THE ROLE OF PREFERRED DEFENSE MECHANISMS AND PERCEIVED SUPPORT ON THE RELATION BETWEEN INTERNALIZED HOMONEGATIVITY AND PSYCHOLOGICAL WELL-BEING AMONG GAY AND LESBIAN YOUNG ADULTS

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The Role Of Preferred Defense Mechanisms And Perceived Support On The Relation Between Internalized Homonegativity And Psychological Well-Being Among Gay And Lesbian Young Adults

Gey ve Lezbiyen Genç Yetişkinlerde İçselleştirilmiş Homonegativite ve Psikolojik İyi Olma Hali Arasındaki İlişkide Tercih Edilen Savunma Mekanizmaları ve Algılanan Desteğin Rolü

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Abstract

The aim of the present study was to explore the relationship between internalized homonegativity and overall psychological well-being characterized by a positive sense of self, improved functioning in interpersonal relationships and lower levels of psychopathological symptoms, with a focus on the role of perceived social support and level of preferred defense mechanisms. A convenience sample of 60 lesbian and gay young adults, contacted through recognized LGBTI organizations in two big cities of Turkey – İstanbul and Ankara – participated in the study. A computer program, together with a survey package, was used. The computer program used Eprime-2 software for the application of Implicit Association Test (IAT). Survey package included Stage Allocation Measure (SAM), Hudson & Ricketts Homophobia Scale (HRHS), The Defense Style Questionnaire (DSQ), Multidimensional Scale of Perceived Social Support (MSPSS), Social Comparison Scale (SCS), Scale of Dimensions of Interpersonal Relationships (SDIP) and Brief Symptom Inventory (BSI), together with Demographic Information and Consent Forms. Internalized homonegativity was expected to impair overall well-being, with mediating effects of perceived social support and preferred defense mechanisms. Yet, the results revealed that internalized homonegativity did have a significant correlation with hostility, but not with overall well-being. The impairing effects of internalized homonegativity on overall well-being might hence be rather indirect, through the involvement of increased hostility and eroded social support. The hypothesized relations of perceived social support and

level of preferred defense mechanisms with overall well-being were in the expected directions: Participants who reported higher levels of perceived social support and less reliance on immature defense mechanisms displayed higher levels of well-being. Although the initial hypothesis on mediation was not confirmed, a moderation model was supported as participants with higher levels of internalized homonegativity received more benefits in terms of overall well-being in case of a decrease in their immature defense use. The major theoretical and clinical implications of this study are discussed, together with suggestions for future research.

Özet

Bu çalışmanın temel amacı, içselleştirilmiş homonegativite ve olumlu kendilik algısı, kişilerarası ilişkilerde yüksek işlevsellik ve psikopatolojik semptomların görece azlığı ile karakterize olan genel psikolojik iyi olma hali arasındaki ilişkiyi, algılanan sosyal destek ve tercih edilen savunma mekanizmalarına odaklanarak incelemektir. Bu çalışmanın temel amacı, içselleştirilmiş homonegativite ve olumlu kendilik algısı, kişilerarası ilişkilerde yüksek işlevsellik ve psikopatolojik semptomların görece azlığı ile karakterize olan genel psikolojik iyi olma hali arasındaki ilişkiyi, algılanan sosyal destek ve tercih edilen savunma mekanizmalarına odaklanarak incelemektir. Araştırmaya, Türkiye'nin iki büyük şehri olan İstanbul ve Ankara'daki LGBTI dernekleri aracılığıyla iletişim kurulan 60 lezbiyen ve gey genç yetişkin katılmıştır. Anket paketine ek olarak bir bilgisayar programı kullanılmıştır. Bilgisayar programı, Örtük Çağrışım Testi'nin uygulanabilmesi için Eprime-2 yazılımını kullanmıştır. Anket paketi, Onam Formu ve Demografik Bilgi Formuna ek olarak, Evre Tayin Ölçeği, Hudson-Ricketts Homofobi Ölçeği, Savunma Biçimleri Testi, Çokboyutlu Algılanan Sosyal Destek Ölçeği, Sosyal Karşılaştırma Ölçeği, Kişilerarası İlişki Boyutları Ölçeği ve Kısa Semptom Envanterini içermektedir. İçselleştirilmiş homonegativitenin genel iyi olma halini olumsuz etkileyeceği, algılanan sosyal destek ve kullanılan savunma mekanizmalarının olgunluk düzeyinin de bu ilişkide aracı bir etkisinin olacağı öne sürülmüştür. Ancak çalışmanın sonuçları, içselleştirilmiş homonegativitenin hostilite ile anlamlı bir korelasyon gösterdiğini, genel

iyi olma hali ile ise anlamlı bir korelasyon göstermediğini ortaya koymuştur. İçselleştirilmiş homonegativitenin, genel iyi olma hali üzerindeki olumsuz etkisinin, hostilite düzeyindeki artışı ve sosyal destekteki aşınmayı da içeren bir yoldan, daha dolaylı şekilde işliyor olabileceği düşünülmüştür. Algılanan sosyal destek ve savunma mekanizmalarının olgunluk düzeyi ile genel iyi olma hali arasındaki ilişkilerin beklenen doğrultuda olduğu görülmüştür: Daha yüksek düzeylerde sosyal destek algısına sahip olan ve immatuür savunma mekanizmalarına bağımlılığı daha düşük olan katılımcıların, genel psikolojik iyi olma hallerinin daha yüksek olduğu görülmüştür. Başlangıçtaki mediasyon hipotezi doğrulanmamışsa da, bulgular, bir moderasyon modelini destekler niteliktedir. Buna gore, daha yüksek düzeylerde içselleştirilmiş homonegativite gösteren bireylerin, immatür savunma mekanizma kullanımlarındaki olası bir azalmanın, genel psikolojik iyi olma halleri üzerinde daha fazla olumlu etkiye yol açtığı görülmüştür. Bu çalışmada elde edilen bulgulardan çıkarım yapılabilecek temel teorik ve klinik sonuçlar tartışılmış ve ileri araştırmalar için öneriler sunulmuştur.

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"One's reputation, whether false or true, cannot be hammered, hammered, hammered, into one's head without doing something to one's character."

(Allport, 1954)

1. Introduction

The mainstream disciplines of psychology, psychiatry and psychoanalysis have until recently adopted a heteronormativist attitude, supporting the view that homosexuality was a mental illness that had to be cured or repaired for a healthy living. Such pathologization of homosexuality brought with it the application of various treatment techniques ranging from psychoanalysis (Roughton, 2002) to psychotherapy, from behavioural conditioning therapies in the form of aversive conditioning against homosexual stimuli and orgasmic reconditioning to biological hormone treatments, and even lobotomies to deal with so-called pathological sexual drives (Clarke, Ellis, Peel, & Riggs, 2010). As Freud has foreseen it as early as in 1920, such treatments aiming to "..convert a fully developed homosexual into a heterosexual does not *(and did not)* offer much more prospect of success than the reverse)" (pp.150-151, italics added). Indeed, such treatment attempts proved more harm than good, leading to increased rates of intimacy avoidance, sexual dysfunction, depression, and suicidality among patients (Haldeman, 2002) and have locked non-heterosexuals into closets of fear and shame (Roughton, 2002).

The de-pathologization of homosexuality was both a scientific and political progress. The removal of homosexuality from the official list of mental disorders by American Psychiatric Association in 1973 was an important first step, followed by American Psychological Association in 1975 and World Health Organization in 1990. American Psychoanalytical

Association (APsaA) adopted non-discriminatory policy statements with regard to homosexuality in 1991. In light of these developments, the official process may seem to be over but as Roughton puts it, "private attitudes often evolve more slowly than public policy decisions" (2002, p.34) and there is still much to accomplish in the field of mental health for LGBT individuals.

It can be said that similar to the developments in gender and family studies, there has been a shift from alpha to beta prejudice (Hare-Mustin, 1987) in the conceptualization of homosexuality in mainstream disciplines of mental health. Alpha prejudice refers to an exaggeration of the differences between heterosexuals and non-heterosexuals, with the explicit assumption that heterosexuality was the "normal" form of human sexuality while homosexuality was treated as sexual perversion at its worst, or as a neurotic condition due to a psychosexual fixation. In the light of scientific evidence, it is now clear that homosexuality is not a disorder but a normal variant of human sexuality (APA, 2012). This improvement in understanding homosexuality became accompanied by the rise of beta prejudice in the field, which took the form of ignoring all differences between life experiences of heterosexual and non-heterosexual individuals. Still, a growing number of research conducted in the newly-introduced field of LGBTQ Psychology reveal increased risk of mental health problems mostly in the form of depression and anxiety disorders, and of suicidality among LGBTQ individuals as compared to heterosexual control groups (Clarke, Ellis, Peel, & Riggs, 2010). Drawing on this evidence, it can be

suggested that although homosexuality is not a disorder, growing up as homosexual in a heterosexist culture makes individuals more susceptible to suffer from mental disorders. The experience of growing up as homosexual and the difficulties embedded in developing a gay or lesbian identity against all prejudice and discrimination should be carefully studied to have an in-depth understanding of the psychological damage inflicted upon LGBTQ individuals and develop effective prevention and intervention strategies to be employed by professionals working with these populations.

This study constitutes such an attempt at delineating the links between negative sense of self and high levels of internalized prejudicial attitudes against homosexuality and psychological well-being of gay and lesbian young adults, with possible mediating roles of the maturity of defense mechanisms employed to deal with the negative affect associated with a negative sense of self due to internalized stigma and the level of perceived support from family, friends and significant others in this internal conflict. The basic tenet of the study will be grounded upon Minority Stress Theory developed by Meyer (1995). Minority Stress Theory will be introduced with a special emphasis on the stressor of "internalized homophobia" conceptualized as the internalization of the negative attitudes of the "heterosexist ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community."(Herek, 1995, p.321). The development of a stigmatized sense of self will be explained with its effects on later psychological well-being. Defense mechanisms and perceived level of social support will be presented

with a brief explanation as regards the reason why these two factors were chosen as possible mediators. Then the aims and hypotheses of the current study will be briefly presented.

1.1. Minority Stress Theory

1.1.1. Overview of Minority Stress Theory

Minority groups have been defined by sociologist Louis Wirth (1945) as "any group of people who, because of their physical or cultural characteristics, are singled out from the others in the society, in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination" (p.347). Minority group designation is based on subordinate position in the society based on the so-called minority group's relative lack of power and exposure to discriminatory practices by the majority. Other common characteristics of minority groups as indicated by Wirth involve exclusion from full participation in social life and from benefits from societal advantages, isolation from dominant group, and minority group status overshadowing individual characteristics (1945). Roughton (2002) exemplifies this last point by emphasizing the stereotyping and discrimination against homosexual people who were considered ineligible for psychoanalytical training despite their high educational qualifications by American Psychoanalytical Association until 1991.

Minority group status does not have a direct relationship with numerical inferiority. Indeed, women who are equal in numbers with

men still occupy a disadvantaged position in society and are considered to constitute a minority group (Hacker, 1951). Besides gender, minority groups can also be defined along racial, ethnic or linguistic differences, political views, immigrant status, religion, sexuality, age, chronic illness such as HIV and physical disabilities. Although the issue of minority groups has been mostly studied within the discipline of sociology from a sociopolitical perspective, short and long-term psychological effects of minority group status on individuals have in the last decades received growing attention from both social and clinical psychologists, leading to the emergence of "Minority Stress Theory".

Minority Stress Theory focuses on the adverse effects of excess stress stemming from stigmatized minority status on psychological well-being and social functioning of affected individuals. Theory posits that individuals from minority populations suffer from acute and chronic stressors peculiar to their group identity (Meyer, 1995). On the basis of research evidence, Meyers enlists the three characteristics of this minority stress as its uniqueness, chronicity and social basis (2003). "Uniqueness" refers to the fact that minority stress is exclusive for the individuals belonging to the minority group and is added upon the general stressors that the individuals from all social groups experience. In this sense, total amount of stress to bear is higher for minority individuals who need to make an extra effort if they are to adjust to

daily life. "Chronicity" concerns the stable and consistent character of minority stress. Neither individual nor public attitudes evolve rapidly enough to allow for a swift transformation of the environmental and social conditions through elimination of prejudice and discrimination against certain social categories. "Social basis" refers to the fact that minority stress is not created solely by individuals' displaying negative attitudes and discriminatory behaviours against minority individuals, but also on an institutionalized level through societal structures and processes (Link & Phelan, 2001). For instance, the institution of marriage which sanctions heterosexual relationships and provides the spouses with visibility and privileged treatment under law is denied to same-sex couples by government and law (Meyer, 2003), creating an excess amount of stress on non-heterosexual commitments. In a similar vein, individuals infected with HIV suffer from socially based stressors due to exposure to governmental, employment and health-care discrimination in many countries around the world ("HIV & AIDS Stigma and Discrimination", 2014).

Drawing from Lazarus and Folkman's (1984) conceptualization of stress, these stressors in the lives of minority individuals are analyzed along a continuum from distal to proximal factors. Distal stressors involve objective events and conditions that involve exposure to prejudice and discriminatory behavior targeted against them. Although these objective stressors also affect one's

quality of life, they gain their essential psychological importance through the way "they are manifested in the immediate context of thought, feeling, and action" (Lazarus & Folkman, 1984, p.321). Proximal stressors involve precisely such individual perceptions and appraisals about one's minority identity. Crocker (1998) describes proximal processes as "states of mind that the experience of stigma may create in the stigmatized" (p.516). Such states of mind are the products of the internalization by minority individuals of the negative views and attitudes about their "stigmatized" characteristics prevailing in all segments of the society and colouring all their social interactions both with other people and with all social institutions and structures (Link & Phelan, 2001). Proximal processes are subjective and related to self-identity. In this regard, development of a sense of self in minority individuals, social and personal meanings embedded in these identities should be examined for an in-depth understanding of the subjective stress that accompanies.

1.1.2. The Development of Self-Concept in Minority Individuals

Self-concept is not an innate quality, rather, it evolves over time in social interactions where the others function as a "looking-glass self" (Cooley, 1902). This term conceptualizes the development of self-concept as a process in which one's idea of his or herself is mostly shaped by the others' regard and evaluations about him or her. A negative reflection in the social mirror, hence, leads to a negative image of self. The quotation from Alport (1954,

p.142), in the beginning of this study points to this inherent connection between negative regard from others and consequent harm to the victim's self-concept and, thereby, psychological functioning. The central importance of affirmative interactions with other people in the formation of a healthy sense of self, or otherwise, the role of unfavorable interpersonal relations in the emergence of problematic self-definitions, is emphasized by numerous theoretical approaches ranging from psychoanalytical object-relational approach (Winnicott, 1965) to attachment theory (Bowlby, 1969), and to cognitive-developmental approach (Piaget, 1945). Blatt and Blass (2013), in their theory of personality development, suggest that the "development of an increasingly differentiated, integrated and mature sense of self is contingent on establishing satisfying interpersonal relationships" (p.313). Although these interpersonal interactions initially consist mainly of the mother-child dyad, over time, they include the relational matrix between the growing individual and other people in his or her immediate environment and society in general. Blatt and Blass claim that the quality of interpersonal interactions and the feelings that emerge within these relationships, both close and distant, become internalized and constitute the sense of self. This point suggests that it is not only relationships with significant others that counts, but rather that all relationships with all other people are significant in developing self. In this regard, social relationships characterized with negativism and

hostility particularly in the form of overt or covert prejudice, stereotyping and discrimination, as is often the case for individuals from minority groups, may lead to deviations from the track of development of a healthy sense of self which may then lead to impairments in one's psychological and social well-being.

For minority individuals, the stigmatized characteristics become loaded with a negative content and hence cannot easily become embraced and integrated into one's self-concept. For LGBT individuals whose stigmatized characteristic is concealable, the lack of harmony between this characteristic and the expectations of the dominant culture leads to disavowal of sexual orientation and the emergence of a "false self" (Winnicott, 1965) and concealment of one's identity from others by staying hidden in the closet. Given that self-perception is cast by the social mirror of others' perceptions of them (Mead, 1934), which, in this case, is loaded with negativity, socially stigmatized individuals experience tremendous conflict between their urge to realize their inner, authentic self and the need to conform to societal expectations and norms to gain approval and positive regard (Martin, 1982). Indeed, such a conflict and the concealment that results are enmeshed with internal feelings of shame and worthlessness (Green, 2003), together with an increased mental preoccupation with the stigmatizing attribute (Smart & Wegner, 2000). The proximal process in the form of internalization of societal stigma and/or exclusion hence implies an inherent

connection to the conflicts and even blockages in the process of the emergence of a healthy sense of "true-self"; this is deeply related with psychological functioning of minority individuals. Indeed, empirical evidence suggests an increased prevalence of adverse physical and psychological health outcomes for ethnic and racial minorities (Williams & Williams-Morris, 2000; Alamilla, Kim & Lam, 2009), individuals with obesity (Carr & Friedman, 2005), and sexual minorities (Meyer, 1995; Frost, Lehavot & Meyer, 2013) due to perceived stigma and discrimination.

1.1.3. The Development of Self Concept in LGBT Individuals

Sexual minorities, or lesbian, gay, bisexual and transgender (LGBT) individuals, constitute a special minority group in society. They experience all four common features of stigma put forward by Crocker, Major and Steele (1998), that is, they are economically disadvantaged, usually become the target of negative stereotypes, rejected interpersonally and become victims of social discrimination due to institutional heterosexism (Hebl, Law & King, 2010). As is evident from this account, not only do they experience proximal stressors of prejudice, discrimination, and violence in the form of physical and sexual assaults (Brooks, 1981), but they also suffer from essential proximal stressors due to their introjection of heteronormative attitudes prevalent in society. Such a process of self-stigmatization leads LGBT individuals to evaluate themselves from the perspective of imagined others in a pejorative way (Thoits,

1985). Having been born into and grown up in a heteronormative society, and being continually exposed to discriminatory attitudes and behaviors in everyday life, internalized stigmatization precedes LGBT individuals' recognition of their gender identity and sexual orientation (Meyer, 1995) and complicates their process of integration of gender and sexuality into their self-definition. Although self-loathing is expected to be greater in the early years of one's self-labeling as LGBT (Meyer, 1995) before the self-acceptance and coming out process is achieved, the residues of internalized stigma may still remain in a covert form (Gonsiorek, 1988) and influence one's psychological adjustment throughout life.

Research evidence suggests that internalized stigma is positively correlated with higher levels of psychological distress (Szymanski, 2005), low self-esteem (Alexander, 1987 & Melamed 1993, as cited in Allen & Oleson, 1999), suicidal ideation and attempt (Hammelman, 1993;Cochran & Mays, 2000), eating disorders (Williamson, 2000), risky sexual behaviours (Meyer & Dean, 1998), and low relational and sexual satisfaction (Melamed, 1993, as cited in Allen & Oleson, 1999; Meyer & Dean, 1998). Indeed, much of this research is conducted with LGB individuals. There is scant research examining the effects of self-stigmatization on transgender individuals. Indeed, based on the premise of "double jeopardy hypothesis", transgender individuals, who constitute a minority group within the LGBT minority group, may suffer from

additional psychological distress as compared to lesbian, gay and bisexual people (Ferraro & Farmer, 1996). Consistent with this hypothesis, research suggests an increased psychological risk associated with transgender individuals' double minority status, as evidenced by the fact that transgender persons are the most likely to be depressed and at risk for suicide, and have the lowest level of social support among LGBT groups (Bockting, Huang, Ding, Robinson & Rosser, 2005).

1.1.3.1. Internalized Negative Attitudes in LGBT Individuals

There is a wide terminology to describe prejudice against LGBT people and the resultant internalization of this stigmatization among LGBT individuals themselves. The most commonly used term is "homophobia", coined by Kenneth Smith in 1971. George Weinberg associated homophobia with the dread of being in physical proximity with homosexual individuals (1972). Homophobia is also defined as the feelings of anxiety, disgust, aversion, anger, discomfort and fear towards lesbians and gay men (Hudson and Ricketts, 1980). In both definitions mentioned above, the affective component of prejudice is emphasized to the neglect of cognitive and behavioural components of its tripartite structure. Indeed, like all attitudes, prejudice also has a cognitive component in the form of stereotypes, defined as beliefs with negative connotations about the characteristics of the members of a target group (Hamilton &

Sherman, 1994), and a conative component which can be defined as a behavioral predisposition to discriminate directly or indirectly against the members of the target group. Another shortcoming of the use of term "homophobia" concerns its narrow focus, precluding bisexual and transgender people (Clarke, Ellis, Peel, & Riggs, 2010). For this reason, new terms like "biphobia" and "transphobia" have been proposed to encompass the experiences of other subgroups in LGBT community. More generally, the term "heterosexism," coined and defined by Herek as "an ideological system that denies … and stigmatises any non-heterosexual form of behavior, identity, relationship, or community" (1990, p.316) can be used to refer to the prejudice against all LGBT individuals. "Internalized" versions of each term, that is, internalized homophobia, internalized biphobia, internalized transphobia and internalized heterosexism, are also used to refer to the emergence of these feelings in LGBT individuals against themselves.

