said that art therapy group activity has a significant effect on increasing the level of psychological well-being.

RECOMMENDATIONS

According to the results of the research; art therapy is an effective method in reducing the burnout syndrome level and increasing the psychological well-being level of refugees and immigrants with chronic diseases. According to the written feedback of the volunteers; it can be said that art therapy has positive effects on the participants' socialisation, emotional awareness, feelings of sincerity and closeness, and their ability to cope with negativity.Experimental and control groups were used in the study. It may be recommended to add a second control group in future studies to evaluate the effectiveness of the research. In the future, it is thought that there is a need for studies in which art therapy will reveal the change in individuals by adding a 2nd control group and long-term follow-up measurements are made.Mood analyses can be revealed more clearly by making the sessions longer. Random observations were made again regarding the continuity of the effectiveness. Therefore, the ongoing situation was followed after the therapy applications. It is thought that more efficient results can be obtained about the clarity of the effect by extending the follow-up period to longer periods.

There is very limited research on art therapy applications as a positive psychotherapy intervention method. When other methods and researches are examined, it is observed that the pathological aspect of people (dementia, forgetfulness problems, etc.) is the subject of research, and the researches conducted to support and increase their existing psychological well-being are very limited. Since it is difficult to apply a separate method for each chronic disease, grouping the diseases and conducting a mixed sample will help to further clarify the results. Based on the discourses of the volunteers and the findings of the research, it is thought that such activities should be made widespread and more people should be aware of and benefit from these practices. In order for these studies to be made widespread, there is a need to focus on the necessary state policies, the training of trained personnel and current research on the changing problems depending on the impact of the age. Focusing on such researches will make serious contributions to the enrichment of scientific literature. Based on the importance of the healing power of art, the fusion of art-health fields, the use of art branches as a treatment method within the field of art therapy, which is accepted as alternative medicine, has been shown to have undeniable positive effects as a result of research on patients and has been proven by the studies and data obtained by important names in the field of health. Based on these findings, when we analyse the historical process, it is seen that there is an important link between art therapy and the field of health in the structuring of societies since the beginning of our historical line.

SOURCE

Bilen, D. & Kıran, B. (2020). Various traumatic experiences of refugees

OPUS International Journal of Social Research, 15(26), 3965-3987.

Demir, A. (2022). "Deliberation as a Consequence of the Right to Rights." In: Iyit, N. & Ozbek, B.

H. & Toptaş, A. (ed.): Current Research in Social, Human and Administrative Sciences. P.

Demirbaş, H. & Bekaroğlu, E. (2013). Psychological Psychological Psychological

Problems and Measures to be Taken. Crisis Journal, 21 (1), 11-24.

Dahinden J. (2013). Cities, Migrant Incorporation, And Ethnicity: A Network Perspective On

Boundary Work, Journal Of International Migration And Integration, 14(1), 39-60.

Renner, W. & Salem, I. (2009). Post-Traumatic Stress in Asylum Seekers and Refugees from

Refugees And Family Reunited Immigrants: Test Of The 'Healthy Migrant

Kirmayer, L. J. & Narasiah, L. & Munoz, M. et al. (2011) Common Mental Health Problems in Immigrants and Refugees:

General Approach in Primary Care. CMAJ, 183(12): 959-966. Lustig,

M. W. & Koester, J. (2009). Intercultural Competence: Interpersonal Communication Across Cultures Author: Myron W. Lustig, Jolene Koeste.

Petruta-Maria, C. (2015). The role of art and music therapy techniques in the educational system of children with

special problems. Procedia-Social and Behavioural Sciences, 187, 277-282.

Reynolds, M. W., Nabors, L., & Quinlan, A. (2000). The effectiveness of art therapy: Does it work?. Art

Therapy, 17(3), 207-213.

Rubin, J. A. (1999). Art therapy: An introduction.(pp.157-164) Psychology Press.

Spaniol, S. (2001). Art and mental illness: where is the link?. The Arts in psychotherapy, 28(4), 221-231.

Springham, N. (2016). Description as social construction in UK art therapy research. International Journal of Art

Therapy, 21(3), 104-115.

Steele, W., & Kuban, C. (2003). Using drawing in short-term trauma resolution. Handbook of art therapy, 139-151.

Vick, R. M. (2003). A brief history of art therapy. Handbook of art therapy, 5-15.

Wahlbeck, H., Kvist, L. J., Landgren, K. (2018). Gaining hope and self-confidence-An interview study of women's

experience of treatment by art therapy for severe fear of childbirth. Women and Birth, 31(4), 299-306.

Walker, M. S., Kaimal, G., Koffman, R., & DeGraba, T. J. (2016). Art therapy for PTSD and TBI: A senior active

duty military service member's therapeutic journey. The Arts in Psychotherapy, 49, 10-18,

Wang, Q. Y., & Li, D. M. (2016). Advances in art therapy for patients with dementia. Chinese Nursing

Research, 3(3), 105-108.

Winnicott, D. W. (2012). Playing and reality. (pp.1-25).routledge.

