MEDIATING ROLE OF PERCEIVED SOCIAL SUPPORT IN THE RELATIONSHIP BETWEEN INTERNALIZED HOMOPHOBIA, DEPRESSIVE SYMPTOMS, AND SELF-ESTEEM AMONG LGBTI+ INDIVIDUALS

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ETHICAL DECLARATION

I hereby declare that I am the sole author of this thesis and that I have conducted my work in accordance with academic rules and ethical behaviour at every stage from the planning of the thesis to its defence. I confirm that I have cited all ideas, information and findings that are not specific to my study, as required by the code of ethical behaviour, and that all statements not cited are my own.

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ABSTRACT

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The present study investigates the mediating role of perceived social support in the relationship between internalized homophobia, self-esteem, and depressive symptoms among LGBTI+ individuals. It is no surprise that the heterosexist and cisgenderistic attitudes are quite common among the society, rendering LGBTI+ people feel wrong about their mode of existence. These discriminating and stigmatizing attitudes seem to be internalized by LGBTI+ individuals, conceptualized as internalized homophobia. In literature, internalized homophobia was shown to be related to depression and self-esteem. It is also well-known that social support has a crucial part in the battle for recognition and equality, as well as in the mental health of the in LGBTI+ community. Thus, it was hypothesized that the perceived social support may have a role in the relationships among internalized homophobia, self-esteem, and depression. To test this hypothesis, 179 LGBTI+ individuals were included in the study. They were applied Internalized Homophobia, Beck Depression, Rosenberg Self-Esteem, and Perceived

Social Support Scales. Results shown that perceived social support had a significant mediating role in the relationship between internalized homophobia and depression, and between internalized homophobia and self-esteem. In conclusion, this study supports our theory. This might mean that perceived social support may alleviate the negative influence of internalized homophobia on depression and self-esteem. As it is not possible to make causal inferences at this point, further analysis will be needed to better understand these phenomena and the relationship among them.

Keywords: Internalized Homophobia, Self-Esteem, Depressive Symptoms, Perceived Social Support, LGBTI+, Queer

ÖZET

LGBTİ+ BİREYLERDE İÇSELLEŞTİRİLMİŞ HOMOFOBİ, DEPRESİF SEMPTOMLAR VE BENLİK SAYGISI ARASINDAKİ İLİŞKİDE ALGILANAN SOSYAL DESTEĞİN ARACI ROLÜ

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Bu çalışma, LGBTİ+ bireylerde içselleştirilmiş homofobi, benlik saygısı ve depresif belirtiler arasındaki ilişkide algılanan sosyal desteğin aracı rolünü incelemektedir. Heteroseksist ve cinsiyete yönelik ayrımcı tutumların toplumda oldukça yaygın olması, LGBTİ+'ların varoluş biçimleri konusunda kendilerini yanlış hissetmelerine neden olmaktadır. Bu ayrımcı ve damgalayıcı tutumlar LGBTİ+ bireyler tarafından içselleştirilmiş gibi görünmekte ve bu da içselleştirilmiş homofobi olarak kavramsallaştırılmaktadır. Literatürde içselleştirilmiş homofobinin depresyon ve benlik saygısı ile ilişkili olduğu gösterilmiştir. Toplumsal destek ve dayanışmanın, LGBTİ+ topluluğunun ruh sağlığı üzerinde ve tanınma ve eşitlik mücadelesinde önemli bir yeri olduğu bilinmektedir. Dolayısıyla içselleştirilmiş homofobi, benlik saygısı ve depresyon arasındaki ilişkide algılanan sosyal desteğin anlamlı bir rolü olabileceği varsayılmıştır. Bu hipotezi test etmek için 179 LGBTİ+ birey çalışmaya dahil edilmiştir. Katılımcılara İçselleştirilmiş Homofobi Ölçeği, Beck Depresyon

Ölçeği, Rosenberg Benlik Saygısı Ölçeği ve Algılanan Sosyal Destek Ölçeği uygulanmıştır. Elde edilen sonuçlar, algılanan sosyal desteğin içselleştirilmiş homofobi ile depresyon arasındaki ilişkide ve içselleştirilmiş homofobi ile benlik saygısı arasındaki ilişkide anlamlı bir aracı rolü olduğunu ortaya koymuştur. Sonuç olarak, bu çalışma algılanan sosyal desteğin içselleştirilmiş homofobi, depresyon ve benlik saygısı arasındaki ilişkide anlamlı bir rolü olduğu teorimizi desteklemektedir. Eld edilen bulgular, algılanan sosyal desteğin içselleştirilmiş homofobinin depresyon ve benlik saygısı üzerindeki olumsuz etkisini azaltabileceği anlamına gelebilir. Bu noktada nedensel çıkarımlarda bulunmak mümkün olmadığından, bu olguları ve aralarındaki ilişkiyi daha iyi anlamak için daha fazla çalışmaya ihtiyaç duyulacaktır.

Anahtar Kelimeler: İçselleştirilmiş Homofobi, Benlik Saygısı, Depresif Semptomlar, Algılanan Sosyal Destek, LGBTİ+, Kuir

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LIST OF ABBREVIATIONS

ACT UP: AIDS Coalition to Unleash Power

AIDS: Acquired Immunodeficiency Syndrome

ANOVA: Analysis of Variances

APA: American Psychiatric Association

CBT: Cognitive-Behavior Therapy

DLPFC: Dorsolateral Prefrontal Cortex

HIV: Human Immunodeficiency Virus

HIV+: Testing positive for HIV

LGB: Lesbian, Gay, Bisexual

LGBTI+: Lesbian, Gay, Bisexual, Transgender, Intersex, and other diverse gender identities and sexual orientations.

MRI: Magnetic Resonance Imaging

SSRI: Selective Serotonin Reuptake Inhibitor

SNRI: Serotonin-Norepinephrine Reuptake Inhibitor

CHAPTER 1: INTRODUCTION

Sexual orientation and gender identity are among the crucial aspects of one's self. While identifying ourselves, we often refer to the gender to which we conform, as well as to whom we are attracted to. Both sexual orientation and gender identity are broad concepts which incorporates so many different existences. After all, every individual is unique in their sexual and gender experiences and expressions. Unfortunately, the society seldom appreciates this diversity, and often tries to compress people into certain stereotypes. This heterosexist, homophobic, and cisgenderistic attitudes exhibited in the social world invalidating any existence other than heterosexual and cisgendered identities frequently cause LGBTI+ people to feel wrong, abnormal, and diseased (Gill & Randhawa, 2021). It is not uncommon that people from LGBTI+ community internalize these negative attitudes of others and adopt a homophobic, discriminative regard towards themselves (Ventriglio et al., 2021). It was shown that internalized homophobia and psychological well-being were strongly related constructs (Benesch, 2022) and that internalized homophobia was linked to decreased levels of emotional stability and self-efficacy; while lower levels of emotional stability and self-efficacy were associated with higher reports of symptoms related to depression, and even suicidal ideation (Munn & James, 2022). It was also revealed that there is a positive correlation between internalized homophobia and depressive symptoms (Yolaç & Meriç, 2020). Overall, LGBTI+ people who suffer from internalized homophobia are under greater risk to develop a psychological health problem compared to the cisgendered-heterosexual people.

When it comes to identities and the self, there is another concept worth mentioning in relation to one's mental health and psychological well-being, which is self-esteem. Self-esteem means people's positive or negative attitudes towards themselves (Rosenberg et al., 1995). Orth and Robins (1995) pointed out that self-esteem is an important aspect of one's well-being, especially in terms of relationships, work, and health. Herek, Gillis, and Cogan (2009) revealed that negative stigmas about the self has reduced the self-esteem and increased psychological distress among sexual minority adults. Supported by these research, it is not a surprise that LGBTI+ individuals have long been suffering from low levels of self-esteem, and high levels of internalized homophobia which in turn increase their vulnerability to mental health problems such as depression and anxiety.

It is crucial to see how society's discriminating and stigmatizing LGBTI+ individuals contribute to the impairment of their self-image and self-esteem, and sow the seeds of psychopathology through the internalization of those negative attitudes.

For humans, social acceptance was shown to have a strong relationship with subjective well-being and happiness (Arslan, 2018). It would be safe to assume that the risks posed by internalized homophobia, and depression on LGBTI+ individuals may be reduced by social support received from friends, families, and the community itself. It is also believed that feeling like being supported in the community could have beneficial effects on one's self-esteem. In other words, perceived social support may reduce depression and internalized homophobia, while improving self-esteem. This study aims to investigate the mediating role of perceived social support in the relationship between internalized homophobia, self-esteem and depressive symptoms in the LGBTI+ community. After this brief introduction, now, a detailed definition of the abovementioned concepts and relevant literature review will be presented in the sections below.

1.1. LGBTI+ Community

LGBTI+ is an inclusive acronym that stands for Lesbian, Gay, Bisexual, Transgender, and Intersex, with the "+" sign representing the inclusion of other sexual orientations, gender identities, and gender expressions that may not be explicitly listed (Moleiro & Pinto, 2015). The acronym is used as an umbrella term to encompass diverse sexual orientations, gender identities, and gender expressions that may not conform to societal norms related to binary concepts of sex, gender, and sexual orientation (McEwing et al., 2022). Lesbian is a term used to describe women who experience emotional, romantic, or sexual attraction towards other women. Gay, on the other hand, refers to men who feel emotional, romantic, or sexual attraction towards other men. Additionally, these terms can also be used inclusively to encompass individuals of any gender who are attracted to people of the same gender. Bisexual, on the other hand, refers to individuals who are emotionally, romantically, or sexually attracted to both males and females, or more broadly, to more than one gender. Transgender refers to individuals whose gender identity does not align with the sex they were assigned at birth. Transgender individuals may identify as male, female, both, neither, or as a

different gender altogether. Intersex refers to individuals who are born with physical or biological characteristics that do not fit in typical definitions of male or female. Intersex individuals may have variations in their chromosomes, hormones, or reproductive or sexual anatomy (United Nations, 2019). Finally, "+" sign represents the inclusion of other sexual orientations, gender identities, and gender expressions that may not be explicitly listed in the acronym, acknowledging and affirming the diverse and evolving nature of human identities.

It's important to use inclusive and affirming language when discussing sexual orientation, gender identity, and gender expression, and to respect individuals' self-identified identities and experiences. It's also important to recognize that the experiences and identities of individuals within the LGBTI+ community can vary widely, and that intersectionality plays a crucial role in shaping an individual's experiences and identities within this community.

Since LGBTI+ is an umbrella term, it sometimes can be confusing to understand what and who it actually represents. In order to overcome this confusion and to give a better insight, gender identity, gender expression, and sexual orientation concepts are explained in detail in the following section.

1.1.1. Gender Identity, Gender Expression, and Sexual Orientation

1.1.1.1. Gender Identity

Gender identity refers to an individual's deeply held and internal sense of their own gender. It is a personal understanding and perception of oneself as male, female, or non-binary, and it may or may not align with the sex assigned to them at birth. Gender identity is an intrinsic aspect of a person's identity and encompasses their deeply felt sense of being a man, a woman, or outside of the traditional gender binary (United Nations, 2019).

Gender identity goes beyond societal expectations and stereotypes associated with gender roles. It is a subjective experience that is shaped by a combination of factors, including psychological, cultural, and social influences. While gender identity can be influenced by biological factors, such as hormonal and genetic influences, it is primarily a psychological and emotional construct (Polderman et al., 2018).

For cisgender individuals, their gender identity aligns with the sex assigned to them at birth. For example, a person assigned male at birth who identifies and experiences themselves as male would have a cisgender male identity. However, for transgender individuals, their gender identity does not correspond to their assigned sex at birth. For instance, a person assigned female at birth who identifies and lives as a man has a transgender male identity.

It is important to note that gender identity exists on a spectrum, beyond the binary categories of male and female. Non-binary, genderqueer, genderfluid, and other gender identities recognize and embrace the diversity of experiences beyond the traditional gender binary.

Respecting and affirming individuals' self-identified gender identities is crucial for promoting inclusivity, equality, and the well-being of all individuals. It involves recognizing the autonomy of individuals to define and express their own gender identity, free from discrimination and societal pressures.

1.1.1.2. Gender Expression

Gender expression refers to the external manifestation of one's gender identity, typically through behavior, clothing, hairstyle, voice, and other forms of self-presentation. It is the way individuals communicate their gender identity to others and express themselves in alignment with their internal sense of gender. Gender expression is not inherently tied to a person's biological sex or assigned gender at birth, but rather reflects their own unique understanding and presentation of gender (United Nations, 2019).

Gender expression can vary widely and is influenced by cultural, societal, and personal factors. Some individuals may express their gender in ways that align with societal expectations for their assigned gender at birth, while others may express themselves in ways that challenge or transcend traditional gender norms and expectations. For example, someone assigned male at birth may express themselves through clothing, mannerisms, or interests typically associated with femininity, while someone assigned female at birth may express themselves in ways traditionally associated with masculinity. Others may present themselves in a more androgynous or gender-neutral

manner, blending elements of both masculinity and femininity, or may change their expression over time.

It is important to note that gender expression is distinct from gender identity. While gender identity refers to one's internal sense of gender, gender expression refers to the outward expression and presentation of that identity. Individuals may express their gender in various ways, regardless of their gender identity or sexual orientation. Respecting and acknowledging diverse forms of gender expression is crucial for promoting inclusivity and understanding the complexities of gender.

1.1.1.3. Sexual Orientation

Sexual orientation is a complex and multifaceted aspect of human identity that encompasses a person's emotional, romantic, and sexual attractions to others. It is an enduring pattern that emerges during adolescence or earlier and influences an individual's overall sense of self and relationships (United Nations, 2019). Society commonly categorizes sexual orientation into distinct labels such as heterosexual, homosexual, bisexual, and asexual, among others. However, it is important to recognize that sexual orientation exists on a spectrum, with a wide range of experiences and identities.

Heterosexuality is the most widely recognized sexual orientation, characterized by an attraction to individuals of the opposite sex or gender. It is often considered the societal norm and is prevalent across many cultures. Heterosexual individuals may experience emotional, romantic, and sexual connections with opposite-sex partners. Homosexuality refers to an enduring pattern of attraction to individuals of the same sex or gender. Gay is a term often used to describe male individuals attracted to other males, while lesbian is commonly used for female individuals attracted to other females. Homosexuality is an innate characteristic and is present in various cultures and societies throughout history. Same-sex relationships and identities have gained increasing recognition and legal protection in many parts of the world. Bisexuality is a sexual orientation characterized by attractions to both the same and opposite sexes or genders. Bisexual individuals may experience varying degrees of attraction to different genders, and their experiences can differ widely. Some individuals may have a preference for one gender over another, while others may experience relatively equal

attraction to multiple genders. It is important to understand that bisexuality does not reinforce the notion of binary gender; rather, it recognizes the potential for attraction to diverse gender identities. Pansexuality is a sexual orientation where individuals are attracted to others regardless of their sex, gender, or gender identity. Pansexual individuals may emphasize factors such as personality, emotional connection, or other aspects beyond traditional gender distinctions. Pansexuality acknowledges and affirms the spectrum of genders and recognizes the fluidity and diversity within human attraction. Asexuality is a sexual orientation characterized by a lack of sexual attraction or a minimal interest in sexual activity. Asexual individuals may still experience romantic or emotional attraction and form deep connections with others. Asexuality does not imply a lack of capacity for love or affection; rather, it signifies a distinct orientation that exists outside the realm of sexual attraction.

In addition to these specific orientations, the term "queer" has emerged as an inclusive and umbrella term that encompasses a wide range of non-heterosexual and non-cisgender identities. Queer is often used by individuals who reject or feel restricted by traditional labels and categories. It acknowledges the fluidity and diversity of sexual orientations and gender identities, and it emphasizes the importance of self-determination and personal expression.

1.1.1.4. The Differences between Gender Identity, Gender Expression, and Sexual Orientation

As these three concepts are often confused with each other, I would like to stress their differences. As already mentioned, sexual orientation focuses on the gender(s) to which a person is primarily attracted. Gender identity encompasses how individuals perceive and understand themselves as male, female, or non-binary, regardless of whom they are attracted to. Gender expression, on the other hand, is the way individuals communicate their gender identity to others and can encompass a range of expressions, from conforming to societal gender norms to intentionally challenging or transcending those norms.

It should be noted that while sexual orientation, gender identity, and gender expression are interconnected, they are distinct aspects of identity. Recognizing this diversity and complexity within these dimensions is crucial for promoting inclusivity and affirming

the identities and experiences, as everyone deserves to be treated as equal and have equal rights in the society. Unfortunately, recognition and affirmation of queer identities has required lot of resistance and combating throughout the history, and they still do. This struggle was described in the next section in detail.