Indeed, an important critique of the use of all these terms concerns their focus on individual factors, to the neglect of their social roots (Clarke, Ellis, Peel, & Riggs, 2010). Indeed, individual-level processes of prejudice and discrimination are produced and maintained by institutional and cultural forces that legitimize unfair treatment of particular groups of people (Dovidio, Hewstone, Glick & Esses, 2010). The "internalized"

versions of these terms are also considered to be problematic for emphasizing the intra-psychic distress as personal issue requiring individual intervention, while the real solution would be reducing prejudice and discrimination through radical social change (Kitzinger & Perkins, 1993).

In the light of all these criticisms, in this study, the more comprehensive term of "internalized homonegativity" (Mayfield, 2001) is preferred with an emphasis on its social roots, that is, embeddedness in the cultural fabric of the society.

1.1.3.2.Implicit and Explicit Negative Attitudes

Given that stereotypes, prejudice and discrimination are embedded in the social system, all individuals, including those that belong to the marginalized minority groups themselves, have learned and possibly internalized these negative attitudes as regards their group identity from many sources including parents, peers, social institutions such as education and legal systems, and media (Whitley &Kite, 2006). In case of "explicit negative attitude (or explicit prejudice)", individuals know that they hold some negative beliefs and attitudes against certain groups of people. If they think that their prejudice is wrong and inacceptable and they have enough time before reacting, they can exert control and eliminate the effects of their negative attitudes on their behavior, minimizing the risk of engaging in overt or covert discrimination (Devine, 1989). In case of "implicit

negative attitude (or implicit prejudice)", individuals lack an awareness of that prejudice while the prejudice still gets unintentionally activated and becomes manifest in some behaviours.

Historically, prejudice has been assessed by asking respondents directly about their attitudes on a given subject. Such traditional measures of prejudice may yield reliable estimates only when the respondents are firstly, aware of their prejudices and secondly, are willing to report that (Dovidio, Hewstone, Glick & Esses, 2010). In case of explicit prejudice, first condition is satisfied but the second may or may not be met. Social norms might make the frank confession of bias against a certain minority group impossible for those individuals who adopt egalitarian beliefs at a conscious level. This difficulty can be explained both by concerns about social desirability and a desire to avoid the distress caused by the cognitive dissonance between their egalitarian ideological stance and prejudiced attitude. In case of implicit prejudice, use of explicit measures is rendered meaningless due to lack of awareness about the very existence of a negative attitude. One cannot be expected to provide accurate answers as regards their negative feelings to a certain minority group when these negative feelings are covert and inaccessible even to the individual him or herself. In either case, thus, self-report measures in the form of attitude

questionnaires may not be able to accurately capture the real nature of the attitudes of the respondents for different reasons.

To address this problem, implicit measures have been developed for the study of prejudice and discrimination. These measures aim to assess prejudice that individuals are either unaware of or are unwilling to admit (Correll, Judd, Park & Wittenbrink, 2010). These measures assess either implicit cognitions or physiological reactions. Physiological assessment measures changes in cardiovascular (ECG), muscular (EMG) and cerebral (fMRI) activity in response to stimuli about a target group (Whitley &Kite, 2006). Implicit cognition measures, based on response latencies, assess the degree of association between different concepts in one's memory on the basis of speed of response. The underlying assumption concerns the associative networks theory of memory. The more the strength of association between two concepts (i.e. Blacks and sports) or one concept and an evaluative connotation (i.e. Men and aggressive), the faster and easier one responds when the task at hand requires Blacks/sports or Men/aggressive combinations. The advantage of implicit measures concerns their ability to grasp more subtle and socially acceptable, i.e. modern, forms of prejudice.

Given that internalized homonegativity, or internalized negative attitudes about homosexuality in the form of self-loathing, usually operate out of conscious awareness of the

individual, and may be hard to admit even if the individual is consciously aware of it, assessment of internalized homonegativity may require the use of implicit measures.

1.1.4. Towards a Positive Psychology: Minority Resilience

Minority Stress Theory has attracted much attention in the field. Still, although there is an extensive literature on risk factors, including internalized homophobia, that compromise the psychological health of LGBT populations, possible resiliency and hardiness factors that Meyer refers to as "minority resilience hypothesis" have been relatively neglected (Szymanski, Kashubeck-West & Meyer, 2008; Meyer, 2003). Although members of minority groups suffer from a large number of stressors ranging from distant to proximal factors, they also develop some very important coping skills and resilience factors that may offset the potential harmful effects of those psychological risk factors on their day-to-day functioning (Meyer, 2007). As early as 1974, Weinberg and Williams emphasized the importance of a shift in psychological research from risk factors to "the human capacity for adaptation" (p.151). Indeed, positive coping is not an exception for minority individuals struggling with stigma (Clark, Anderson, Clark & Williams, 1999). A number of studies have provided evidence for the protective effects of social support (Kertzner, 2001), self-acceptance (Hershberger & D'Augelli, 1995), and in-group solidarity and cohesiveness (Clark et al., 1999) in counteracting the

effects of minority status on psychological well-being of stigmatized individuals.

Meyer (2007) points to the distinction between personal resources and group resources as ameliorative adaptive processes. According to this distinction, personal resources refer to some conscious and unconscious intrapsychic processes such as the personality structure, coping skills, ego strength, and defense mechanisms, and interpsychic processes of acceptance and support in meaningful relationships. Group resources, on the other hand, refer to in-group processes such as group solidarity and cohesiveness, provision of support and communion by the environment that are common to all members of the minority group. Although conceptualized as distinct categories, personal and group resources operate concomitantly. The extent to which minority individuals access and make use of group resources depend on their personal resources such as self-acceptance of the relevant minority identity and ability to reach out to others for help and support. Group resources may have little, if any, protective effect on individuals who lack personal resources. In this respect, personal resources may have precedence over group resources in determining mental health outcomes.

In this study, two personal resources, namely defense mechanisms and perceived social support, will be investigated.

1.2. Defense Mechanisms

1.2.1. Description and Theoretical Background of Defense Mechanisms

Defense mechanisms are introduced into psychoanalytic literature in 1893 by Sigmund Freud through an analysis of the use of a specific defense mechanism which is later on called "repression". In Freud's words, "the basis for repression itself can only be a feeling of displeasure, the incompatibility between the single idea that is to be repressed and the dominant mass of ideas constituting the ego" (1893, p.116). According to this conceptualization, the aim of repression mechanism was to prevent the conscious recognition and expression of intolerable or inacceptable drives and impulses by censoring them out of consciousness, thereby, on the one hand reducing anxiety and conforming to the demands of external world (Cramer, 2006), while on the other hand leading to pathogenic outcomes. The concept of defense mechanisms, thereafter, became a major cornerstone in psychoanalytic thinking. Until Freud's clarification of the difference between the terms "repression" and "defense mechanisms" in 1926, the two terms were treated as synonyms and used interchangeably. In 1926, in his article entitled "Inhibitions, Symptoms and Anxiety", Freud suggested the use of the term "defense mechanisms" as an umbrella term covering all defense mechanisms including repression

which is since then considered as the most important of all defense mechanisms (Hentschel, Draguns, Ehlers & Smith, 2004).

Starting with his daughter, Anna Freud, Freud's followers in psychoanalytical school of thought made important contributions to the conceptualization of defense mechanisms, broadening its formulation (A. Freud, 1946; Kohut, 1977; Cooper, 1998; Cramer, 2000). The first systematic effort for the study of defense mechanisms was undertaken by Anna Freud in her book called "The Ego and The Mechanisms of Defense" (1946). Anna Freud's contribution was significant in two ways. First, she developed a comprehensive formulation as regards the nature of defense mechanisms and described most prominent defense mechanisms in a detailed way. Second, and most important, Anna Freud's work shifted the focus away from the pathogenic consequences of defense mechanisms in the form of distorting the reality towards an emphasis on their adaptive consequences. With her work, it became clear that defense mechanisms are part of normal development and essential for healthy functioning in everyday life. What is considered pathological became then the unusually heavy reliance on certain defense mechanisms (Cramer, 2004).

In Freud's formulation, defenses were conceptualized as forces directed against internal forces. Drives and impulses that would create a significant amount of distress if consciously registered are pushed into unconscious in order to avoid intrapsychic

conflict and resultant overwhelming anxiety. Freud's descendants, on the basis of clinical observations and empirical evidence, expanded the use of defense mechanisms as a reaction against external sources of stress such as threats to self-esteem (Kohut, 1977), danger to life and limb (Horowitz, 1986), threats to identity status (Cramer 1995) and self-esteem (Grzegolowska-Klarkowsla & Zolnierczyk, 1988).

In the light of contemporary contributions, Cramer suggests that "...defenses may be defined as unconscious mental mechanisms that are directed against both internal drive pressures and external pressures, especially those that threaten self-esteem or the structure of the self" (2004, p.7). This definition is more comprehensive as compared to the original conceptualization of defense mechanisms by Freud.

1.2.2. Distinction between Defenses and Coping Mechanisms

The definition of defense mechanisms in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994) "Defense mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors. Individuals are often unaware of these processes as they operate. Defense mechanisms mediate the individual's reaction to emotional conflicts and to internal and external stressors." (p.751) reflects the prevailing confusion in

current psychological thinking as regards the differentiation between the terms of "defense mechanisms" and "coping styles" which are used interchangeably. Although both concepts refer to adaptational processes that aim to protect the individual from the adverse emotional consequences, i.e. anxiety, triggered by internal and external stressors, Cramer suggests some criteria that may be useful for their disentanglement (1998). The major criterion concerns the conscious/unconscious status of the mental process and the involvement of intentionality.

Coping mechanisms operate at a level of conscious awareness and are solution-focused, that is, they are aimed at developing solutions for a problem situation of which the individual is consciously aware. The use of coping strategies is hence under the conscious control of the individual and involves intentional attempts of the individual (Affleck & Tennen, 1996). In this sense, LGBT individuals may employ various coping strategies to deal with the distal stressors, that is, social prejudice and discrimination. For instance, concealing one's sexual orientation may be a coping strategy (Miller & Major, 2000) to ward off possible negative consequences such as exposure to mobbing or risk of redundancy in workplace. Or, they may try hard to suppress their romantic and sexual desires for same-sex partners.

Defense mechanisms, on the other hand, operate outside of conscious awareness against disruptive external events and

unconscious psychological states (Cramer, 1998). They function without any conscious intentionality or rational decision on the part of the individual. Various defense mechanisms may also be employed by LGBT individuals to avoid adverse emotional consequences of both distal and proximal stressors related to their sexual orientation. For instance, their homosexual desires may be "repressed", that is, withheld from their consciousness. Given that internalized negative attitudes against homosexuality may trigger an anxiety-provoking state, individuals may employ "denial" and literally do not consciously register their own negative attitudes about being gay or lesbian. Likewise, they may disown their homophobic reactions, "project" them to other people and attribute a homophobic connotation to all others say and do; or use "reaction formation" to display extreme gay pride despite having high levels of internalized homonegativity.

As internalized homonegativity is considered to function at an unconscious level without conscious awareness of the individual, the processes employed to deal with the resultant psychological state of negative affectivity should also operate in the unconscious, without the intentionality, will or rational decision of the individual. Defense mechanisms, hence, may be more relevant in dealing with the internal stress triggered by internalized homonegativity.

1.2.3. Classification of Defense Mechanisms

Defense mechanisms are adaptational processes helping us to restore psychological homeostasis and maintain psychological well-being (Cramer, 2004). Indeed, Vaillant describes defenses as "creative, healthy, comforting and coping" (1993, p.18). Still, as is clearly stated by Anna Freud (1936), although defenses are a part of normal development and have a significant role in healthy adaptation, the excessive use of certain defense mechanisms, or the use of immature defenses may also point to psychological disturbance. In this sense, defense mechanisms are intrinsically related with both psychological well-being and psychopathology (Vaillant, 1992).

Since Anna Freud's (1946) list of ten major defense mechanisms described in Sigmund Freud's psychoanalytical work with neurotic patients, the proposed number of defense mechanisms has increased drastically (Hentschel, Draguns, Ehlers & Smith, 2004). Various researchers has come up with different suggestions as to the total number of defense mechanisms, such as Laughlin (1963) advocated for 22 major and 26 minor mechanisms; Horowitz, Markman, Stinson, Fridhandler and Ghannam (1990) proposed 28 defense mechanisms. The difference in numbers partly stem from the confusion between defenses and coping mechanisms mentioned above. For instance, Vaillant (1977) includes suppression in his list of defense mechanisms although it involves a conscious effort on the

part of the individual who "...intentionally avoids thinking about disturbing problems, wishes, feeling or experiences" (DSM-IV-TR, APA, 2000, p.813). Despite the lack of an agreement on the exact number of defense mechanisms, there is a consensus on the conceptualization of defense mechanisms along a hierarchical continuum on the basis of developmental levels, psychological maturity or cognitive complexity (Cramer, 1988). The ongoing quest for the classification of defense mechanisms into organized categories is still contentious; although there is a scientific consensus as regards the main criteria along which this hierarchical classification should be made, the total number of clusters is found to vary among different theoreticians.

Vaillant (1977) proposed one hierarchical scheme where he categorized defense mechanisms into four clusters along a developmental continuum. The lowest level is labeled "psychotic mechanisms" and consists of delusional projection, denial and distortion. The second level, "immature mechanisms", are projection, schizoid fantasy, hypochondriasis, passive aggression, acting out and dissociation; "neurotic defenses" of third level concern isolation, intellectualization, repression, displacement and reaction formation. Fourth and highest level of "mature mechanisms" includes altruism, suppression, anticipation, sublimation and humour. The main criterion determining the

developmental level of any defense mechanism is the degree of reality distortion involved.

According to Nancy McWilliams (1994), developmental level of any given defense mechanism is determined on the basis of presence or lack of attainment of the reality principle, as in Vaillant's formulation (1977), and appreciation of the separateness and constancy of those outside the self. She categorizes defense mechanisms into two: primitive and secondary. Defense mechanisms that distort external reality with their magical and prelogical characteristics are called "primitive" while others that constitute more sophisticated means of processing anxiety and adapting to a complex and disturbing reality are called "secondary". Primitive defenses (primitive withdrawal, denial, omnipotent control, primitive idealization and devaluation, projection, introjection, projective identification, and splitting of the ego) deal with the boundary between self and the outer world while higher-order ones (regression, isolation, rationalization, moralization, undoing, turning against self, compartmentalization, displacement, reaction formation, reversal, identification, acting out, sexualization, and sublimation) deal with the boundaries between ego and superego, or between experiencing and observing parts of the ego. Although all individuals may employ primitive defenses without having any psychopathology, it is the persistent use of primitive defenses to the

exclusion of more mature higher-order processes that poses a problem (McWilliams, 1994).

Bond, Gardner, Christian and Segal (1983) also propose a hierarchy among defense mechanisms. They cluster defenses under certain groups which they call "defense styles". These defense styles are called "maladaptive action patterns", "image distorting", "self-sacrificing", and "adaptive". With further revisions from Andrews, Sigh and Bond (1993), defense mechanisms are clustered under three dimensions of immature, neurotic and mature. At the immature end of this continuum, defense mechanisms (projection, passive aggression, acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, somatization) distort contact with reality; at the mature end, defenses (sublimation, humor, anticipation, suppression) are more adaptive in dealing with stress and adapting to external reality. Neurotic defenses (undoing, pseudo-altruism, idealization, reaction formation), located in the middle part of the continuum, modify external reality at varying rates to be able to handle the distress. The assessment of defenses in this study will follow this conceptualization.

Given that all individuals have certain defense mechanisms which they automatically rely on without being consciously aware of it, it can be said that one's mode of struggling with both internal and external stressors is overdetermined by one's psychic structure developed as a result of the interaction between one's biological

constitution and early relational and learning experiences (Waelder, 1960). In this regard, one's preferred defense mechanism can be said to depend more on dispositional, rather than situational factors (Cramer, 1998). Understanding one's personality and psychological functioning in daily life thereby is inherently connected with an in-depth understanding of his or her defensive processes. For LGBT individuals, the defense mechanisms employed to avoid or manage the adverse emotional experiences related with internalized homonegativity while still maintaining self-esteem may be an important risk or resiliency factor on the road to an impaired or restored psychological functioning.

1.2.4. Defense Mechanisms in Psychopathology and Psychotherapy

Defenses not only determine the ways we deal with excessive anxiety triggered by internal and external stressors, they also colour the way we perceive the world, ourselves and our psychological functioning. Although the shift in psychoanalytical understanding of defense mechanisms has led to an emphasis on their adaptive, creative and healthy aspects, as with all psychological processes, the excessive use of defense mechanisms may signal psychopathology (Cramer, 2004). Indeed, it is the degree of the distortions in the individual's reality testing capacity, rather than the mere use of several defense mechanisms clustered under the immature defensive style, that differentiates psychiatric and non-psychiatric individuals.

Cramer's (2004) review of research evidence on the relation between defense mechanisms and psychopathology suggest that the greater use of immature defense mechanisms together with a decreased use of mature defense mechanisms predict presence of psychopathology and psychiatric symptoms. For instance, the incidence of depression among college men and posttraumatic stress disorder among World War II veterans were higher for those using less adaptive defenses (Vaillant, 2000).

Nancy McWilliams (1994, 1999) suggests that different personality structures, which take the form of personality disorders at extremes, are characterized by the use of certain defense mechanisms. Psychopathic (or antisocial) people characteristically use the primary defense of projection, narcissistic individuals generally use idealization and devaluation again with primary process features. People with hysteric personality structure are characterized by their heavy reliance on the secondary defense mechanism of repression. Cramer (2004) orders the disorder forms of these three personality structures grouped together under Cluster-B in DSM-IV in a hierarchical manner where hysteric (or histrionic) personality disorder occupies the highest level of developmental maturity and antisocial personality disorder is considered to be lowest. This overlap between the relative maturity of personality structures (or disorders) and the characteristic defense mechanisms used by each indicates the importance of the use of defense

mechanisms as a valuable tool for understanding psychopathology (Vaillant, 1994). Still, research yields inconsistent findings as regards the use of defense mechanisms in differential diagnosis of axis-I clinical and axis-II personality disorders (Cramer, 2004).

Although above evidence suggests a relation between the use of an immature defensive style and increased risk for certain psychological symptoms (which may or may not reach the required threshold for the diagnosis of any Axis I or II disorders), understanding one's preferred defensive style can not lead to a specific diagnosis. Indeed, defense assessment leads to a better formulation of the case, facilitates the diagnosis, and guides the therapeutic approach (Cramer, 2004). Choosing the type of intervention that is compatible with the defensive style of the patient (Bond, 2004) is considered to strengthen therapeutic alliance which is brought forward by a number of research as the major determinant of therapy outcome (Lambert & Barley, 2001). McWilliams (1999) also points to the importance of the accurate assessment of the patient's defensive structure in order to be able to find the most appropriate way of communicating with the patient who might otherwise drop out of therapy. In this regard, therapists may meticulously tailor their interpretations so as to render them compatible with the defensive needs of the patient (McWilliams, 1999; Bond, 1992). Successful psychotherapy depends on an understanding of the defensive style of the patient, conveying this

understanding to the patient through a careful analysis from surface to depth and altering this defensive system towards a more healthy and adaptive way (McWilliams, 1999; Vaillant, 1994; Vaillant & McCullough, 1998). Although the match between the patient's defensive style and therapist's intervention is more important than the characteristics of the patient's defensive style itself in predicting therapy outcome, clinicians are found to have some implicit expectations as regards a higher probability of good prognosis among patients with relatively mature defenses, especially intellectualization and compensation (Conte, Plutchik & Draguns, 2004). Cramer (2004) asserts that, in line with this implicit expectation, psychotherapy often leads to an increase in the use of mature defenses and/or a decrease in the use of immature defenses as evidenced by outcome research (Albucher, Abelson & Nesse, 1998).