Hogan, S. (2001). Healing arts: The history of art therapy. Jessica Kingsley Publishers.

Hogan, S. (2015). Art therapy theories: A critical introduction. (pp.163,164). Routledge.

Holmqvist, G., Roxberg, Å., Larsson, I., & Lundqvist-Persson, C. (2017). What art therapists consider to be patient's

inner change and how it may appear during art therapy. The arts in psychotherapy, 56, 45-52.

Junge, M. B. (2010). The modern history of art therapy in the United States. Charles C Thomas Publisher.

Kaimal, G., Carroll-Haskins, K., Mensinger, J. L., Dieterich-Hartwell, R. M., Manders, E., & Levin, W. P. (2019).

Outcomes of art therapy and colouring for professional and informal caregivers of patients in a radiation

oncology unit: A mixed methods pilot study. European Journal of Oncology Nursing, 42, 153-161.

Khadar, M. G., Babapour, J., & Sabourimoghaddam, H. (2013). The effect of art therapy based on painting therapy

in reducing symptoms of oppositional defiant disorder (ODD) in elementary school boys. Procedia-Social

and Behavioural Sciences, 84, 1872-1878.

Klimovsky, G., Vainer, S. B., De Goldberg, D. B., De Kuitca, M. K., de Liberman, J. F., & Siniavsky, M. (1994).

Change in psychoanalysis: epistemological aspects. International journal of psycho-analysis, 75, 51-58.

Malchiodi, C. A. (Ed.). (2011). Handbook of art therapy. (pp.1-10). Guilford Press.

Malchiodi, C. A. (Ed.). (2013). Expressive therapies. Guilford Publications.

Mousavi, M., & Sohrabi, N. (2014). Effects of art therapy on anger and self-esteem in aggressive children. Procediasocial and behavioural sciences, 113, 111-117.

Guseva, E. (2019). Art Therapy in Dementia Care: Toward Neurologically Informed, Evidence-Based Practice. Art

Therapy, 36(1), 46-49.

Guttmann, J., & Regev, D. (2004). The phenomenological approach to art therapy. Journal of contemporary

psychotherapy, 34(2), 153-162.

Haeyen, S., Van Hooren, S., & Hutschemaekers, G. (2015). Perceived effects of art therapy in the treatment of

personality disorders, cluster B/C: A qualitative study. The Arts in Psychotherapy, 45, 1-10.

Edwards, D. (2014). Art therapy. sage.

Farokhi, M. (2011). Art therapy in humanistic psychiatry. Procedia-Social and Behavioural Sciences, 30, 2088-2092.

Fraser, K. D., & al Sayah, F. (2011). Arts-based methods in health research: A systematic review of the literature. Arts

and Health, 3(2), 110-145.

Freud, S. (1977). Introductory lectures on psychoanalysis.(pp.160-165)

Bartram, David - Poros, Maritsa V. - Monforte, Pierre, Basic Concepts in Migration Issues, trans. Itır Ağabetoğlu Tuncay, Ankara, Hece Publications, 2017.

Castles, Stephen - Miller, Mark J., The Age of Migration: International Migration Movements in the Modern World, trans. Bülent Uğur Bal, İbrahim Akbulut, İstanbul, İstanbul Bilgi University Publications, 2008.

Chambers, Iain, Migration, Culture, Identity, trans. İsmail Türkmen, Mehmet Beşikçi, İstanbul, Ayrıntı Yayınları, 2014.

Adıgüzel, Yusuf, Migration Sociology, Ankara, Nobel Akademi Yayınları, 2016.

Directorate General of Migration Management. (2021, 11. 03). Temporary Protection. www.goc.gov.tr/: https://

www.goc.gov.tr/gecici-koruma5638

Hoberg, G. (1991). Sleeping with an Elephant: the American Influence on Canadian Environmental Regulation. Journal of Public Policy, 11, 32-107.

Hulme, R. (2006). The Role of Policy Transfer in Assessing the Impact of American Ideas

on British Social Policy. Global Social Policy, SAGE Publications, 6(2), 173-195. https://hal.archives-ouvertes.fr/hal-00571793/document

Humanitarian Issues Working Group. (1994, March 08). Survey on the Implementation of

Temporary Protection. Retrieved on October 04, 2019, from refworld.org: https://www.refworld.

org/docid/3ae6b3300.html

Kapucu, N., & Kösecik, M. (2003). Administrative Reform Transfer between Countries: The New

Kamu Yönetimi Örneği. (M. A. Çukurçayır, Dü.) Konya: Çizgi Kitabevi.

Kaya, M. (2017). Syrians in Turkey Internal Transitions and Encounters. Istanbul: Hiper

Publication.

THANK YOU

This project is supported by the European Union. We would like to thank the European Union and the Norway National Agency for their support in this whole process so that we can realise our project.

EMALTPROJECT TEAM

2023

Co-funded by the European Union

"The European Commission's support for the production of this publication does not constitute an endorsement of the contents, which reflect the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein."

ISBN: 979-8-39861-625-5