1.1.2. History of LGBTI+ Movement

The history of the LGBTI+ movement is a complex tapestry of social, political, and cultural events that have shaped the struggles and achievements of the community over the years. Prior to the emergence of the modern LGBTI+ movement, same-sex relationships and non-binary gender identities were often marginalized or criminalized in many societies. However, throughout history, there have always been individuals and communities who challenged societal norms and expressed diverse sexual orientations and gender identities (Morris, 2023).

In the late 19th and early 20th centuries, the early roots of LGBTI+ activism began to take shape. Pioneers such as Karl Heinrich Ulrichs, Magnus Hirschfeld, and Harry Hay laid the foundation for future movements by advocating for the decriminalization of homosexuality and fostering early LGBTI+ organizations (Bullough, 2002).

The modern LGBTI+ movement gained significant momentum following the Stonewall Riots in June 1969. The riots erupted when police raided the Stonewall Inn, a gay bar in New York City. The queer patrons fought back against the harassment and discrimination, leading to several nights of protests and demonstrations. The Stonewall Riots are widely seen as a turning point in the fight for LGBTI+ rights, galvanizing a broader movement for social change (Matzner, 2015).

In the 1970s, various LGBTI+ organizations emerged across the United States and in other parts of the world. These groups, including the Gay Liberation Front and the Gay Activists Alliance, sought to challenge societal norms, combat discrimination, and advocate for equal rights (Bateman, 2004). Pride marches and parades also became prominent during this time as a means of raising visibility and demanding recognition.

The 1980s brought both challenges and resilience to the movement. The emergence of the HIV/AIDS epidemic disproportionately affected the LGBTI+ community, leading to widespread activism and the establishment of organizations such as ACT UP (AIDS

Coalition to Unleash Power). Activists fought for increased government funding, access to medication, and an end to stigmatization and discrimination (Sears, 2001).

The 1990s and early 2000s marked a period of significant legal and social advancements for the LGBTI+ movement. Denmark became the first country to legally recognize same-sex partnerships in 1989, followed by several others in subsequent years. In 2001, the Netherlands became the first country to legalize same-sex marriage, setting a precedent that many other nations would follow. These advancements in marriage equality and legal protections for LGBTI+ individuals paved the way for further progress globally (Belmonte, 2020). Presently, 34 countries recognize same-sex marriage (Human Rights Campaign, 2023).

Transgender rights and issues also gained greater recognition within the movement during this time. Activists advocated for legal recognition, healthcare access, and the right to self-determination for transgender and non-binary individuals. The fight for transgender rights continues to be a crucial aspect of the broader LGBTI+ movement (Currah, Juang and Minter, 2006).

The movement has achieved significant milestones in recent years. Marriage equality has expanded to numerous countries, and laws protecting LGBTI+ individuals from discrimination have been enacted in many places. However, challenges and inequalities persist, with varying degrees of acceptance and legal protection across different regions and cultures (Knauer, 2012). LGBTI+ activists and organizations continue to advocate for comprehensive legal protections, inclusive education, healthcare access, and cultural acceptance.

The history of the LGBTI+ movement is a testament to the resilience, determination, and collective action of individuals and communities who have fought for their rights and the recognition of their diverse identities. The movement's progress is an ongoing journey, as the fight for equality, justice, and inclusivity remains a central focus for the LGBTI+ community and its allies worldwide. Unfortunately, the current situation of the movement is still far from what is ideal.

1.1.3. Issues Faced by LGBTI+ Community

The LGBTI+ community faces a myriad of complex challenges that deeply impact the lives of its members. One of the most pervasive issues is societal discrimination and

stigma. Homophobia, transphobia, and biphobia continue to persist, leading to exclusion, harassment, and violence against LGBTI+ individuals (United Nations, 2017). This discrimination not only hampers their ability to live authentically, but also contributes to higher rates of mental health issues such as depression, anxiety, and suicidality (Almeida et al., 2009). Moreover, societal prejudice often results in social isolation, strained relationships, and limited opportunities for education and employment, exacerbating the marginalization experienced by the community (Garcia et al., 2020).

1.1.3.1. Minority Stress Theory

The Minority Stress Theory is a psychological framework that examines the unique stressors faced by individuals belonging to marginalized and stigmatized groups. Developed by Meyer (2003), this theory proposes that minority individuals experience higher levels of stress due to the social, cultural, and structural factors associated with their minority status. These stressors can be categorized into three main types: external, internalized, and institutionalized. External stressors include experiences of discrimination, prejudice, and violence, which can have detrimental effects on the well-being of minority individuals. Internalized stressors refer to the internalization of negative societal attitudes, leading to feelings of self-stigma, shame, and low self-esteem. Lastly, institutionalized stressors arise from discriminatory policies, laws, and social norms that limit opportunities and resources available to minority groups. This theory highlights the importance of recognizing and addressing the unique stressors faced by marginalized individuals to promote their psychological well-being and social inclusion. By understanding and intervening in the factors contributing to minority stress, researchers and practitioners can work towards creating more equitable and supportive environments for all individuals (Alessi, 2014)

1.1.3.2. Legal Issues

Legal disparities also pose significant challenges for the LGBTI+ community. Despite notable progress in recent years, many countries still lack comprehensive legal protections for LGBTI+ individuals (Gonzales and Ehrenfeld, 2018). Marriage equality, adoption rights, and anti-discrimination laws based on sexual orientation and

gender identity remain contentious issues in numerous jurisdictions. The absence of legal recognition and protections perpetuates inequality and hinders the ability of LGBTI+ individuals to fully participate in society, enjoy equal rights, and access essential services (Hopkins, Sorensen, and Taylor, 2013).

1.1.3.3. Healthcare Issues

Access to healthcare is another critical concern for the LGBTI+ community. Discrimination and lack of cultural competency among healthcare providers can lead to inadequate or inappropriate care. LGBTI+ individuals often encounter challenges when seeking gender-affirming healthcare, mental health services, or HIV/AIDS prevention and treatment (Fingerhut and Abdou, 2017). Disparities in healthcare access contribute to higher rates of substance abuse, sexually transmitted infections, and overall poorer health outcomes within the community (Addis et al., 2009). It is crucial to establish inclusive healthcare systems that address the specific needs and experiences of LGBTI+ individuals, promoting equitable access to quality care.

1.1.3.4. Mental Health Issues

Mental health disparities are also prevalent among the LGBTI+ community. The constant stressors arising from societal discrimination, family rejection, and internalized stigma can significantly impact psychological well-being. LGBTI+ individuals are at a higher risk of experiencing mental health conditions such as depression, anxiety, and substance abuse (Russell and Fish, 2016; Boswick et al., 2010). However, due to the lack of awareness, culturally competent mental healthcare providers, and affordable services, many individuals within the community struggle to access appropriate support and treatment.

1.1.3.5. Intersectionality

Intersectionality further compounds the challenges faced by the LGBTI+ community. Intersectionality is a concept coined by legal scholar Kimberlé Crenshaw in 1989 to describe how various forms of social categorizations and systems of oppression intersect and overlap, resulting in unique experiences of discrimination and

disadvantage for individuals who belong to multiple marginalized groups. Individuals may possess multiple social identities, such as race, gender, class, sexual orientation, disability, and more, and that these interactions may shape their experiences of privilege or marginalization (Phoenix and Pattynama, 2006). The compounded effects of racism, ableism, and transphobia, for example, result in even greater barriers to equality, representation, and well-being (Denise, 2014). Although each of these concepts deserves equal attention, as per the purpose of this paper, now the concepts of homophobia, and internalized homophobia will be examined in detail.

1.2 Homophobia

Homophobia is an umbrella term used to describe fear, hatred, or prejudice against individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, or from other diverse sexual orientations and gender identities (Barragan-Medero and Perez-Jorge, 2020). It refers to negative attitudes, beliefs, and behaviors towards individuals who are perceived as not conforming to societal norms around sexual orientation and gender identity. Homophobia can manifest in various ways, including discrimination, prejudice, violence, harassment, rejection, exclusion, and stigmatization of LGBTI+ individuals (Beusekom et al., 2018). It can occur at an individual level, interpersonal level, systemic level, or within institutions, and it may be expressed overtly or covertly (Castromonte and Grijalva, 2017). For instance, research conducted by Albuquerque et al. (2016) revealed that individuals within the homosexual population encounter challenges when attempting to access healthcare services due to the presence of heteronormative attitudes enforced by healthcare providers. DeSouza, Wesselmann, and Ispas (2017) pointed out that LGBT people are exposed to discrimination in work settings in the form of ignorance, exclusion, and microaggression. Homophobia has significant negative impacts on the mental health, emotional well-being, and overall quality of life of LGBTI+ individuals (Ventriglio et al., 2021). Mongelli et al. (2019) shown that being exposed to homophobia may result in heightened levels of stress, anxiety, and depression, as well as decreased self-esteem and feelings of shame or guilt.

The discrimination, prejudice, and stigma faced by LGBTI+ individuals due to homophobia can lead to social isolation, rejection, and a sense of being "less than" or

unworthy. This can further exacerbate mental health challenges and contribute to a decreased sense of psychological well-being. One of the most crippling results of this is that it may also lead to internalized homophobia, wherein individuals who identify as LGBTI+ may internalize negative societal attitudes and beliefs about their sexual orientation or gender identity, leading to self-hatred, shame, guilt, and psychological distress (Cochran and Mays, 2000). Let's now take a closer look at this concept.

1.3. Internalized Homophobia

Internalized homophobia is a complex psychological process that occurs when an individual who is identifying as LGBTI+ internalizes negative attitudes, beliefs, and prejudices of others about their sexual orientation or gender identity, or both (Newcomb and Mustanski, 2010). It can be seen as a form of internalized oppression, where individuals accept and believe in the negative stereotypes and stigmatization that they encounter in their environment and apply them to themselves.

From a psychological perspective, internalized homophobia can be explained by social learning theory, which suggests that individuals learn attitudes, beliefs, and behaviors from observing and imitating others in their environment (Bandura, 1977). In this case, individuals who are exposed to negative attitudes and stigma towards homosexuality or being LGBTI+ in their environment, such as family members, peers, media, or society at large, may internalize these beliefs and attitudes as their own.

The cognitive-behavioral model also offers insights into the psychological process of internalized homophobia. This model suggests that individuals develop negative self-beliefs and thought patterns that contribute to psychological distress (Pachankis et al., 2015). In the case of internalized homophobia, negative self-beliefs may include beliefs that being LGBTI+ is shameful, wrong, or immoral, and that one should hide or deny their sexual orientation. These beliefs can lead to negative thought patterns, such as self-blame, self-doubt, and self-criticism, which can contribute to depressive symptoms.

From a psychodynamic perspective, internalized homophobia can be seen as a defense mechanism against anxiety and fear. This perspective suggests that individuals who experience anxiety or fear related to their sexual orientation may cope by dissociating,

repressing, or denying their feelings and desires, leading to a lack of self-awareness and acceptance (Cabaj, 2000).

There are several risk factors that can contribute to the development of internalized homophobia among individuals who identify as LGBTI+. For instance, individuals who are raised in environments, such as families, communities, or cultures, that hold negative attitudes towards homosexuality or being LGBTI+ can be at higher risk for internalized homophobia (Igartua, Gill, and Montoro, 2003). Ross and Rosser (1996) pointed out that being exposed to messages that homosexuality is wrong, immoral, or unacceptable can lead individuals to internalize these beliefs and attitudes about themselves. Ongoing exposure to discrimination, prejudice, or harassment can lead individuals to internalize the negative messages and beliefs about their own sexual orientation, resulting in internalized homophobia. Moreover, McLaren (2015) revealed that lack of social support, such as from friends, family, or community, may increase the risk of internalized homophobia. If individuals who identify as LGBTI+ do not have a supportive environment where they feel accepted, loved, and affirmed, they may internalize negative beliefs about their sexual orientation or gender identity, resulting in internalized homophobia. Religious or spiritual beliefs that are not accepting or affirming of LGBTI+ individuals can also be a risk factor for internalized homophobia. Barnes and Meyer (2012) shown that if an individual's religious or spiritual beliefs conflict with their sexual orientation or gender identity, they may internalize negative attitudes towards themselves, resulting in internalized homophobia. Negative self-beliefs, such as feeling ashamed, guilty, or unworthy due to one's sexual orientation or gender identity, can contribute to internalized homophobia. Intersectional identities, such as being LGBTI+ and also belonging to other marginalized groups based on race, ethnicity, gender, socioeconomic status, or disability, can increase the risk of internalized homophobia. Experiencing multiple forms of oppression or discrimination can compound the effects of internalized homophobia and contribute to increased psychological distress. Ching et al. (2018) found out that Asian American LGBTI+ people are more prone to get traumatized and develop psychopathology compared to White American minorities. Another study revealed that anticipated discrimination and homophobia can have adverse impacts on the health outcomes and HIV vulnerability of sexual minority men of color who navigate multiple intersecting identities (Ramos et al., 2021).

In parallel with the findings presented above, it is important to note that internalized homophobia is not an inherent trait of being LGBTI+, but rather a result of external factors, such as societal stigma, discrimination, and prejudice; and it can have negative impacts on an individual's mental health and well-being. Internalized homophobia can manifest in different ways, and its psychological impact may vary from person to person. For some, internalized homophobia can lead to negative self-perception, self-doubt, and self-blame related to one's sexual orientation or LGBTI+ identity. This can result in feelings of shame, guilt, or disgust towards oneself, leading to a negative self-concept and low self-esteem. For others, internalized homophobia can create a conflict between an individual's sexual orientation and their internalized beliefs about what is considered socially acceptable or normal. This conflict can result in confusion, ambivalence, or denial about one's sexual orientation, leading to emotional distress and inner turmoil. People may also face fear of rejection, discrimination, or ostracism from others, including family members, friends, colleagues, or society at large. As Meyer (2003) pointed out, this can lead to self-censorship, self-restriction, or suppression of one's authentic self, resulting in emotional distress and a lack of self-acceptance.

People who struggle with internalized homophobia may adopt negative coping strategies, such as denial, avoidance, or self-medicating, in an attempt to cope with the internalized shame, guilt, or anxiety related to one's sexual orientation, as revealed by Kaysen et al. (2014) in a study conducted with sexual minority women. These coping strategies may provide temporary relief but can have negative long-term consequences on one's mental health and well-being. Internalized homophobia can also impact relationships with others, including difficulties in forming and maintaining healthy relationships, fear of intimacy, or difficulties in trusting others with one's authentic self. Frost and Meyer (2009) found out that the presence of internalized homophobia was linked to increased difficulties in relationships, particularly when depressive symptoms played a mediating role in the relationship between internalized homophobia and relationship problems. This, in turn, may result in social isolation, loneliness, and interpersonal conflicts, contributing to psychological distress.

To sum up, the discrimination, stigmatization, and homophobia can have detrimental effects on individuals' mental health and interpersonal relationships. Intersectionality further compounds these challenges, as individuals may face multiple forms of

discrimination. Moreover, these experiences often lead to difficulties in forming and maintaining healthy relationships. People sometimes adopt harmful coping strategies to reduce the pain they suffer, which often make things worse in practice. In the following chapters, several concepts closely related to internalized homophobia and its consequences, which are depression, self-esteem, and social support, will be discussed.

1.4. Depression

1.4.1. Definition

Depression is a mental health disorder characterized by persistent feelings of sadness, emptiness, or hopelessness (Hammen, 2005). It is more than just a temporary state of low mood or feeling down, and it can significantly impact a person's thoughts, emotions, behavior, and overall well-being (Boland et al., 2009). It manifests itself as one or more of the followings: Persistent feelings of sadness, anxiety, or emptiness, loss of interest or pleasure in previously enjoyed activities, changes in appetite and weight (either significant weight loss or weight gain), difficulty sleeping or excessive sleeping, fatigue or loss of energy, feelings of worthlessness, guilt, or self-blame, difficulty concentrating, making decisions, or remembering things, restlessness or slowed movements and speech, recurrent thoughts of death or suicide (APA, 2013). Depression is among the most encountered psychological disorder worldwide, and the lifetime prevalence for European countries was found to be 11.3% (Gutiérrez-Rojas et al., 2020).