1.2.5. Assessment of Defenses

Although the importance of understanding defensive functioning for determining psychotherapeutic interventions that would yield to successful outcome is clear by now, the assessment of the use of defense mechanisms is fraught with some difficulties (Cramer, 2004). The first difficulty concerns the lack of consensus among researchers as to the total number of defense mechanisms and the conceptualization of agreed-upon, definitive hierarchical categories (Bond, 2004). The second difficulty concerns the unconscious character of defense mechanisms. Given that defense

mechanisms operate outside of conscious awareness, they are not highly amenable to measurement via self-report scales that ask the individual, rather paradoxically, to be able to report directly and openly on the unconscious means of managing their intolerable instincts and affects (Hentschel, Draguns, Ehlers & Smith, 2004). Still, many researchers including Bond (2004) and Cramer (2004) suggest that self-report scales can be used with an adjustment of the question format so as to ask the behavioural derivatives of defense mechanisms, rather than asking directly about the mechanisms themselves. Indeed, although people may be blind to the underlying cognitive operations and unconscious motives, they are mostly aware of their behaviours in stressful and anxiety-provoking conditions. Other than self-reports, observer-rated methods in the form of clinical observations and interviews, analysis of the narratives prompted by projective tests are also used for the measurement of defenses (Hentschel, Draguns, Ehlers & Smith, 2004; Cramer, 2004). Despite their vulnerability to become distorted by subject's biased response style and lack of an insight even to the behavioral derivatives of their defenses, self-report scales are widely used as they are time and cost-effective (Bond, 2004).

1.3. Perceived Social Support

Defined in general terms as "the support accessible to an individual through social ties to other individuals, groups, and the larger community" (Lin, Ensel, Simeone & Kuo, 1979, p.109), the

conceptualization of social support and its operationalization in empirical studies have been highly diversified (Barrera & Ainlay, 1983). Various researchers proposed different classification systems for social support functions (Caplan & Killilea, 1976; Foa, 1971). In their review of this prolific literature, Barrera and Ainlay (1983) suggested four main categories of social support functions, namely, directive guidance, non-directive support, positive social interactions, and tangible assistance. These four attributes are then renamed as emotional, instrumental, informational and appraisal (Barrera, 1986). Emotional support concerns the provisioning of affective assistance in the form of love, care and intimacy; while instrumental support is about delivering tangible assistance of money, housing, work aid (Langford, Bowsher, Maloney & Lillis, 1997). Informational support concerns provisioning of information in order to assist the other in a problem-solving situation (Cutrona & Russsell, 1990), and appraisal support concerns provisioning of affirmative and accepting information to be used in self-evaluation (House, 1981 as cited in Langford, Bowsher, Maloney & Lillis, 1997). Research suggests that the importance individuals attach to different types of social support may depend on the age of the individual as, for instance, the relative importance of instrumental support seems to be highest for younger people (Lynch, Mendelson, Robins, Krishnan, George, Johnson & Blazer, 1999). Other distinctions may be drawn on the basis of the identity of the support provider or the support provided for different life issues (Barrera & Ainlay, 1983). The importance of

parental support seems to decrease and be replaced by friends' support over time (Ozbay, Johnson, Dimoulas, Morgan, Charney & Southwick, 2007).

Still, the major distinction concerns the difference between received and perceived social support (Norris & Kaniasty, 1996). Received social support refers to the actual amount of support that has been and is still provided to the individual while perceived social support is the amount of support that the individual thinks might be available in case a need might arise (Barrera & Ainlay, 1983). Hobfold's comprehensive definition of social support as "those social interactions or relationships that provide individuals with actual assistance or that embed individuals within a social system believed to provide love, caring, or sense of attachment to a valued social group or dyad" (1988; as cited in Norris & Kaniasty, 1996) concern both types of social support. Although the concepts of received and perceived support are interdependent, they are not identical as research evidence suggests a relatively low correlation between levels of received and perceived support (Dunkel-Schetter & Bennett, 1990). Part of the variance in perceptions of available support can be explained by the history of previous and current experiences of having or not having received enough support in times of need, while the remaining part is thought to reflect an underlying personality characteristic as support perceptions are found to be relatively stable over time (Sarason, Sarason & Pierce, 1992). Some researchers explain this stability with the aid of the

Bowlby's (1969) concept of working models of self and others that develop early in infancy and influence relationship patterns throughout life. There seems to be a strong association between positive perceptions of self and others and perceived social support (Sarason, Pierce, Shearin, Sarason, Waltz & Poppe, 1991). Individuals who are able to find assets in themselves together with a belief that others will also hold similar positive views of them, report higher levels of perceived social support and feel more comfortable to turn to others for encouragement and assistance in times of adversity which overwhelm their personal coping resources.

Overall, social support is an important factor that increases resilience to distress and leads to subsequent psychological well-being as measured by increases in feelings of personal competence, effective coping behaviors, sense of control and stability and a decrease in the frequency and severity of psychopathological symptoms (Langford, Bowsher, Maloney & Lillis, 1997). Although the bio-psycho-social mechanisms that mediate the relation between perceived social support and physical and mental health are not completely understood yet, both animal and human studies suggest a neuro-endocrinological mechanism in which social support leads to decreased stress reactivity and thereby to positive health states (Ozbay, Johnson, Dimoulas, Morgan, Charney & Southwick, 2007). Accumulating research evidence over the years has provided evidence for the superiority of support perceptions over the actual amount of support reported to have been received from others in

predicting stress responses, psychological and physical health (Sarason, Pierce, Shearin, Sarason, Waltz & Poppe, 1991; Norris & Kaniasty, 1996). Indeed, the protective effects of received support on psychological well-being seem to be more indirect, through its bolstering effect on support perceptions (Wethington & Kessler, 1986). In this study, perceived social support will be investigated as a possible mediator between internalized homonegativity and psychological well-being.

1.4. Psychological Well-Being

Although the theory of psychological well-being can be traced back to the work of Aristotle, the concept has been introduced and gained popularity in the field of psychology since 1960s with the rise of positive psychology movement and the shift in emphasis from psychopathology and mental illness to personal growth and flourishing (Ryan & Deci, 2001). Two different approaches, both dating back to ancient Greece, predominate in the tradition of the study of psychological well-being. The hedomonic approach emphasizes the importance of the feelings of happiness. The psychological term that corresponds to the hedomonic approach to well-being is subjective well-being (SWB) which consists of an emotional component characterized by the predominance of positive over negative affect (Bradburn, 1969) and a cognitive component characterized by a sense of life satisfaction (Ryan & Deci, 2001). Eudaimonic approach, following the Aristotle's line of thought, is mainly advocated by Ryff's seminal work (1989).

This perspective offers a richer and multidimensional view of psychological well-being that goes much beyond a sense of happiness; it refers both to knowing yourself and to becoming what you are by actualizing your inner potentials as basic virtues of human life. Ryff suggests that psychological well-being consists of six distinct but interrelated dimensions, namely, autonomy, personal growth, self-acceptance, life purpose, mastery, and positive relatedness (Ryff, 2014). Ryan and Deci, in their Self-Determination Theory, also attribute the attainment of psychological well-being to the fulfillment of three basic psychological needs of autonomy, competence and relatedness (Ryan & Deci, 2001).

Current conceptualizations of psychological well-being reflect a blend of these two perspectives in which the prevalence of positive affective states and self-realization in order to fully function both as an autonomous and relational individual are both considered important (Winefield, Gill, Taylor & Pilkington, 2012; Ryan & Deci, 2001). As the theoretical stance of different researchers determine the relative importance attached to various aspects of this multidimensional phenomenon and thereby the instruments used for its assessment, there is not a best golden measure of psychological well-being (Winefield, Gill, Taylor & Pilkington, 2012).

In this study, a more eudaimonic approach to psychological well-being is adopted. Psychological well-being is discussed as an outcome of the experiences in different life areas (Ryff, 2014), including the level

of development of a gay or lesbian identity, personality correlates of internalized homonegativity and preferred defense mechanisms, and supportive experiences with family and friends. Psychological well-being is conceptualized as the ability to function with optimal effectiveness in individual and social life (Winefield, Gill, Taylor & Pilkington, 2012) as evidenced by a positive sense of self and an increased ability to have healthy and satisfying relationships. Lack of psychological impairment is not equated with psychological well-being (Ryan & Deci, 2001). Given that psychological dysfunctions and psychological well-being are not the opposite ends of the same continuum (Winefield, Gill, Taylor & Pilkington, 2012) but are complementary as regards the information they provide about the overall mental health of an individual (Ryff, 2014), a brief symptom inventory is also used to check for the presence of any symptoms that may or may not reach the threshold for a clinical diagnosis.

1.5. Current Study

1.5.1. Aim of the Study

The major aim of this study is to draw attention to the difficulties embedded in the experience of growing up as homosexual and developing a relevant gay or lesbian identity in the heterosexist culture of Turkey. Minority Stress Theory developed by Meyer (1995) constitutes the theoretical foundation for the study. Being exposed to negative societal messages about homosexuality and engaging in interpersonal interactions associated with

negativism and hostility for many years all along their developmental process, lesbian and gay individuals may unwittingly internalize these prevailing negative attitudes about homosexuality (Weinberg, 1972), a process described by Alport as "one's sense of shame for possessing the despised qualities of one's group as well as repugnance for other members of one's group because they possess these qualities" (1954, p.152). This self-stigmatization may diminish self-acceptance as a lesbian or gay, hamper the development of a relevant sexual identity and impair one's psychological adjustment throughout life (Meyer, 2003).

Although a comprehensive literature suggests a positive correlation between internalized homonegativity and increased risk for various mental health problems in lesbian and gay individuals (Meyer, 2003), few studies address the potential mediating pathways between stigma and problems in psychological well-being. Besides, even fewer studies are conducted on minority resilience factors which, even in the face of serious distal and proximal stress factors, contribute to an increased capacity for adaptation and preservation of well-being (Weinberg & Williams, 1974). This study addresses this shortcoming of the literature by focusing on the possible mediating roles of preferred defense mechanisms and perceived social support.

Although both defense mechanisms and coping styles are conceptualized in DSM-IV (American Psychiatric Association, 1994) as adaptational processes against anxiety provoked by internal

and/or external stressors, they are differentiated on the basis of the conscious/unconscious status of the processes; with coping mechanisms being conceptualized as operating at a level of conscious awareness and defense mechanisms as operating at an unconscious level (Cramer, 1998). The reason why defense mechanisms are studied as a possible mediational factor in this study is the fact that both internalized homonegativity and defense mechanisms employed to deal with the subsequent anxiety operate at the unconscious level. Besides, relatively little is known about defense mechanisms whereas the mediator role of coping styles between internalized homonegativity and well-being has already been studied (Meyer, 2003; Szymanski & Owens, 2008). Drawing on a comprehensive literature providing evidence for the protective effects of, especially perceived, social support (Sarason, Pierce, Shearin, Sarason, Waltz & Poppe, 1991; Norris & Kaniasty, 1996), perceived social support is also suggested as an important mediating factor between internalized homonegativity and psychological well-being which, in turn, is evaluated in three domains, namely, sense of self, interpersonal relationships and psychopathological symptoms.

The study aims to elucidate the potential mediating pathways from experiences of stigmatization and internalization of such stigma to impairments or resiliency in the realm of psychological well-being in homosexual young adults. The relations between internalized negative attitudes against homosexuality, preferred

defense mechanisms, perceived support and psychological well-being will be studied. An in-depth understanding of these relations would be expected to yield clinical implications to enrich affirmative psychotherapeutic practice with LGB populations.

1.5.2. Hypotheses

Hypothesis 1: Having grown up in the heteronormativist culture of Turkey, individuals are expected to display high levels of homophobia in Implicit Association Test.

Hypothesis 2: Given that internalized homonegativity may function at an unconscious level without the individual being consciously aware of it, and that even when the individual is aware of carrying negative attitudes against homosexuality, it may be challenging and socially unacceptable to report such self-stigmatizing attitudes; individuals' underlying attitudes and concerns are expected to be better captured with implicit measures as opposed to explicit measures. The level of correspondence between what one truly feels inside and reports to others may not be very high. Indeed, given that social desirability is more of a concern as regards the socially sensitive issues of prejudice and discrimination, this level of correspondence is expected to decrease further. Hence, a weak correlation between explicit and implicit levels of internalized homonegativity is expected.

Hypothesis 3: The three domains of psychological well-being are expected to be related with each other. People who self-

evaluate in more positive terms will **a)** score lower on approval dependency dimension and higher on empathy, trusting others, and emotional awareness dimensions of interpersonal relationships; **b)** score lower in all five symptom dimensions of somatization, depression, anxiety, hostility, and negative sense of self.

Hypothesis 4: Implicit levels of internalized homonegativity will be negatively correlated with psychological well-being in all or some of the three domains of psychological well-being, as evidenced by; **a)** self-evaluation in more negative terms, **b)** maladaptive relational patterns with high approval dependency, **c)** the presence of psychopathological symptoms which may or may not reach the threshold for a clinical diagnosis.

Hypothesis 5: There may be a discrepancy between one's level of homonegativity in implicit and explicit measures. It is hypothesized that, in such cases, one's relative standing in implicit measure will be higher than his or her of explicity-reported level of homonegativity. That is, individuals are expected to portray themselves as someone who endorses more egalitarian and humanistic views, and thereby, is less homophobic. The disparity between one's level of internalized homonegativity in implicit and explicit measures will be negatively correlated with psychological well-being.

Hypothesis 6: 6.a. In line with the extant literature, individuals with more mature defense mechanisms, such as

sublimation or humor, are expected to demonstrate better psychological functioning. The use of immature defense mechanisms such as denial is hypothesized to become associated with lower levels of psychological well-being.

6.b. In line with existing findings, perceived social support is expected to have a positive correlation with psychological well-being in all three domains of sense of self, interpersonal relationships and psychopathological symptoms. Given that perceived social support is hypothesized to be associated with working models of self and others, positive correlations are expected between self-evaluation, trusting others in interpersonal relationships and level of perceived social support.

6.c. A positive correlation is expected between the use of more mature defense mechanisms and level of perceived support.

Hypothesis 7: The use of more mature defense mechanisms and level of perceived support are expected to mediate the relation between internalized homonegativity and psychological well-being. That is, individuals will exhibit optimal functioning in individual and social life even in the presence of high levels of internalized homonegativity if their defense mechanisms are mature and they think others might provide them with assistance in difficult times.

2. Method

2.1. Participants

Individuals were eligible to participate in the study if they (a) self-identified as male or female and were assigned that sex at birth, that is, did not self-identify as transgender; (b) self-identified as homosexual, either lesbian or gay, or had doubts as regards his or her sexual orientation.

In total, 60 participants (48 male, 12 female) attended the study on a voluntary basis. The participants involved lesbian and gay people living in two big cities of Turkey, namely, İstanbul and Ankara, with varying levels of personal contact and involvement with LGBT organizations of SPOD, LAMBDA and KAOS-GL. The predominance of male participants over female participants indeed seemed to reflect the relative invisibility of lesbians within LGBT movement (Minkoff, 2013). Each participant completed all measures included in the survey package. As only a few items were not completed in some of the packages, the missing information did not require the exclusion of any participants from statistical analyses. In the same vein, any outliers were not detected.

The final sample consisted of 60 participants with ages ranging from 18 to 44 (M=27.10, SD=7,005). All participants had high level of education; 40 had either graduated from or were still enrolled in an undergraduate program, and 20 had MA or PhD degree. They had mid to high socioeconomic status, with 40 participants reporting to have a

monthly income above the minimum wage of 1000 TRY in Turkey. As regards their coming out process, 27 participants identified themselves as partially and 33 as completely open about their sexual orientation. 58 participants located themselves as being in one of the three upmost stages of the process of homosexual identity development. Precisely, 45 participants reported being in the stage of identity synthesis, 7 in the stage of identity pride, 6 in the stage of identity acceptance, 1 in identity tolerance and 1 in identity confusion.

2.2. Instruments

All instruments were administered through face to face interviews by the researcher. A computer program, together with a survey package, was used. The computer program used E-Prime - 2.0 software for the application of Implicit Association Test (IAT). Survey package included Stage Allocation Measure (SAM), Hudson & Ricketts Homophobia Scale (HRHS), The Defense Style Questionnaire (DSQ), Multidimensional Scale of Perceived Social Support (MSPSS), Social Comparison Scale (SCS), Scale of Dimensions of Interpersonal Relationships (SDIP) and Brief Symptom Inventory (BSI), together with a Demographic Information Form.

2.2.1. Demographic Information Form

The demographic information form includes questions as regards the age, gender, level of education, working status and monthly income, interpersonal intimacy and level of coming out of the participants. The form is presented in Appendix A.

2.2.2. Stage Allocation Measure (SAM)

Development of a sense of self and acquisition of a homosexual identity in lesbian and gay individuals has been theorized to proceed along a pathway consisting of some developmental stages common to all members of their group. Vivienne Cass (1984) developed Stage Allocation Measure (SAM) in order to ascertain the developmental stage for each individual at a given point in time. The measure identifies seven distinct developmental stages of which the first stage is rather a pre-stage while the remaining six stages, starting with identity confusion, progress through identity comparison, identity tolerance, identity acceptance, identity pride and culminate in identity synthesis. Each stage is described in one paragraph and the individuals are asked to choose the description that matches best with their experience of homosexuality (see Appendix C). Given that SAM is a simple measure for identifying the stage of homosexual identity formation, Cass has not conducted advanced statistical analyses as regards its reliability and validity.

Turkish translation of SAM was completed by Uluboy (2010) for her master's thesis.

2.2.3. Hudson & Ricketts Homophobia Scale (HRHS)

HRHS is a self-report measure developed by Hudson and Rickets (1980) to assess one's level of homophobia conceptualized as the level of discomfort one has working or associating with gay and lesbian individuals. The scale consists of 25 items answered on a 6-point Likert-scale, where "1"

stands for "totally disagree" and "6" stands for "totally agree". The original scale yielded high levels of internal reliability ($\alpha = .90$).

HRHS was adapted into Turkish by Sakallı and Uğurlu (2001). The Turkish version of the scale, presented in Appendix D, consists of 24 questions with a high level of internal reliability evidenced by a Coefficient alpha level of ($\alpha = .94$).

2.2.4. Implicit Association Test (IAT)

IAT is a computerized test (Greenwald, McGhee & Schwartz, 1998) that assesses implicit attitudes about socially sensitive topics such as racism, ageism, prejudice and discrimination against any group in society. It simply measures the strength of associations between concepts and evaluative attributes such as good/bad or pleasant/unpleasant. It is widely used in social psychology research as it has the ability to detect attitudes that people may be unwilling or unable to report explicitly if asked about it. The basic premise of the test is that people tend to associate concepts with stereotypically related evaluative attributes with a faster response time and higher accuracy.

The format used in "Project Implicit" conducted by Harvard University was followed with one modification. The modification concerns the choice of stimuli. In Project Implicit, the concepts of homosexuality and heterosexuality are presented with a combination of pictures and words referring to either same sex (both male-male and female-female) or opposite-sex couples, respectively. In this study, the pictures were eliminated from the set of stimuli in order, first, to make the presentation of

the concepts of homosexuality/ heterosexuality and the evaluative concepts of good/bad more similar, and second, to avoid any confounds that might stem from the details in the pictures, whereby, it might be impossible to differentiate between homonegativistic attitudes and negative attitudes against same-sex marriage given in reaction to the picture of the marriage of a same-sex couple. For the evaluative concepts of "good" and "bad", all the words were borrowed from "Project Implicit" study. Each of the four categories of Homosexual, Heterosexual, Good and Bad consists of eight words. Drawing on research evidence suggesting that IAT is able to provide valid results with only 2 exemplars per category as long as each item is representative of the relevant concept and category membership for each item can be easily identified with no confounds (Nosek, Greenwald & Banaji 2005), eight items per category are acceptable.

The task involved five steps. First and second steps of the study constituted practice trials during which the participants learned the task for both the concept and the attribute dimensions; fourth step included a switch in the spatial location of the concept categories. Two critical tasks were presented in third and fifth steps. In the third and fifth steps, participants were either asked to use the same key to categorize together the words that belonged either to the concept of homosexuality or good, and another key to categorize the words that belonged either to the concept of heterosexuality or bad; or to do the same thing for the opposite association in which homosexual and bad items were categorized with one key and heterosexual and good items categorized with the other key. The order of these two

associations was counterbalanced to avoid order effects as a confounding variable.

The list of eight stimulus items for each of the four categories is presented in Appendix E.

2.2.5. The Defense Style Questionnaire (DSQ)

Defense Style Questionnaire was first developed by Bond, Gardner, Christian and Sigal (1983) as a self-report measure consisting of 88 items. The original version was designed to assess the use of 26 distinct defense mechanisms clustered into four styles ranked on a developmental continuum, from maladaptive action patterns, through image-distorting defenses, self-sacrificing defenses, and to adaptive defenses. Through further revisions, the final version of the scale was developed by Andrews, Singh, Bond (1993) in which 20 distinct defense mechanisms clustered under three dimensions of immature, neurotic and mature. The final version of the scale consists of 40 items answered on a 9-point Likert scale where 1 indicates "strongly disagree" and 9 indicates "strongly agree". Internal consistency values for Mature, Neurotic and Immature factors were reported as .68, .58 and .80, respectively.

The scale was translated into Turkish by Yılmaz, Gençöz and Ak (2007). Psychometric properties of the Turkish version of the scale was found to be similar to those obtained in the original study with internal consistency values for Mature, Neurotic and Immature factors being .70, .61 and .83, respectively. The scale can be found in Appendix F.

2.2.6. Multidimensional Scale of Perceived Social Support (MSPSS)

Developed by Zimet, Dahlem, Zimet, and Farley (1988), MSPSS is designed to assess perceived social support from three different sources, namely, family, friends and significant others. Although the original version of the scale included 24 items rated on a 5-point Likert-scale, following a series of statistical analyses, Zimet et al. (1988) modified the scale and retained 12 items answered on a 7-point Likert scale from 1 to 7 where 1 stands for "very strongly disagree" and 7 for "very strongly agree" (1988). Each of the three subscales consists of 4 items. The obtained points may range between 4 and 28 for each subscale, and between 12 and 84 in total with higher the obtained points, the higher the perceived social support. The adaptation and standardization into Turkish was conducted by Eker and Arkar (1995). The scale is presented in Appendix G.

2.2.7. Social Comparison Scale (SCS)

Given that one's self-concept is shaped on the basis of one's perceived relative standing in one's comparison with other people, Social Comparison Scale (SCS) is a valuable tool for measuring self-esteem. The original scale, developed by Allan and Gilbert (1995), consisted of five incomplete sentences which subjects had to complete by putting a mark on a ten point scale anchored with each of the following bipolar constructs: inferior-superior, less competent-more competent, likeable-less likeable, less reserved-more reserved, left out-accepted. The Cronbach alpha for the scale was .87 and test-retest reliability at four months was .84.

Turkish adaptation of the scale involved an increase in the total number of constructs from five to six (Şahin & Şahin, 1992), and then, from six to eighteen (Şahin, Durak & Şahin, 1993), rated on a 6-point Likert-scale. The latest version of the Turkish scale (Şahin & Durak, 1994) yielded high internal reliability as evidenced by a Cronbach alpha value of .89 (Şahin Durak & Şahin, 1993). Higher points correspond to a higher level of self-esteem and a more positive self-concept. The scale is presented in Appendix H.

2.2.8. Scale of Dimensions of Interpersonal Relationships (SDIP)

Developed by İmamoğlu and Aydın (2009) as a convenient scale for predicting interpersonal relationships in the context of Turkey, SDIP examines relationship dimensions along 4 factors, namely, Approval Dependence, Empathy, Trusting Others, and Emotional Awareness. The scale consists of 53 items rated on a 5-point Likert scale ranging from 0 ("doesn't represent me at all) to 4 ("totally represents me"). The scale has high internal reliability as evidenced by Coefficient alpha values between $\alpha = .78$ and $\alpha = .85$ for subscales, and test-retest reliability coefficient between .62 and .96. The scale is given in Appendix I.

2.2.9. Brief Symptom Inventory (BSI)

The BSI is a shortened version of the revised form of Symptom Checklist (SCL-90-R). The original scale, developed by Derogatis (1977), consists of 90 items that load on 9 factors, 3 global indices and additional items. Included factors, or primary symptom dimensions, are somatization,

obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychosis. Global indices correspond to Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. BSI, developed again by Derogatis (1992), preserves the same factor structure as SCL-90-R. It involves 53 items rated on a 5-point Likert scale from 0 to 4, where "0" indicates "none" and "4" indicates "a lot/too much". BSI is reported to have high internal reliability as evidenced by Cronbach alpha values ranging between .71 and .85 for sub-scales (Derogatis & Lazarus, 1994).

The BSI was adapted into Turkish and standardized both for Turkish adults (Şahin & Durak, 1994) and adolescents (Sahin, Batıgün & Uğurtaş, 2002), yielding high reliability (α = .94). Research on Turkish samples provided evidence for 5 factors, instead of 9, which are anxiety, depression, somatization, hostility, and negative sense of self. Cronbach alpha values ranging between .70 and .88 for five factors are consistent with those obtained with the original scale. The scale is presented in Appendix J.

2.3. Procedure

All measures used in the study, except for Implicit Association Test, were translated and standardized into Turkish by previous researchers. Implicit Association Test is developed on the basis of the format used in Project Implicit. New words were added to the categories of homosexuality and heterosexuality, as determined with the consensus of all members of the thesis committee. Data collection process began after the finalization of all

the scales and the approval from Ethics Committee Board of Istanbul Bilgi University. Participation in the study was voluntary.

As IAT is a computerized test installed in the private computer of the researcher, all data was gathered through face-to-face interviews by the researcher herself. A computer program, together with a survey package, was used. An informed consent form was obtained from all participants before their enrollment into the study. In order to avoid any implicit or explicit influence on the performance in IAT, this measure was completed at the beginning of the study. The order of the completion of paper-and-pencil scales was not fixed. Brief information about scales was given at the beginning of each section. After completing the measures, participants were thanked and encouraged to contact the researcher in case they had any questions may arise regarding the study or if they experienced adverse reactions following their participation in the study.

3. Results

3.1. Preliminary Analyses

As explained in "Methods" section, all scales used in the study had high reliability. Still, prior to investigating the relationship between the study variables, scores for each variable were computed according to the scoring manual of each scale and reliability coefficients were calculated in order to assess the internal consistency of the measures for that study . Cronbach coefficients for each measure are presented in Table 1.

Table 1 *Reliability Coefficients (α) for Scales in the study*

Scales / Subscales	*A*
Hudson-Rickett's Homophobia Scale	0,65
Perceived Support-Total	0,774
- Family	0,842
- Friends	0,755
- Significant Other	0,941
Defense Styles Questionnaire	
- Immature	0,805
- Neurotic	0,325
- Mature	0,589
Social Comparison Scale	0,759
Brief Symptom Inventory	
- Anxiety	0,894
- Depression	0,891
- Somatization	0,85
- Hostility	0,804
- Negative Sense of Self	0,849
Dimensions of Interpersonal Relationships	
- Approval Dependence	0,758
- Empathy	0,69
- Trusting Others	0,859
- Emotional Awareness	0,711

As presented in Table 1, all scales and subscales used in the study yielded acceptable reliability coefficients with alpha values ranging from .65 to .89. The only exception concerned the Mature and Neurotic subscales of the Defense Style Questionnaire. The alpha coefficients for these subscales were .59 and .33, respectively, far below the acceptable range. Hence, these subscales were excluded from further statistical analyses. The analyses on defense styles were carried out using solely the Immature subscale of DSQ.

For other scales, a correlation analysis was conducted to evaluate the relationship between different subscales involved. High correlation coefficients, presented in Table 2, provided additional evidence for the reliability of the measures. Thus, all other scales and subscales administered were included in analyses.

Table 2 *Correlation coefficients (Pearson's r) for subscales of MSPSS, BSI, SDIP*

Table 2.1. *Perceived Social Support (MSPSS)*

	1	2	3	4
1. MSPSS_Family	1	,019	,055	,619**
2. MSPSS_Friend	,019	1	,212	,447**
3. MSPSS_Other	,055	,212	1	,764**
4. MSPSS_Total	,619**	,447**	,764**	1

**. Correlation is significant at the 0.01 level (2-tailed).

Table 2.2. *Brief Symptom Inventory (BSI)*

	1	2	3	4	5	6	7
1. Anxiety	1	,742**	,762**	,829**	,736**	,915**	,875**
2. Depression	,742**	1	,789**	,726**	,737**	,902**	,818**
3. NegativeSelf	,762**	,789**	1	,715**	,772**	,900**	,806**
4. Somatization	,829**	,726**	,715**	1	,789**	,893**	,765**
5. Hostility	,736**	,737**	,772**	,789**	1	,878**	,781**
6. Severity	,915**	,902**	,900**	,893**	,878**	1	,907**
7. Total Symptom	,875**	,818**	,806**	,765**	,781**	,907**	1

**. Correlation is significant at the 0.01 level (2-tailed).

Table 2.3. *Dimensions of Interpersonal Relationships (SDIP)*

	1	2	3	4
1. Approval Dependency	1	,082	-,226	-,315*
2. Empathy	,082	1	,306*	,291*
3. Trust	-,226	,306*	1	,442**
4. Emotional Awareness	-,315*	,291*	,442**	1

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

3.2. Descriptive Statistics

Descriptive statistics with means and standard deviations for all study variables are listed in Table 3.

Table 3 *Descriptive statistics for all study variables*

Scales / Subscales	*Min*	*Max*	*M*	*SD*
Hudson-Rickett's Homophobia Scale	1,21	2,79	1,57	0,30
Implicit Association Test				
- Homosexual- Bad Mean RT (IAT 4)	692,22	4178,94	1669,40	776,07
- Homosexual-Good Mean RT (IAT 5)	689,91	3594,72	1273,62	457,17
- Difference (IAT 5 - IAT 4)	-2606,63	741,50	-395,78	613,99
Perceived Support-Total	37,00	84,00	66,52	11,31
- Family	5,00	28,00	19,37	6,45
- Friends	15,00	28,00	25,14	3,31
- Significant Other	4,00	28,00	22,15	7,49
Defense Styles Questionnaire				
- Immature	1,63	6,33	4,15	1,07
- Neurotic	2,88	7,25	5,15	1,02
- Mature	3,00	8,63	5,98	1,14
Social Comparison Scale	45,00	105,00	80,47	9,97
Brief Symptom Inventory				
- Anxiety	0,00	45,00	12,40	10,59
- Depression	0,00	40,00	15,50	10,41
- Somatization	0,00	25,00	5,62	6,90
- Hostility	0,00	25,00	7,52	6,15
- Negative Sense of Self	0,00	31,00	10,63	8,39
- Positive Symptom Total Index	2,00	51,00	24,40	12,82
- Positive Symptom Distress Index	1,00	3,69	1,93	0,69
- Global Severity Index	0,04	2,45	0,97	0,72
Dimensions of Interpersonal Relationships				
- Approval Dependence	11,00	45,00	27,63	7,86
- Empathy	21,00	36,00	28,92	3,90
- Trusting Others	10,00	57,00	37,35	9,98
- Emotional Awareness	18,00	50,00	36,70	7,55

Internalized homonegativity was assessed using both Hudson-Rickett's Homophobia Scale and Implicit Association Test. As can be seen in Table 3, responses to Hudson-Rickett's scale's questions showed

little variance (M=1.5681, SD=0.3016). Implicit Association Test results were analyzed using mean reaction times (RT) in two conditions where categories of Homosexual / Heterosexual and Good / Bad were combined pairwise. Homonegativity was inferred by assessing the difference between mean RTs in Homosexual & Good (Heterosexual & Bad) and Homosexual & Bad (Heterosexual & Good) pairings. A participant's level of homonegativity is inferred by the sign and magnitude of the IAT Difference score. That is, a greater score of IAT difference would mean increased level of homonegativity. Hence, rather than assigning subjects into categories, homonegativity is taken as a continuous variable in all statistical analyses. Means and standard deviations for mean RT's in both conditions and for the individual difference scores between two conditions are presented in Table 3.

The participants reported high levels of social support in general (M = 66.5172, SD = 11.3094). Most prevalent source of support was found to be "Friends" (M = 25.1356, SD=3.3138), followed by "Significant Others" (M = 22.15, SD = 7.4875). Perceived social support of the "Family" was found to fall way behind other sources of support (M = 19.3729, SD = 6.4538).

Preferred defense style was analyzed through the Immature subscale of DSQ. This subscale yielded a wide range of distribution with M = 4.1476, SD = 1,0672. In the analyses, defense style was also treated as a continuous variable where a higher score in Immature scale referred

to more frequent or intense of defense mechanisms classified as Immature.

Reports of psychological well-being were clustered into three domains. Symptom checklist results were adjusted on the basis of number of items in each category. Adjusted results, obtained by the division of mean score by number of items in each category, revealed that participants were mostly prone to feel depression (M = 15.5, $adjM$ = 1,2917) and hostility (M = 7.5167, $adjM$ = 1.0738) followed by anxiety (M = 12.4, $adjM$ = 0.95). Negative self (M = 10.63, $adjM$ = 0.89) and somatization (M = 5.612, $adjM$ = 0.6241) were less frequently observed. Overall, the prevalence of positive symptoms showed a wide variety ranging between 2 and 51 (M = 24.4) with a mean global severity of 0.975. Participants' self-evaluations were found to have a tendency to become more positively coloured (M = 80.4667, SD = 9.9685). Interpersonal relationship scores were also adjusted as the means scores were not comparable due to uneven distribution of items in subscales. Adjusted scores provided evidence for the fact that subjects reported to have high levels of empathy (M = 28.9167, $adjM$ = 3.2129), high emotional awareness (M = 36.7, $adjM$ = 2.6214) and relatively low approval dependence (M = 27.63, $adjM$ = 1.842) in interpersonal relationships. At the same time, they seemed to have slight problems in trusting others (M = 37.35, $adjM$ = 2.49).

3.3. Analyses Relevant to the Hypotheses

Hypothesis 1: Participants are expected to display high levels of homophobia in Implicit Association Test as evidenced by an increase in reaction time in Homosexual-Good pairing condition and / or a decrease in reaction time in Homosexual-Bad pairing condition.

To test this hypothesis, a paired samples t-test was conducted in order to compare mean RT's in Homosexual-Bad (IAT 4) and Homosexual-Good (IAT 5) conditions. In case of higher levels of homonegativity, subjects would associate the concepts of homosexual and bad more quickly and we would expect to find significantly lower RT's in IAT 4 as compared to IAT 5. The results revealed that, contrary to our initial hypothesis, there was a statistically significant tendency to associate the concepts of homosexual and good together more easily and quickly (M = 1273.6156, SD = 457.1743) than pairing the concepts of homosexual and bad together (M = 1669.3984, SD = 776.0689), $t(59) = 4.993$, $p<.01$.

Hypothesis 2: A weak correlation between explicit and implicit levels of internalized homonegativity is expected.

This hypothesis was tested using Pearson correlation analysis on participants' scores in Hudson-Rickett's Homophobia Scale (HRHS, explicit homonegativity) and difference scores between two conditions of Implicit Association Test (implicit homonegativity).

The results of the analysis revealed that there was no significant correlation, not even a weak one, between the two measures, $r(60) = 0.021, p = \text{n.s.}$

Another Pearson correlation analysis was conducted using mean RT's for two conditions of IAT this time, rather than their difference. Still, no significant correlation was found between HRHS and IAT 4, $r(60) = -0.02, p = \text{n.s.}$, or between HRHS and IAT 5, $r(60) = -0.005, p = \text{n.s.}$

Hypothesis 3: The three domains of psychological well-being are expected to be related with each other.

This hypothesis was tested by a bivariate correlation analysis among Social Comparison Scale (SCS), four subscales of Scale of Dimensions of Interpersonal Relationships (SDIP), and five subscales and three indices of Brief Symptom Inventory (BSI). Related correlation coefficients, supporting the hypothesis, can be seen in Table 4.

As displayed in Table 4, SCS has statistically significant positive correlations with Empathy and Trust in interpersonal relationships, and statistically significant negative correlations with Approval dependency and all subscales of BSI except for Positive Symptom Distress Index.

Trusting Others and Emotional Awareness subscales of SDIP have statistically significant negative correlations with all subscales and indices of BSI. The subscale of

Table 4 *Pearson Correlation Coefficients among Variables of Psychological Well-Being*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. SDIP-Approval	**1**													
2. SDIP-Empathy	**0,082**	**1**												
3. SDIP –Trust	**-0,226**	**,306***	**1**											
4. SDIP-Awareness	**-,315***	**,291***	**,442****	**1**										
5. BSI-Total Symptom	**,400****	**-0,179**	**-,471****	**-,523****	**1**									
6. BSI-Symptom Distress	**0,232**	**-0,024**	**-,577****	**-,298***	**,530****	**1**								
7. BSI-Global Severity	**,371****	**-0,149**	**-,602****	**-,485****	**,907****	**,798****	**1**							
8. BSI-Depression	**,284***	**-0,112**	**-,569****	**-,362****	**,818****	**,747****	**,902****	**1**						
9. BSI-Negative Self	**,426****	**-0,13**	**-,637****	**-,500****	**,806****	**,750****	**,900****	**,789****	**1**					
10. BSI-Somatization	**0,253**	**-0,155**	**-,526****	**-,383****	**,765****	**,706****	**,893****	**,726****	**,715****	**1**				
11. BSI-Hostility	**,259***	**-,256***	**-,484****	**-,490****	**,781****	**,704****	**,878****	**,737****	**,772****	**,789****	**1**			
12. BSI-Anxiety	**,407****	**-0,075**	**-,485****	**-,462****	**,875****	**,680****	**,915****	**,742****	**,762****	**,829****	**,736****	**1**		
13. SCS-Sum	**-,428****	**,284***	**,268***	**0,172**	**-,424****	**-0,204**	**-,403****	**-,404****	**-,397****	**-,293***	**-,334****	**-,356****	**1**	
14. PWB-Comp	**-,605****	**,382****	**,702****	**,673****	**-,829****	**-,527****	**-,809****	**-,718****	**-,793****	**-,659****	**-,699****	**-,746****	**,669****	**1**

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Approval Dependency has significant positive correlations with most components of BSI, except for Positive Symptom Distress Index and Somatization subscale. Empathy in interpersonal relationships is found to have a statistically significant negative correlation with Hostility.

Given that the emphasis in this study was on overall psychological well-being of individuals that involves both level of symptomatic disturbance and perceptions about self, others and relations, rather than focusing on one selected area, a composite well-being score was computed by subtracting Total Symptom Index score from the sum of SCS and SPID-total score. The correlations of composite well-being score was found highly correlated with each single indices of well-being, suggesting that this score yields an accurate representation of overall level of well-being of the individual.

Hypothesis 4: Implicit levels of internalized homonegativity will be negatively correlated with psychological well-being.

In order to evaluate the quality and strength of the relationship between internalized homophobia and psychological well-being, a bivariate correlation analysis was carried out between IAT measures and SCS, four subscales of SDIP, five subscales and three indices of BSI and composite score of well-being. The results of this analysis are summarized in Table 5.

The only statistically significant correlation was found between internalized homonegativity as implied by a decrease in reaction time in homosexual-bad pairing in IAT 4 condition (thereby, a subsequent increase in IAT Difference score), and increased hostility, $r(60) = -0.328$, $p < .05$. No significant relationship was observed between reaction time in homosexual-good pairing in IAT 5 condition and any indicator of psychological well-being.

The composite well-being score was used in following analyses, together with Hostility subscale of BSI which was the sole subscale of psychological well-being that was found to have a significant correlation with internalized homonegativity.

In order for further inquiry, internalized homonegativity scores as calculated by the difference between two conditions in IAT were divided into three groups, labeled as low, moderate and high homonegatives using quartile values. 25% of the participants with the lowest homonegativity scores were categorized as having low homonegatives, 25% with highest scores as high homonegatives and those in the interquartile range as moderate homonegatives. The mean well-being scores for low and high homonegative groups were compared conducting independent samples t-test.

Table 5 *Pearson Correlation Coefficients between measures of Internalized Homonegativity and Psychological Well-Being*

	SCS-Sum	BSI-Anxiety	BSI-Depression	BSI-Negative Self	BSI-Somatization	BSI-Hostility	BSI-Severity	BSI-Total Symptom	BSI-Symptom Distress	SPID-Approval Dependency	SPID-Empathy	SPID-Trust	SPID-Emotional Awareness	PWB
IAT 4 RT-mean (Homosexual & Bad)	,208	-,234	-,150	-,165	-,165	**-,328***	-,225	-,176	-,162	-,154	-,013	-,096	-,077	,111
IAT 5 RT-mean (Homosexual & Good)	,150	-,092	-,110	-,177	-,041	-,174	-,130	-,083	-,129	-,060	,011	-,001	,013	,089
IAT-Difference	-,151	,227	,108	,077	,178	**,285***	,188	,161	,108	,150	,025	,120	,107	-,074

*. Correlation is significant at the 0.05 level (2-tailed).

The results of the t-test failed to provide support for a statistically significant difference between two groups regarding both the composite well-being score $t(28) = 0.835$, p = n.s., and Hostility score $t(28) = -1,637$, p = n.s. Although between-group differences were insignificant, low homonegative group displayed higher levels of psychological well-being ($M = 137.40$) and lower levels of hostility ($M = 4.74$) as compared to high homonegatives ($M = 126.53$ and $M = 8.47$, respectively). The only statistically significant difference was observed with regard to Total Positive Symptom Index of BSI, $t(28) = -1,336$, $p < .05$. High homonegative group had more psychopathological symptoms ($M = 25.67$)than low homonegatives ($M = 19.67$).

Hypothesis 5: The difference between one's level of internalized homonegativity in implicit and explicit measures will be negatively correlated with psychological well-being.

In order to test this hypothesis, participants were clustered into three categories. This categorization was made on the basis of the z-scores in explicit and implicit measures of homonegativity. The groups were labeled as "explicitly reported", "low incongruency" and "high incongruency".