1.4.2. Etiology

1.4.2.1. Neurobiological Approach

The current understanding of the origins of depression can be summarized as a typical model of gene-environment interaction, resembling those found in other complex diseases like cancer, hypertension, and diabetes. This model places emphasis on three key monoamine systems which are serotonin, norepinephrine, and dopamine (Saveanu and Nemeroff, 2012). Altered levels of those neurotransmitters seems to play a significant role in the development of depression. While it is widely acknowledged

that different neurotransmitter systems play a role in the pathoetiology of depression, no single neurotransmitter system can be solely attributed to its development. A more contemporary conceptualization of the biological basis of depression involves recognizing it as a disorder that affects multiple crucial brain regions and their interconnected pathways (Dean and Keshavan, 2017). MRI studies have shown that depressed individuals have reduced brain volume compared to healthy controls, particularly in the anterior cingulate, orbitofrontal cortex, putamen, and caudate, which play role in mood regulation and emotional behavior (Koolschijn et al., 2009). Reduced volumes of amygdala, which is associated with emotional memory, also shown to be related with depression and were thought to play a role in ruminations. (Hamilton, Siemer and Gotlib, 2008). Similarly, Rao et al. (2010) suggested that depressed people had significantly lower left and right hippocampal volume, which might be responsible for the memory and learning problems experienced by depressed people. Reduced activity of dorsolateral prefrontal cortex (DLPFC) was also evident in depressed people and might be responsible for psychomotor retardation and anhedonia (Drevets, 1998). Moreover, increased levels of inflammatory cytokines, which regulate the immune response, and activation of their signaling pathways, have been observed both in the brain and peripheral blood of patients with depression (Miller and Raison, 2016). Considering that cytokines have an effect on neurotransmitter systems and might be activated due to stressful life events, inflammation might be a factor that contributes to the pathophysiology of depression.

In addition, research often pointed out the role of genes in the etiology of depression. Twin studies revealed that the concordance rate for depression was 46% for monozygotic and 20% for dizygotic twins (McGuffin, 1996). Caspi et al. (2003) shown that people having two copies of the short allele of a specific gene tend to exhibit higher rates of depressive symptoms, diagnosed more with depression, and more suicidal when faced with stressful life events, in comparison to individuals who has a homozygous long allele.

1.4.2.2. Childhood Trauma

Childhood trauma also seems to contribute to the etiology of depression. Several research studies have provided evidence that the occurrence and course of mood

disorders, including depression, is significantly influenced by stressful life events experienced during childhood (McCauley et al., 1997; Young et al., 1997). Shapero et al. (2010) revealed that when individuals who have experienced higher levels of emotional abuse in the past encounter stressful life events, they tend to exhibit greater escalation in depressive symptoms. Similarly, Heim et al. (2008) suggested that childhood trauma is linked to the enduring sensitization of stress responses and changes in the functioning of (HPA) axis, which in turn associated with symptoms of depression.

1.4.2.3. Cognitive Approach

The cognitive model of depression, developed by psychologist Aaron Beck, proposes that depression is primarily influenced by negative thought patterns and maladaptive cognitive processes. According to this model, individuals with depression tend to interpret events, themselves, and the world in negative and biased ways, leading to the development and maintenance of depressive symptoms (Beck and Alford, 2009).

At the core of the cognitive model is the concept of the cognitive triad, which consists of negative thoughts and beliefs about oneself, the world, and the future. Individuals with depression often hold negative self-perceptions, viewing themselves as inadequate, worthless, or unlovable. They may also perceive the world as overwhelmingly negative, seeing little joy or positivity in their surroundings. Additionally, their view of the future tends to be pessimistic, anticipating further failure, disappointment, or unhappiness. These negative beliefs contribute to a sense of hopelessness and despair, reinforcing depressive symptoms (Beck, 2002).

Another key component of the cognitive model is cognitive distortions. These are biased or irrational thinking patterns that influence how individuals interpret information and experiences. Common cognitive distortions seen in depression include all-or-nothing thinking (seeing situations in black and white terms), overgeneralization (drawing broad negative conclusions based on limited evidence), and personalization (attributing excessive blame or responsibility to oneself). These distortions reinforce negative thinking and contribute to the maintenance of depressive symptoms (Beck, 1963).

Furthermore, the cognitive model emphasizes the role of automatic negative thoughts. These are spontaneous, repetitive, and intrusive thoughts that often occur without conscious awareness. Automatic negative thoughts are typically negative and self-critical, further fueling depressive feelings. They can act as triggers for emotional distress and can perpetuate the negative cognitive triad and cognitive distortions.

1.4.3. Treatment

Current treatment options for major depression include pharmacological interventions and psychotherapeutic approaches. Pharmacological interventions such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and atypical antidepressants are commonly prescribed to target neurotransmitter imbalances associated with depression (Hollon, Thase, and Markowitz, 2002).

Cognitive-behavioral therapy (CBT) aims to identify and challenge negative thoughts, beliefs, and cognitive distortions. Through CBT, individuals learn to reframe negative thinking patterns, develop more balanced and realistic perspectives, and develop healthier coping strategies (Beck, 1979). By addressing the cognitive factors that contribute to depression, individuals can experience significant improvements in mood and overall well-being. In their meta-analysis study, Cujipers et al. (2013) revealed that CBT is an effective therapy technique to treat adult depression. Other psychotherapeutic approaches, such as psychodynamic therapy, interpersonal psychotherapy, and problem-solving therapy also focus on addressing negative thought patterns, improving interpersonal relationships, and enhancing self-awareness in order to treat depression (Cujipers et al., 2008).

Having explored the depths of depression, now another concept closely related to our well-being, which is self-esteem, will be examined.

1.5. Self-Esteem

Self is a multidimensional construct that encompasses an individual's perception, beliefs, and understanding of their own identity, characteristics, and experiences (Oyserman, Elmore, and Smith, 2012). It represents the subjective sense of being an

individual with unique thoughts, emotions, and agency. The self includes various components, such as self-awareness, self-concept, self-esteem, and self-identity. Self-awareness involves the ability to introspect and recognize one's own thoughts, emotions, and behaviors (Oden, Miner-Holden, and Balkin, 2009). Self-concept refers to the collection of beliefs, attitudes, and values that individuals hold about themselves, including their abilities, traits, and roles (Gecas, 1982). The concept of self is complex and influenced by personal experiences, social interactions, and cultural contexts, shaping an individual's perception of their identity, and influencing their thoughts, emotions, and behaviors.

Various influential psychologists have offered their definitions of the self, each emphasizing different aspects and perspectives. Freud, for instance, viewed the self as composed of three parts: the id, ego, and superego. The id represents primitive desires and instincts, the ego mediates between the id and external reality, and the superego incorporates societal norms and moral values (Freud, 1923). Rogers, on the other hand, emphasized the concept of self-actualization and believed that the self consists of the actual self (perceptions of one's current attributes and experiences) and the ideal self (aspirations and goals). According to Rogers, a congruence between the actual self and ideal self is essential for psychological well-being (Rogers, 2013). Piaget's cognitive developmental theory suggests that the self develops through interaction with the environment. He proposed that the self emerges during childhood and evolves as individuals acquire cognitive abilities, self-awareness, and the capacity to differentiate themselves from others (Fox and Riconscente, 2008). Bandura's social cognitive theory posits that the self is shaped through a reciprocal interaction between personal factors, behavior, and the environment. He highlighted the role of self-efficacy, which refers to an individual's belief in their ability to succeed in specific situations, as a crucial aspect of the self (Bandura, 2008). Erikson proposed a psychosocial theory of development that included a focus on the self. He emphasized the formation of a coherent and positive identity as a central task of adolescence and highlighted the importance of resolving identity crises to achieve a strong sense of self (Erikson, 1968). James emphasized the subjective experience of self as a stream of consciousness. He described the self as comprising both the "I", the subjective knower, and the "Me", the object of self-reflection and self-identification (James, 2007). Finally, Jung's theory of the self is rooted in his concept of individuation. He viewed

the self as the central archetype representing the striving for wholeness and integration of the conscious and unconscious aspects of the psyche (Alcaro, Carta, and Panksepp, 2017). The common theme among different definitions of the self proposed by the pioneering psychologists in the field is that a person's self is characterized by growing towards integrity, with the help of positive interactions with one's environment. In this way, our selves shall be deemed to be esteemed, so to speak.

Self-esteem refers to an individual's subjective evaluation and perception of their self-worth and self-acceptance (Pyszczynski et al., 2004). It encompasses cognitive and affective components, representing self-beliefs and emotions associated with one's value. Self-esteem plays a significant role in mental health outcomes, influencing various aspects of an individual's life (Cast and Burke, 2002). It is believed to have an impact on emotional well-being, relationships, academic and professional achievements, and overall psychological functioning (Budiarto and Helmi, 2021). Low self-esteem has been linked to increased vulnerability to mental health issues, such as depression, anxiety, and eating disorders (Sowislo and Orth, 2013). Conversely, high self-esteem contributes to resilience, adaptive coping strategies, and positive mental health outcomes (Baumeister et al., 2003).

1.6. Perceived Social Support

The term "social support" was coined by Sheldon Cohen in the late 1970s. Cohen, a prominent psychologist and researcher, introduced the concept to encompass the idea of individuals receiving assistance, resources, and emotional comfort from their social networks. Cohen and Wills (1985) recognized the significance of social relationships in promoting well-being and their potential to buffer against the negative effects of stress. Cohen's pioneering work laid the groundwork for the study of social support and its impact on various aspects of health and quality of life. Since then, social support has become a widely studied and recognized concept in the fields of psychology, sociology, and public health.

Perceived social support, refers to the perception of the availability and effectiveness of support from one's social network in coping with stressors (Lakey and Cassady, 1990). It encompasses the belief that others are available to provide assistance, understanding, and emotional comfort when needed. Perceived social support plays a

vital role in mental health outcomes, as it serves as a protective factor against the adverse effects of stress and contributes to overall psychological well-being (Wang et al., 2018). Research consistently demonstrates the positive association between higher levels of perceived social support and improved mental health, including lower levels of anxiety, depression, and psychological distress (Lakey and Cassady, 1990; Gülaçtı, 2010; Norris and Kaniasty, 1996). Furthermore, perceived social support enhances coping mechanisms, self-esteem, and resilience, providing individuals with a sense of belonging, validation, and reassurance in times of challenge and adversity (Lane et al., 2002; Detrie and Lease, 2007).

Social support also plays a crucial role in human rights movements by providing the necessary foundation for collective action and social change. It brings together like-minded individuals who share common goals, fostering unity and mobilization. Through emotional encouragement, shared resources, and a collective belief in the cause, social support amplifies the voices of marginalized individuals and empowers them to speak up and advocate for their rights. It creates a sense of solidarity, resilience, and validation, enabling the movement to gain momentum and effectively challenge existing power structures. Additionally, social support networks provide spaces for strategizing, organizing, and sustaining activism, making them indispensable in driving human rights movements forward and achieving meaningful societal transformation (Louis and Montiel, 2018).

1.7. The Relationship between Internalized Homophobia, Depression, Self-Esteem, and Perceived Social Support among LGBTI+ Individuals

1.7.1. Internalized Homophobia and Depressive Symptoms

As we discussed earlier, minority groups are more vulnerable to develop depressive symptoms compared to others, especially due to stigma, victimization, and discrimination. For instance, Suh et al., (2023) suggests that minority stereotypes reduce self-esteem which in turn increase depressive symptoms among Asian Americans. A similar trend is evident in LGBTI+ individuals as well. In a meta-analytic study, it was revealed that suicidality and depression was more prevalent among LGBTI+ youth compared to their heterosexual counterparts (Marshal et al., 2011). Bockting et al. (2013) revealed that compared to cisgender individuals,

transgender individuals exhibited significantly elevated rates of depression, anxiety, somatization, and general psychological distress. Similarly, according to research conducted by Kaniuka et al., (2019), LGBTI+ people have found to be more vulnerable to depression compared to their heterosexual counterparts. But what makes LGBTI+ people so vulnerable? One reason for that might be the internalized negative attitudes towards one's own identity. Considering LGBTI+ community, these internalized negative attitudes are called internalized homophobia. Various research has shown that there is a significant relationship between internalized homophobia and depressive symptoms among individuals who identify as LGBTI+ (Bariola, Lyons, and Leonard, 2016; Meyer, 2003; Hyemin, 2019; Wang, 2021; Yolaç and Meriç, 2021; Duc et al., 2020). One reason for this might be the emotional burden resulting from the conflict between an individual's sexual orientation or gender identity and their internalized beliefs about what is considered socially acceptable or normal. This conflict may lead to self-doubt, self-blame, and feelings of shame or guilt, leading to a negative self-concept and self-esteem. Consequently, this negative self-concept may contribute to depressive symptoms. Puckett et al. (2015) revealed that LGBTI+ individuals who internalize negative societal attitudes towards their sexual orientation may also experience social rejection, discrimination, and prejudice from others, including family members, friends, colleagues, or society at large. This may result in chronic stress, isolation, and alienation, which can contribute to depressive symptoms (Taylor et al., 2018). In order to avoid stigmatization and cope with internalized homophobia, some individuals may choose to hide or deny their sexual orientation, leading to a lack of authenticity and self-expression; which in turn may result in a sense of emotional and psychological isolation, as well as feelings of shame or guilt for not being true to oneself (Newheiser and Barreto, 2014). These factors may collectively contribute to depressive symptoms. Moreover, internalized homophobia can impact an individual's ability to seek and receive social support from others, as they may fear judgment, rejection, or discrimination. According to Taylor (2011), lack of social support may exacerbate depressive symptoms and contribute to feelings of loneliness, isolation, and hopelessness.

1.7.2. Internalized Homophobia and Self-Esteem

As mentioned before, internalized homophobia refers to the internalization of societal messages of homophobia, discrimination, and marginalization that can result in

negative attitudes and beliefs about oneself as a member of the LGBTI+ community (Shidlo, 1994). Internalized homophobia can lead to feelings of shame, guilt, self-doubt, and fear of rejection or discrimination. This negative self-perception may cause a decrease in self-esteem, as the individual may believe that they are not deserving of respect, love, or acceptance. A study conducted with lesbians revealed that low self-esteem or a lack of self-acceptance may contribute to internalizing negative attitudes towards one's own sexual orientation or gender identity (Peterson and Gerrity, 2006). Another study conducted with gay men revealed a strong relationship between low self-esteem and internalized homophobia (Allen and Oleson, 1999). In their study conducted with transgendered and gender non-conforming adults, Austin and Goodman (2017) pointed out that self-esteem was negatively impacted by internalized transphobia.

Internalized homophobia can lead to a cycle of negative self-perception and negative experiences. For example, an individual who feels shame about their sexual orientation or gender identity may avoid seeking out social support, which can further exacerbate feelings of isolation and loneliness. This, in turn, can lead to a further decrease in self-esteem, as the individual may believe that they are not worthy of support or connection with others.

Conversely, positive self-esteem can serve as a protective factor against the negative effects of internalized homophobia. When an individual has a positive self-perception and believes that they are deserving of respect, love, and acceptance, they may be more likely to seek out supportive social networks and resources to help them cope with negative experiences (Mann et al., 2004).

1.7.3. Internalized Homophobia and Perceived Social Support

Studies have consistently found that internalized homophobia and perceived social support had a negative relationship among LGBTI+ individuals (Calvo et al., 2021; Puckett, 2015). In other words, individuals who experience higher levels of internalized homophobia are less likely to feel supported by their social network. This relationship is believed to be mediated by negative mental health outcomes, such as depression, anxiety, and stress (Earle, 1999; Herek et al., 1998). This might mean that individuals who experience higher levels of internalized homophobia may have a more

negative view of themselves and their social environment, leading to poorer mental health outcomes. Several factors may impact the relationship between internalized homophobia and perceived social support. For example, several research has found that the intersectionality of identities, such as gender identity or race, may impact the relationship between internalized homophobia and perceived social support. According to Wilson et al. (2016), transgender individuals may face additional stigma and discrimination, leading to lower levels of perceived social support compared to cisgender individuals. A study conducted by Huang et al. (2020) revealed that intersectional identities such as HIV+ gay men, lesbians of color, Chinese immigrant gay men are at more risk in terms of mental disorder partly due to low levels of perceived social support. Puckett et al. (2015) revealed that parental rejection is another factor that leads to stress and decreases perceived social support among LGBTI+ community.