This grouping was done by the subtraction of z-scores in the explicit measure from the z-score in the implicit measure (IAT difference score). As the excess of implicit homonegativity was hypothesized to be meaningful, only those individuals for whom the

result of this subtraction was positive were included in the analysis. A median-split was used to label the people above the median as "highly incongruent" and those below the median as "lowly incongruent". According to this categorization principle, 17 participants were found to fall into the category of low incongruence while 18 had a high level of incongruence between their explicitly reported and implicitly inferred levels of homonegativity.

To test this hypothesis, one-way ANOVA was conducted with level of incongruency (high incongruency, low incongruency, or explicityly reported homonegativity) as independent variable and composite score of psychological well-being as the dependent variable. The results of the analysis revealed that there was not statistically significant difference between groups in terms of their reported psychological well-being, $F(2,57) = .213$, p = n.s. (Figure 1).

Although the differences between groups were below the threshold of statistical significance, the high incongruency group had the lowest level of psychological well-being ($M = 127.83$) as expected.

Hypothesis 6: 6.a. In line with extant literature, less frequent use of immature defense mechanisms is expected to have a positive correlation with psychological well-being.

This hypothesis was tested by carrying out bivariate correlation analysis between Immature subscale of DSQ and our

composite score for well-being, and Hostility subscale of BSI. In support of our hypothesis, the results revealed a statistically significant negative correlation of the frequency and intensity of immature defense use with psychological well-being $r(60) = -.68, p < .01$ (see Table 6), and a significant positive correlation with Hostility, $r(60) = .58, p < .01$.

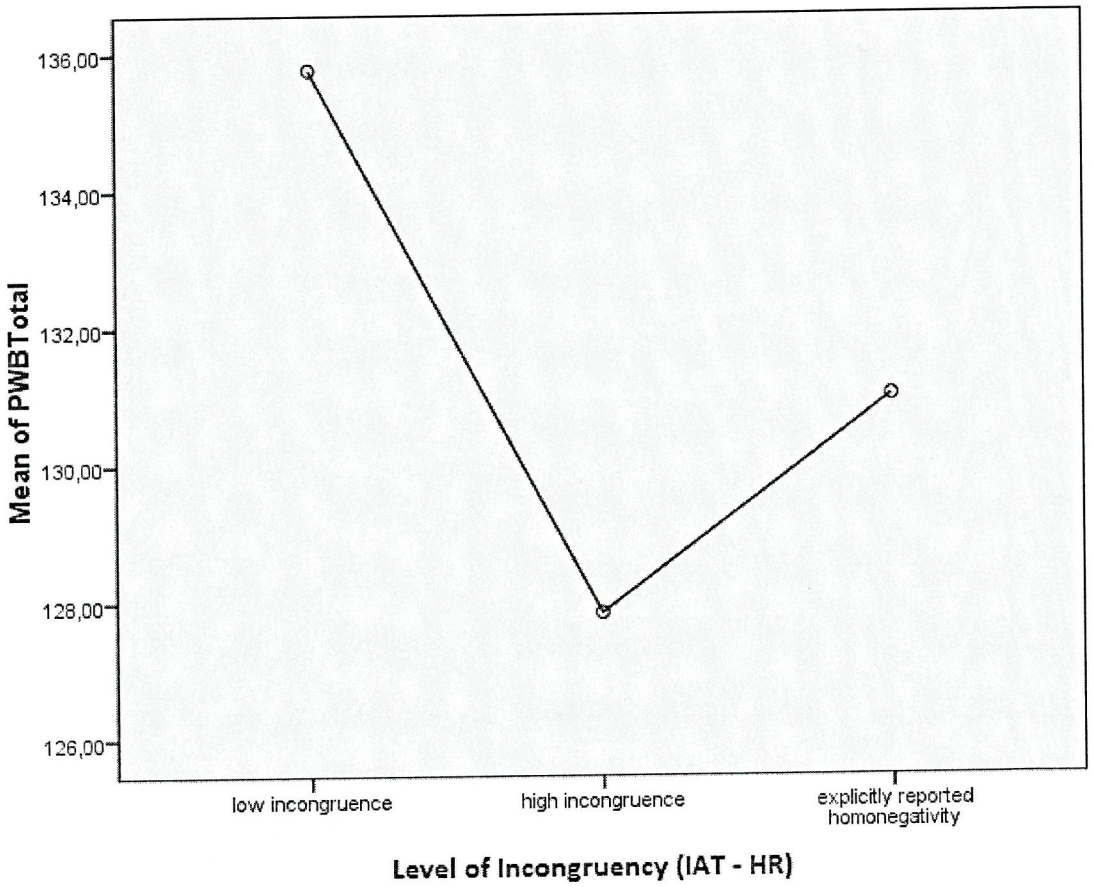


Figure 1 *Means of Composite Well-Being scores for High Incongruence, Low Incongruence and Explicitly Reported Homonegativity Groups*

6.b. Perceived social support is expected to have a positive correlation with psychological well-being.

A bivariate correlational analysis was conducted between three subscales and total score of MSPSS and our composite score for well-being. The results provided support for the hypothesis as perceived social support from both family, friends and significant others, and thereby total amount of perceived support, were found to be positively correlated with a sense of well-being. Related correlation coefficients are presented in Table 6.

Besides, for each subscale of MSPSS, participants were divided by a mean split into two groups of high and low support from the given source and group means were compared using independent samples t-test. Results revealed that the level of psychological well-being was significantly higher for participants with high family support (M = 145.13) as compared to those with low family support (M = 115.37), $t(57)$ = -3.46, $p < .01$. In the same vein, participants who received more social support from a significant person displayed higher levels of psychological well-being (M = 139.45) than those who received less support (M = 117.50), $t(58)$ = -2.39, $p < .05$. The discrepancy between participants with high (M = 136.44) and low (M = 122.17) friend support was not statistically significant $t(57)$ = -1.51, p = n.s.

6.c. The use of more mature defense mechanisms and level of perceived support are expected to be related to each other.

The results of the correlation analysis supported our hypothesis, indicating a significant negative correlation between level of perceived support and use of immature defenses, $r(58) = -.319$, $p < .05$ (see Table 6 for a detailed list).

Table 6 *Pearson Correlation Coefficients between perceived social support, immature defense use and psychological well-being*

	1	2	3	4	5	6
1. Composite Well-Being	**1**					
2. MSPSS-Family	**,433****	**1**				
3. MSPSS-Friend	**,290***	**,019**	**1**			
4. MSPSS-Significant Other	**,353****	**,055**	**,212**	**1**		
5. MSPSS-Total	**,569****	**,619****	**,447****	**,764****	**1**	
6. DSQ-Immature	**-,682****	**-,420****	**-,042**	**-,096**	**-,319***	**1**

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed)

Hypothesis 7: The use of more mature defense mechanisms and level of perceived support are expected to mediate the relation between internalized homonegativity and psychological well-being.

Previous analyses aforementioned above showed that there was not a significant correlation between internalized homonegativity and measures of psychological well-being except for the hostility scale. Thus, mediation effects could not be tested.

3.4. Additional Analysis of Moderation Effect

In addition to the analyses relevant to the hypotheses, two univariate analyses of variance was conducted to examine possible moderator effects of immature defense use and perceived level of social support on the relationship between internalized homonegativity and psychological well-being. For the transformation of the continuous variables of internalized homonegativity, perceived social support and immature defense use into categorical variables, the sample was split into two halves using the mean score. The indices of psychological well-being were both our composite well-being score and Hostility subscale of BSI.

First moderation analysis concerned the exploration of the moderator effect of immature defense use. Results indicated a significant main effect of the level of immature defense use, $F(1,56) = 19.21, p < .01$, but not of internalized homonegativity, $F(1,56) = .02, p =$ n.s, on psychological well-being. The main effect of immature defense use was qualified by a significant interaction between the two factors, $F(1,56) = 6.64$, $p = .01$, indicating that the effects of level of immature defense use differed for individuals in different categories of homonegativity (see Figure 2). The impact of an increase or decrease in the intensity and frequency of immature defense use seemed to have a more pronounced affect for individuals with higher levels of homonegativity. The repetition of this analysis with Hostility subscale of BSI as the index of

psychological well-being revealed again a significant main effect both for the level of immature defense use ($F(1,55) = 9.90, p < .01$) but not for homonegativity ($F(1,55) = 1.09, p =$ n.s), or interaction ($F(1,55) = 1.18, p =$ n.s.

Figure 2 *Estimated marginal means of composite Psychological Well-Being scores according to Homonegativity categories by level of Immature defense use*

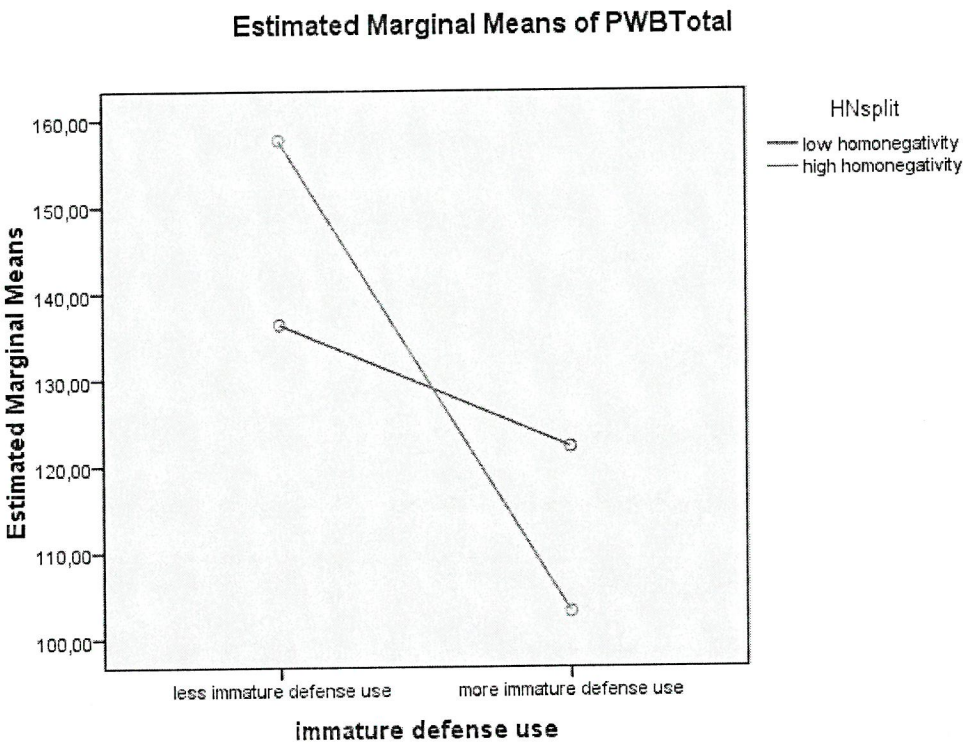
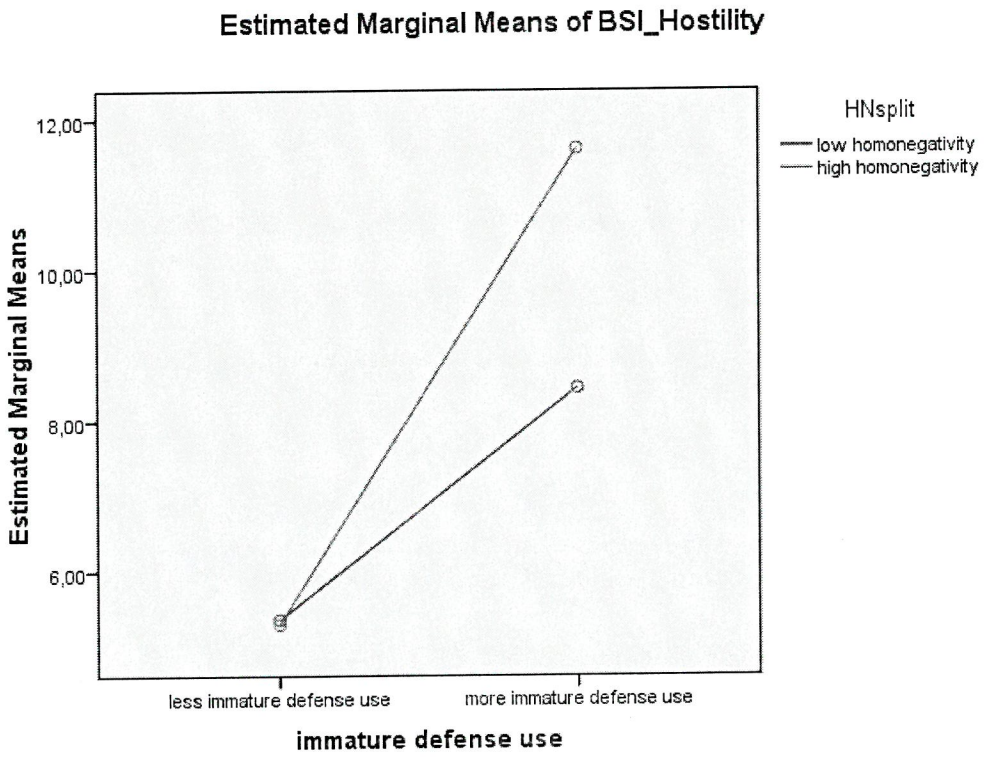


Figure 3 *Estimated marginal means of Hostility according to Homonegativity categories by level of Immature defense use*



The second moderation analysis concerned the exploration of the moderator effect of perceived level of social support on the relationship between internalized homonegativity and psychological well-being. Results indicated a significant main effect of level of perceived social support on psychological well-being, $F(1,54) = 18.61, p < .01$, with no main effect of level of homonegativity ($F(1,54) = .34, p$ = n.s) or no interaction between the two factors, F(1,54) = 1.95, p = n.s. (see Figure 4). The repetition of this analysis with Hostility subscale of BSI as the index of psychological well-being also revealed only a significant main effect of perceived support, $F(1,53) = 7.97, p < .01$ (see Figure 5). To

investigate the relationship in the other direction, one last analysis was conducted. This analysis concerned an independent samples t-test between more and less hostile groups in terms of their levels of total perceived support. The results of the t-test suggested that individuals with high levels of hostility reported lower levels of perceived social support ($M = 68.92$) as compared to those with low levels of hostility ($M = 62.59$), $t(56) = 2.13, p < .05$.

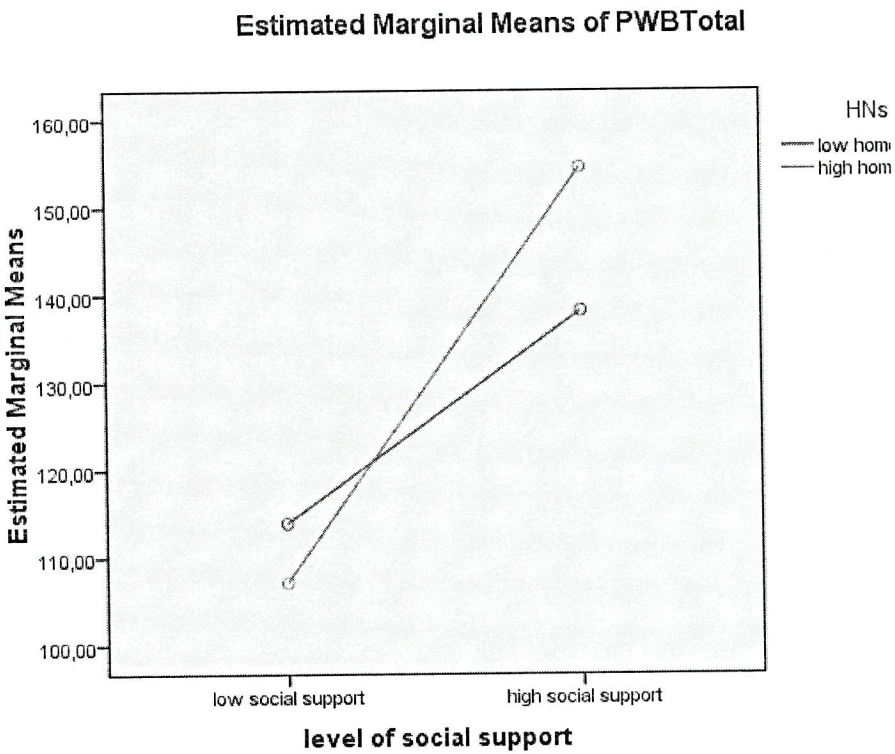


Figure 4 *Estimated marginal means of Psychological Well-Being according to Homonegativity categories by level of Perceived Social Support*

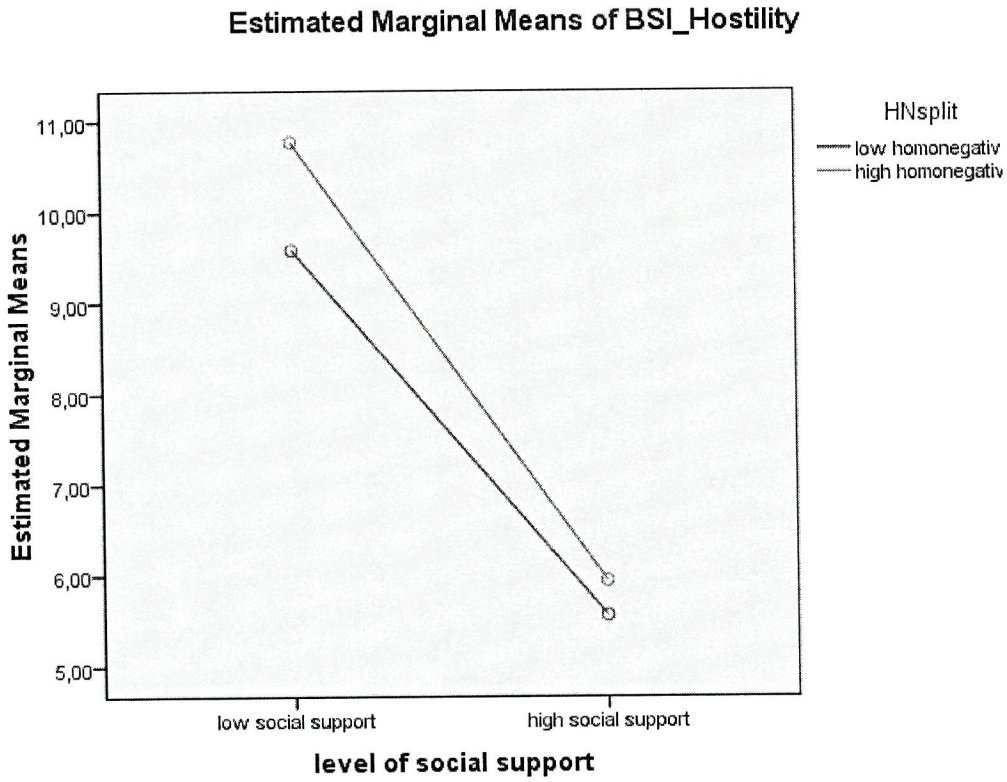


Figure 5 *Estimated marginal means of Hostility according to Homonegativity categories by level of Perceived Social Support*

3.5. General Summary of the Results

The present study aimed to investigate the possible mediating role of perceived social support and level of preferred defense mechanisms in the relationship between internalized homonegativity and psychological well-being. However, as the results of the analyses failed to provide support for a significant relationship between internalized homonegativity and psychological well-being, except for the dimension of hostility, a mediation analysis was rendered invalid.

Statistical analyses inquiring the role of perceived social support on psychological well-being revealed that, individuals with higher levels of perceived social support, especially from the family and significant others, and who uses immature defense mechanisms with less intensity and less frequency displayed higher levels of psychological well-being in all three domains, that is, as regards their self-perception, functioning in interpersonal relationships and symptomatic disturbance.

Instead of a mediation, a moderation model was supported for the relationship between internalized homonegativity, level of preferred defense mechanisms and psychological well-being.

Although internalized homophobia by itself did not have a significant main effect on psychological well-being, its interaction with the level of immature defense use was significant, suggesting that the protective and even recuperative effects of a a decrease in the use of immature defense mechanisms which are substituted by more mature and adaptive ones, differed between the groups with more and less homonegativity. Less

homonegative individuals seemed to be the less affected from the benefits of decreased use of immature defenses. The importance of a relative emancipation from a heavy reliance on immature defenses was especially notable for individuals categorized as more homonegatives.

4. Discussion

The major aim of this study was to contribute to the understanding of the difficulties embedded in the experience of growing up as homosexual and developing a gay or lesbian identity in the heterosexist culture of Turkey. Residing at the point of intersection of multiple disciplines, especially political sciences, law, sociology and psychology, the multidimensionality of this issue on minority rights was remunerated by exploring the relationships between several constructs of internalized homonegativity, perceived social support, level of preferred defense mechanisms and psychological well-being.

4.1. Discussion of Descriptive Findings:

Results suggested that the sample was rather a homogenous group, consisting solely of individuals with an undergraduate or graduate degree and belonging to mid to high socioeconomic class. Nearly all (58 participants out of 60) identified themselves with the upmost stages of homosexual identity development and coming out process.