1.7.4. Perceived Social Support and Depressive Symptoms

Positive social interactions are of immense importance in human life, as they profoundly impact our overall well-being and sense of belonging. Kuntz (1990) revealed that social interactions have positive effect on psychological well-being at every stage of life. Engaging in meaningful conversations, experiencing empathy, and receiving support from others can greatly enhance our emotional well-being, reducing stress and loneliness (Kessler, Price, and Wortman, 1985). These interactions contribute to our mental health by boosting self-esteem, providing a sense of purpose, and fostering psychological resilience (Schaefer, Coyne and Lazarus, 1981). Moreover, Gallant (2003) revealed that positive social connections have tangible effects on our physical health, promoting healthier lifestyles and even reducing the risk of chronic diseases such as diabetes. Beyond the immediate benefits, social interactions also stimulate cognitive functioning, broadening our perspectives and enhancing critical thinking skills. A study conducted on cognitive aging revealed that emotional support had positive impact on cognitive performance, and follow-up measurements predicted a better cognitive performance after 7.5 years (Seeman et al., 2001). Poor social interaction and isolation, on the other hand, was associated with cognitive decline and poor mental health (Morgan et al., 2007; Cacioppo and Hawkley, 2009). All these findings also apply to LGBTI+ individuals. In his literature review,

McDonald (2018) revealed that lack of social support demonstrated a correlation with increased rates of depression, anxiety, substance abuse, engagement in risky sexual behaviors, feelings of shame, and diminished self-esteem in LGBTI adolescents. Ryan et al. (2010) revealed that family support protects LGBTI+ youth against depression, suicidal ideation, and substance abuse.

1.7.5. Perceived Social Support and Self-Esteem

Another relationship between human social interaction and mental health worth taking a closer look is the one between perceived social support and self-esteem. The relationship between social support and self-esteem is reciprocal and mutually reinforcing. Positive social support provides individuals with validation, acceptance, and a sense of belonging, which can bolster their self-esteem. When individuals feel supported and valued by others, it enhances their confidence, self-worth, and self-belief. Moreover, social support can provide a source of feedback and validation, helping individuals develop a more positive and accurate perception of themselves. In a study conducted by Ikiz and Cakar (2010), a statistically significant positive association was observed between the levels of self-esteem and perceived social support in adolescents. A recent study conducted with a Chinese LGB population revealed that receiving support from friends contributes to self-esteem, and by this means, helps reduce stress (Song et al., 2023). Another study conducted with LGBTI+ people pointed out that receiving support from family and friends specifically for their gender identity and sexual orientation had strong relationship with their level of self-esteem (Snapp et al., 2015).

Conversely, individuals with low self-esteem may struggle to seek and receive social support. They may have difficulty trusting others, fear rejection or judgment, and may even reject or discount positive support when it is offered (Marigold et al., 2015). This can create a cycle of isolation and further diminish their self-esteem. Moreover, when individuals lack sufficient social support, it can negatively impact their self-esteem. The absence of supportive relationships and positive social interactions can lead to feelings of loneliness, inadequacy, and a distorted sense of self-worth. Without the affirmation and validation that social support provides, individuals may experience

heightened self-doubt, self-criticism, and a negative self-image (Hermann, Leonardelli, and Arkin, 2002).

1.7.6. Perceived Social Support as Mediator/Moderator

Perceived social support was examined in various studies in order to better explain the relationship of two variables thought to be related with the well-being of LGBTI+ people. A study examined the relationship between disclosing one's identity and psychological well-being revealed the moderating role of perceived social support in this relationship (Beals, Peplau, and Gable, 2009). In other words, disclosure was linked to increased feelings of support and understanding, which contributed to overall improved psychological well-being. Another study conducted with transgender black women pointed out that low levels of perceived social support increased the likelihood of depression in the presence of intimate partner violence (Bukowski et al., 2019). Calvo et al. (2018) found out that insecure attachment orientations can have an indirect impact on the development of internalized homophobia in gay men, with perceived social support playing a mediating role in this relationship. In another research, it was suggested that social support plays a crucial mediating role in the connection between sexual orientation victimization and depression among lesbian, gay, and bisexual youths in Hong Kong, pointing out that perceived social support had negative correlation with both sexual orientation victimization and depression (Chen and Hung, 2021).

1.8. Aim of the Study

The primary objective of this study is to explore and analyze the mediating role of perceived social support in the intricate relationship between internalized homophobia, self-esteem, and depressive symptoms among LGBTI+ individuals. By delving into these variables, the study aims to offer a comprehensive understanding of the underlying mechanisms that influence the psychological well-being of LGBTI+ individuals.

One of the aims of this research is to investigate group differences among participants based on various demographic variables within the context of the LGBTI+ community. Specifically, the study will explore how age, gender identity, sexual orientation, level

of education, level of income, and the presence of a psychiatric diagnosis makes a difference in terms of internalized homophobia, depression, self-steem, and perceived social support. By examining these demographic factors, the study seeks to gain a comprehensive understanding of the unique challenges and strengths of diverse subgroups within the LGBTI+ population. The findings will contribute valuable insights to inform targeted interventions, support systems, and policies that promote inclusivity, well-being, and equality for all members of the LGBTI+ community.

The study will also examine the extent to which internalized homophobia affects self-esteem and subsequently contributes to depressive symptoms among LGBTI+ individuals. Additionally, it seeks to investigate whether perceived social support acts as a mediator in these relationships. It is hypothesized that higher levels of internalized homophobia will lead to lower self-esteem, and will increase the likelihood of experiencing depressive symptoms. Furthermore, social support is expected to play a significant mediating role, buffering the negative impact of internalized homophobia on self-esteem and subsequently reducing the occurrence of depressive symptoms.

The findings of this research will provide valuable insights into the psychological well-being of LGBTI+ individuals, shedding light on the complex interplay between internalized homophobia, self-esteem, and depressive symptoms. The mediating role of perceived social support in the relationship between internalized homophobia, self-esteem, and depressive symptoms will be investigated in order to put forth its importance on mental health of LGBTI+ individuals. As mentioned before, minority people are at higher risk of suffering from mental health problems and having an unsatisfying, isolated life. While being discriminated and marginalized in the society, having support from a few friends or family could make a great difference in LGBTI+ people's lives. The results will not only contribute to academic knowledge but also inform the development of interventions, policies, and support systems aimed at promoting the mental health and well-being of LGBTI+ individuals. Ultimately, the study aspires to contribute to the advancement of inclusive and affirming practices that enhance the overall quality of life for LGBTI+ individuals.

1.8.1. Hypotheses

H1: A significant difference is expected between gender identities in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H2: A significant difference is expected between sexual orientations in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H3: A significant difference is expected between levels of education in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H4: A significant difference is expected between levels of income in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H5: A significant difference is expected between people who did and did not have a psychiatric diagnosis in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H6: A significant difference is expected between different age groups in terms of internalized homophobia, depression, self-esteem, and perceived social support.

H7: A significant positive correlation is expected between internalized homophobia and depressive symptoms.

H8: A significant negative correlation is expected between internalized homophobia and self-esteem.

H9: A significant negative correlation is expected between internalized homophobia and perceived social support.

H10: A significant positive correlation is expected between self-esteem and perceived social support.

H11: A significant negative correlation is expected between depressive symptoms and perceived social support.

H12: A significant negative relationship is expected between self-esteem and depressive symptoms.

H13: A significant mediating effect of perceived social support is expected in the relationship between internalized homophobia and depressive symptoms, and in the relationship between internalized homophobia and self-esteem.

H14: Demographic variables and study variables were expected to significantly predict depression.

H15: Demographic variables and study variables were expected to significantly predict self-esteem.

CHAPTER 2: METHOD

2.1. Participants

The participants for this study recruited from the LGBTI+ community, and included individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer, non-binary, or as any other non-heterosexual or non-cisgender identity. The sample consisted of 179 individuals, aged between 18 and 65, coming from diverse backgrounds. Participants were invited to the study via various online platforms and LGBTI+ organizations and were asked to complete an online survey prepared on Google Forms. The answers to the questionnaires were recorded anonymously. The inclusion criteria for participation were being identified as LGBTI+, or queer in a broader sense, and being an adult which means being 18 and over and 65 and under. The study aimed to recruit a diverse sample in terms of age, gender identity, and sexual orientation, in order to obtain a comprehensive understanding of the relationship between internalized homophobia, perceived social support, self-esteem, and depressive symptoms among LGBTI+ individuals. Before starting the survey, participants were presented an informed consent form. After they consented, the survey questions started to appear on the screen.

2.2. Instruments

In order to test the hypothesis, an online survey was created to collect data from participants. The survey included a demographic information sheet to collect demographic data. Also, Internalized Homophobia Scale, Beck Depression Scale, Rosenberg Self-Esteem Scale and Perceived Social Support Scale were presented. In the following sections, each tool was described in detail.

2.2.1. Demographic Information Sheet

The participants first were asked to provide several demographic details which consisted of their age (18 to 65), gender identity (man, woman, trans man, trans woman, non-binary), sexual orientation (gay, lesbian, bisexual, pansexual), level of income (low, lower-middle, upper-middle, high), level of education (high school

degree, university degree, master's degree, PhD degree), and having a psychiatric diagnosis (yes, no).

2.2.2. Beck Depression Inventory

The Beck Depression Inventory (BDI) is a questionnaire consisting of 21 items that allows individuals to self-report on their attitudes and symptoms of depression (Beck, et al., 1961). Various versions of the BDI have been created, such as computerized forms, card forms, a shorter 13-item version, and the more recent BDI-II (Beck, Steer, and Brown, 1996; Groth-Marnat, 1990). The BDI takes about 10 minutes to complete. The BDI has good internal consistency, with reliability coefficients ranging from .73 to .92 and a mean of .86; and alpha coefficients for the BDI are high for both patients and healthy individuals, at .86 and .81 respectively (Beck, Steer, and Garbin, 1988). Scores on the BDI can range from 0 to 63, with higher scores indicating a higher severity of depressive symptoms. Considering the total scores, 0–9 refers to minimal depression, 10–18 points to mild depression, 19–29 indicates moderate depression, and 30–63 means severe depression. Hisli (1989) carried out the Turkish standardization procedure of the scale.

2.2.3. Internalized Homophobia Scale

Internalized Homophobia Scale used in this study is a 10-item scale developed by Herek et al. (1989) in order to evaluate originally the level of internalized homophobia of gay men and lesbians. It is a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). There is no reverse item in the scale. Higher scores mean higher internalized homophobia. Turkish standardization of the scale was performed by Gençöz and Yüksel (2006). The Cronbach alpha value of the Turkish version was found to be .82. In our corresponding with Mrs. Gençöz, she stated that it is appropriate to replace the subject in each item with "LGBTI+" and adjust the items accordingly in order to render the scale applicable to the entire LGBTI+ community.

2.2.4. Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem scale was developed by Rosenberg in 1965. The original version of the scale consists of 12 sub-dimensions and 63 items, with one of the sub-dimensions specifically assessing self-esteem. However, in this study, the focus was on the self-esteem sub-dimension, which comprises 10 questions. 5 of these questions were reverse coded. Consequently, scores obtained from the scale range between 0 and 6. Within the self-esteem sub-category, a score of 0-2 indicates high self-esteem, 2-4 points suggests medium self-esteem, and 5-6 points reflects low self-esteem. Thus, a higher score on the scale corresponds to lower self-esteem. Regarding the reliability of the scale, Rosenberg's original study reported a test-retest reliability coefficient ranging from .82 to .88 and a Cronbach's alpha coefficient between .77 and .88. In the Turkish context, the scale was translated by Çuhadaroğlu (1986). and the test-retest reliability was conducted by Korkmaz (1996), reporting the coefficient as ranged from .48 to .79.

2.2.5. Multidimensional Perceived Social Support Scale

This scale was originally developed by Zimet et al. (1988) in USA. It consists of 12 items and 3 sub-dimensions which are receiving support from family, friends, and significant other. Each sub-dimension consists of 4 items. The internal reliability of the total score was .93, indicating strong consistency in the measurements. The subdimensions of the scale showed internal reliability coefficients of .89, .91, and .91 for friends, family, and significant others, respectively. The Multidimensional Scale of Perceived Social Support (MSPSS) was adapted to Turkish culture by Eker and Arkar in 1995, and the Turkish version demonstrated reliability with coefficients ranging from .80 to .95.

2.3. Procedure

An online survey consisting of the demographic data sheet and the scales mentioned above was created. In the beginning, a consent form was provided, and the participants were asked to approve to participate to the study. Upon their approval, the scales appeared on the screen one by one. They were not allowed to leave a question unanswered, so they needed to answer each question in order to proceed to the next

one. It took approximately 15 minutes to complete the entire survey. An online access link was created for the survey, and shared on social media accounts of various LGBTI+ people and associations. Consequently, 179 LGBTI+ adults have been reached out.

2.4. Data Analysis

The study employed a quantitative research design, utilizing survey questionnaires to collect data from a diverse sample of LGBTI+ individuals. Participants' ages were assessed to understand potential age-related differences in the relationship between the variables. Sexual orientation and gender identity were examined to explore their influence on internalized homophobia, self-esteem, depressive symptoms, and perceived social support. The participants' level of income and level of education were included as additional demographic factors, as they can influence both the experience of discrimination and the availability of resources. The presence of a psychiatric diagnosis was considered as a potential confounding variable, as individuals with mental health conditions may exhibit different levels of internalized homophobia, self-esteem, depressive symptoms, and perceived social support. Thus, it was also asked to the participants.

The dependent variables were measured using four scales. The Rosenberg Self-Esteem Scale assessed participants' self-esteem levels, the Internalized Homophobia Scale evaluated the extent to which individuals internalize negative beliefs about their sexual orientation or gender identity, Beck Depression Scale measured depressive symptoms, and Perceived Social Support Scale gauged participants' subjective perceptions of the availability and adequacy of support from others.

The data collected were analyzed via SPSS 26.0. Descriptive statistics such as frequency, percentage, arithmetic mean, and standard deviation were employed to analyze the sample distribution. The reliability of the scales used in the study was assessed through the calculation of Cronbach's Alpha coefficient. Descriptive analysis, including standard deviation, arithmetic mean, skewness, and kurtosis, was utilized to examine the distribution of the scores. Skewness and kurtosis values fall between -1.5 and +1.5 were accepted as normal distribution. To test for differences between groups, independent samples t-test and ANOVA test was utilized. The Levene test was

conducted to assess the homogeneity of variances. As the data exhibited a normal distribution, Pearson correlation was employed to explore the relationships between the scores obtained from the questionnaires. Additionally, a multiple linear regression model was established to investigate the mediating role of perceived social support in the relationship between depressive symptom and internalized homophobia, and in the relationship between self-esteem and internalized homophobia. PROCESS macro version 4.2 used for this purpose. Finally, Hierarchical regression was used to investigate to what extent the variables analyzed in this study predict the variations in depression and self-esteem.

CHAPTER 3: RESULTS

The statistical analysis of the data was carried out via IBM SPSS Statistics 26.0 software. First, all the demographic data of the participants were analyzed. Then, the reliability of the questionnaires was checked. Afterwards, the data was checked to see if it distributes normally, in order to decide whether to use a parametric or a non-parametric test. Then, the main analyses were conducted. The Pearson correlation test was performed to explore the relationship between internalized homophobia, depression, self-esteem, and perceived social support questionnaires. ANOVA and t-test analyses were used to discover the differences between the groups in terms of internalized homophobia, self-esteem, depressive symptoms, and perceived social support. In order to examine the mediating role of perceived social support in the relationship between internalized homophobia and self-esteem, and in the relationship between internalized homophobia and depressive symptoms; regression analyses via PROCESS Macro 4.2 were performed. Finally, hierarchical regression model was employed to better understand the predictive value of demographic and study variables contributing to the variation in depression and self-esteem.

3.1. Descriptive Data

In the present study, data collected from a total of 179 LGBTI+ participants. The age of the participants ranged from 18 to 55 (M = 26.65, SD = 6.95). Frequencies of the demographics consisting of gender identity, sexual orientation, level of education, level of income, and whether having a psychiatric diagnosis were provided in the table below.

Table 1. Demographic Information of the Participants

	N	*M*	*SD*	Minimum	Maximum
Age	179	26.65	6.95	18	55

Table 1. (Continued) Demographic Information of the Participants

		N (%)
Gender		
	Cisgendered Woman	89 (49.7)
	Cisgendered Man	42 (23.5)
	Transgendered Woman	4 (2.2)
	Transgendered Man	7 (3.9)
	Non-Binary	37 (20.7)
Sexual Orientation		
	Lesbian	47 (26.3)
	Gay	38 (21.2)
	Bisexual	67 (37.4)
	Pansexual/Queer	27 (15.1)
Level of Education		
	Primary School Graduate	3 (1.7)
	High School Graduate	56 (31.3)
	University Graduate	80 (44.7)
	Master's Graduate	39 (21.8)
	PhD Graduate	1 (0.6)
Level of Income		
	Low	20 (11.2)
	Lower-Middle	96 (53.6)
	Upper-Middle	58 (32.4)
	High	4 (2.2)
Previous Psychiatric Diagnosis		
	Yes	103 (57.5)
	No	76 (42.5)

As mentioned before, Internalized Homophobia Scale, Rosenberg Self-Esteem Scale, Beck Depression Scale, and Perceived Social Support Scale were applied to the participants in order to collect data to test the study variables. Descriptive statistics of the scores obtained from these scales are given below.

Table 2. Descriptive Statistics of the Scale Scores

	N	*M*	*SD*	Minimum	Maximum
Internalized Homophobia Scale	179	1.69	6.73	1	3.80
Rosenberg Self-Esteem Scale	179	18.29	6.52	1	30
Beck Depression Scale	179	18.73	11.20	0	51
Perceived Social Support Scale	179	4.65	1.33	1	7

3.2. Reliability Analysis of the Scales

In order to demonstrate the reliability of the scales used in this study, Cronbach's Alpha values of each scale have been calculated. It was revealed that all scales have high Cronbach's Alpha values, which means the internal consistency of the scales were satisfactory. The reliability test values of each scale in this study and the ones obtained during the standardization studies for Turkish samples were given below.

Table 3. Reliability Values of the Scales

Scales	Cronbach's Alpha (present study)	Cronbach's Alpha (standardization study)
Internalized Homophobia Scale	.86	.82
Rosenberg Self-Esteem Scale	.92	.79
Beck Depression Scale	.86	.86
Perceived Social Support Scale	.89	.88

3.3. Main Analyses

3.3.1. Normality Test

As the sample size was greater than 50, Kolmogorov Smirnov test was carried out to check the normality of the distribution of the data. The results shown that data did not distribute normally for any of the four scales, $p < .05$. However, after checking the skewness and kurtosis values, it was seen that the relevant values of all scales fall between -1.5 and +1.5. Given that the sample size is relatively big, it was decided to use parametric test to analyze the data.

3.3.2. Correlational Analysis of Questionnaires

Pearson correlation analysis was employed to examine the associations between internalized homophobia, self-esteem, depression, and perceived social support. The results indicated several significant findings. Firstly, a statistically significant, moderate negative relationship was observed between internalized homophobia and self-esteem, $r = -.27$, $p < .001$. Additionally, a weak but significant positive relationship emerged between internalized homophobia and depressive symptoms, $r = .17$, $p < .05$. Moreover, a significant moderate negative relationship was identified between internalized homophobia and perceived social support, $r = -.32$, $p < .001$. Furthermore, a significant moderate positive relationship was found between self-esteem and perceived social support, $r = .32$, $p < .001$. The analysis also revealed a strong negative relationship between self-esteem and depressive symptoms, which was highly significant, $r = -.71$, $p < .001$. Finally, a statistically significant moderate negative relationship was observed between depressive symptoms and perceived social support, $r = -.40$, $p < .001$.

Table 4. Pearson's Correlation Analysis Results for Questionnaires

	1	2	3	4
1. Internalized Homophobia Scale	-			
2. Rosenberg Self-Esteem Scale	-.27**	-		
3. Beck Depression Scale	.17*	-.71**	-	
4. Perceived Social Support Scale	-.32**	.36**	-.40**	-

**$p < .001$, *$p < .05$ (two-tailed)

3.3.3. Between Group Differences for Demographic Variables

3.3.3.1. Gender Identity

Independent samples t-test was conducted to explore between-group differences among cisgender and transgender+ queer individuals in terms of internalized homophobia, self-esteem, perceived social support, and depression. Levene's test revealed that variances distributed equally, p > .05. The results of the t-test revealed that the difference between gender identities in terms of internalized homophobia was not significant, t (177) = 1.45, p > .05. Groups also did not significantly differ in terms of self-esteem, t (177) = 1.43, p > .05. Similarly, the difference between gender identities in terms of depressive symptoms was not significant, t (177) = -1.45, p > .05. Lastly, the difference between gender identities in terms of perceived social support was found to be non-significant, t (177) = .10, p > .05. The results were presented in the table below.

Table 5. Gender Identity vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Gender Identity	*N*	*M*	*SD*	*t*	*df*	*p*
Internalized Homophobia	Cisgender	131	1.74	.67	1.45	177	> .05
	Transgender+	48	1.57	.68			
Self-Esteem	Cisgender	131	18.71	6.52	1.43	177	> .05
	Transgender+	48	17.15	6.43			
Depression	Cisgender	131	18.00	11.35	-1.45	177	> .05
	Transgender+	48	20.73	10.63			
Perceived Social Support	Cisgender	131	4.65	1.37	.10	177	> .05
	Transgender+	48	4.63	1.19			

**p < .001, *p < .05 (two-tailed)

The individuals then regrouped in order to check the difference between queer men, women, and non-binary individuals. Levene's test revealed that all variances were equal. Thus, ANOVA test was performed. Results indicated that groups did not differ in terms of internalized homophobia, F (2, 178) = 2.16, p > .05; self-esteem, F (2, 178)

= 1.52, $p > .05$; depression, F (2, 178) = 1.00, $p > .05$; and perceived social support, F (2, 178) = .02, $p > .05$.

Table 6. Gender Identity vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Gender Identity	*N*	*M*	*SD*	*F*	*df*	*p*
Internalized Homophobia	Woman	93	1.66	.61	2.16	178	> .05
	Man	49	1.85	.70			
	Non-Binary	37	1.57	.75			
Self-Esteem	Woman	93	18.37	6.55	1.52	178	> .05
	Man	49	19.27	6.47			
	Non-Binary	37	16.81	6.40			
Depression	Woman	93	18.49	11.65	1.01	178	> .05
	Man	49	17.53	10.60			
	Non-Binary	37	20.92	10.80			
Perceived Social Support	Woman	93	4.66	1.50	.02	178	> .05
	Man	49	4.62	1.21			
	Non-Binary	37	4.65	1.33			

**$p < .001$, *$p < .05$ (two-tailed)

3.3.3.2. Sexual Orientation

One-way ANOVA was conducted to explore between-group differences among different sexual orientations for Internalized Homophobia Scale, Rosenberg Self-Esteem Scale, Perceived Social Support Scale, and Beck Depression Scale. It was revealed that the variances of all groups were homogenous, except for self-esteem. ANOVA test results revealed that the difference between sexual orientations in terms of internalized homophobia was not significant, F (3, 175) = .81, $p > .05$. Similarly, the difference between sexual orientations in terms of depressive symptoms was not significant, F (3, 175) = .79, $p > .05$. Lastly, the difference between sexual orientations in terms of perceived social support was also found to be non-significant, F (3, 175) = .05, $p > .05$. Welch test revealed that the difference between sexual orientations in

terms of self-esteem was significant, F (3, 75.90) = 2.88, $p < .05$. Games-Howell multiple comparison test revealed that the mean value of gays was significantly higher than the mean value of bisexuals, $p < .05$. The results were presented in the table below.

Table 7. Sexual Orientation vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Sexual Orientation	*N*	*M*	*SD*	*F*	*df*	*p*
Internalized Homophobia	Gay	38	1.76	.75	.81	178	> .05
	Lesbian	47	1.69	.73			
	Bisexual	67	1.73	.61			
	Pansexual	27	1.51	.61			
Self-Esteem	Lesbian	38	20.42	5.99	2.88	75.90	< .05*
	Gay	47	18.70	7.32			
	Bisexual	67	17.01	5.40			
	Pansexual	27	17.74	7.72			
Depression	Lesbian	38	17.82	10.91	.79	178	> .05
	Gay	47	17.13	11.85			
	Bisexual	67	19.66	10.60			
	Pansexual	27	20.52	12.02			
Perceived Social Support	Lesbian	38	4.62	1.42	.05	178	> .05
	Gay	47	4.66	1.58			
	Bisexual	67	4.68	1.18			
	Pansexual	27	4.57	1.09			

**$p < .001$, *$p < .05$ (two-tailed)

3.3.3.3. Age

A t-test analysis was conducted to investigate the age differences in terms of internalized homophobia, self-esteem, perceived social support, and depressive symptoms. Participants were divided into two groups which are ages between 18-25 and between 26-40 in order to see the differences between two generations, namely

gen Y and gen Z. As there were only 5 people over the age 40, they were not included in this analysis. Levene's test revealed that variances were equal for self-esteem and internalized homophobia, and perceived social support, but not for depression. Test results revealed that the difference between age groups in terms of internalized homophobia was not significant, t (172) = .33, p > .05. On the other hand, there was a statistically significant difference between age groups in terms of self-esteem, t (172) = -4.31, p < .001. Mean value of gen Z was lower than mean value of gen Y. The difference between the groups in terms of depression was also significant, t (170.9) = 3.02, p < .05. Gen Z exhibited more depression compared to gen Y. Finally, the difference between the age groups in terms of perceived social support was also statistically significant, t (172) = -2.86, p < .05. Mean value of perceived social support reported by gen Z was lower than gen Y. The results were presented in the table below.

Table 8. Age vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Age	*N*	*M*	*SD*	*t*	*df*	*p*
Internalized Homophobia	18-25	90	1.74	.63	1.19	172	> .05
	26-40	84	1.62	.70			
Self-Esteem	18-25	90	16.46	6.64	-4.31	172	< .001**
	26-40	84	20.54	5.79			
Depression	18-25	90	20.96	11.75	3.02	170.90	< .05*
	26-40	84	15.94	10.11			
Perceived Social Support	18-25	90	4.45	1.31	-2.86	172	< .05*
	26-40	84	4.99	1.16			

**p < .001, *p < .05 (two-tailed)

3.3.3.4. Level of Education

Originally, level of education had been divided into four groups. However, they were regrouped into two categories as some of the original groups included only a few participants. A t-test analysis then was conducted to investigate the difference between levels of education and internalized homophobia, self-esteem, perceived social support, and depressive symptoms. Levene's test revealed that variances were equal,

except for perceived social support. Test results revealed that the difference between levels of education and internalized homophobia was not significant, t (177) = 1.30, p > .05. On the other hand, there was a statistically significant difference between levels of education in terms of self-esteem, t (177) = -3.18, p < .01. People who have a high school or a lower degree had lower self-esteem compared to the people who have a university degree or higher. The difference between levels of education in terms of depression was also significant, t (177) = 2.68, p < .01. People with lower levels of education had lower scores on depression. Finally, the difference between the levels of education in terms of perceived social support was also statistically significant, t (95.07) = -3.39, p < .01. People who have lower levels of education reported less perceived social support. The results were presented in the table below.

Table 9. Level of Education vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Level of Education	*N*	*M*	*SD*	*t*	*df*	*p*
Internalized Homophobia	High school & lower	59	1.79	.67	1.30	177	> .05
	University & higher	120	1.65	.67			
Self-Esteem	High school & lower	59	16.14	6.26	-3.18	177	< .05*
	University & higher	120	19.35	6.41			
Depression	High school & lower	59	21.88	11.07	2.68	177	< .05*
	University & higher	120	17.18	10.98			
Perceived Social Support	High school & lower	59	4.15	1.48	-3.66	95.07	< .05*
	University & higher	120	4.89	1.17			

**p < .001, *p < .05 (two-tailed)

3.3.3.5. Level of Income

Like level of education, level of income had been divided into four groups in the beginning. However, they were regrouped into two categories as some of the original groups included only a few participants. Original groups were low, middle-low, middle-high, and high income. After re-assignment of the groups, two groups have been created which are low-middle and below, and high-middle and above. A t-test analysis then was conducted to investigate the difference between levels of income and internalized homophobia, self-esteem, perceived social support, and depressive symptoms. Levene's test revealed that variances were equal, except for internalized homophobia. Results of the analysis revealed that there was a significant difference between levels of income in terms of internalized homophobia, t (146.42) = 2.16, $p <$ .05. People having lower-middle and low income had higher levels of internalized homophobia. In addition, there was significant difference between levels of income in terms of self-esteem, t (176) = -2.32, $p < .05$. People having higher-middle and high income reported higher levels of self-esteem. Similarly, the difference between levels of income in terms of depression was found to be significant, t (176) = 2.76, $p < .05$. People having lower-middle and low income had higher levels of depression. Finally, there was significant difference between levels of income in terms of perceived social support, t (176) = -2.71, p < .05. Lower- middle and low income group had lower levels of perceived social support compared to people having higher levels of income. The results were presented in the table below.

Table 10. Level of Income vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Level of Income	*N*	*M*	*SD*	*t*	*df*	*p*
Internalized Homophobia	Below middle	116	1.76	.70	2.16	146.42	< .05*
	Above middle	62	1.55	.58			
Self-Esteem	Below middle	116	17.51	6.62	-2.32	176	< .05*
	Above middle	62	19.85	6.09			
Depression	Below middle	116	20.43	11.07	2.76	176	< .05*
	Above middle	62	15.65	10.92			

Table 10. (Continued) Level of Income vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

Perceived Social Support	Below middle	116	4.46	1.29	-2.71	176	< .05*
	Above middle	62	5.01	1.32			

**p < .001, *p < .05 (two-tailed)

3.3.3.6. Having a Psychiatric Diagnosis

An independent samples t-test was performed to investigate the difference between having a psychiatric diagnosis and having no psychiatric diagnosis in terms of internalized homophobia, perceived social support, self-esteem, and depressive symptoms, respectively. Levene's test revealed that variances were equal, except for depression and social support. Results revealed that there was a significant difference between the groups in terms of self-esteem, t (177) = 4.52, p < .001. People who have a psychiatric diagnosis exhibited lower levels of self-esteem. The difference between groups in terms of depressive symptoms was also statistically significant, t (146.52) = -4.82, p < .001. Depression scores of people who have a diagnosis was higher than people who do not have a diagnosis. On the other hand, the difference between groups in terms of internalized homophobia was not statistically significant, t (177) = -1.63, p > .05. Similarly, there was a non-significant difference between groups in terms of perceived social support, t (174.12) = 1.57, p > .05. The results were presented in the table below.

Table 11. Having a Psychiatric Diagnosis vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

	Having a Diagnosis	*N*	*M*	*SD*	*t*	*df*	*p*
Internalized Homophobia	No	103	1.62	.65	-1.63	177	> .05
	Yes	76	1.79	.69			
Self-Esteem	No	103	20.1	6.03	4.52	177	< .05**
	Yes	76	15.86	6.40			

Table 11. (Continued) Having a Psychiatric Diagnosis vs. Internalized Homophobia, Self-Esteem, Depressive Symptoms, and Perceived Social Support

Depression	No	103	15.40	9.80	-4.82	146.52	< .05**
	Yes	76	23.25	11.45			
Perceived Social Support	No	103	4.78	1.41	1.57	174.12	< .05*
	Yes	76	4.47	1.18			

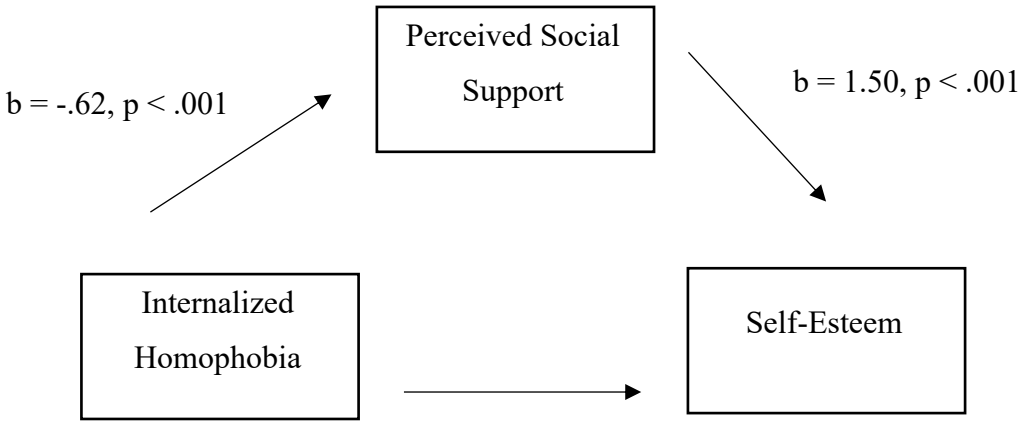
**$p < .001$, *$p < .05$ (two-tailed)

3.3.4. Mediation Analyses

Multiple regression analyses were conducted to investigate the mediating role of perceived social support in the relationship between internalized homophobia and self-esteem, and in the relationship between internalized homophobia and depression. Direct, indirect, and total effects of the variables have been investigated. The analyses were carried out via PROCESS macro version 4.2. The results of the analyses were presented below.