Participants in general reported to have high levels of social support. The most prominent and steady source of support was found to be friends, followed by other significant people and family members. Indeed, as all participants reported to receive mid to high levels of social support from

friends, there was a much wider range for other two sources of support. An explanation for the primacy of friends may be relevant to the age characteristics of the sample consisting mainly of late adolescents and young adults given that the optimal source of support shifts from family to friends towards the end of adolescence period (Stice, Ragan & Randall, 2004). Apart from age, it may be due to the greater importance of close friends constituting the "chosen family" which is valued over biological family for LGBT individuals. Friend (1990) explains this preference of friends over family as follows: "...connectedness to others like oneself offers an environment that does not need to be defended, explained or justified".

Participants in the present sample also reported relatively higher levels of psychological well-being in all three domains of self-perception, interpersonal relationships and symptomatic disturbance, as compared to the findings of other studies on the prevalence of mental health problems in LBGT populations (Meyer, 2003). They displayed a tendency to evaluate themselves in a positive light and identify with positively valenced adjectives. Their psychological symptoms were slightly elevated from the norms but still within the normal range. They were also high functioning in social relationships.

Taken together, the demographic characteristics, high levels of social support and high levels of psychological well-being suggest that the present sample might have had a specific participant profile. Paralleling the cautions of Meyer and Colten (1999), consisting mainly of individuals who are

highly affiliated with radical LGBT organizations and contacted through the gay community, participants in the final sample might have been those people who have lower levels of internalized homophobia and psychological problems, endorse similar positive attitudes about homosexuality and enjoy higher social support, especially from family. Hence, the results obtained in this study may not encompass all LGBT populations, but rather, be representative of only the most politically activist and open out segments of gay and lesbian community. This point should always be kept in mind while interpreting the results.

4.2. Discussion of Main Findings:

4.2.1. Internalized Homonegativity

Internalization of the social stigma about homosexuality is one of the essential constituents of Minority Stress Theory. Meyer (1995), drawing on former theoretical discussions and empirical findings, asserts that although its intensity may decrease over time with the progression of the individual in the coming-out process and with the formation and strengthening of his or her identity as a homosexual, internalized homophobia is always there. Hence, in the present study, it was also assumed that all participants would display internalized homophobia at different levels and internalized homonegativity was considered as a continuous variable. The positions of "no homonegativity at all" or "totally homonegative" were not taken into consideration on the basis of Freud's assertion that human beings are all ambivalent in their every emotion, attitude

and behavior (Freud, 1918) and this ambivalence, indeed, is an indication of psychological health (Schulz, 2002). Besides, internalized homonegativity is conceptualized as an all-encompassing developmental outcome for lesbian and gay individuals (Shidlo, 1994).

At group level, the level of homonegativity was low and there was rather a tendency to associate homosexuality with the concept of "good" more easily, yielding two alternative explanations.

The first explanation concerns the sample characteristics. As nearly all participants have progressed through the stages of coming-out process, they might have acquired identity valence which led to self-acceptance and feeling of ease with one's homosexuality, thereby, to the abatement of internalized homophobia (Coleman, 1981-1982).

The second explanation may be grounded on another theoretical concept called "ingroup bias". According to this concept, homosexual individuals may, rather than directing the social stigma towards their self, develop a psychological primacy as characterized by feelings of familiarity, intimacy and attachment for their ingroup members (Brewer, 1999). The tendency, in present study, for an ingroup favouritism in the form of relatively more positive attitudes toward homosexual people as compared to heterosexuals, replicates the findings of previous studies on group dynamics (Jellison, McConnell, & Gabriel, 2004).

In this group, individuals were scattered along a continuum and labeled as low, moderate or high homonegatives on the basis of their relative position as compared to the group mean in the implicit homonegativity measure.

4.2.1.1. Implicit and Explicit Measurement of Homonegativity

The correspondence between implicit and explicit measures of attitudes, especially about the prejudice and discrimination against certain groups in society, had already been questioned by many researchers (Greenwald, McGhee & Schwartz, 1998) advocating the use of implicit measures. Indeed, the gap between explicit and implicit measures are claimed to enlarge for sensitive topics for which social desirability concerns are high and in social contexts where egalitarian and democratic political views prevail (Clarke, Ellis, Peel, & Riggs, 2010).

Given the difficulty of expressing homonegative attitudes and behaviours for an individual who identifies himself or herself as homosexual, in our study, a large gap was expected between implicit and explicit measures as evidenced by a weak correlation. Indeed, the results of the correlation analysis failed to provide evidence even for a significant weak correlation between two constructs.

Indeed, explicit measure of homonegativity (HRHS) is likely to have produced a "floor effect" as all participants scored as "non-homonegative". This floor effect may stem again from the sample

characteristics, that is, it is a possibility that subjects did not endorse much negative attitudes about homosexuality. Yet, given the fact that there was some variation across individuals in IAT, this floor effect might better be attributed to the characteristics of the scale that seems to have led to a response bias among participants. In addition to the possible confounding effects of social desirability concerns, the answers of participants might have also been influenced by an extreme response bias. Participants had a tendency either to totally agree or totally disagree with the statements. This issue might be resolved by a modification of the wording of the statements. Indeed, another problem with HRHS concerns the load of unwarranted assumptions concealed in questions on issues like religiosity, family structure. Still another problem, addressed by a number of participants during data collection, is about the item 19 in which participants had much confusion in making a distinction between jealousy towards their partner and their attitudes on homosexuality. Unless these problems are resolved, although the scale yields high reliability scores, its validity may be impaired and the scale may fail to measure homonegativity as it intends to.

4.2.1.2. Internalized Homonegativity and Psychological Well-Being

Both the implicit and explicit measures of internalized homonegativity werefound to have a significant correlation with the

Hostility subscale of BSI. Indeed, a tendency to associate the concepts of Homosexual and Bad more rapidly in IAT and a higher score in HRHS predicted a higher Hostility score. Neither any other single indices by itself of nor our composite score for psychological well-being had a meaningful relationship with the level of internalized homonegativity.

Although the differences between low and high homonegativity groups were below the threshold of statistical significance, low homonegative group displayed higher levels of psychological well-being and lower levels of hostility, suggesting a possible relation between the two factors. The present study may have failed to find evidence for this relation due to a number of factors. The first factor concerns the problem of restricted range. As the sample involved a relatively homogenous group of participants with scores clustered in a narrow range, the obtained values of correlation coefficients might have been distorted, underestimating the true degree of relationship between two factors. Indeed, even the discrepancy between the lowest and highest quartiles was not very pronounced, hence, such an artificial grouping for independent samples t-test might have been inadequate to detect any statistically significant difference. With a more diverse sample representing a broader range of homonegativity scores, a stronger relationship would have emerged.

The Hostility subscale of BSI was the sole indicator of well-being that was found to have a meaningful positive correlation with both implicit and explicit measures of homonegativity. Hostility, consisting of cognitive, affective and behavioural components, is characterized by cynical mistrust, rage and aggressive verbal and physical acts aiming to harm others, respectively (Geipert, 2007). This increased tendency for aggression and violence accompanying higher levels of homonegativity might be interpreted in relation to a vulnerability of the self (Harter, 1999). Although the participants in high homonegativity group also reported explicitly to have a favourable sense of self in SCS, this high self-esteem may not be an accurate reflection of their inner uncertainty and instability as to their worth as a person and their relentless preoccupation in quest for affirming self-worth in the presence of self-stigmatization about homosexuality. Indeed, such fragile self-esteem, concealed behind a persona of a rather inflated self-confidence, results in an insecurity and vulnerability for narcissistic injuries the defense against which takes the form of anger, aggression and violent destruction (Harter, Low & Whitesell, 2003), conceptualized by Kohut as "narcissistic rage" (1972).. In light of McWilliams' (1994) emphasis on the preponderance of feelings of shame in individuals with narcissistic tendencies, together with some research evidence for a mediating role of feelings of shame and humiliation on the relationship between narcissistic fragility and hostile aggression (Harter, 1999;

Dost & Yagmurlu, 2008), the role of narcissistic tendencies and shame-proness seems to require further research in order for an in-depth understanding of increased hostility in individuals with high internalized homonegativity.

4.2.2. Perceived Social Support and Psychological Well-Being

Parallel with the existing literature, the beneficial effects of perceived social support on psychological well-being have been supported by the findings obtained in this study. Although the overall level of social support was found to be a strong predictor of psychological well-being, the source of the support also seemed to make a difference. Indeed, perceived social support from family and significant other had higher correlation coefficients with psychological wellbeing scores compared to perceived support from friends. This relative primacy of family and significant others, mostly romantic partners, has already been suggested by previous research (Stice, Ragan & Randall, 2004; Shulman, Kalnitzki & Shahar, 2009; Tam & Lim, 2009). Several explanations have been suggested to account for the differential impact of support from different sources. First explanation concerns the distinct functions different types of support may fulfill. According to this view, while friend support serves to strengthen the social integration, support from family members and romantic partners satisfies the need for attachment, intimacy and emotional support (Pettit, Roberts, Lewinsohn, Seeley & Yaroslavsky, 2011). Another explanation

emphasizes the temporal stability and higher quality of parental support as it is much less likely to display transitions and erosions over time (Stice, Ragan & Randall, 2004). A third explanation, following Blos' (1967) conceptualization of adolescence the second individuation process, emphasizes the parallels between rapprochement phase in early childhood and developmental challenges of emerging adulthood (Pettit, Roberts, Lewinsohn, Seeley & Yaroslavsky, 2011). This explanation suggests that, in order for an emerging adult to form an identity autonomous from but still connected to the family of origin, one first has to feel attached to and supported by one's family. Although above explanations are all plausible for clarifying the importance of support from family and members and other significant people, the importance of peer support for the participants in present study should not be underestimated. Given that friends were the most prevalent source of support for all participants, the rates of friend support varied between mid and high levels, leading to the emergence of a restricted range for this variable. Hence, the difference between low and high friend support group was not salient which may be the real reason underlying the absence of a statistically significant difference between the level of psychological well-being of individuals with low as opposed to high friend support.

Besides, the lack of significant correlations among three subscales of MSPSS might be interpreted as contradicting previous

research evidence on the stability of support perceptions across various sources due to its inherent connection to one's internal working models of attachment (Bowlby, 1969; Ammaniti & Sergi, 2003).

Alternatively, the relation between perceived social support and psychological well-being may also be bidirectional, implying that, perceived social support leading to higher levels of psychological well-being may not be the only interpretation possible. Indeed, it may be the case that one's current level of psychological well-being may distort, rather enhance or undermine, one's support perceptions (Pettit, Roberts, Lewinsohn, Seeley & Yaroslavsky, 2011). In this case, the causal relationship in between these factors is rather ambiguous, precluding an accurate inference of causality.

4.2.3. Level of Preferred Defense Mechanisms and Psychological Well-Being

The findings of the present study revealed a significant negative correlation of psychological well-being with level of immature defense use, implying that participants who use immature defense mechanisms more frequently and more intensely report decreased levels of psychological functioning. This finding is consistent with Cramer's (2006) assertion that although so-called immature defense mechanisms are present in all individuals, it is the intensity of the use of these defenses that differentiates psychological health from psychopathology. In this sense, the main defining feature

of psychological disturbance is not qualitative, but rather quantitative (Costa, Somerfield & McCrae, 1996).

Yet, McWilliams (2004) also adds a qualitative dimension to the definition of psychopathology, suggesting that what defines psychopathology is not only the intense use of immature defenses, but also the absence of secondary defense mechanisms. Following McWilliams' conceptualization, a positive correlation was also expected between the level of use of neurotic, and especially mature, defenses and psychological well-being. Yet, the present study failed to confirm this expectation as Neurotic and Mature subscales of DSQ were not included in statistical analyses due to the deficiencies of the scale characteristics of DSQ. Both the original scale and its Turkish version have yielded less than adequate reliability coefficients for Neurotic (α = .58 and .61, respectively) and Mature (α = .68 and .70, respectively) subscales. The uneven number of items in three subscales, that is, 8 items in each of Neurotic and Mature subscales and 24 items in Immature subscale- aggravated the problem by further complicating any comparison among 3 subscales.

The possible narcissistic vulnerabilities of gay and lesbian populations, especially those with higher levels of negative attitudes against their sexual orientation, were explained above. In line with this narcissistic tendency, an increased level of reliance on the specific primary defense mechanisms of rationalization, denial, projection (Cramer, 2006) and primitive idealization and devaluation

(McWilliams, 1994) might have been expected. Besides, there was a significant positive correlation between immature defense use and Hostility. Drawing on research evidence suggesting an increased risk of violence for individuals who use denial and projection more frequently (Conte, Plutchik & Draguns, 2004), an increased reliance on these two defenses might have been expected among individuals with higher levels of Hostility. However, the fact that DSQ assesses every single immature defense mechanism with only 2 items limits the reliability of any analysis conducted on the basis of individual defense scales (Yılmaz, Gençöz & Ak, 2007), leaving these questions unanswered.

These statistical traps limit the informativeness of DSQ, posing Immature subscale as the only reliable indices for the assessment of defense style. Still, the findings on immature defense use are consistent with previous research evidence suggesting a greater use of immature defenses in patient group as compared to non-patient healthy adjustment groups (Cramer, 2006), and providing evidence for a link between high reliance on immature defenses and poor interpersonal and global functioning (Vaillant & Vaillant, 1992). Yet, the findings of the present study cannot provide any interpretations as to the consequences of neither the mature and neurotic, or secondary, defenses nor specific immature defenses on psychological well-being and Hostility.

4.3. Clinical Implications:

For there is scant literature on psychotherapy with LGBTI populations (Ritter & Terndrup, 2002), one of the major aims of the present study was, first, to understand the specific dynamics through which psychotherapy would avail lesbian and gay individuals, and second, to come up with suggestions as to enhance the efficiency of psychotherapy by modifying it to match the unique sociocultural reality of LGBTI populations. The clinical implications of this study are explained below.

The most important finding concerns the presence of varying levels of homonegativity even in the individuals who belong to the most open-out and activist segments of LGBT population and explicitly claim to be homopositive. This issue of internalized negative attitudes against one's homosexuality should be assessed and worked through in therapy with gay and lesbian clients although the client seems to have completely resolved it.

The findings of the present study did not provide support for a significant direct relation between internalized homonegativity and overall psychological functioning. Although this finding is against the initial hypothesis, it indeed is consistent with existing research evidence suggesting that there is no evidence as to the direct effects of homophobia on the emergence or progression of psychological disturbances (Williamson, 2000). Indeed, homonegativity impacts psychological well-being through its interaction with other factors. The present study also revealed such an interaction effect between internalized homonegativity and level of immature defense use. According to this interaction, the beneficial effects of

a decrease in the reliance on immature defense mechanisms were significantly more pronounced for individuals with higher levels of internalized homonegativity. The implications of this finding become meaningful in light of evidence from psychotherapy outcome research suggesting that successful psychotherapy leads to a decrease in the use of immature defenses (Cramer, 2006). These findings together suggest that, although gay and lesbians with high levels of homonegativity are more likely to suffer from some problems in psychological functioning in case of heavy reliance on immature defenses to deal with their anxiety, they are also more likely to benefit from psychotherapy.

The second finding with primary importance is the significant positive correlation between internalized homonegativity and hostility. Indeed, this finding is very important in two ways. Firstly, as this correlation might be attributed to the narcissistic vulnerabilities of individuals with high levels of internalized homonegativity, psychotherapy would help overcome hostile aggression by encouraging self-acceptance, thereby, internalized homonegativity is diminished (Meyer, 2003), an optimal self-esteem is attained which is characterized by a realistic evaluation of one's strengths and weaknesses (Crocker & Park, 2004), and hostility is settled down. Secondly, as heightened hostility may impair interpersonal functioning and cause an erosion of social support, especially from peers and romantic partners (Stice, Ragan & Randall, 2004), it may lead indirectly to a significant decrease in overall psychological well-being of the individual in the long-run. Besides, increased levels of hostility also constitute a serious

risk factor for psychophysiological, especially cardiac, problems (Geipert, 2007). Hostility may hence end in both physical and psychological problems if no psychological interventions are offered.

4.3.1. Affirmative Psychotherapy:

Above evidence provide support for the need for efficient psychotherapy for lesbian and gay individuals in order to decrease their internalized stigma, feelings of hostility and reliance on immature defenses and to build an enhanced capacity for resiliency. Indeed, what constitutes an efficient psychotherapy for lesbian and gay individuals has been discussed within the psychotherapeutic community, leading to the emergence of LGB affirmative therapies. The therapist's therapeutic approach seems to make no difference as an effective affirmative psychotherapy can be conducted in psychodynamic, cognitive-behavioural, existential, humanistic or any other approach (Falco, 1996) as long as the guidelines presented in Table 7 (APA, 2000) are successfully integrated into the therapy practice. The main objective of these guidelines is to assure that the effectiveness of psychotherapy is not compromised by an explicit or implicit heterosexist bias on the part of the therapist. Affirmative therapy, informed by the context of LGBTI experience and concerned about LGBTI issues, aims to help patients recognize the effects of the pervasive power of societal heterosexism in the form of feelings of internalized stigma, achieve identity valence and self-acceptance (Ritter & Terndrup, 2002; Meyer, 2003).

Indeed, the degree of "affirmativeness" of affirmative therapies has been largely questioned, leading to a conceptual distinction between a weak

Table 7 *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000)*

Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients

Attitudes toward Homosexuality and Bisexuality

Guideline 1: Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.
Guideline 2: Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.
Guideline 3: Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.
Guideline 4: Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process.

Relationships and Families

Guideline 5: Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.
Guideline 6: Psychologists strive to understand the particular circumstances and challenges faced by lesbian, gay, and bisexual parents.
Guideline 7: Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.
Guideline 8: Psychologists strive to understand how a person's homosexual or bisexual orientation may have an impact on his or her family of origin and the relationship to that family of origin.

Issues of Diversity

Guideline 9: Psychologists are encouraged to recognize the particular life issues or challenges that are related to multiple and often conflicting cultural norms, values, and beliefs that lesbian, gay, and bisexual members of racial and ethnic minorities face.
Guideline 10: Psychologists are encouraged to recognize the particular challenges that bisexual individuals experience.
Guideline 11: Psychologists strive to understand the special problems and risks that exist for lesbian, gay, and bisexual youth.
Guideline 12: Psychologists consider generational differences within lesbian, gay, and bisexual populations and the particular challenges that lesbian, gay, and bisexual older adults may experience.
Guideline 13: Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals experience with physical, sensory, and cognitive-emotional disabilities.

Education

Guideline 14: Psychologists support the provision of professional education and training on lesbian, gay, and bisexual issues.
Guideline 15: Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.
Guideline 16: Psychologists make reasonable efforts to familiarize themselves with relevant mental health, educational, and community resources for lesbian, gay, and bisexual people.

version called "ethically affirmative" and a stronger version labeled as "LGB affirmative" therapies (Langridge, 2007):

> *"The weak version could be thought of as "ethically affirmative" therapy; it is concerned with a form of practice with LGB clients, which is ethical in the full sense of that term. This results in a form of therapy where LGB identities are valued equally with heterosexual identities, giving due consideration to LGB cultures and the unique problems that such clients may bring to therapy. The strong version, termed here "LGB affirmative" therapy, adopts a more radical notion in which a therapist may engage in affirming responses to elements in the expression of LGB identities. The therapist not only recognizes and values an LGB identity, but also uses positive affirmation to directly ameliorate the effects of heterosexism (p.30)"*

The distinction above makes clear that the weak version is indeed the ethically appropriate frame of reference for psychotherapy with lesbian and gay clients, put forward by the Council of Representatives of the American Psychological Association (APA, 2000) and based on the primary principle of respect for the integrity of the client (Davies, 1996). The more radical version is irreconcilable with, and even contradictory to, the principle of therapeutic neutrality in psychodynamic, humanistic and existential approaches, the proponents of which raise doubts as to the potential adverse effects of the projection of the therapist's, although liberal and supportive,

agenda on the process of construction of an appropriate lesbian or gay identity on the part of the client (Cross, 2001).

Thus, an efficient psychotherapy practice with lesbian and gay individuals seems indeed to embody an ethically affirmative approach in which LGB identities and culture are valued but not actively encouraged or provoked, leaving space for the doubts and questions of the patient.