3.3.4.1. Mediating role of perceived social support in the relationship between internalized homophobia and self-esteem

A multiple regression analysis was conducted to examine the mediating role of perceived social support in the relationship between internalized homophobia and self-esteem. Results shown that internalized homophobia significantly predicted perceived social support, $b = -0.62$, 95% CI [−0.90, −0.35], $t = -4.43$, $p < .001$. Internalized homophobia explained %1 of the variance, and they had a negative relationship. Internalized homophobia significantly predicted self-esteem when included perceived social support, $b = -1.68$, 95% CI [−3.08, −0.29], $t = -2.38$, $p < .05$. Perceived social support significantly predicted self-esteem, $b = -1.50$, 95% CI [.79, 2.21], $t = 4.18$, $p < .001$. When perceived social support is not in the model, internalized homophobia significantly predicted self-esteem, $b = -2.62$, 95% CI [-4.00, -1.23], $t = -3.73$, $p < .001$. Indirect effect of internalized homophobia on self-esteem was found to be significant, $b = -.93$, 95% CI [-1.70, -0.37].



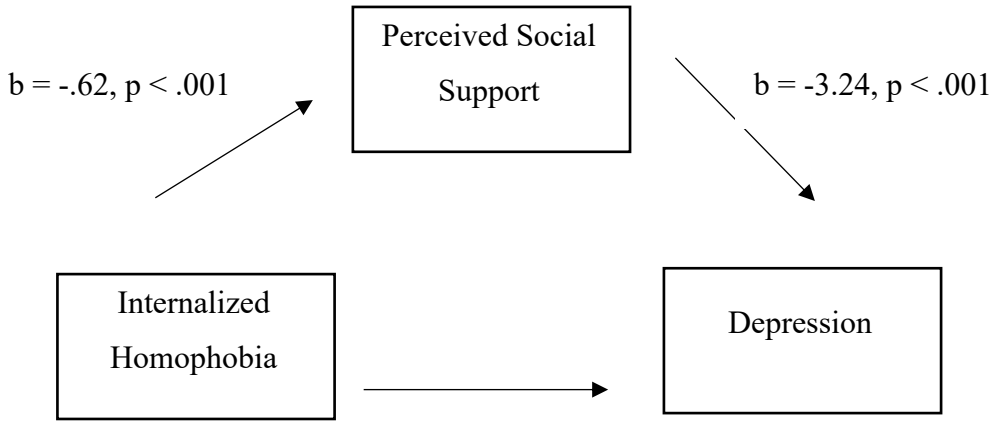
Direct effect (c): b = -2.62, p < .001

Indirect effect (c') = b = -.93, 95% CI [-1.70, -0.37]

Figure 1. Mediation Model for Perceived Social Support, Internalized Homophobia and Self-Esteem

3.3.4.2. Mediating role of perceived social support in the relationship between internalized homophobia and depression

A mediation analysis was conducted to examine the mediating role of perceived social support in the relationship between internalized homophobia and depression. Results shown that Internalized homophobia significantly predicted perceived social support, $b = -0.62$, 95% CI [−0.90, −0.35], $t = -4.43$, $p < .001$. Internalized homophobia explained %1 of the variance, and they had a negative relationship. Internalized homophobia did not predict depression when perceived social support was included, $b = .78$, 95% CI [−1.62, 3.17], $t = .64$, $p > .05$. On the other hand, perceived social support significantly predicted depression, $b = -3.24$, 95% CI [-4.45, -2.02], $t = -5.26$, $p < .001$. When perceived social support was not in the model, internalized homophobia significantly predicted depression, $b = 2.79$, 95% CI [.36, 5.23], $t = 2.26$, $p < .05$. Indirect effect of internalized homophobia on depression was also significant, $b = 2.01$, 95% CI [.81, 3.51].



Direct effect (c): b = -2.79, p < .05

Indirect effect (c'): b = 2.01, 95% CI [.81, 3.51]

Figure 2. Mediation Model for Perceived Social Support, Internalized Homophobia and Depression

3.3.5. Hierarchical Regression

3.3.5.1. Depression

A four-step hierarchical regression analysis was conducted to evaluate the predictors of depression. In step one, demographic variables were tested. Demographic variables accounted for 19% of the variation in depression and significantly contributed to the model, $R^2 = .19$, F (6, 171) = 6.48, $p < .001$. Addition of internalized homophobia explained 1% more of the variation in the model, but was not statistically significant, $R^2 = .20$, F (1, 170) = 2.22, $p > .05$. When we include self-esteem in the model, it accounted for an additional 34% variation in depression and contributed significantly, $R^2 = .54$, F (1, 169) = 127.01, $p < .001$. Finally, perceived social support was included in the model, which accounted for 2% additional variation in depression and contributed significantly to the model, $R^2 = .56$, F (1, 168) = 8.50, $p < .001$. The overall model explained %56 variation in depression.

Table 12. Hierarchical Regression Analysis Predicting Depression

	Depression			
	b	*SE B*	*beta*	*p*
Step 1				
Gender	0.209	0.504	0.029	0.679
Sexual Orientation	-0.094	0.819	-0.008	0.909
Level of Education	-2.039	1.069	-0.140	0.058
Level of Income	-2.091	1.186	-0.127	0.080
Psychiatric Diagnosis	7.251	1.635	0.320	0.000**
Age	-0.153	0.119	-0.095	0.201
Step 2				
Gender	0.303	0.506	0.042	0.550
Sexual Orientation	0.062	0.823	0.005	0.940
Level of Education	-1.766	1.081	-0.121	0.104
Level of Income	-1.873	1.191	-0.114	0.118
Psychiatric Diagnosis	6.871	1.649	0.304	0.000**
Age	-0.167	0.119	-0.103	0.163
Internalized Homophobia	1.805	1.211	0.107	0.138
Step 3				
Gender	0.108	0.384	0.015	0.778
Sexual Orientation	-0.658	0.627	-0.058	0.295
Level of Education	-0.778	0.823	-0.053	0.346
Level of Income	-0.788	0.907	-0.048	0.386
Psychiatric Diagnosis	3.095	1.294	0.137	0.018*
Age	-0.029	0.091	-0.018	0.753
Internalized Homophobia	-0.633	0.943	-0.038	0.503
Self-Esteem	-1.150	0.102	-0.668	0.000**

Table 12. (Continued) Hierarchical Regression Analysis Predicting Depression

Step 4

Gender	0.161	0.376	0.023	0.669
Sexual Orientation	-0.589	0.614	-0.052	0.339
Level of Education	-0.093	0.839	-0.006	0.912
Level of Income	-0.398	0.898	-0.024	0.658
Psychiatric Diagnosis	3.075	1.266	0.136	0.016*
Age	-0.058	0.090	-0.036	0.520
Internalized Homophobia	-1.133	0.938	-0.067	0.229
Self-Esteem	-1.073	0.103	-0.623	0.000**
Perceived Social Support	-1.469	0.504	-0.174	0.004*

**$p < .001$, *$p < .05$ (two-tailed)

3.3.5.2. Self-Esteem

A four-step hierarchical regression analysis was conducted to evaluate the predictors of self-esteem. In step one, demographic variables were tested. Demographic variables accounted for 18% of the variation in self-esteem and significantly contributed to the model, $R^2 = .18$, F (6, 171) = 6.39, $p < .001$. Addition of internalized homophobia explained 5% more of the variation in the model, and was statistically significant, $R^2 = .23$, F (1, 170) = 9.44, $p < .01$. When we included depression in the model, it accounted for an additional 33% variation in self-esteem and contributed significantly, $R^2 = .56$, F (1, 169) = 127.01, $p < .001$. Finally, perceived social support was included in the model, which accounted for no additional variation in self-esteem and did not contribute to the model, $R^2 = .56$, F (1, 168) = .54, $p > .05$. The overall model explained %56 variation in self-esteem.

Table 13. Hierarchical Regression Analysis Predicting Self-Esteem

	Self-Esteem			
	b	*SE B*	*beta*	*p*
Step 1				
Gender	-0.059	0.293	-0.014	0.841
Sexual Orientation	-0.443	0.476	-0.067	0.354
Level of Education	1.180	0.622	0.139	0.059
Level of Income	1.200	0.690	0.125	0.084
Psychiatric Diagnosis	-3.729	0.951	-0.284	0.000**
Age	0.104	0.069	0.111	0.135
Step 2				
Gender	-0.169	0.288	-0.041	0.559
Sexual Orientation	-0.626	0.469	-0.095	0.184
Level of Education	0.859	0.616	0.101	0.165
Level of Income	0.943	0.678	0.099	0.166
Psychiatric Diagnosis	-3.284	0.940	-0.250	0.001*
Age	0.120	0.068	0.128	0.079
Internalized Homophobia	-2.120	0.690	-0.217	0.002*
Step 3				
Gender	-0.056	0.219	-0.013	0.798
Sexual Orientation	-0.603	0.355	-0.092	0.092
Level of Education	0.200	0.470	0.024	0.671
Level of Income	0.244	0.518	0.026	0.638
Psychiatric Diagnosis	-0.719	0.748	-0.055	0.337
Age	0.058	0.052	0.062	0.266
Internalized Homophobia	-1.446	0.526	-0.148	0.007*
Depression	-0.373	0.033	-0.643	0.000**

Table 13. (Continued) Hierarchical Regression Analysis Predicting Self-Esteem

Step 4				
Gender	-0.064	0.219	-0.016	0.769
Sexual Orientation	-0.606	0.356	-0.092	0.090
Level of Education	0.102	0.489	0.012	0.835
Level of Income	0.190	0.524	0.020	0.717
Psychiatric Diagnosis	-0.736	0.749	-0.056	0.327
Age	0.062	0.052	0.066	0.235
Internalized Homophobia	-1.362	0.539	-0.140	0.012*
Depression	-0.365	0.035	-0.628	0.000**
Perceived Social Support	0.220	0.301	0.045	0.465

**$p < .001$, *$p < .05$ (two-tailed)

3.4. Summary of the Results

In this section, a summary of the findings of this study was presented. Results of the analyses indicated that there were significant pairwise correlations among internalized homophobia, self-esteem, depressive symptoms, and perceived social support, as hypothesized in the introduction.

The scores did not differ significantly in terms of gender identity. Also, there was no significant difference among sexual orientations in terms of scores obtained from the scales, except for self-esteem. Detailed analysis revealed that bisexuals had significantly lower self-esteem than gays. Age groups shown significant difference in their scores of self-esteem, depressive symptoms, and perceived social support, but not of internalized homophobia. Similarly, there were significant differences among levels of education based on their self-esteem, depression, and perceived social support, but not on internalized homophobia. The difference between levels of income was statistically significant for all four variables. There was also a significant difference between people who have and did not have a psychiatric diagnosis in terms of all variables, except for internalized homophobia.

Mediation analyses revealed that perceived social support had a significant mediating role on the relationship between internalized homophobia and self-esteem. Internalized homophobia significantly predicted social support. It also predicted self-

esteem when perceived social support is included. Finally, perceived social support significantly predicted self-esteem.

Similarly, the mediating role of perceived social support on the relationship between internalized homophobia and depression was found to be significant. Internalized homophobia significantly predicted social support. It did not predicted depression when perceived social support is included. Finally, perceived social support significantly predicted depression.

Moreover, two separate 4-step hierarchical regression analyses were conducted to explore how much of the variation in depression and self-esteem was explained by which variable or variable groups. Results shown that the overall model consisting of demographic variables, self-esteem, internalized homophobia, and perceived social support explained %56 variation in depression. Similarly, the overall model consisting of demographic variables, depression, internalized homophobia, and perceived social support explained %56 variation in self-esteem.

CHAPTER 4: DISCUSSION

The purpose of the study was to investigate the mediating role of perceived social support in the relationship between internalized homophobia and depression and in the relationship between internalized homophobia and self-esteem among LGBTI+ community. Results revealed that there were significant pairwise correlations among internalized homophobia, depression, self-esteem, and perceived social support. Moreover, perceived social support significantly mediated the relationship between internalized homophobia and self-esteem, and the relationship between internalized homophobia and depression.

In the following sections, the results of the analyses will be discussed in detail, within the framework of relevant literature.

4.1. Correlational Analyses between Internalized Homophobia, Depression, Self-Esteem, and Perceived Social Support

Marginalization of the minorities and its destructive effects on the quality of life of the said groups have always been among the major subjects studied in human sciences, and of course, in psychology. Homophobia, a frequently encountered type of discrimination within the society, have long been linked to depression (Mongelli et al., 2019; Cochran and Mays, 2000; Marzetti, McDaid, and O'Connor, 2022), self-esteem (Stokes and Peterson, 1998), and perceived social support (Garcia et al., 2016). According to minority stress theory suggested by Meyer (2003), stressors are internalized by the minorities and lead to internalized stigma, low self-esteem, and shame. His hypotheses were tested many times, and studies revealed that there is indeed a significant relationship between internalized homophobia and depression (Newcomb and Mustanski, 2010; Frost and Meyer, 2009; Igartua, Gill, and Montoro, 2009; Yolaç and Meriç, 2021; Herek et al., 1998; Moody et al., 2018); self-esteem (Blais, Gervais, and Hebert, 2014; Allen and Oleson, 1999; McGregor et al., 2001); and social support (Szymanski, 2001; Calvo et al., 2021). Overall, the results obtained from the correlational analyses was compatible with the existing literature. The more people experienced internalized homophobia, the more they had depressive symptoms, the lower their self-esteem was, and the less they felt supported by their family, friends, and significant others. This finding supports our hypotheses. The consistency between

our findings and the existing literature strengthens the understanding that internalized homophobia may have detrimental effects on the well-being and social relationships of individuals who experience it. Or if we look from the opposite perspective, feeling supported by the people who loves and cares about them might make LGBTI+ people feel better about their identities and consequently may decrease their internalized stigma or homonegativity, increasing their quality of life and well-being. Further analyses are required in order to better understand the cause-effect relationship between these phenomena.

4.2. Group Differences in terms of Internalized Homophobia, Depression, Self-Esteem, and Perceived Social Support

ANOVA and t-test were conducted to investigate the group differences among different age groups, gender identities, sexual orientations, levels of education, levels of income, and whether having a psychiatric diagnosis, in terms of internalized homophobia, depression, self-esteem, and perceived social support, respectively. In the following sections, results of each analysis will be discussed briefly.

4.2.1. Gender Identity

ANOVA and t-test were conducted to reveal gender differences in terms of internalized homophobia, depression, self-esteem, and perceived social support. First, the participants were divided into two groups as cisgender and transgender. Results revealed that there was no significant group difference among cisgender and transgender non-heterosexual individuals in terms of internalized homophobia, depression, self-esteem, and perceived social support. It is important to note that only non-heterosexual, in other words, queer individuals were included in this study, which means the aforementioned cisgender individuals still fall within LGBTI+ community. Since the majority of the studies regarding the transgender+ community compare them to cisgender individuals without controlling their sexual orientation, it is not clear whether cisgender and transgender+ queer individuals differ in terms of internalized homophobia, self-esteem, depression, or perceived social support. Further analyses are needed to get a much clear picture on that matter. Similar results obtained when the

LGBTI+ participants were regrouped as men, women, and non-binary. There was no significant difference among those groups as well.

Similarly, no gender difference was found by Zea, Reisen, and Poppen (1999) in terms of depression and by Igartua, Gill, and Montoro (2003) in terms of internalized homophobia, which means our findings are in line with the findings presented in this paper. On the other hand, one study revealed that gay men had significantly more internalized homophobia than gay women (Newcomb and Mustanski, 2010). However, they did not take gender and sexual orientation as different concepts, which means their finding doesn't say much about the gender differences. Exclusion of the people of other sexual orientations may have confounded their results.

The majority of the studies conducted with LGBTI+ individuals included them as one group, and did not investigate the differences among genders in LGBTI+ community in terms of depression, self-esteem, internalized homophobia, or perceived social support. Thus, more studies are needed in order to better understand what these findings might mean. However, considering that every individual identifying as queer constantly face with homophobia and discrimination, it is not surprise that they are similarly influenced by self-esteem, depression, internalized homophobia and social support issues, no matter what their gender identity is.

4.2.2. Sexual Orientation

Considering sexual orientation, the gay, lesbian, bisexual, and pansexual individuals did not significantly differ in terms of internalized homophobia, self-esteem, depression, and perceived social support. One exception was that bisexuals had significantly lower self-esteem compared to gays. In general, gays and lesbians have more visibility, while bisexuals were seen as "confused" or "on the fence" and are being exposed to comments such as "pick a side!". This prejudice and discrimination in the society may prevent bisexuals from feeling accepted, and finding bisexual-affirmative support (Ross et al., 2017). Consequently, they may feel wrong and insecure about themselves. This may negatively influence their self-esteem and overall well-being. In a study conducted by Ross et al. (2007), bisexuals were found to be more resistant to depression treatment compared to other sexual minorities.

The differences between different sexual orientations were seldom examined in terms of depression, self-esteem, internalized homophobia, or perceived social support in the literature. Majority of the studies were conducted to compare LGBTI+ individuals with the general population or heterosexual cisgender individuals, or evaluated them as a group (Albuquerque et al., 2016; McLaren, 2016; Meyer, 2012; Frost and Meyer 2009), rather than comparing them to each other. We need more studies to be conducted on the matter to better understand the differences among various sexual orientations.

4.2.3. Age

In this study, the age interval of the participants was between 18 and 55. As there were only 5 people above 40, they were excluded from the age analysis, and the remaining participant were divided into two categories which are 18-25 and 26-40, or in other words, gen Y and gen Z. results revealed that the groups differ in terms of depression, self-esteem, and internalized social support. Although no study compared gen Y and gen Z LGBTI+ individuals in terms of depression, self-esteem, and internalized social support; Lucassen et al. (2017) revealed that sexual minority youth were more depressed compared to their heterosexual counterparts. In addition, according to Center for American Progress (2020), nearly half of the gen Z LGBTI+ individuals reported experiencing discrimination, and they presented a higher rate compared to other generations. Gen Z is considered as the most depressed generation (Akers, 2022). In addition, younger people tend to be insecure about themselves, are economically dependent, and uncertain and hopeless about their future in the present Turkey. Especially the oppressions coming from the government making life much harder for LGBTI+ people. Criminalization of homosexuality or all other non-heterosexual non-cisgender existences fundamentally damaged hopes and perception of safety of the sexual minority youth in Turkey (Evrensel, 2022).

4.2.4. Level of Education

Results revealed that LGBTI+ individuals having a high school degree or lower had significantly higher levels of depression, lower self-esteem, and less perceived social support, compared to individuals who had a university degree or higher. However, groups did not differ in terms of internalized homophobia. Similarly, Szymanski and

Kashubeck-West (2008) revealed that lower levels of education were associated with higher levels of psychological distress among sexual-minority women. With regard to the relationship between education level and self-esteem and social support, there was no study in the literature focusing on the differences among LGBTI+ community. Regarding our results, one explanation might be the society's negative regard to people who do not have a college degree. Kuppen et al. (2018) pointed out that more educated people look down on less educated people, which is a phenomena called educationism. This discriminative attitude might contribute to self-esteem issues among less educated people. Moreover, this attitude may contribute to the isolation of less educated people, and consequently decrease their levels of perceived social support. Considering the discrimination and exclusion the LGBTI+ people face, their self-esteem may decrease, and this might have kept them away from school as well, as it was revealed that self-esteem is correlated with academic success (Ferkany, 2008). Since the literature is scarce on the group differences in LGBTI+ community with regard to education levels and their relationship with mental health correlates, further investigations are required.

4.2.5. Level of Income

Results revealed that LGBTI+ individuals with lower income had significantly higher levels of depression, lower self-esteem, higher internalized homophobia, and less perceived social support, compared to individuals who had higher levels of income. Similarly, Meriç and Yolaç (2021) revealed that LGBTI+ individuals with higher levels of income had statistically less internalized homophobia compared to their counterparts. In addition, findings of McConell, Birkett, and Mustanski (2018), where low income levels among LGBTI+ community were associated with less social support, were in line with our findings. Economic factors, such as financial struggles, limited access to healthcare, and reduced opportunities for social engagement, may contribute to increased stress and psychological distress. Economic disparities can also lead to feelings of hopelessness and a lack of control over one's life circumstances, which may contribute to depressive symptoms. As we already discussed, LGBTI+ people struggle with financial problems due to discrimination in the work life as well. As is the case with the other types of discriminations, being stigmatized and marginalized in the work environment may also decrease their self-esteem and social

support perception as well as increase their chance of poverty. Financial constraints can limit access to social networks, supportive communities, and opportunities for participation in social activities. Social support plays a crucial role in buffering stress and promoting well-being. A lack of perceived social support can contribute to feelings of isolation, which may further increase psychological distress among LGBTI+ individuals with lower income. Moreover, LGBTI+ individuals who suffer from self-esteem problems and feel alone and isolated may tend to experience problems finding a job, or maintaining their position in a work environment. More research is needed, as the literature incorporates only a few studies on the said differences.

4.2.6. Having a Psychiatric Diagnosis

Results revealed that LGBTI+ individuals with a psychiatric diagnosis had significantly higher levels of depression, lower self-esteem, and less perceived social support, compared to individuals who do not have a diagnosis. Groups did not differ in terms of internalized homophobia. The group having a psychiatric diagnosis was quite heterogenous in terms of the diagnosis they had, but the most frequently encountered disorders were depression, anxiety, obsessive-compulsive disorder, attention deficit and hyperactivity disorder, bipolar disorder, eating disorder, and borderline personality disorder in our sample. However, the differences among disorders were not checked, as the number of participants in each group was low, and some of them had multiple diagnosis. Thus, the type of diagnosis did not include in the equation.

Our findings indicated that individuals with pre-existing mental health conditions may be more vulnerable to depressive symptoms. The presence of a psychiatric diagnosis, which could include mood disorders or anxiety disorders as in our population, may contribute to a greater likelihood of experiencing depression among LGBTI+ individuals. In literature, there is no study conducted with LGBTI+ community showing the difference between psychiatric and non-psychiatric individuals in terms of internalized homophobia, self-esteem or social support. On the other hand, Rizwan and Ahmad (2015) conducted a study with psychiatric patients in general population, and revealed that they had lower levels of self-esteem compared to non-patients. Similarly, Silverstone and Salsali (2003) revealed that having a psychiatric diagnosis

was significantly related to lower self-esteem in general population. So far, we understand that individuals who suffer from a psychiatric condition also struggle with self-esteem issues. Mental health conditions can impact one's self-perception and self-worth. Individuals with psychiatric diagnoses may struggle with negative thoughts, low self-confidence, or feelings of inadequacy, which can lead to lower self-esteem. This finding highlights the importance of addressing self-esteem issues as part of mental health interventions for LGBTI+ individuals with psychiatric diagnoses as well, as being a minority increases the risk for suffering from self-esteem issues.

In terms of perceived social support, Neeleman and Power (1994) revealed a similar finding as given in this study. Furukawa et al., (1999) also revealed that psychiatric patients reported they had less support compared to healthy controls. It is not uncommon that LGBTI+ individuals are discriminated, marginalized, or even unwanted by their loved ones. Family members, friends and relatives often walk away from queer individuals once they find out about their identity. This may have detrimental effects on one’s mental health. It is also possible that the presence of a mental health condition may affect an individual's ability to develop and maintain strong social networks. Stigma surrounding mental illness, lack of understanding, and social withdrawal can contribute to reduced perceived social support among LGBTI+ individuals with psychiatric diagnoses. This finding underscores the need for interventions that promote social connectedness and support systems for this population.

Interestingly, the study did not find any significant differences in levels of internalized homophobia between LGBTI+ individuals with and without a psychiatric diagnosis. This suggests that the presence of a mental health condition does not necessarily increase internalized homophobia in this particular sample. However, it is important to note that internalized homophobia is a complex construct influenced by various factors, and further research is needed to explore the relationship between mental health and internalized homophobia among LGBTI+ individuals.

4.3. Mediation Analyses

In this study, it was revealed that internalized homophobia had a significant direct effect on perceived social support. Similarly, perceived social support had a significant

direct effect on self-esteem. In a study conducted by Blair et al. (2019) with queer women, it was revealed that perceived social support had a significant direct effect on self-esteem. Moreover, internalized homophobia had a direct significant effect on self-esteem. Finally, perceived social support significantly mediated the relationship between internalized homophobia and self-esteem. These findings support our hypotheses. LGBTI+ individuals who suffer from internalized homophobia tend to have lower self-esteem. However, people who feel supported by their friends, family, and any other significant person, seems to have less internalized homophobia and more self-esteem. In our society, we often face with discrimination, stigmatization, and homophobia. This study suggests that social support can be a protective factor for our self-esteem which is connected to our self-worth and self-acceptance (Pyszczynski et al., 2004). As low self-esteem has been linked to increased vulnerability to mental health issues, such as depression, anxiety, and eating disorders (Sowislo and Orth, 2013) whereas high self-esteem contributes to resilience, adaptive coping strategies, and positive mental health outcomes (Baumeister et al., 2003); this finding suggests that social support has a significant role for queers to live healthy, satisfying lives.

Mediation analysis also revealed that perceived social support had a significant direct effect on depression. In the literature, similar findings have been reported by several other researchers. Cain et al. (2017) reported that social support was directly related to depression among gay and bisexual men. Davidson et al. (2016) revealed that sense of belonging to society had a significant direct effect on depression among gay men. As we discussed, having a reliable support system can provide emotional validation, practical assistance, and a sense of belonging, all of which can help individuals cope with stressors and reduce the risk of depression.

In addition, internalized homophobia had a significant direct effect on depression. Similarly, Gold, Marx, and Lexington (2007) reported the same effect in a sample of gay men. Moreover, internalized homonegativity had a direct effect on depression in a population of LGB individuals (Morandini et al., 2015), and gay men (Davidson et al., 2016). These findings support the idea that people who has negative attitude towards their own identity tend to suffer from depressive symptoms. It also highlights the importance of addressing and reducing internalized homophobia to promote better mental well-being among LGBTI+ individuals.

Finally, perceived social support significantly mediated the relationship between internalized homophobia and depression. This finding is compatible with the existing literature. Hatzenbuehler, (2009) for example, found that family support significantly mediated the relationship between internalized stigma and depression. In the same study, they also found that social/interpersonal problems mediated the relationship between discrimination and depression. In another study conducted by Hatzenbuehler, McLaughlin, and Xuan (2012) with a sample of sexual minority youth, they revealed that social connectedness mediated the relationship between not internalized homophobia but homosexuality and depressive symptoms among males. Our study may shed light on their finding, suggesting that the difference between homosexual and heterosexual participants may be rooted in their internalized negative believes on their sexual orientation.

Our finding suggests that individuals who experience higher levels of internalized homophobia may also perceive lower levels of social support, which in turn contributes to increased depressive symptoms. Internalized homophobia, with its associated negative self-perceptions and feelings of shame or guilt, can hinder the formation and maintenance of supportive relationships. As a result, the lack of perceived social support exacerbates the risk of depression among LGBTI+ individuals.

4.4. Hierarchical Regression Analyses

Two hierarchical regression analyses conducted to explore predictors of depression and self-esteem. Considering depression, demographic variables explained 19%, internalized homophobia 1 %, self-esteem 34%, and perceived social support 2% of the variation in the model. Overall, this model explained 56% variation in depression. This suggests that demographic factors, although contributing to the model, have a relatively modest impact on explaining the variation in depression among LGBTI+ individuals. On the other hand, self-esteem appears to be a significant factor, explaining a substantial portion of the variation in depression scores. Internalized homophobia and perceived social support, while still playing a role, have relatively smaller contributions. Although internalized homophobia did not make a significant contribution to the model, Hatzenbuehler et al., (2009) found out that internalized

stigma significantly predicted depression. In the same study, it was also pointed out that self-esteem significantly predicted psychological distress. In a study conducted with Latino gay and bisexual men, it was revealed that social discrimination was a strong predictor of psychopathology (Diaz et al., 2001). Our findings suggest that having self-esteem issues greatly contributes to depression. On the other hand, having a positive self-esteem can help LGBTI+ individuals navigate the challenges they may face due to societal attitudes, discrimination, and stigma. It can provide a sense of self-acceptance, resilience, and empowerment, allowing individuals to cope more effectively with stressors and adversity.

Considering self-esteem, demographic variables explained 18%, internalized homophobia 5 %, and depression 33% variation in the model. Perceived social support did not predict self-esteem. Overall, this model explained 56% variation in self-esteem. Conversely, in their study, Bond and Miller (2021) reported that social connectedness predicted self-esteem among the minority youth. In addition, in a study conducted with sexual minority youth, internalized homophobia did not predict self-esteem (Blais, Gervais and Hebert, 2014). The difference between their findings and ours may be resulting from the difference of the demographics.

Our finding suggests that individuals who experience higher levels of internalized homophobia may have lower self-esteem, possibly due to the negative self-perceptions and feelings of shame associated with internalized homophobia. Moreover, individuals experiencing higher levels of depressive symptoms may also have lower self-esteem. Depression can impact self-perception and self-worth, leading to decreased self-esteem. Interestingly, perceived social support did not predict self-esteem in this model. This finding indicates that the support individuals receive from their social networks may not have a direct influence on their self-esteem levels in this particular study. However, it's important to consider that social support can still be valuable for overall well-being, mental health, and other factors related to self-esteem, even if it did not have a direct impact in this specific analysis.

4.5. Limitations and further suggestions

This study has certain limitations. First, the participants are recruited via LGBTI+ associations and over social media. This presumably biased the recruitment process

and led us reach out to a certain group of people. As those associations are one of the main solidarity and socialization settings for queers, less supported and isolated LGBTI+ individuals could not be included in the study. future research could consider implementing diverse recruitment strategies. This may involve reaching out to a broader range of community settings to include individuals who may be less connected to LGBTI+ associations or social media platforms. Additionally, better ensuring the anonymity and confidentiality of participants during data collection can help create a safe space for individuals who may be more hesitant to participate due to concerns about privacy or discrimination.

Second, we could recruit only participants among 18-40 years old, which left out older LGBTI+ individuals. We can only make inferences for gen Y and gen Z queers. To gain a more comprehensive understanding of the experiences of LGBTI+ individuals across different generations, future research could aim to include a broader age range or specifically focus on older cohorts. This would enable a more representative and nuanced understanding of the diverse experiences and needs of LGBTI+ individuals across their lifespan.

Third, the group differences in regression analyses were overlooked. Due to low number of people in each demographic level, we failed to understand how each gender identity and sexual orientation differ in terms of mediating role of internalized homophobia. Moreover, how different levels of demographics differ in terms of internalized homophobia, self-esteem, depression, and perceived social support for each sexual orientation and gender identity could not be investigated. To address these limitations, future research could aim to recruit larger and more diverse samples that adequately represent various demographic categories within the LGBTI+ community. This would allow for more robust analyses, including subgroup analyses, to explore how different factors operate within specific groups. Furthermore, employing a mixed-methods approach that combines quantitative analyses with qualitative interviews or focus groups can provide a more comprehensive understanding of the experiences, challenges, and differences across various gender identities, sexual orientations, and demographic categories.

Fourth, inclusion of participants with a psychiatric diagnosis within the LGBTI+ population can be considered another limitation of this study. While incorporating individuals with diverse mental health conditions enhances the study's external

validity, it may also introduce confounding factors that could influence the results. Psychiatric diagnoses can significantly impact an individual's psychological well-being, self-perception, and coping mechanisms, which may intersect with or overshadow the effects of the demographic variables under investigation. As a result, it might be challenging to disentangle the specific contributions of demographic factors from the influence of psychiatric conditions on the outcomes measured in the study. Moreover, individuals with psychiatric diagnoses may experience varied degrees of internalized stigma and self-acceptance, which could further complicate the interpretation of the findings. To mitigate this limitation, sensitivity analyses and subgroup analyses can be employed to assess the impact of psychiatric diagnoses on the results and to explore potential interactions between demographic variables and mental health conditions. Additionally, future research could consider replicating the study with a focus on participants without psychiatric diagnoses to better isolate the effects of demographic factors on the outcomes of interest within the LGBTI+ community.

Finally, LGBTI+ individuals tend to be precautionary about disclosing information regarding their identities. They sometimes can be overprotective of their private life, as they are afraid of being judged, marginalized, or somehow discriminated. Many individuals within the LGBTI+ community face societal stigma, discrimination, and prejudice, which can create a fear of being judged or experiencing negative consequences. As a result, some LGBTI+ individuals may hesitate to openly disclose their feelings about their sexual orientation or gender identity in various contexts, including research surveys or interviews. This response bias might have had a confounding effect in the data. Similarly, social desirability bias might also have played a role.

CHAPTER 5: CONCLUSION

To the best of our knowledge, this study is the first to examine the mediating role of perceived social support in the relationship between internalized homophobia and depression and between internalized homophobia and self-esteem among LGBTI+ community. Moreover, this study is the first one establishing a significant mediation model which revealed significant indirect effects of perceived social support in the relationship between internalized homophobia and depression and between internalized homophobia and self-esteem.