4.4. Limitations and Implications for Future Research

The main limitation of this study concerns the sample characteristics. The uniformity of participant profile might be most probably related to the sampling procedure employed in this study. Participants were all contacted through the gay community of the two big cities of Turkey, İstanbul and Ankara, hence, they were highly involved in political activism for minority rights, affiliated with LGBT organizations and surrounded by a safe and explicitly gay-affirmative social network. Besides, their educational and vocational qualifications provided them with some autonomy and independence from the family. Recruiting a convenience sample from such biased sources in homosexual community means the exclusion of those segments of gay and lesbian population who are either distressed or confused about their sexual orientation and in the earlier stages of homosexual identity development and coming out processes, or unaffiliated with other people with same sexual orientation and with the larger LGBTI community due to lack of either personal resources such as assertiveness or financial or residential difficulties. Having a more diverse and larger sample would have broadened the range of participants, yielding results that would

be more generalizable to the lesbian and gay community as a whole. Future research may overcome this issue by using other sampling techniques such as Random Digit Dialing suggested by Meyer and Colten (1999) to reduce sampling bias in research on LGBTI populations.

Another important limitation of the present study concerned the inability of DSQ to assess the use of mature and neurotic defense styles, and of individual defense mechanisms. Further studies might use other assessment techniques of defenses such as Life Style Index (LSI), Defense Mechanism Inventory (DMI) or, at best, Defense Mechanism Manual (DMM) in order to have a better understanding of the functioning of ego defenses of participants. Indeed, DMM would present the most optimal option as all other measures rely on the self-report of participants while DMM uses a narrative approach in which the information about the participant's defense use is gathered through one's stories which are thought to reflect one's inner world including all his or her deepest wishes, fears and conflicts (Cramer, 2006).

Although all the initial hypotheses were not supported by the findings of the statistical analyses, the present study had some major theoretical and clinical implications as discussed in detail above. Further investigation of these contributions is of major importance for an in-depth understanding of unique risk and resilience factors impacting lesbian and gay individuals, and thereby, for the development of efficient prevention and intervention strategies to promote their feelings of well-being.

First point that considers further attention is the finding on ingroup favouritism. Brewer (1999) suggests that, although ingroup love and attachment does not necessarily lead to outgroup hate, hostility towards outgroup members is triggered when the intergroup relations are conflict-based and influenced by power differentials. In the context of lesbian and gay subculture, hence, social differentiation that relegates LGBTI groups to the minority status in society and leads to their politicization, may be considered as important risk factors for the escalation of hate and hostility towards members of the dominant heterosexual culture. Further studies should investigate whether ingroup preference and outgroup discrimination coexist in lesbian and gay individuals, together with an inquiry into the possible solutions to promote intergroup cohesion.

Second point that deserves further inquiry is the concept of Hostility, together with its precursors and consequences. Indeed, given its direct strong relationship with internalized homonegativity, future research may choose to focus specifically on this construct and use measures designed for the assessment of hostility. As regards the antecedents of hostility, the role of narcissistic vulnerabilities related to a fragile sense of self and shame-proneness should also be studied. Taking together the present findings on the correlation between internalized homonegativity and hostility, and the fact that previous research on hostility focus mostly on the evidence that hostile individuals become more likely to engage in negative healthy behaviours (Everson, Kauhanen, Kaplan, Goldberg, Julkunen, Tuomilehto & Salonen, 1997) and more susceptible to physical health, especially cardio-

vascular, problems due both to their neglect and to physiological stress responses in the body (Geipert, 2007; Miller, Smith, Turner, Guijarro & Hallet, 1996); future research studying the effects of internalized homonegativity might better include an assessment of the physical health of the participants as well.

5. Conclusion

The present study concerned an important but small contribution for the visibility of LGBTI individuals and culture in academia which is rather blind to the issue as evidenced by the scarcity of literature on the psychology of lesbian, gay, bisexual and transgender individuals in Turkey. Drawing on previous research evidence suggesting an inverse relation between internalized homonegativity and psychological well-being in lesbian and gay individuals, and together with an acknowledgement of its complexity, this relation was addressed by taking into consideration the possible effects of perceived social support and level of preferred defense mechanisms.

Analyses revealed that, although internalized homonegativity did not have a direct negative effect on overall psychological well-being, it was related with an escalation of hostile aggression. Besides, both higher levels of social support and lower reliance on immature defense use predicted higher levels of well-being. In addition, although an increase in the level of perceived social support, especially from family members and significant others, had a positive influence on all individuals, independent of their levels of internalized homonegativity; the positive impact of a decrease in

the frequency and intensity of immature defense use differed for individuals with high and low homonegativity scores: The favorable effects of a decrease in immature defense use were more pronounced for individuals with higher levels of internalized homonegativity.

These findings suggest a number of things. First, considering the fact that higher levels of hostility lead to an erosion of the social support from rather more unstable sources of friends and significant others over time, and that a decrease in social support impairs psychological functioning, it can be said that internalized homonegativity has an indirect negative effect on psychological well-being. Secondly, the provisioning of supportive and nurturing environments for all lesbian and gay people is very important to promote their well-being. Thirdly, a decrease in the reliance on immature defenses to deal with internal and external stressors enhances a sense of goodness, reducing the risk of psychopathology.

In light of above evidence, two solutions become prominent. At individual level, internalized homonegativity has to be dealt with through ethically affirmative psychotherapy. Yet, a more radical and permanent solution would be a comprehensive social transformation by waging a war against cultural and institutional heterosexism prevailing in all layers of society. Indeed, although the psychological problems of lesbian and gay people should be addressed by academicians and professionals working in the field of mental health, it should be acknowledged that the roots of the problem do not lie in the individuals, but in the larger sociopolitical system based on inequality.

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APPENDICES

Appendix A

Demographic Information Form

(Demografik Bilgi Formu)

Katılımcı No:

Adınızın ve Soyadınızın Baş Harfleri:

Yaşınız:

Cinsiyetiniz: ☐ Kadın ☐ Erkek

Eğitim Durumunuz: ☐ İlköğretim
☐ Lise
☐ Üniversite
☐ Yüksek Lisans/Doktora

Çalışma Durumunuz: ☐ Çalışıyorum. ☐ Çalışmıyorum.

Aylık Ortalama Geliriniz: ☐ 0 TL
☐ 1 – 1000 TL
☐ 1000 – 3000 TL
☐ 3000 TL ve üzeri

Kendinizi en yakın hissettiğiniz kişi: ☐ Aile bireylerinden biri: .....
☐ Arkadaş
☐ Romantik – cinsel partner
☐ Diğer: .....

Cinsel yöneliminiz ile ilgili : ☐ Tamamen açığım.
☐ Kısmen açığım.
☐ Kapalıyım.

Appendix B

Consent Form

(Onam Formu)

Sayın Katılımcı;
Bu çalışma Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi ve araştırma görevlisi olan Hilal Akekmekçi tarafından Prof. Dr. Hale Bolak Boratav danışmanlığında, cinselliğe dair tutumlar ile psikolojik iyi olma hali arasındaki ilişkinin incelenmesi amacıyla, yüksek lisans tezi kapsamında yürütülmektedir.

Çalışma kapsamında sizden bilgisayar ve kağıt kalem kullanarak bazı görevleri tamamlamanız beklenecektir. Bu amaçla hazırlanan çalışma paketinde, her bölümün başında, ilgili bölümdeki ölçeğin nasıl cevaplanacağı konusunda bilgi verilmiştir. Verilen bilgi dışında bir sorunuz olursa araştırmacıya sorabilirsiniz. Paketin cevaplanması yaklaşık 45 dakika sürmekte olup herhangi bir süre kısıtlaması bulunmamaktadır.

Bu çalışma kapsamında verecek olduğunuz tüm bilgiler tamamen gizli kalacaktır. Çalışmanın hiçbir bölümünde isminiz veya kimliğinizi ortaya çıkaran herhangi bir soru bulunmamaktadır. Doldurduğunuz anketlere verdiğiniz cevaplar ve araştırma süresince bilgisayar kullanılarak edinilen her türlü bilgi yalnızca bilimsel amaçlar için kullanılacaktır. Bilgileriniz hiçbir kimse ile ya da ticari bir amaç için paylaşılmayacaktır. Çalışmanın objektif olması ve elde edilecek sonuçların güvenirliği bakımından uygulama süresinde içtenlikle duygu ve düşüncelerinizi yansıtacak yanıtlar vermeniz önemlidir.

Çalışmaya katılım tamamiyle gönüllülük esasına dayanmaktadır. Anket genel olarak, kişisel rahatsızlık verecek sorular içermemektedir ancak, katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, cevaplama işini istediğiniz anda bırakmakta serbestsiniz. Verdiğiniz bilgiler gizli tutulacak ve sadece araştırmacılar tarafından değerlendirilecektir; elde edilecek bilgiler bilimsel yayımlarda kullanılabilir.

Çalışma hakkında daha fazla bilgi almak için Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı Araştırma Görevlisi Hilal Akekmekçi (Tel: 212 311 76 20; e-posta: hilal.akekmekci@bilgi.edu.tr) veya Prof. Dr. Hale Bolak Boratav (e-posta: hale.boratav@bilgi.edu.tr) ile iletişim kurabilirsiniz.

Bu bilgilendirilmiş olur belgesini okudum ve anladım. Çalışmaya katılmayı kabul ediyor ve bu onam belgesini kendi hür irademle imzalıyorum. Araştırmacı saklamam için bu belgenin bir kopyasını bana teslim etmiştir.

Katılımcının Adı-Soyadı ve İmzası:_____

Ekteki anketleri doldurmanız ve araştırmacıya teslim etmeniz durumunda, uygulamayı istediğiniz zaman bırakabileceğinizi bildiğiniz, çalışmaya tamamen gönüllü olarak katıldığınız ve çalışmanın bilimsel amaçlı yayımlarda kullanılmasını kabul ettiğiniz varsayılacaktır.

Appendix C

Stage Allocation Measure

(Evre Tayin Ölçeği)

Bu soru formunda İKİ aşama bulunmaktadır.

1.AŞAMA

1. Bundan sonraki iki sayfada YEDİ tip insan tanımlanmıştır.
2. Her tanımı dikkatlice okuyunuz ve sizin ŞU ANDAKİ durumunuza en iyi uyanı işaretleyiniz. Bu tanımın yanındaki kutuya bir çarpı işaret [X] koyunuz.
3. Eğer tanımlardan hiçbiri size tam olarak benzemiyorsa, şu anda sizi EN FAZLA tanımlayanı seçiniz.
4. Tanımlardan birini seçmelisiniz.

[ ] 1. Heteroseksüel olduğunuza inanıyorsunuz ve bunu hiçbir zaman sorgulamazsınız. Belki de nadiren ben gey/lezbiyen miyim diye merak etmiş olabilirsiniz. Geyliğin/lezbiyenliğin kişisel olarak sizinle herhangi bir ilgisi olduğuna inanmıyorsunuz.

[ ] 2. Kim olduğunuzdan emin değilsiniz. Ne tür bir insan olduğunuz ve hayatınızın nereye gittiği hakkında kafanız karışıktır. Kendinize "Ben kimim? "Benim gey/lezbiyen olmam mümkün mü?", "Ben gerçekten heteroseksüel bir insan mıyım?" gibi sorular sorarsınız. Bazen bir gey/lezbiyen gibi hissediyor, düşünüyor ya da davranıyorsunuz ama nadiren, şayet olduysa, bunun hakkında herhangi biriyle konuşursunuz. Geyliğin/lezbiyenliğin kişisel olarak sizinle bir ilgisi olduğundan oldukça eminsiniz. "Gey/lezbiyen olabilirim" deme noktasında olabilirsiniz.

[ ] 3. Kesinlikle emin olmamanıza rağmen *muhtemelen* gey/lezbiyen olduğunuzu hissetmeye başlıyorsunuz. Bunun sizi diğer insanlardan farklı kıldığını fark ediyor ve mesafeli ya da onlardan kopmuş hissediyorsunuz. Farklı olmayı sevebilirsiniz veya bunu sevmeyip kendinizi çok yalnız hissedebilirsiniz. Farklı hissetmek hakkında biriyle konuşmak istediğinizi hissedersiniz. Diğer gey/lezbiyen kişilerle bir araya gelmenin yardımcı olabileceğini düşünmeye başlıyorsunuz ama gerçekten isteyip istemediğinizden emin değilsiniz. Gey/lezbiyen olabileceğiniz gerçeğini kimseye söylemek istemiyor ve tamamen heteroseksüel görünmeyi tercih ediyorsunuz.

[ ] 4. Gey/lezbiyen olma konusunda daha emin hissetmeye başlıyorsunuz. Buna tahammül edebilir veya tolere edebilirsiniz. Kendinizi *şimdilik* gey/lezbiyen olarak görüyorsunuz ama gelecekte nasıl olacağınız konusunda emin değilsiniz. Hayatınızdaki özel bir insan nedeniyle kendinizi gey/lezbiyen olarak görebilirsiniz. Diğer insanların sizi geyliğinizi/lezbiyenliğinizi bilmelerinden hoşnut değilsiniz ve genellikle heteroseksüel bir görüntü ortaya koymaya dikkat edersiniz. Diğer insanların size tepkileri hakkında kaygı duyarsınız ve eşcinsel damgasının çok farkındasınız. Ancak diğer gey/lezbiyen kişilere açılmaya başlıyorsunuz ve onlarla sosyal olarak karışmaya başlıyorsunuz – veya en azından kendinize benzer başkalarıyla birlikte olma ihtiyacı nedeniyle bunu yapmak isterdiniz.

[ ] 5. Şimdi gey/lezbiyen olduğunuzdan oldukça eminsiniz. Bu durumu rahatlıkla kabul etmeye başlıyorsunuz. Gey/lezbiyen olduğunuzu birkaç kişiye söylemeye hazırsınız (arkadaşlar, aile üyeleri vs. gibi) ancak kime söyleyeceğinizi dikkatlice seçersiniz. Başka insanların gey/lezbiyen kişilere sorun çıkarabileceğini hissedersiniz ve bu yüzden herhangi biri gibi yaşamınızı devam edebileceğiniz bir tutum benimsemeye çalışırsınız. Uyum

sağlamak ve problem yaratmamak istiyorsunuz. Bazı insanlar için kabul edilemez olan bir azınlık grubuna ait olduğunuzu asla unutmuyorsunuz. Gey/lezbiyen olduğunuzu söylemediğiniz insanlardan özel yaşamınızı ayrı tutuyorsunuz. Eğer ilgili herkesi utandıracaksa insanları geyliğinizle/lezbiyenliğinizle yüzleştirmede hiç bir anlam görmüyorsunuz. Gey/lezbiyen kişilerle sosyal olarak oldukça sık karışıyorsunuz.

[ ] 6. Gey/lezbiyen olmaktan gurur duyduğunuzu hissediyor ve hoşlanıyorsunuz. Gey/lezbiyen kişilerle ilgili kitap ve dergileri, özellikle eğer geyliği/lezbiyenliği iyi resmediyorlarsa okumaktan hoşlanıyorsunuz. Birçok insana gey/lezbiyen olduğunuzu açıklamaya hazırsınız ve bu gerçeği saklama çabasında bulunmuyorsunuz. Genellikle gey/lezbiyen karşıtı tutumlara sahip oldukları için sosyal olarak heteroseksüellerle karışmamayı tercih edersiniz. Heteroseksüellerin gey/lezbiyen kişiler hakkında konuşma ve onlara davranma şekillerine kızıyorsunuz. Bu "onlar ve biz" gibi hissettiriyor. Üzerinde "ne cüretle heteroseksüel olduğumu var sayarsın" gibi sloganların olduğu rozetleri taşımaktan ve heteroseksüelleri gey/lezbiyen kişilere yönelik tutumlarıyla yüzleştirmekten mutlusunuz.

[ ] 7. Eğer uygun olursa gey/lezbiyen olduğunuzu herhangi birine söylemeye hazırsınız. Gey/lezbiyen olmaktan mutlusunuz ama şimdi bunun sizin tamamınız değil yalnızca bir parçanız olduğunu görüyorsunuz. Geyliğinize/lezbiyenliğinize daha öncesine göre daha az ve hayatınızın diğer yanlarına daha fazla ilgi gösteriyorsunuz. Hem geyler/lezbiyenler ve destekleyici heteroseksüel kişilerle, hem de sizin geyliğiniz/lezbiyenliğiniz hakkında tamamen açık olanlarla sosyal olarak karışıyorsunuz. Özelde kim olduğunuz ve toplum içinde kim olduğunuz arasında küçük fark vardır. Gey/lezbiyen kişilerin gördüğü muameleye kızgınsınız ama bu eskisi kadar bunaltıcı değildir. Gey/lezbiyen kişileri destekleyen ve kabul eden, fikirleri dinlemeye değer bazı heteroseksüeller olduğuna inanıyorsunuz. Gey/lezbiyen olmaktan gurur duyarsınız ama kendinizi daha az bir azınlık grubunun üyesi gibi hissedersiniz.

Şimdi bir sonraki sayfadaki 2. aşama ile devam ediniz.

2. AŞAMA

Seçmiş olduğunuz tanım, şu andaki düşünme ve hissetme şeklinize NE KADAR BENZİYOR?

[ ] Tamamen benziyor

[ ] Çoğunlukla benziyor

[ ] Oldukça benziyor

[ ] Biraz benziyor

Appendix D

Hudson & Ricketts Homophobia Scale (HRHS)

(Hudson & Ricketts Homofobi Ölçeği)

Aşağıda verilen ifadelerle hemfikir olup olmadığınızı, verilen ölçekteki sayılardan birini seçerek, ifadelerin yanındaki boşluklardan birine (**X**) koyarak işaretleyiniz.

1 2 3 4 5 6

Hiç katılmıyorum **Tamamen katılıyorum**

	1	2	3	4	5	6
1) Bir eşcinsel grubunun içinde olmaktan rahatsızlık duyarım.						
2) Kendi cinsimden birisi bana karşı cinsel ilgi gösterirse sinirlenirim.						
3) Çocuğumun eşcinsel olduğunu öğrenseydim hayal kırıklığına uğrardım.						
4) Kardeşimin eşcinsel olduğunu öğrenseydim üzülürdüm.						
5) Eşcinsellerin katıldığı sosyal aktivitelere katılmaktan hoşlanırım.						
6) Kızımın öğretmeninin lezbiyen olduğunu öğrenmek beni rahatsız etmez.						
7) Kendi cinsimden birisi bana karşı cinsel ilgi gösterirse canım sıkılır.						
8) Bir partide bir eşcinselle rahatça konuşurum.						
9) Oğlumun erkek öğretmeninin eşcinsel olduğunu öğrenmek beni rahatsız eder.						
10) Erkek bir eşcinselle beraber çalışmak beni rahatsız etmez.						
11) Kendi cinsimden birisinin bana cinsel ilgi göstermesi beni rahatsız etmez.						
12) Çocuğumun eşcinsel olduğunu öğrenirsem iyi bir ebeveyn olmadığımı düşünürüm.						
13) Kendi cinsimden birisini çekici bulmaktan rahatsızlık duymam.						
14) Toplum içinde iki erkeğin el ele tutuştuğunu görmek beni iğrendirir.						
15) Doktorumun eşcinsel olduğunu öğrenmek beni rahatsız eder.						
16) Patronumun eşcinsel olduğunu öğrenmek beni rahatsız eder.						
17) Kendi cinsimden birisinin bana cinsel ilgi göstermesi beni gururlandırır.						
18) Bir kadın eşcinselle beraber çalışmak beni rahatsız etmez.						
19) Eşimin ya da partnerimin kendi cinsinden birisine ilgi duyması beni rahatsız eder.						
20) Komşumun eşcinsel olduğunu öğrenmek beni rahatsız eder.						
21) Eşcinsellerin gittiği bir barda görülmek beni rahatsız eder.						
22) Mensubu olduğum dinin din adamının eşcinsel olduğunu öğrenmek beni rahatsız etmez.						
23) Kendi cinsimden en iyi arkadaşımın eşcinsel olduğunu öğrenmek beni rahatsız etmez.						
24) Kendi cinsimden insanları beni çekici bulması beni rahatsız etmez.						

Appendix E

Implicit Association Test

(Örtük Çağrışım Testi)

E-prime2 programı kullanılarak geliştirilmiş olan ve bilgisayar üzerinden uygulanan Örtük Çağrışım Testi'nde kullanılan kategori başlıkları ve bu kategorilere ait öğeler aşağıda listelenmiştir.

Kavram Kategorileri		**Değerlendirme Kategorileri**	
Eşcinsel İnsanlar	**Heteroseksüel İnsanlar**	**İyi**	**Kötü**
Homoseksüel	Heteroseksüel	Neşe	Istırap
Eşcinsel	Karşı cinse ilgi duyan	Sevgi	Berbat
Lezbiyen	Heteroseksüel kadın	Huzur	Korkunç
Gey	Heteroseksüel erkek	Harika	Çirkin
Kadın seven kadın	Kadın seven erkek	Keyif	Fena
Erkek seven erkek	Erkek seven kadın	Muhteşem	Rezil
Ali + Ahmet	Ali + Ayşe	Kahkaha	Başarısızlık
Ayşe + Merve	Ahmet + Merve	Mutlu	Acı

Appendix F

Defense Style Questionnaire (DSQ)

(Savunma Biçimleri Ölçeği)

Lütfen her ifadeyi dikkatle okuyup, bunların size uygunluğunu yan tarafında 1 den 9 a kadar derecelendirilmiş skala üzerinde seçtiğiniz dereceyi çarpı şeklinde (X) işaretlemek suretiyle gösteriniz.

Örnek:

Bana hiç uygun değil 1 2 3 4 X 6 7 8 9 Bana çok uygun

1. Başkalarına yardım etmek hoşuma gider, yardım etmem engellenirse üzülürüm.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

2. Bir sorunum olduğunda, onunla uğraşacak vaktim olana kadar o sorunu düşünmemeyi becerebilirim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

3. Endişemin üstesinden gelmek için yapıcı ve yaratıcı şeylerle uğraşırım(resim, el işi, ağaç oyma).
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

4. Arada bir bu gün yapmam gereken işleri yarına bırakırım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

5. Kendime çok kolay gülerim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

6. İnsanlar bana kötü davranmaya eğilimliler.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

7. Birisi beni soyup paramı çalsa, onun cezalandırılmasını değil ona yardım edilmesini isterim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

8. Hoş olmayan gerçekleri, hiç yokmuşlar gibi görmezlikten gelirim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

9. Süpermen'mişim gibi tehlikelere aldırmam.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

10. İnsanlara, sandıkları kadar önemli olmadıklarını gösterebilme yeteneğimle gurur duyarım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

11. Bir şey canımı sıktığında, çoğu kez düşüncesizce ve tepkisel davranırım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

12. Hayatım yolunda gitmediğinde bedensel rahatsızlıklara yakalanırım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

13. Çok tutuk bir insanım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

14. Her zaman doğruyu söylemem
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

15. Sorunsuz bir yaşam sürdürmemi sağlayacak özel yeteneklerim var.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

16. Seçimlerde bazen haklarında çok az şey bildiğim kişilere oy veririm.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

17. Bir çok şeyi gerçek yaşamımdan çok hayalimde çözerim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

18. Hiçbir şeyden korkmam
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

19. Bazen bir melek olduğumu, bazen de bir şeytan olduğumu düşünürüm.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

20. Kırıldığımda açıkça saldırgan olurum.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

21. Her zaman, tanıdığım birinin koruyucu melek gibi olduğunu hissederim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

22. Bana göre, insanlar ya iyi ya da kötüdürler.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

23. Patronum beni kızdırırsa, ondan hıncımı çıkarmak için ya işimde hata yaparım ya da işi yavaşlatırım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

24. Her şeyi yapabilecek güçte, aynı zamanda son derece adil ve dürüst olan bir tanıdığım var.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

25. Serbest bıraktığımda, yaptığım işi etkileyebilecek olan duygularımı kontrol edebilirim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

26. Genellikle, aslında acı verici olan bir durumun gülünç yanını görebilirim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

27. Hoşlanmadığım bir işi yaptığımda başım ağrır.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

28. Sık sık, kendimi kesinlikle kızmam gereken insanlara iyi davranırken bulurum.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

29. Hayatta, haksızlığa uğruyor olduğuma eminim
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

30. Sınav veya iş görüşmesi gibi zor bir durumla karşılaşacağımı bildiğimde, bunun nasıl olabileceğini hayal eder ve başa çıkmak için planlar yaparım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

31. Doktorlar benim derdimin ne olduğunu hiçbir zaman gerçekten anlamıyorlar.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

32. Haklarım için mücadele ettikten sonra, girişken davrandığımdan dolayı özür dilemeye eğilimliyimdir.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

33. Üzüntülü veya endişeli olduğumda yemek yemek beni rahatlatır.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

34. Sık sık duygularımı göstermediğim söylenir.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

35. Eğer üzüleceğimi önceden tahmin edebilirsem, onunla daha iyi baş edebilirim.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

36. Ne kadar yakınırsam yakınayım, hiçbir zaman tatmin edici bir yanıt alamıyorum.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

37. Yoğun duyguların yaşanması gereken durumlarda, genellikle hiçbir şey hissetmediğimi fark ediyorum.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

38. Kendimi elimdeki işe vermek, beni üzüntülü veya endişeli olmaktan korur.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

39. Bir bunalım içinde olsaydım, aynı türden sorunu olan birini ararım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

40. Eğer saldırganca bir düşüncem olursa, bunu telafi etmek için bir şey yapma ihtiyacı duyarım.
Bana hiç uygun değil 1 2 3 4 5 6 7 8 9 Bana çok uygun

Appendix G

Multidimensional Scale of Perceived Social Support (MSPSS)

(Algılanan Çok Boyutlu Sosyal Destek Ölçeği)

Aşağıda 12 cümle ve her bir cümle yanında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alrak işaretleyiniz. Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz. Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1. 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
2. Ailem ve arkadaşlarım dışında olan ve sevinç ve kederimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
3. Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalışır.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
4. İhtiyacım olan duygusal yardımı ve desteği ailemden (örneğin, annemden, babamdan, eşimden, çocuklarımdan, kardeşimden) alırım.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
5. 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
6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
8. Sorunlarımı ailemle (örneğin, annemle, babamla, eşimle, çocuklarımla, kardeşlerimle) konuşabilirim.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
10. 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
11. Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya isteklidir.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet
12. Sorunlarımı arkadaşlarımla konuşabilirim.								
Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

Appendix H

Social Comparison Scale (SCS)

(Sosyal Karşılaştırma Ölçeği)

Sizin de bildiğiniz gibi, hepimiz zaman zaman kendimizi diğer insanlarla karşılaştırır ve bazı değerlendirmeler yaparız. Bu değerlendirmeler sonucunda kendimizle ilgili bazı fikirler ediniriz. Sizin de kendinizle ilgili bazı görüşleriniz mutlaka vardır. Lütfen aşağıdaki sıfatların herbirinde, size en iyi yansıtan rakamın üzerine çarpı (X) işareti koyunuz.

(1) : Sol taraftaki boyuta en yakın olmayı ifade eder.

(6) : Sağ taraftaki boyuta en yakın olmayı ifade eder.

Sol							**Sağ**
Yetersiz	(1)	(2)	(3)	(4)	(5)	(6)	Yeterli / Üstün
Beceriksiz	(1)	(2)	(3)	(4)	(5)	(6)	Becerikli
Başarısız	(1)	(2)	(3)	(4)	(5)	(6)	Başarılı
Sevilmeyen biri	(1)	(2)	(3)	(4)	(5)	(6)	Sevilen biri
İçedönük	(1)	(2)	(3)	(4)	(5)	(6)	Dışadönük
Yalnız	(1)	(2)	(3)	(4)	(5)	(6)	Yalnız değil
Dışta bırakılmış	(1)	(2)	(3)	(4)	(5)	(6)	Kabul edilmiş
Sabırsız	(1)	(2)	(3)	(4)	(5)	(6)	Sabırlı
Hoşgörüsüz	(1)	(2)	(3)	(4)	(5)	(6)	Hoşgörülü
Söyleneni yapan	(1)	(2)	(3)	(4)	(5)	(6)	İnisiyatif sahibi
Korkak	(1)	(2)	(3)	(4)	(5)	(6)	Cesur
Kendine güvensiz	(1)	(2)	(3)	(4)	(5)	(6)	Kendine güvenli
Çekingen	(1)	(2)	(3)	(4)	(5)	(6)	Atılgan
Dağınık	(1)	(2)	(3)	(4)	(5)	(6)	Düzenli
Pasif	(1)	(2)	(3)	(4)	(5)	(6)	Aktif
Kararsız	(1)	(2)	(3)	(4)	(5)	(6)	Kararlı
Antipatik	(1)	(2)	(3)	(4)	(5)	(6)	Sempatik
Boyun eğici	(1)	(2)	(3)	(4)	(5)	(6)	Hakkını arayıcı

Appendix I

Scale of Dimensions of Interpersonal Relationships (SDIP)

(Kişilerarası İlişki Boyutları Ölçeği)

Aşağıdaki kendinize ve diğer insanlara yönelik algınız, bakış açınızla ilgili ifadeler bulunmaktadır. Bu ifadeleri dikkatlice okuyup, ifadenin sizi ne kadar tanımladığını düşünerek, size en uygun olanını işaretleyin.

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendirin:

(0) Hiç Tanımlamıyor	(1) Çok az tanımlıyor	(2) Kısmen tanımlıyor	(3) Oldukça tanımlıyor	(4) Tamamen tanımlıyor

		Hiç	Çok
1	İnsanların sözünde duracağına güvenirim.	(0) (1) (2) (3) (4)	
2	Kendimi iyi hissetmediğim zaman, bana ilgi ve şefkat gösterilmesinden hoşlanırım.	(0) (1) (2) (3) (4)	
3	Kendimi kolayca kaybedip, öfkelenebilirim.	(0) (1) (2) (3) (4)	
4	İnsanların benim hakkımdaki düşünceleri, benim duygularımı etkiler.	(0) (1) (2) (3) (4)	
5	Kimseye kolay kolay güvenmem.	(0) (1) (2) (3) (4)	
6	Karşımdaki insana duygularımı belli etmekte zorlanmam.	(0) (1) (2) (3) (4)	
7	Fikirlerimi söylemeden önce, başkalarının ne düşündüğünü bilmek isterim.	(0) (1) (2) (3) (4)	
8	Tartışma durumlarında konuyu kişiselleştirmem.	(0) (1) (2) (3) (4)	
9	Benimle ters düşen insanlardan öç almak isterim.	(0) (1) (2) (3) (4)	
10	Öfkelendiğimde ağzıma geleni söylerim.	(0) (1) (2) (3) (4)	
11	İnsanların hareketlerimi yanlış yorumlamalarından endişelenirim.	(0) (1) (2) (3) (4)	
12	Eleştirildiğim zaman otomatikman savunmaya geçerim.	(0) (1) (2) (3) (4)	
13	Bir kişi ile bir sorun yaşadığımda, sakin kafa ile düşünmeye, öfkelenmemeye çalışırım.	(0) (1) (2) (3) (4)	
14	Başkalarına güvenmenin beni sıkıntıya sokacağını düşünürüm.	(0) (1) (2) (3) (4)	
15	Öfkemi kolaylıkla kontrol edebilirim	(0) (1) (2) (3) (4)	
16	Başkasının, haklı da olsa, beni eleştirmesine dayanamam.	(0) (1) (2) (3) (4)	
17	Bir başka insanın düşünce ve duygularından kolaylıkla etkilenirim.	(0) (1) (2) (3) (4)	

18	Bana dostça yaklaşılması, o kişi ile yakın İlişki kurmamı kolaylaştırır.	(0) (1) (2) (3) (4)
19	Eğer bir insan ile geçmişte olumsuz, bir yaşantım olmuş ise, o insan benim gözümde hep haksızdır.	(0) (1) (2) (3) (4)
20	Karşımdaki insanların beni inciteceklerinden korkarım.	(0) (1) (2) (3) (4)
21	Diğer insanların hedeflerini kabul etmektense, kendi hedeflerimi kendim belirlemeyi tercih ederim.	(0) (1) (2) (3) (4)
22	Sırlarımı paylaştığım insanların, sırlarımı tutacaklarına güvenirim.	(0) (1) (2) (3) (4)
23	İnsanların beni kullandıklarını düşünürüm.	(0) (1) (2) (3) (4)
24	Ailemden başka hiç kimseye güvenmem.	(0) (1) (2) (3) (4)
25	Kızdığım kişiyi kolaylıkla affedemem.	(0) (1) (2) (3) (4)
26	Hoşuma gitmese de diğerlerini memnun edecek şekilde davranırım.	(0) (1) (2) (3) (4)
27	Karşımdaki insanın bakış açısını anlamada zorluk çekmem.	(0) (1) (2) (3) (4)
28	Herkesin karşı çıkacağını bilsem de, fikirlerimi ortaya koymaktan çekinmem.	(0) (1) (2) (3) (4)
29	İnsanların beni önemsediklerini sanmam.	(0) (1) (2) (3) (4)
30	Diğer insanlardan beklediğim tepkileri alamazsam, cesaretim kırılır.	(0) (1) (2) (3) (4)
31	İnsanların iyi niyetli olmadıklarını düşünürüm,	(0) (1) (2) (3) (4)
32	Başkalarının benim hakkımdaki düşünceleri, kendimi değerlendirmemde son derece önemlidir.	(0) (1) (2) (3) (4)
33	Karşı traftan sevgi alamazsam kendimi çaresiz hissederim.	(0) (1) (2) (3) (4)
34	Bir insanı önemsediğimi, ona ifade edebilirim.	(0) (1) (2) (3) (4)
35	İhtiyacım olduğunda İnsanları yanımda bulacağımı biliyorum.	(0) (1) (2) (3) (4)
36	Başkalarının önerileri, nasihatleri olmadan kendi kendime hedefler koymada zorlanırım.	(0) (1) (2) (3) (4)
37	Konuşmalarım yapıcı ve olumludur.	(0) (1) (2) (3) (4)
38	İnsanların yalan söylediklerine inanırım.	(0) (1) (2) (3) (4)
39	Başkaları ile yakınlık kurmakta zorluk çekmem.	(0) (1) (2) (3) (4)
40	Önemsediğim kişilerin beni onaylamaması, canımı acıtır.	(0) (1) (2) (3) (4)

41	Önemsediğim kişilerin bana ne yapacağımı söylemesi, işimi kolaylaştırır.	(0) (1) (2) (3) (4)
42	Olumlu duygularımı, karşımdaki kişiyle paylaşabilirim.	(0) (1) (2) (3) (4)
43	Başkalarının benim gerçek düşüncelerimi bilmelerini istemem.	(0) (1) (2) (3) (4)
44	Diğer insanlarla yakın ilişki kurduğumda kendimi iyi hissederim.	(0) (1) (2) (3) (4)
45	Etrafımda benden daha güçlü ya da zeki insanlar olduğunda, kolaylıkla kendime güvenimi kaybederim.	(0) (1) (2) (3) (4)
46	Duygularımı kontrol altında tutmak benim için oldukça zordur.	(0) (1) (2) (3) (4)
47	Tanımadığım insanlar arasında kendimi gergin hissederim.	(0) (1) (2) (3) (4)
48	Karşımdaki kişinin ihtiyaçlarını, göz önüne alırım.	(0) (1) (2) (3) (4)
49	Karşımdakini olduğu gibi kabul etmede güçlük yaşarım.	(0) (1) (2) (3) (4)
50	Yeni bir ortamda bile, insanlara güvenmek gerektiğini düşünürüm.	(0) (1) (2) (3) (4)
51	Bir iş yaparken, karşımdaki kişinin de duygularını hesaba katarım.	(0) (1) (2) (3) (4)
52	Problemli durumlarda, başkalarını suçlama eğilimindeyim.	(0) (1) (2) (3) (4)
53	İnsanların sadece kendi çıkarları ile ilgilendiklerini düşünürüm.	(0) (1) (2) (3) (4)

Appendix J

Brief Symptom Inventory (BSI)

(Kısa Semptom Envanteri)

Aşağıda, insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyun. Daha sonra o belirtinin sizde, bugün dahil, son bir haftadır ne kadar var olduğunu yandaki bölmede, uygun olan yerde işaretleyin. Her belirti için sadece bir yeri işaretlemeye ve hiçbir maddeyi atlamamaya özen gösterin.

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendirin:

(0) Hiç yok	(1) Biraz var	(2) Orta derecede var	(3) Epeyce var	(4) Çok fazla var

Bu belirtiler <u>son bir haftadır</u> sizde ne kadar var?

		Hiç				Çok fazla
1	İçinizdeki sinirlilik ve titreme hali	(0)	(1)	(2)	(3)	(4)
2	Baygınlık, baş dönmesi	(0)	(1)	(2)	(3)	(4)
3	Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	(0)	(1)	(2)	(3)	(4)
4	Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	(0)	(1)	(2)	(3)	(4)
5	Olayları hatırlamada güçlük	(0)	(1)	(2)	(3)	(4)
6	Çok kolayca kızıp öfkelenme	(0)	(1)	(2)	(3)	(4)
7	Göğüs (kalp) bölgesinde ağrılar	(0)	(1)	(2)	(3)	(4)
8	Meydanlık (açık) yerlerden korkma duygusu	(0)	(1)	(2)	(3)	(4)
9	Yaşamınıza son verme düşünceleri	(0)	(1)	(2)	(3)	(4)
10	İnsanların çoğuna güvenilmeyeceği hissi	(0)	(1)	(2)	(3)	(4)
11	İştahta bozukluklar	(0)	(1)	(2)	(3)	(4)
12	Hiçbir nedeni olmayan ani korkular	(0)	(1)	(2)	(3)	(4)
13	Kontrol edemediğiniz duygu patlamaları	(0)	(1)	(2)	(3)	(4)
14	Başka insanlarla beraberken bile yalnız hissetmek	(0)	(1)	(2)	(3)	(4)
15	İşleri bitirme konusunda kendini engellenmiş hissetmek	(0)	(1)	(2)	(3)	(4)
16	Yalnızlık hissetmek	(0)	(1)	(2)	(3)	(4)

17	Hüzünlü, kederli hissetmek	(0)	(1)	(2)	(3)	(4)
18	Hiçbir şeye ilgi duymamak	(0)	(1)	(2)	(3)	(4)
19	Ağlamaklı hissetmek	(0)	(1)	(2)	(3)	(4)
20	Kolayca incinebilme, kırılmak	(0)	(1)	(2)	(3)	(4)
21	İnsanların sizi sevmediğine, kötü davrandığına inanmak	(0)	(1)	(2)	(3)	(4)
22	Kendini diğerlerinden daha aşağı görme	(0)	(1)	(2)	(3)	(4)
23	Mide bozukluğu, bulantı	(0)	(1)	(2)	(3)	(4)
24	Diğerlerinin sizi gözlediği ya da hakkınızda konuştuğu duygusu	(0)	(1)	(2)	(3)	(4)
25	Uykuya dalmada güçlük	(0)	(1)	(2)	(3)	(4)
26	Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek	(0)	(1)	(2)	(3)	(4)
27	Karar vermede güçlükler	(0)	(1)	(2)	(3)	(4)
28	Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkmak	(0)	(1)	(2)	(3)	(4)
29	Nefes darlığı, nefessiz kalmak	(0)	(1)	(2)	(3)	(4)
30	Sıcak soğuk basmaları	(0)	(1)	(2)	(3)	(4)
31	Sizi korkuttuğu için bazı eşya, yer ya da etkinliklerden uzak kalmaya çalışmak	(0)	(1)	(2)	(3)	(4)
32	Kafanızın bomboş kalması	(0)	(1)	(2)	(3)	(4)
33	Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	(0)	(1)	(2)	(3)	(4)
34	Günahlarınız için cezalandırılmanız gerektiği	(0)	(1)	(2)	(3)	(4)
35	Gelecekle ilgili umutsuzluk duygusu	(0)	(1)	(2)	(3)	(4)
36	Konsantrasyonda (dikkati bir şey üzerinde toplama) güçlük/zorlanmak	(0)	(1)	(2)	(3)	(4)
37	Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi	(0)	(1)	(2)	(3)	(4)
38	Kendini gergin ve tedirgin hissetmek	(0)	(1)	(2)	(3)	(4)

39	Ölme ve ölüm üzerine düşünceler	(0)	(1)	(2)	(3)	(4)
40	Birini dövme, ona zarar verme, yaralama isteği	(0)	(1)	(2)	(3)	(4)
41	Bir şeyleri kırma dökme isteği	(0)	(1)	(2)	(3)	(4)
42	Diğerlerinin yanındayken yanlış bir şeyler yapmamaya çalışmak	(0)	(1)	(2)	(3)	(4)
43	Kalabalıklarda rahatsızlık duymak	(0)	(1)	(2)	(3)	(4)
44	Bir başka insana hiç yakınlık duymamak	(0)	(1)	(2)	(3)	(4)
45	Dehşet ve panik nöbetleri	(0)	(1)	(2)	(3)	(4)
46	Sık sık tartışmaya girmek	(0)	(1)	(2)	(3)	(4)
47	Yalnız bırakıldığında/kalındığında sinirlilik hissetmek	(0)	(1)	(2)	(3)	(4)
48	Başarılarınız için diğerlerinden yeterince takdir görmemek	(0)	(1)	(2)	(3)	(4)
49	Yerinde duramayacak kadar tedirgin hissetmek	(0)	(1)	(2)	(3)	(4)
50	Kendini değersiz görmek/değersizlik duyguları	(0)	(1)	(2)	(3)	(4)
51	Eğer izin verirseniz insanların sizi sömüreceği duygusu	(0)	(1)	(2)	(3)	(4)
52	Suçluluk duyguları	(0)	(1)	(2)	(3)	(4)
53	Aklınızda bir bozukluk olduğu fikri	(0)	(1)	(2)	(3)	(4)