Internalized homophobia, self-esteem, depression, and perceived social support had pairwise significant correlations. In addition, differences among age groups, levels of income, levels of education, and whether having a psychiatric diagnosis were significant in terms of self-esteem, depression, and perceived social support, but not of internalized homophobia. Perceived social support significantly mediated the relationship between internalized homophobia and depression, and between internalized homophobia and self-esteem. In the first mediation model, internalized homophobia significantly predicted depression and perceived social support, and perceived social support significantly predicted depression. Internalized homophobia did not predict depression when perceived social support was included. In the second model, internalized homophobia significantly predicted self-esteem and perceived social support, and perceived social support significantly predicted self-esteem. Internalized homophobia significantly predicted self-esteem when perceived social support was included.

Taking a closer look, the variation in depression was significantly contributed by having a psychiatric diagnosis, self-esteem, and perceived social support. In addition, the variation in self-esteem was significantly contributed by having a psychiatric diagnosis, internalized homophobia, and depression.

5.1. Clinical Implications

Our study highlights the significant mediating role of perceived social support in the relationship between internalized homophobia and both depression and self-esteem. This finding emphasizes the importance of fostering social support networks for LGBTI+ individuals. Mental health professionals should focus on helping individuals

build and maintain supportive relationships, both within the LGBTI+ community and in other areas of their lives. Interventions that promote social integration and provide opportunities for building strong support systems can have a positive impact on mental health outcomes.

In addition, perceived social support significantly mediated the relationship between internalized homophobia and depression, as well as between internalized homophobia and self-esteem. This indicates that reducing internalized homophobia is crucial for improving mental health outcomes among LGBTI+ individuals. Therapeutic approaches such as cognitive-behavioral therapy can be effective in helping individuals challenge and overcome internalized homophobia. Supporting individuals in developing self-acceptance and embracing their sexual orientation or gender identity can lead to improved self-esteem and reduced depressive symptoms.

Our study also found that having a psychiatric diagnosis significantly contributed to variations in depression and self-esteem. This highlights the importance of considering comorbid mental health conditions when developing treatment plans for LGBTI+ individuals. A comprehensive assessment that takes into account both the individual's sexual orientation or gender identity and their specific mental health needs is crucial. Collaborative care involving mental health professionals and psychiatrists may help ensure integrated treatment approaches that address both the psychiatric diagnosis and the unique experiences of LGBTI+ individuals.

Moreover, this study identified significant differences in self-esteem, depression, and perceived social support based on age groups, income levels, education levels, and psychiatric diagnosis status. Clinicians should consider these demographic factors when designing interventions and treatment plans. A culturally sensitive and inclusive approach that accounts for these variations can promote better mental health outcomes.

Given the interrelationships between internalized homophobia, perceived social support, depression, and self-esteem, a holistic and multidimensional approach to care is essential. Mental health professionals should collaborate with other healthcare providers and support services to provide integrated care that addresses the social, psychological, and emotional needs of LGBTI+ individuals. This may involve working alongside support organizations, community groups, and healthcare providers

to create comprehensive support systems that foster inclusivity and promote well-being.

By considering these clinical implications, mental health professionals can contribute to the well-being and resilience of LGBTI+ individuals, creating supportive environments and providing effective interventions that address their unique challenges and promote positive mental health outcomes.

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APPENDICES

Appendix A: Ethics Committee Approval

SAYI : B.30.2.İEÜ.0.05.05-**020**-*273* 28.02.2023

KONU : Etik Kurul Kararı hk.

Sayın Prof. Dr. Falih Köksal ve Bengi Balcılar,

"The mediating role of perceived social support in the relationship between internalized homophobia, selfesteem, and depressive symptom in LGBTI+ individuals" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 28.02.2023 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir.

Sonuçta 28.02.2023 tarihinde **"The mediating role of perceived social support in the relationship between internalized homophobia, selfesteem, and depressive symptom in LGBTI+ individuals"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

Appendix B: Consent Form

ARAŞTIRMAYA GÖNÜLLÜ KATILIM FORMU

Bu çalışma, İzmir Ekonomi Üniversitesi bünyesinde, Klinik Psikoloji Yüksek Lisans programı kapsamında Prof. Dr. Falih Köksal danışmanlığında, Bengi Balcılar tarafından yürütülmektedir. Bu form sizi çalışma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Bu çalışmanın amacı, LGBTİ+ bireylerde içselleştirilmiş homofobi ile benlik saygısı ve depresif semptomlar arasındaki ilişkide algılanan sosyal desteğin aracı rolünü incelemektir. Bu bağlamda sizlere maruz kalmış olabileceğiniz homofobi, deneyimlemekte olabileceğiniz depresif semptomlar, kendilik algınız ve çevrenizden gördüğünüz destek ile ilgili sorular yöneltilecektir.

Bize Nasıl Yardımcı Olursunuz?

Bu aşamada, sadece 10-15 dakikanızı alacak kısa anketimizi doldurmanız istenecektir. Soruları kendi başınıza cevaplamanız ve cevaplarken samimi yanıtlar vermeniz çalışma sonuçlarının doğruluğu ve güvenilirliği açısından çok önemlidir. Bu sebeple lütfen sizin için en doğru olan yanıtı veriniz.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Verdiğiniz yanıtlardan elde edilen bilgiler, tamamen gizli tutulacak, bu bilgilere yalnızca araştırmacılar ulaşabilecektir. Katılımcıların kimliğini gizli tutmak şartıyla elde edilecek bilgiler toplu halde değerlendirilecek, sonuçlar ise öğrencinin tezinde, bilimsel yayınlarda veya eğitim amaçlı olarak kullanılabilecektir.

Katılımınızla İlgili Bilmeniz Gerekenler:

Bu çalışmaya katılımınız tamamıyla gönüllülük temelinde olmalıdır. Anket genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, soruları cevaplarken ya da herhangi başka bir nedenden dolayı kendinizi rahatsız hissetmeniz durumunda çalışmaya katılmayı reddedebilir, cevaplama işini yarıda bırakabilirsiniz.

Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı öğrencisi Bengi Balcılar ile iletişim kurabilirsiniz

Bu çalışmaya tamamen gönüllü olarak katılıyor ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

☐ Evet

☐ Hayır

Appendix C: Demographic Information Sheet

DEMOGRAFİK VERİ FORMU

1. Yaşınız:_____

2. Atanmış (Biyolojik) Cinsiyetiniz (Sex):

   Kadın

   Erkek

   İnterseks

3. Toplumsal Cinsiyetiniz (Gender):

   Kadın

   Erkek

   Trans Kadın

   Trans Erkek

   Non-Binary

   Diğer:_____

4. Cinsel Yöneliminiz:

   Lezbiyen

   Gey

   Biseksüel

   Diğer:_____

5. Eğitim Seviyeniz:

   İlkokul Mezunu

   Lise Mezunu

   Üniversite Mezunu

   Yüksek Lisans Mezunu

   Doktora Mezunu

6. Gelir Düzeyiniz:

   Alt

   Alt-Orta

   Üst-Orta

   Üst

7. Herhangi bir psikiyatrik tanı aldınız mı?

   Evet

   Hayır

8. Aldıysanız belirtiniz:_____

Appendix D: Internalized Homophobia Scale

Aşağıda dokuz cümle ve her birinde cevaplarınızı işaretlemeniz için 1'den 5'e kadar rakamlar verilmiştir. Her cümlede verilen bilginin sizin için ne kadar doğru olduğunu belirtmek için o cümlenin yanındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu değerlendirmede aşağıdaki açıklamaları ve verilen tanımları dikkate alınız:

1= Kesinlikle katılmıyorum

2= Katılmıyorum

3= Kararsızım

4= Katılıyorum

5= Kesinlikle katılıyorum

Karşı cins: Atanmış (doğduğundaki) cinsiyeti erkek olanlar için kadın, kadın olanlar için erkek.

Hemcins: Atanmış (doğduğundaki) cinsiyeti erkek olanlar için erkek, kadın olanlar için kadın.

LGBTİ+: Cis-Het (biyolojik ve toplumsal cinsiyeti uyumlu olup, geleneksel anlamda heteroseksüel olan) bireyler dışında kalan tüm kimlik ve yönelimleri ifade etmektedir.

1. Diğer LGBTİ+ bireylerle kişisel ya da toplumsal beraberliklerden mümkün olduğunca kaçınırım.	1	2	3	4	5
2. Genel olarak hemcinslerimi çekici bulmamaya çalışırım.	1	2	3	4	5
3. Birisi bana tamamen heteroseksüel olma imkânı sağlasaydı, bu şansı kaçırmazdım.	1	2	3	4	5
4. Keşke LGBTİ+ bir birey olmasaydım	1	2	3	4	5
5. LGBTİ+ bir birey olduğum için kendime yabancılaştığımı hissediyorum	1	2	3	4	5
6. Keşke karşı cinse karşı daha fazla cinsel ilgi duyabilseydim.	1	2	3	4	5
7. LGBTİ+ bir birey olmamın benim için kişisel bir eksiklik olduğunu hissediyorum	1	2	3	4	5
8. Cinsel yönelimimi heteroseksüelliğe çevirmek için bir uzmandan yardım almak isterdim	1	2	3	4	5
9. LGBTİ+ olduğu alenen anlaşılan bireylerle ilişki kurmaktan ve birlikte görünmekten kaçınırım	1	2	3	4	5
10. Karşı cinse daha fazla cinsel ilgi duymak için çaba sarfediyorum	1	2	3	4	5

Appendix E: Beck Depression Scale

BECK DEPRESYON ENVANTERİ

AÇIKLAMA:

Sayın cevaplayıcı aşağıda gruplar halinde cümleler verilmektedir. Öncelikle her gruptaki cümleleri dikkatle okuyarak, BUGÜN DÂHİL GEÇEN HAFTA içinde kendinizi nasıl hissettiğini en iyi anlatan cümleyi seçiniz. Eğer bir grupta durumunuzu, duygularınızı tarif eden birden fazla cümle varsa her birini daire içine alarak işaretleyiniz.

Soruları vereceğiniz samimi ve dürüst cevaplar araştırmanın bilimsel niteliği açısından son derece önemlidir. Bilimsel katkı ve yardımlarınız için sonsuz teşekkürler.

1- 0. Kendimi üzüntülü ve sıkıntılı hissetmiyorum.
1. Kendimi üzüntülü ve sıkıntılı hissediyorum.
2. Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
3. O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

2- 0. Gelecek hakkında mutsuz ve karamsar değilim.
1. Gelecek hakkında karamsarım.
2. Gelecekten beklediğim hiçbir şey yok.
3. Geleceğim hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

3- 0. Kendimi başarısız bir insan olarak görmüyorum.
1. Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.
2. Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
3. Kendimi tümüyle başarısız biri olarak görüyorum.

4- 0. Birçok şeyden eskisi kadar zevk alıyorum.
1. Eskiden olduğu gibi her şeyden hoşlanmıyorum.
2. Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
3. Her şeyden sıkılıyorum.

5- 0. Kendimi herhangi bir şekilde suçlu hissetmiyorum.
1. Kendimi zaman zaman suçlu hissediyorum.
2. Çoğu zaman kendimi suçlu hissediyorum.
3. Kendimi her zaman suçlu hissediyorum.

6- 0. Bana cezalandırılmışım gibi geliyor.
1. Cezalandırılabileceğimi hissediyorum.
2. Cezalandırılmayı bekliyorum.
3. Cezalandırıldığımı hissediyorum.

7- 0. Kendimden memnunum.
1. Kendi kendimden pek memnun değilim.
2. Kendime çok kızıyorum.
3. Kendimden nefret ediyorum.

8- 0. Başkalarından daha kötü olduğumu sanmıyorum.
1. Zayıf yanların veya hatalarım için kendi kendimi eleştiririm.

2. Hatalarımdan dolayı ve her zaman kendimi kabahatli bulurum.
3. Her aksilik karşısında kendimi hatalı bulurum.

9- 0. Kendimi öldürmek gibi düşüncelerim yok.
1. Zaman zaman kendimi öldürmeyi düşündüğüm olur. Fakat yapmıyorum.
2. Kendimi öldürmek isterdim.
3. Fırsatını bulsam kendimi öldürürdüm.

10- 0. Her zamankinden fazla içimden ağlamak gelmiyor.
1. Zaman zaman içinden ağlamak geliyor.
2. Çoğu zaman ağlıyorum.
3. Eskiden ağlayabilirdim şimdi istesem de ağlayamıyorum.

11- 0. Şimdi her zaman olduğumdan daha sinirli değilim.
1. Eskisine kıyasla daha kolay kızıyor ya da sinirleniyorum.
2. Şimdi hep sinirliyim.
3. Bir zamanlar beni sinirlendiren şeyler şimdi hiç sinirlendirmiyor.

12- 0. Başkaları ile görüşmek, konuşmak isteğimi kaybetmedim.
1. Başkaları ile eskiden daha az konuşmak, görüşmek istiyorum.
2. Başkaları ile konuşma ve görüşme isteğimi kaybetmedim.
3. Hiç kimseyle konuşmak görüşmek istemiyorum.

13- 0. Eskiden olduğu gibi kolay karar verebiliyorum.
1. Eskiden olduğu kadar kolay karar veremiyorum.
2. Karar verirken eskisine kıyasla çok güçlük çekiyorum.
3. Artık hiç karar veremiyorum.

14- 0. Aynada kendime baktığımda değişiklik görmüyorum.
1. Daha yaşlanmış ve çirkinleşmişim gibi geliyor.
2. Görünüşümün çok değiştiğini ve çirkinleştiğimi hissediyorum.
3. Kendimi çok çirkin buluyorum.

15- 0. Eskisi kadar iyi çalışabiliyorum.
1. Bir şeyler yapabilmek için gayret göstermem gerekiyor.
2. Herhangi bir şeyi yapabilmek için kendimi çok zorlamam gerekiyor.
3. Hiçbir şey yapamıyorum.

16- 0. Her zamanki gibi iyi uyuyabiliyorum.
1. Eskiden olduğu gibi iyi uyuyamıyorum.
2. Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.
3. Her zamankinden çok daha erken uyanıyor ve tekrar uyuyamıyorum.

17- 0. Her zamankinden daha çabuk yorulmuyorum.
1. Her zamankinden daha çabuk yoruluyorum.
2. Yaptığım her şey beni yoruyor.
3. Kendimi hemen hiçbir şey yapamayacak kadar yorgun hissediyorum.

18- 0. İştahım her zamanki gibi.
1. İştahım her zamanki kadar iyi değil.

2. İştahım çok azaldı.
3. Artık hiç iştahım yok.

19- 0. Son zamanlarda kilo vermedim.
1. İki kilodan fazla kilo verdim.
2. Dört kilodan fazla kilo verdim.
3. Altı kilodan fazla kilo vermeye çalışıyorum.

20- 0. Sağlığım beni fazla endişelendirmiyor.
1. Ağrı, sancı, mide bozukluğu veya kabızlık gibi rahatsızlıklar beni endişelendirmiyor.
2. Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.
3. Sağlığım hakkında o kadar endişeliyim ki başka hiçbir şey düşünemiyorum.

21- 0. Son zamanlarda cinsel konulara olan ilgimde bir değişme fark etmedim.
1. Cinsel konularla eskisinden daha az ilgiliyim.
2. Cinsel konularla şimdi çok daha az ilgiliyim.
3. Cinsel konular olan ilgimi tamamen kaybettim.

Depresyon derecesi	**Toplam**
• Minimal depresyon	0-9
• Hafif depresyon	10-16
• Orta depresyon	17-29
• Şiddetli depresyon	30-63

Appendix F: Rosenberg Self-Esteem Scale

Rosenberg Benlik Saygısı Ölçeği

Sizin için uygun olanı seçiniz.

1) Kendimi en az diğer insanlar kadar değerli buluyorum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

2) Bazı olumlu özelliklerim olduğunu düşünüyorum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

3) Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

4) Ben de diğer insanların birçoğunun yapabildiği kadar bir şeyler yapabilirim.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

5) Kendimde gurur duyacak fazla bir şey bulamıyorum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

6) Kendime karşı olumlu bir tutum içindeyim.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

7) Genel olarak kendimden memnunum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

8) Kendime karşı daha fazla saygı duyabilmeyi isterdim.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

9) Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

10) Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.

a) Çok doğru b) Doğru c) Yanlış d) Çok yanlış

Appendix G: Perceived Social Support Scale

ÇBASDÖ

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemek için 1'den 7 'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini işaretleyiniz. Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.

Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya çalışır.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

İhtiyacım olan duygusal yardım ve desteği ailemden (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) alırım.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

İşler kötü gittiğinde arkadaşlarıma güvenebilirim.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Sorunlarımı ailemle (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) konuşabilirim.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Ailem ve arkadaşlarım dışında olan ve duygularıma önem veren bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya isteklidir.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Sorunlarımı arkadaşlarımla konuşabilirim.

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet