Effects of LGBTI+ Community-based Organisations on LGTBI+s in the Northern Part of Cyprus

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ABSTRACT

This study focused on the effect of community-based organisations on sexual health, mental and social well-being as well as alcohol and substance use of LGBTI+s in the northern part of Cyprus. These variables have been linked in the literature as syndemic health inequalities (Hegazi & Pakianathan, 2018). Recent research has concluded that both discrimination and tolerance created higher levels of threatened social identity needs, which are self-esteem, meaning, belonging, efficacy and continuity, that affects the psychological well-being of LGBTI+s (Bagci et al., 2020a). Therefore, is proposed that there is a link between social well-being and psychological well-being. Within the literature it has been discussed that the sexual health of LGBTI+s comes with many perceived stigmas which is also a contributing factor for not receiving medical care, therefore, making specifically men who have sex with men, trans as well as those who engage in anal sex higher risk group for sexual health deficits (Hegazi & Pakianathan, 2018). There is also a great body of research highlighting that LGBTI+s are using higher rates of alcohol and other substances whether as a coping mechanism or a cultural stress output (Burgard et al., 2005; Johnson et al., 2008; Northridge et al., 2007; Roxburgh et al., 2016). In contrast to all these factors that affect LGBTI+s negatively, participation in LGBTI+ community-based organizations has been found to have a positive impact on these variables (Fish et al., 2019). Many of these organisations provide psycho-social services, legal guidance, educational programs as well as medical referrals specific to LGBTI+s (Allen et al., 2012). Therefore, it was expected that participation in an LGBTI+ community-based organisation in the northern part of Cyprus will have a positive effect on LGBTI+s mental and social well-being, alcohol and substance use as well as

sexual health. Out of all of these hypotheses, it was found that participation in community-based organisations only had a significant effect on the reported sexual health of LGBTI+s in the northern part of Cyprus.

Keywords: Community-based Organisations, LGBTI+, Mental Wellbeing, Social Wellbeing, Alcohol and Substance Use

ÖZ

Bu çalışma, Kıbrıs'ın kuzeyindeki LGBTİ+'ların cinsel sağlık, psikolojik ve sosyal iyilik hali ile alkol ve madde kullanımına yönelik toplum temelli kuruluşların etkisine odaklanmıştır. Bu değişkenler literatürde sendromik sağlık eşitsizlikleri olarak ilişkilendirilmiştir (Hegazi & Pakianathan, 2018). Yakın zamanda yapılan bir araştırma hem ayrımcılığın hem de hoşgörünün, LGBTİ+'ların psikolojik iyi oluşlarını etkileyen özsaygı, anlam, aidiyet, etkinlik ve süreklilik gibi daha yüksek düzeyde tehdit altındaki sosyal kimlik gereksinimleri yarattığı sonucuna varmıştır (Bağcı ve ark., 2020a). Dolayısıyla sosyal iyi oluş ile psikolojik iyi oluş arasında bir bağlantı olduğu ileri sürülmektedir. Literatürde, LGBTİ+'ların cinsel sağlığının birçok damgalama algısı ile birlikte geldiği ve bunun da tıbbi bakım alamamalarına katkıda bulunan bir faktör olduğu, bu nedenle özellikle erkeklerle seks yapan erkekleri, transları ve cinsel ilişkiye girenleri trans haline getirdiği tartışılmaktadır. anal sekste cinsel sağlık açıkları için daha yüksek risk grubunda (Hegazi & Pakianathan, 2018). LGBTİ+'ların bir baş etme mekanizması veya kültürel bir stres çıktısı olarak daha yüksek oranlarda alkol ve diğer maddeleri kullandığını vurgulayan çok sayıda araştırma da var (Burgard ve diğerleri, 2005; Johnson ve diğerleri, 2008; Northridge ve diğerleri, ., 2007; Roxburgh ve diğerleri, 2016). LGBTİ+'ları olumsuz etkileyen tüm bu faktörlerin aksine, LGBTİ+ toplum temelli organizasyonlara katılımın bu değişkenler üzerinde olumlu etkisi olduğu tespit edilmiştir (Fish vd., 2019). Bu kuruluşların birçoğu psiko-sosyal hizmetler, yasal rehberlik, eğitim programları ve LGBTİ+'lara özel tıbbi yönlendirmeler sağlamaktadır (Allen ve diğerleri, 2012). Bu nedenle, Kıbrıs'ın kuzey kesiminde LGBTİ+ toplum temelli bir organizasyona katılımın LGBTİ+'ların zihinsel ve sosyal esenliği, alkol ve madde kullanımı ile cinsel

sağlık üzerinde olumlu bir etkisi olması bekleniyordu. Tüm bu hipotezlerden, toplum temelli kuruluşlara katılımın yalnızca Kıbrıs'ın kuzeyindeki LGBTİ+'ların rapor edilen cinsel sağlıkları üzerinde önemli bir etkisi olduğu bulundu.

Anahtar Kelimeler: Toplum Temelli Kuruluşlar, LGBTİ+, Akıl Sağlığı, Sosyal İyilik, Alkol ve Madde Kullanımı

DEDICATION

I would like to dedicate this thesis to Lesbian, Gay, Bisexual, Trans, Intersex and more as well as the activists, that live in the northern part of Cyprus, who are working to achieve full equity regardless of sexual orientation, gender identity, characterises and expression. Despite the hate, up with life!

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and Other Drugs
CBO	Community-Based Organisations
GB	Gay and Bisexual
GLBTQ	Gay Lesbian Bisexual Trans and Queer
LGB	Lesbian Gay and Bisexual
LGBTI+s	Lesbian Gay Bisexual Trans Intersex and Pluses
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale
WHO	World Health Organisation
YRBSS	Youth Risk Behavior Surveillance System

Chapter 1

INTRODUCTION

1.1 History of LGBTI+ Research

Psychology as a field has been interested in gender identity and sexual orientation minorities (LGBTI+s) for nearly more than half a century. Initially, it was a topic of interest for clinical psychologists and psychiatrists in a quest to try to analyse and understand the nature of LGBTI+s existence in order to suggest it is a personality disturbance, psychosexual disorder, and then possessive of other psychopathological implications (Clarke et al., 2010; Morin, 1977). However, much research and different theorising have brought a new area of study for the scientific community as the shift in research has been observed towards understanding the experiences of and attitudes towards LGBTI+s rather than attempting at finding an ultimate cure for a so-called sexual deviation (Hegarty, 2017; Ruth & Santacruz, 2017). As time progressed, community-based and civil society organisations established by LGBTI+s have been able to voice their concerns, highlight practices and legislative challenges in accessing the basic human rights of LGBTI+s. However, even with the rights-based approaches being perceptually more apparent in scientific writings, the political and social change has been on the slow burn.

In line with the shift in approach, researchers have taken an interest in more LGBTI+ affirming studies that centralize on understanding the formation of negative attitudes towards LGBTI+s and how to resolve and change these attitudes (Ruth & Santacruz, 2017). To be able to understand the experiences of the LGBTI+s Herek

(1990) proposes the use of the term heterosexism which includes the power dynamics and the hierarchy of sexualities. According to Neisen (1990, p.25), the term heterosexism allows having a more in-depth analysis of the relationship between gender-role stereotypes and anti-homosexual sentiments. According to Herek's definition of heterosexism (1990, p.316), it is the denigration, stigmatisation and denial of any non-heterosexual behaviour, identity, relationship, or community within an ideological system. Including gender identity, characteristics and expression in this discourse lead to the term cis-heteronormativity which in its essence highlights the acceptance of being cisgender and heterosexual at the centre of human existence and condition (Worthen, 2016). Therefore, looking through the lens of cis-heteronormativity, the degree to which LGBTI+s face discrimination becomes clearer rather than using analysis through the classical understanding of phobias (i.e., homophobia, biphobia or transphobia). With that in mind, it is important to look at queer theory to be able to get a more holistic understanding of the previously mentioned factors as influencing the lives of LGBTI+s and their shared oppression. In this light, this study aims to look at the effects of active participation in LGBTI+ community-based organisations on mental health indicators in LGBTI+s, namely well-being, sexual health, and substance use in the northern part of Cyprus.

1.2 Queer Theory

Today, we know that there are many factors that affect LGBTI+s' mental health, that would range from stigma, lack of social and/or familial support, access to basic human rights etc. due to their sexual orientation and/or gender identity, expression (Ruth & Santacruz, 2017). The social stigma that LGBTI+s face in the form of homophobia, biphobia and transphobia is usually identified as "an attitude of hostility toward male or female homosexuals, bisexuals and transgenders" (Borrillo,

2001; Chamberland & Lebreton, 2012; Herek, 1990). However, using phobia to explain the context and the basis of the discrimination has been criticised to be relatively restrictive as well as taking the phenomenon out of its collective and socio-political context to make it more individual-based discrimination and rejection (Fraïssé & Barrientos, 2016). Within the previous section, the approach taken by Herek has been highlighted due to its essence in combining the political, social and psychological aspects. He used his combined approach in formation and understanding of how interchangeably attitudes affect society at large and how socio-political systems impose attitudinal norms with regards to sexual orientation, gender identity and expression. However, there is a vast need for research that takes more Queer theoretical approaches in studying LGBTI+ experiences, in that creating more holistic studies that are able to draw analysis from micro and macro levels of socio-political oppressions that show differentiation based on cultural and social norms, institutions and practices (Semp, 2011).

The queer theory postulates that gender and sexuality are not situated as biologically deterministic existence, but rather performative in that the innate existence with the influence of socio-political environment allows for different drives to lead to attitudinal and behavioural dispositions (Butler, 1990). This theorisation centralises the normative understandings of gender and sexuality, which have become scientific truth regimes throughout the enlightenment age, to be the root of oppression and erasure of any so-called deviation from the norm (Foucault, 1997; Molacı, 2020; Weir, 2008). Thus, the Queer theory itself allows for a more holistic approach to the subject of gender and sexual diversity, positioning them as social constructs which inevitably is produced and reproduced within cultural as well as political spaces.

Butler (1990) postulates that there are variations between men and

masculinities as well as women and femininities. These concepts are not followed through a binary understanding of one or the other, gender identity does not exist beyond the expression of it, which is performative in its essence as a social construct (Meyerhoff, 2014). What performativity refers to in this theorisation is different from than conscious act of performing. It rather highlights a series of internal factors which leads to choices, behaviours and attitudes that are acted out subconsciously (Salih, 2002). Thus, it is important to acknowledge the subjectivity in which these internal factors affect any given individual. People who identify with the same gender do not make up the same conceptual person, personality traits or behavioural composition, instead, show the stereotypical responses that are expected based on their expression of performativity (Jackson, 2004). Thus, one can simply set forth that the gendered world and gendered norms are only reflections of social constructions and learned behaviour. Therefore, the dichotomy of nature versus nurture proves itself to be self-destructive in that it takes away the holistic understanding and force the focus on the age-old question which has been proven to be an interplay of many factors rather than one being more dominant than the other. This theorisation brings the understanding that social construction is one of the predominant factors in which performativity is subjectively represented and any form of such identification is up to interpretation based on societal but subjective contexts and truths(Jackson, 2004).

Within psychology, one theory that comes close to playing along the queer theory is the minority stress framework by highlighting a series of internal and external factors in which experiences can be empirically analysed. Thus, within the below section minority stress theory shall be explained further to help queer theory in the formulation and explanation of LGBTI+ experiences.

1.3 Minority Stress Theory

Theories of social psychology and more specifically social identity and self-categorisation broadens the area in understanding how self and health of minorities are disproportionately affected by intergroup relations (Meyer, 2003). Therefore, it can be stated that there's an importance of interaction with others as well as the society as pivotal in the process of developing a sense of self and well-being. From these postulations, it can be drawn that negative interactions could potentially deteriorate the sense of self of individuals, on top of that if there are more negative interactions due to belonging to a minority group, the level of negative interactions could be higher than those who belong to the dominant culture/majority group (Dentato, 2012).

As mentioned in the above section Queer theory helps in the identification of differential power dynamics within its postulation that enables to look at the experiences of LGBTI+s' oppression, the stigma faced and socio-political and economical impoverishment. Thus, providing an important insight into the minority stress theory in identifying the root causes of debilitation of LGBTI+s in relation to the struggle that they have with the dominating power dynamics within a given cis-heterosexist society.

The experiences of the minority group members which are in conflict with the social environment due to the correspondence of minority and dominant values are called minority stress (Dentato, 2012). In its essence, the theory describes and catalogues the chronic levels of stress faced by minority group members and their influences on the individual. Basal assumptions regarding the minority stress during its construction as a concept was that it is (1) unique, (2) chronic, and (3) socially based. The first one refers to the postulation that minority stress is presented in addition to general stressors which are faced by everyone, thus, enforcing those who face

minority stress to develop and put in more adaptive efforts when compared to those who are less marginalised by the dominant culture. Whereas being chronic and socially based, refers to the idea that minority stress is reasonably grounded in social and cultural institutions of construction and structures which indicates that it is rooted in beyond individual events or conditions or basic stressors that are not possessive of social characteristics (Meyer, 2003). It is also suggested to take a distal – proximal approach to minority stress theory/model, due to the fact that it centralises the influence of external social conditions and structures in relation to the individual as it is more consistent with minority stress in the formulation of stress. The distal stressors refer to events and conditions that are external and objective which in comparison proximal refers to those that are more subjective in nature due to the fact that they depend upon the perception and appraisals of the individuals (Meyer, 2003). Diamond (2000) states that the former can be seen as free from how one identifies with the assigned minority status in that merely being perceived as a member of the minority group can consequently mean that the person can be affected by the stressors related to prejudice regarding that minority group. On the other hand, when looking at the proximal stressors it can be seen that they are more subjective, thus, relating to how one identifies themselves and what these identifications entail in subjective meaning in relation to the social positions they hold. Minority stress theory, specifically for LGBTI+s, postulates that there are various processes of stress ranging from distal to proximal. These can be described as (1) chronic and acute stressors which refers to objective events and conditions, (2) presumption that these events will take place as well as the vigilance required in anticipation, (3) internalization of such negative attitudes, and (4) being in the closet which is concealing self's identity of being LGBTI+. Due to the fact that the effects of stress caused by concealment of LGBTI+

identities happen through internal psychological processes, it is seen as a proximal stressor that is widely influential in minority stress of LGBTI+s (Cole et al., 1996; Pennebaker, 1995). In sections below minority stress theory will be used to look at and try to explain (1) mental and social wellbeing, (2) alcohol and substance use, (3) sexual health attitudes in LGBTI+s.

1.4 Well-being in LGBTI+

Psychology as a field has been affected by the zeitgeist in its area of interest since its conception. After the Second World War, psychology began to be seen as a therapeutic science field. Later, its area of interest shifted towards an understanding that emphasized the strengths of individuals. The change in the view of psychology in line with this trend has also been reflected in the research, and some scientists have pointed out that studies on the positive aspects of mental health have been studied very little when compared to numerous studies on the negative aspects of mental health such as anxiety and depression (Seligman & Czikszentmihalyi, 2000). When we come to the present from the past research, we can see that the theoretical studies on the concept of "well-being" are based on two basic ideas; understanding of hedonism and psychological functionality (eudaionic) (Tennant et al., 2007). When well-being is evaluated in line with the concept of getting pleasure, the presence of positive affect is accepted as the absence of negative affect, and this is also called subjective well-being. On the other hand, when we look at it from the psychological functionality approach, well-being focuses on accepting life as it is and living in a meaningful way (psychological functioning and self-realisation), and it is also called psychological well-being (Deci & Ryan, 2008). However, social wellbeing, as defined by Keyes (1998), is an assessment of one's status and function in society. It can be defined as an individual's perceptions of the quality of their relationships with their neighbours, their

environment, and other people. Later on, the definition has been explained as the harmony of the individual with the social world around them. It entails a variety of features such as how one feels in relation to their social contribution, perception of the society as being comprehensible and meaningful, a grasp of social belonging, attitudes that are positive towards others and a positive belief in the potential for social evolution to better (Kertzner et al., 2009). So where psychological wellbeing is denominated by internal cognition and functionality of an individual aimed at the self, social wellbeing refers to the social positioning of an individual within their environment which defines their being and functionality.

The established definition of social wellbeing goes hand in hand with the models that focus on the formation of identities of sexual orientation and gender identity. In that, dismissal of the dichotomic understanding of good and bad based on orientation, diminishment of anger, detachment, exasperation and also feelings of being more than one's sexual orientation which elevates feelings of being a part of the world at large (Cass, 1996; Eliason, 1996). Also, it is important to mention that social wellbeing plays an integral part in mitigating the stressors associated with and impacted by minority stress. In that reaffirming social environments without stigmatisation provides coping resources with positive self-appraisals as explained in section 1.7 Participation in Community-Based Organisations (Crocker & Major, 1989; Ilan H. Meyer, 2003). In addition to being a mitigating factor in coping with stressors, social wellbeing has been shown to positively influence the mental wellbeing of LGBTI+s as it enables environments in which people can be more out, have social support and identify with an ingroup, thus encouraging the acceptance of sexual and/or gender identity minority status (Halpin & Allen, 2004; Jordan et al., 2016; Ilan H. Meyer, 2003).

Research on a European level has found that LGBTI+s face prejudice and discrimination in school (61%), family (51%), the community they live in (38%), circle of friends (30%) as well as 75% of the participants stating they see elements of prejudice and discrimination towards LGBTI+s within national media (Takács, 2006). Thus, predominantly facing social stigmatisation and exclusion due to lack of support, role models as well as socialisation processes that centralise cis-heteronormativity. The term cis-heteronormativity refers to the hegemonic social norms in which being cis-gender (gender identity matching with assigned gender) and heterosexual are constructed to be the natural as well as superior sexual identity over the others (Warner, 1991). It authorises and validates discrimination towards gender and sexual minorities within socio-political structures of the society (Robinson, 2016). Thus, creating a threat to the social wellbeing of those who identify as gender and/or sexual minorities.

In reference to queer and minority stress theories, it is clear to understand that the disproportionate health inequalities faced by LGBTI+s can be analysed through social norms of cis-heterosexism. Meyer (1995) clearly states that social stigmatisation and oppression of sexual and gender diversity is at the root of many mental and emotional health challenges that LGBTI+s face rather than being inherent to such identities. Minority stress model in application to LGBTI+s postulates that the stress of the experienced sexual and gender-based prejudice has adverse mental health outcomes (Cochran, 2001; Gilman et al., 2001; Meyer, 1995).

The systemic discrimination that LGBTI+s face whether that would be on the macro or micro level creates an environment that possesses higher risks for deterioration in mental health (i.e. depression, mood disorders, post-traumatic stress disorder, alcohol use and abuse, suicide ideation and attempts, etc.) (Bostwick et al., 2010; Burgard et al., 2005; Cochran et al., 2003; Cochran et al.,2011; Gilman et al.,

2001; Hatzenbuehler, 2009). It is also important to mention that these are mostly the interpersonal factors that work at an interplay to influence the mental and social well-being of LGBTI+s. Three findings that have been brought forward after extensive population surveys are that; (1) prevalence of suicide attempts is higher amongst gays, lesbians and bisexuals in comparison to heterosexuals (Balsam et al., 2005; Cochran & Mays, 2000; Garofalo et al., 1999; Gilman et al., 2001; Remafedi et al., 1998; Saewyc et al., 1998), (2) in comparison to heterosexual, gay and bi men have higher rates of depression prevalence of which distribution based on orientation sometimes also applies to women as well (Cochran et al., 2003; S. D. Cochran & Mays, 2000b; Fergusson et al., 1999; Gilman et al., 2001; Russell & Joyner, 2001), (3) also higher rates of occurrence observed in substance use for lesbian and bi in comparison to heterosexual women (Burgard et al., 2005; Cochran & Mays, 2000a, 2000b; Drabble et al., 2005).

The fact that one's minority group identity is targeted and devalued is a significant feature of much stigmatization, whether in the shape of discrimination or toleration. Experiences of people with regards to being discriminated and tolerated can take many forms and occur in a variety of circumstances, but in general, they all pose a danger to the psychological need of having control over one's own life, being accepted and valued (Richman & Leary, 2009; Verkuyten et al., 2019). Limited research indicates the vulnerability of LGBTI+s the social exclusion and discrimination. A study that was done by Bagci and colleagues (2020) looked at the effect of toleration and discrimination on the psychological well-being of LBGTI+s in Turkey. Researchers indicated that physical and psychological abuse and attacks are very common among LGBTI+s. As a result, LGBTI+s are more likely to engage in suicidal tendencies and have a higher prevalence of mental health problems.

Discrimination and tolerance were found to be associated with self-worth, life satisfaction, and negative well-being. Another study looked at the relationships between three aspects of sexual orientation (identification, attraction, and behaviour), lifetime and past-year mood and anxiety disorders, and sex using data from a nationally representative sample for the United States of America (Bostwick et al., 2010). Results have shown that sex, sexual orientation dimension, and sexual minority groups all had different mental health effects. While both men and women had elevated prevalence for mood and/or anxiety disorders, if they identified as lesbian, they had the lowest prevalence of most disorders. Sexual minority men had a significantly higher lifetime risk of any mood or anxiety disorder than sexual minority women. Finally, bisexuals regardless of their gender identity had the highest risk of developing any form of mood or anxiety disorder (Bostwick et al., 2010). This could be explained by the lack of bisexual inclusivity as well as identity erasure of both within and out of the LGBTI+ community, Research also shows that there is a strong association between physical harm and harm threats, like hate crimes and hate speeches, poor mental health for LGBTI+s (Herek et al., 1999; Herek & Garnets, 2007). Research that was done on bisexuality illustrates that bisexuals not only experience homonegativity like their lesbian and gay peers but also the legitimacy and trustworthiness of those who identify as bisexual based on socio-political dynamics as well as beliefs which is a direct identity threat that affects mental wellbeing with double minority stress (Israel & Mohr, 2004).

There is a growing focus on diversity in general with acknowledgement of the mental health consequences of stigma for those who identify as sexual or gender minorities. Yet, in the field of severe mental disorders, it is woefully undeveloped. In a meta-analysis, Kidd and colleagues (2016) outlined the existing literature in these

domains so that additional study, practice, and policy directions might be better informed. There was a total of 27 papers selected for review and research found an elevated risk of severe mental disorders for the lesbians, gays, bisexuals, transgenders, and transsexuals (LGBTs), also, a link between that risk and prejudice, and the real value of creating venues in which LGBTs may be "out" in all parts of their lives were drawn. In the setting of serious mental disorders, sexual and gender identity are rarely discussed. The little amount of research in this field reveals that, when compared to the general population, LGBTI+ people are at a higher risk of having severe mental disorders—a risk that appears to be linked to prejudice.

Thus, a growing body of research indicates that the social well-being of LGBTI+s is under constant threat by the power of cis-heterosexist norms. These norms aid the deterioration of mental well-being of those who identify as LGBTI+s due to perceived and actual stigmatisation, discrimination, tolerance and lack of adequate visible positive social narratives to empower LGBTI+s. Disparities in social and mental well-being inconsequently have an effect on substance use as well as the sexual health of LGBTI+s which shall be further examined and analysed in the below sections.

1.5 Alcohol and Substance Use

A great body of research highlights that LGBTI+s are using higher rates of alcohol and other substances whether as a coping mechanism or a cultural stress output (Burgard et al., 2005; Johnson et al., 2008; Northridge et al., 2007; Roxburgh et al., 2016). Many studies have shown that minority stress, along with many mental health adversities, help explain the alcohol and substance use disorders amongst the gender and sexuality minorities (Augelli, 1993; M. Mays et al., 1994; I. H. Meyer, 1995; Margaret Rosario et al., 1996). A significant stressor that is the internalisation of

negative attitudes has also been closely correlated with mood and substance disorders (DiPlacido, 1998; Ilan H Meyer & Dean, 1998; Williamson, 2000).

The higher probability is often times accredited to heterosexist discriminatory practices (Mays & Cochran, 2001; Mays et al., 2004; Ilan H. Meyer, 2003). To add to that, even though there were expectations for gay and bisexual men to have a higher prevalence of substance use the results were inconclusive for such generalisation (Cochran & Mays, 2007). The increased prevalence amongst LGBTI+s has been observed when compared to heterosexual counterparts in international research that looked at alcohol and other drugs (AOD) use prevalence. According to Roxburgh (2016), there are possibly a number of factors that increases the rate of AOD prevalence amongst LGBTI+s. Many research highlights the use of drugs amongst gay and bisexual men for increased sexual sensation and pleasure (Hurley & Prestage, 2009; Mansergh et al., 2001; Prestage et al., 2009). The focus on the use of drugs amongst gay and bisexual men has coined the term chemsex (using drugs, aka chemicals, for sexual pleasure). Though the use of drugs during sex is not exclusive to this key population it is highlighted that there are unique factors for which it happens. Some of these factors include; (1) the stigma and negative social attitudes towards not just homosexuality but men having sex with men, (2) stigma and social trauma that is prevalent in the association of sex with the AIDS pandemic, (3) inhibition of pleasure due to cultural and/or religious attitudes for men who have sex with men, (4) the change of experiencing sex and love with the introduction of gay dating apps that created a hook-up culture, (5) the culture of rejection that has arisen due to the hook-up culture based on solely based on appearance (height, weight, body and facial hair, presenting masculine and/or feminine) as well as ethnic and racial background (Stuart, 2019). Another factor that has been contextually discussed is the normalisation of

substance use amongst LGBTI+s as a shared value due to the fact that for decades the only socialisation processes that LGBTI+s were allowed to have was lesbian and gay bars (Hughes & Eliason, 2002; Southgate & Hopwood, 2001).

To add to that, minority stress has been theorised for being a denominating factor in higher rates of AOD amongst LGBTI+s (Meyer, 2003). Minority stress theory holds that those who belong to minority communities, due to levels of stigmatisation, experience increased social stress, thus, having higher probabilities of developing issues regarding substance use and mental health adversities (Lea et al., 2014; Meyer, 2003). Roxburgh and colleagues' (2016) study has illustrated that there is a higher rate of illicit drug use prevalence for lesbians, gays and bisexuals. There were distinctive differences especially for the type of psychostimulant drugs that were being used, in that, in comparison to their heterosexual counterparts, LGBs were reportedly had a higher prevalence of methamphetamine, cocaine and ecstasy use across their lifespan. A similar study that had the same finding proposed that the choice of such substances, though cannot be explained, shows a pattern in which being openly LGBTI+, stigmatisation, minority group membership stressors and internalised negative self-perception plays a role (Cochran & Cauce, 2006). Findings proposed that prior inception of tobacco and alcohol use for LGB women, in comparison to heterosexual women, has a higher rate as well as drug injections, weekly cannabis and risky alcohol consumption along with illicit drug use within the past year. There are clear indicators for gender differences amongst LGB men and women in terms of problematic substance use markers. Regardless of the fact that the study did not include direct analyses of differences, the author suggests that women, especially bisexual women, have reportedly been more exposed to anxiety and depression as shown by previous research when compared to men (Bolton & Sareen, 2011; S. D. Cochran et al., 2003;

Gilman et al., 2001; Grella et al., 2009). This difference could also be explained through the minority stress model in which two minority identity statuses of being LB and women could be at an intersect in creating a double minority identification and also bisexual identity erasure within the community can be an additive factor. The combination of stressors that comes with these identifications leads to more severely affected social wellbeing which consequently affects mental wellbeing to result in unhealthy coping mechanisms and avoidance by increased use of alcohol and other substances.

1.6 Sexual Health Attitudes

To define sexuality is a matter of complex issue that requires an intersectional approach in understanding how differing factors at the interplay of creating social meaning and biological mechanism. The definition should be rounded in understandings of cognitive, cultural, legal, historical, socio-political, psychological, biological as well as religious, ethical and spiritual contextualisation of the behavioural dispositions that come to influence its very own ontological being (WHO, 2006). Sexuality, today, is understood in terms of being a spectrum that is fluid in expression and sole being of it which is not fixated across the lifespan of an individual, regardless of the fact that there are proposed identifications (i.e., heterosexual, bisexual, homosexual, etc.). Fluidity in sexuality is explained in terms of flexibility in the sexual attraction of someone that can be situation-dependent towards any given gender regardless of one's sexual orientation (Bailey et al., 2016). There is uncertainty when it comes to what the terms specified refer to, it could very well be only used to refer to one's sexual behaviour or from a more holistic understanding to one's emotional, cognitive and behavioural composition in terms of attraction (Edwards, 2004). Therefore, there are considerable apprehensions when it comes to being able to also

define the term healthy sexuality in itself. A plenary discussion that was held by WHO (2006) raised many concerns that what is deemed as healthy could be misconstrued based on social values and prejudices specifically by certain segments within any given society. Thus, the use of sexual health is found to be more prompt in disenfranchising any social interpretation based on the wording and driving the focus into matters of public health. Yet, it is important to be reminded that these terms do not necessarily have to be separated but in fact be understood in terms of an interplay where sexual health could be seen as more attainable when the sexuality is healthy. Therefore, the definition used by the World Health Organisation becomes more comprehensive as it states that it is not only the lack of any dysfunctions, infections and infirmity but rather "a state of physical, emotional, mental and social well-being in relation to sexuality" (Hegazi, 2018, p. 300).

Within the literature it has been discussed that the sexual health of LGBTI+s comes with many perceived stigmas which is also a contributing factor for not receiving medical care, therefore, making specifically men who have sex with men, trans as well as those who engage in anal sex as higher risk groups for sexual health deficits (Hegazi & Pakianathan, 2018; Logie et al., 2020; Mink et al., 2014; Pakianathan et al., 2016; Whitehead et al., 2016).

Gay and bisexual (GB) identifying men who have sex with men are reportedly exhibiting a higher number of sexual partners in comparison to their heterosexual peers who exclusively have sex with women, also, GB men are reported to have more concurrent partners (Pines et al., 2017). In addition to that, they are more likely to report poorer sexual functions along with experiences of non-consensual sex (Mercer et al., 2016). The interplay of sexual and mental health along with substance use has been found to have more prevalent interaction for those who identify as gay and

bisexual men, though it overlaps in also other populations (Hegazi & Pakianathan, 2018). Thus, it is important to contextualise the sexual health of bisexual and gay men in relation to population-specific markers (i.e., minority status-related stress and coming out), mental and physical health concerns (i.e., alcohol and substance use, anxiety, depression) as well as sexual abuse experienced during childhood along with theoretical factors like intention for practising safer sex. Rosario and colleagues (2006) found in a study, that longitudinally analysed a risk factor model of behaviours that are a subsequent sexual risk for young bisexual and gay men, a factor in predicting for engaging in unprotected anal sex was directly mediated by experiences of negative attitudes towards their sexuality, symptoms of substance abuse as well as negatively impacted intentions to engage in safe sex practices. To add to that the research highlighted that increased quantity of sexual partners and encounters, symptoms of substance abuse were incidentally was related to unprotected anal sex in relation to elevated symptoms of anxiety as well as lower self-esteem (Meyer & Dean, 1995; Rotheram-Borus et al., 1994; Seage et al., 1998; Stueve et al., 2002; Waldo et al., 2000). Also, research shows that multiple minority stress increases risky sexual behaviours (Dentato, 2012). Consequently, highlighting the importance of mental health as well as addressing coming out processes in the design of intervention programs is crucial for promoting sexual health amongst gay and bisexual young men.

A conclusion that can be drawn from this research is that the studies of minority stress it is seen that stressors of being sexual and gender minority come with an increased correlation with the disproportionate decrease in sexual health, especially amongst sexual minority men, this correlation has been found to increase amongst those who experience multiple minority stress such as being a person of colour and sexually diverse. Thus, understanding the markers for sexual health for LGBTI+s,

especially for those that are assigned gender male should be analysed within their social context in relation to the dominant power of cis-heterosexism.

1.7 Participation in Community-based Organisations

In contrast to all these factors that affect LGBTI+s negatively, participation in LGBTI+ community-based organizations has been found to have a positive impact on these variables (Fish et al., 2019). Many of these organisations provide psycho-social services, legal guidance, educational programs as well as medical referrals specific to LGBTI+s (Allen et al., 2012). In addition to that, Meyer posits that the effects of minority stress on mental health can be mitigated with the coping strategies and the support that is provided by LGBTI+ community connections both on the group and individual levels (Mongelli et al., 2019).

Community-based organisations that focus on LGBTI+s have been crucial institutions for especially youth who are sexual orientation and gender identity minorities (Boxer & Cobler, 2013; Shilo et al., 2015; The National GLBTQ Youth Foundation, 2010). Such organisations and programs gain utmost importance in light of the fact that coming-out age is significantly getting younger compared to previous decades, however, regardless of the obvious significance for such organisations, there has not been enough studies that looked at the ramification of long-term involvement for LGBTI+ youth (Allen et al., 2012; Boxer & Cobler, 2013; Williams et al., 2019).

In sustaining the overall health and mental wellbeing of LGBTI+s CBOs have been a denominating factor (Institute of Medicine, 2011; Martos et al., 2017). These organisations have been uniquely situated in addressing the socio-political and health-related needs of the LGBTI+ community as they were comprised of the subjects of the matter themselves. Even decades ago, the importance of such organisations had been highlighted for their quality in providing solidarity, a sense of belonging with similar

others who are sexual orientation, gender identity and expression minorities within a given society (Boxer & Cobler, 2013). Qualitative research that was done by Paceley (2016), which looked at the experiences of gender identity and sexual orientation minorities in nonmetropolitan communities in midwestern states of the United States of America, highlighted themes in relation to spaces that lack safety for youth that identifies as LGBTI+s. Throughout the study, the need for a space in which the LGBTI+ youth can meet peers which consequently reduces the sense of isolation by boosting wellbeing is voiced by the participants. The study has also brought forward the self-reported need of LGBTI+ youth for services and resources that are catered to LGBTI+s in issues surrounding mental health, family (i.e., coming out) and development of identity. Another study that was done by Paceley and colleagues (2019) stated that in nonmetropolitan communities such particular needs go unmet. It has been established through evidence in many studies that disparities in mental health have a prevalence for sexual orientation minorities as mentioned also in section 1.4 Mental and Social wellbeing. However, studies show findings that highlight the role of participating in programs, when consistent, boosts self-esteem in youth who identify as LGBTI+s (Fish et al., 2019). Likewise, the disparities when it comes to substance use outlined in above section 1.5 can be mitigated by the uniquely positioned community-based organisation for LGBTI+s. Inequities of health for LGBTI+s can be traced back to the encounters in adolescence (Margaret Rosario et al., 2014) and enduring impacts of LGBTI+ centred community-based organisations that specially cater for youth reinforces the support received which inconsequently bolstering the mental health of LGBTI+s (Fish et al., 2019).

The mitigating explanation of the role that these community-based organisations play, can be explained through the minority stress framework. As

outlined above (section 1.3) minority stress theory helps understand the disparities in mental and sexual health as well as substance use. The postulation allows for analysis to be drawn from external social factors (i.e., physical, psychological and economical violence as well as discrimination and victimisation) to internal psychological processes (i.e., internalised LGBTI+ phobia, perceived discrimination and sense of identity) in understanding the existence of disparities and inequities throughout the life course of sexual orientation and gender identity minorities (Hatzenbuehler, 2009; Ilan H. Meyer, 2003). Within this framework stigma plays a central role, thus, consequently, the mitigation and the buffering role of LGBTI+ community-based organisations can be further postulated to enable to elevate or deescalate the effects of socio-political oppression of LGBTI+s that are experienced both internally and externally (Allen et al., 2012; Martos et al., 2017; Marx & Kettrey, 2016).

It is also important to mention the role of intersectionality amongst LGBTI+ focused CBOs as it underscores the interconnectedness within the community as well as mutual construction of identities (Collins, 1989; Crenshaw, 1989). Due to its very nature of bringing together people of many different backgrounds who hold possibly many other socially constructed minority identities like ethnicity and religion, on top of their sexual and gender identities, enables a unique environment of contact between outgroup members. Thus, enriching the process of one's identity development as well as fostering a welcoming and accepting environment. In addition to that intersectionality cultivates the ability to comprehend the different power dynamics that are at the play of domination and oppression of youth who encompasses various forms of diversity. Thus, incorporation of intersectional perspectives into social and developmental sciences are crucial in order to give subjects the voice to reconstruct their own reality away from the centuries-old power dynamics built in to protect the

status quo (Santos & Toomey, 2018).

To sum up, the possible life-changing positive effects of LGBTI+ community-based organisations are inevitably clear to see for especially youth. Given the fact that the political discourse all around the world is fluctuating towards more conservative and discriminatory social and political practices, CBO participation gives LGBTI+s the platform to exist outside the bounds of cis-heterosexist power dynamics. Thus, enabling and fostering a healing process as well as serving as a preventive measure against inequitable disparities that are faced in comparison to cisgender heterosexual counterparts.

1.8 Current Study

The focus of the current study was to look at the effects of community-based organisations on the sexual health, mental and social well-being as well as alcohol and substance use of LGBTI+'s in the north of Cyprus. These variables have been linked in the literature as syndemic health inequalities (Hegazi & Pakianathan, 2018). In the northern part of Cyprus, Queer Cyprus Association is a predominant community-based organisation that focuses on creating a world in which people do not face discrimination based on their sexual orientation and gender identity, access to rights and equality (Queer Cyprus Association, 2021d). In a research report by Queer Cyprus Association (2017), it has been clearly illustrated that in the northern part of Cyprus high levels of homophobia and transphobia is prevalent. It was also indicated that out of the 1063 participants that were sampled, 141 participants refused to participate and shared their discomfort with the study, withdrew from the research and tore their questionnaires in protest of the topic which goes to demonstrate the strict negative attitudes and behaviours. These attitudes are expected to have an influence on gender and sexuality diverse people living in the northern part of Cyprus with severe stressors

like being socially isolated, socio-politically and economically disadvantaged as well as being forced to conceal their identities or being able to express themselves only in small circles. Also, other research that focused on attitudes shows that negative attitudes towards LGBTI+s are predominant in the Turkish Cypriot community (Uluboy & Husnu, 2022; West & Hewstone, 2012). Another study that was done by QCA (2021c) found that LGBTI+s that live in the northern part of Cyprus face systemic inequalities in that 92.8% live under the poverty line, only 32% can graduate high school (only 11% of trans-identifying people completed their education) and 40% a bachelor's degree. The same study has found that there are systematic discriminations in access to employment, specifically for trans people of which 44% is unemployed and 50% are identified as sex workers. Further, 54% of the participants said they faced different forms of violence in their daily lives which was predominantly psychological and emotional violence (91%), followed by physical violence (39.6%), sexual violence (32.4%), and economical violence (27%).

Considering the level of negative attitudes towards LGBTI+ presented by the public and the links drawn between each variable and minority stress, it is postulated that LGBTI+s are disproportionately affected in the northern part of Cyprus. Therefore, it is expected that participation in an LGBTI+ community-based organisation in the northern part of Cyprus will have an effect on LGBTI+s mental and social well-being, alcohol and substance use as well as sexual health. It is important to study the LGBTI+s experiences in the northern part of Cyprus to better implement intervention strategies to empower the community as well as see how effective LGBTI+ community-based organisations like Queer Cyprus Association who provide such services as mentioned above.

This research centralises around these general hypotheses;

While controlling for experiences of perceived discrimination, support from family and peers, being ‘out’ and contact with LGBTI+s active participation in LGBTI+ community-based organisation will be positively associated with mental and social well-being of LGBTI+s; positive sexual health attitudes of LGBTI+s, however negatively associated with alcohol and substance use for LGBTI+s.

Chapter 2

METHOD

2.1 Participants

In total 181 people identifying as LGBTI+ participated in the study. The mean age for the participants was 26.91 years which ranged from 18 to 61 years of age. Looking at the education level of the participants 38.1% have a bachelor's degree, 29.8% are high school graduates, 22.7% has a master's or a PhD degree, 6.6% are secondary school graduates and 2.8% only completed primary school. When it comes to employment 45.3% are working full time, 34.3% are still students, 11% are unemployed and 9.4% of the participants are working part-time.

In terms of gender identity of participants 81 people (44.8%) identified as cis-man, 48 people (26.5%) identified as cis-woman, 21 (11.6%) did not identify, 20 people (11%) identified as non-binary and 11 people (6.1%) identified as trans. Sexual orientation distribution of the participants showed that 71 people (39.2%) identified as gay, 67 people (37%) identified under the umbrella term of bisexual, 18 (9.9%) lesbian, 18 (9.9%) unidentified and only 7 (3.9%) of participants identified as heterosexual.

In terms of romantic partners, 51.7% of respondents stated to not be in a relationship compared to 48.3% having a relationship. Out of the 181 participants, 22.8% stated that they are living with a physical condition (hypertension, diabetics, etc.). As for living with sexually transmitted infections, 7.2% responded with yes. 38.3% of participants stated that they are currently diagnosed with a mental disorder

(i.e., depression, anxiety, traumatic disorders, etc.) whereas only 22.7% are currently seeing a therapist and 11.6% are currently using medication for their mental disorder.

2.2 Materials

A demographic questionnaire was used to look at some potential variables that may influence the variables and to gain a better understanding of the characteristics of the sample. Therefore age, gender identity and sexual orientation, educational attainment, employment status, romantic relationship status, contact with other LGBTI+s, whether they are 'out', perceived support from family and friends, perceived discrimination based on gender identity, expression, characteristics and/or sexual orientation (in the workplace, school, home).

A measure of the participation in LGBTI+ community-based organisations was also included which has been developed by the researchers in line with the literature. The scale consisted of 4 items with Likert scale answers ranging from 1 to 5; "To what extent do you participate in the activities of any LGBTI+ non-governmental organization?", "Do you take an active role in any committee/working group of an LGBTI+ non-governmental organization?", "Do you feel that you belong to any LGBTI+ non-governmental organization?", "Do you feel affiliated with any LGBTI+ non-governmental organization?". The reliability of the scale was found to be very high within this research ($\alpha = .84$)

To measure mental well-being a Turkish adaptation of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) was used. The scale was developed by Tennant and colleagues ($\alpha = .83$) which was later adapted to Turkish by Keldal ($\alpha = .92$) (Keldal, 2015; Tennant et al., 2007) The Scale consists of 14 items (i.e., "I am optimistic about the future.", "I am concerned with other people.", "I feel loved.") on a Likert scale ranging from 1 to 5 and within this research, the reliability was found to

be very high (α = .93). Higher values indicated more positive mental well-being.

In order to determine the social well-being of the participants, the Social Wellbeing Scale developed by Keyes (1998) and adapted to Turkish (Akın et al., 2013) was used. The Social Wellbeing scale with 15 items (i.e., “I don't feel like I belong to any group.”, “I feel close to the people around me.”, “People don't care about other people's problems.”) was found to be moderately reliable within this research (α = .79). Higher values indicated more positive social well-being.

In order to measure alcohol and substance use, the Turkish adaptation of the BARPIT- alcohol (α = .70) and BARPIT-substance (α = .88) scales was used (Ögel et al., 2017). The analysis for the Barpit Alcohol and Substance Use Scale, which consisted of 12 items, was found to have high reliability within this research (α = .82). Higher values indicated more risk for higher prevalence for alcohol and substance use.

To measure sexual health attitudes a measure that was adopted in accordance with the literature was used which consists of questions about sexual and reproductive health education status of young people, attitudes and behaviours regarding sexual health problems and questions in the section on sexual behaviours based on the YRBSS-Youth Risk Behavior Surveillance System questionnaire applied by the United States to young people every year. A version of this scale has been used previously by Gürel & Taşkın (2020). The ten items used for this research were about how often condom is used, whether they find their knowledge on sexual health adequate, how often they have issues of sexual health, whether they think protection against STIs is the responsibility of all partners and if there is a need to use protection, whether if they would get tested if a partner is diagnosed with an STI, whether if they would break up with a partner, blame them or don’t care and support them through the

treatment process if their partner was diagnosed with an STI. The items were transformed and coded into a scale. Higher values indicated more positive sexual health attitudes. The scale measuring sexual health within this research consisted was found to be highly reliable (α =.83).

2.3 Procedure

After the ethical approval was received researcher started collecting data through online platforms using google forms. The data was distributed through online social platforms like Facebook, Instagram as well as dating apps used by LGBTI+s like Hornet, Grindr and Wapa to be able to access the LGBTI+ community living in the northern part of Cyprus. When participants agreed to take part in the research, the screen included an informed consent form to fill out and given general information about the research. The participants were informed about the right to withdraw from the research at any given moment and that the process was going to take up approximately 15 minutes. First, they were asked to fill out the BARPIT-alcohol and substance scale, Warwick-Edinburgh Mental Well-being Scale, Social Well-being Scale, and Sexual Health Scale after which demographic questionnaire containing questions regarding the control variables and participation in LGBTI+ community-based organisations followed. Counterbalancing of scales were used, to prevent contamination of scales. At the end of the data collection for each participant, a screen with a debrief form that explains the study in more detail appeared at which point researchers' contact information was given for participants if they had any questions or if they wanted their data to be excluded from the study. After the data collection, the appropriate SPSS analysis was computed (linear multiple regression analysis) to analyse the results.

Chapter 3

RESULTS

3.1 Correlational Analysis

A preliminary Pearson's correlation test was run to assess the initial relationships between the variables included in the study. As can be seen in Table 1, a number of significant relationships were also seen between other variables too, including support and contact, discrimination and social wellbeing mental wellbeing, support and mental wellbeing to name a few.

Table 1: Correlations between support, participation in CBOs, perceived discrimination, sexual health, social wellbeing, mental wellbeing, alcohol and substance use, contact, and being out.

Variable	*n*	M	SD	Min	Max	1	2	3	4	5	6	7	8	9
1. Support	181	3.25	.90	1.00	5.00	-	-							
2. CBO	181	.51	.50	1.00	5.00	.05	-							
3. Discrimination	181	2.52	1.11	1.00	5.00	-.29**	.00	-						
4. Sexual Health	181	4.12	.52	1.78	5.00	.26**	.20**	-.20**	-					
5. Social Wellbeing	181	3.64	.88	1.50	5.71	.26**	.05	-.35**	.33**	-				
6. Mental Wellbeing	181	3.50	.84	1.00	5.00	.21**	.02	-.29**	.29**	.73**	-	-		
7. Alcohol and Substance Use	181	.31	.30	.00	1.50	.06	-.12	.12	-.09	.09	.01	-	-	
8. Contact	181	3.35	1.48	1	5	.37**	.18*	-.04	.26**	.29**	.25**	.11	-	-
9. Out	181	3.65	1.34	1	5	.34**	.09	-.08	.14	.23**	.25**	.12	.44**	-

*p < .05. **p < .01.

3.2 Hierarchical Regression

To approach the question of "What are the effects of participation in Community based organisations, in the northern part of Cyprus for LGBTI+s, on mental and social wellbeing, alcohol and substance use, and sexual health?" four separate hierarchical linear regression analyses were conducted for each dependent measure. For each analysis, the first block of variables were the control variables which were perceived discrimination, support from family and peers, being 'out' and contact with LGBTI+s. In the second step, the main variable of CBO participation was added. Each dependent measure is covered below.

3.2.1 Sexual Health

After entering the first block of control variables, the model was found to be statistically significant, F (4,176) = 6.00, $p < .001$. Within the model contact (β = .07, $p<.01$) and discrimination (β = -.07, $p<.04$) was found to be statistically significant. Additionally, the R^2 value of .12 associated with this regression model suggests that the variables account for 12% of the variation in Sexual Health. For the second block of the analysis, the predictor variable of participation in community-based organizations was added. The results of the second block analysis revealed the model to be statistically significant, F (5,175) = 5.98, $p < .001$). The R^2 change value of .03 associated with this model suggests that the addition of participation in CBO to the first block model accounts for 3% of the variation in sexual health. Within the second block contact (β = .06, $p<.03$), discrimination (β = -.07, $p<.04$) and CBO participation (β = .17, $p<.05$) were found to be significant.

3.2.2 Social wellbeing

The model in the first block was found to be statistically significant, F (4,176) = 11.15, $p < .0001$. The variables that were found to be significant were contact (β =

.13, $p<.001$) and discrimination ($\beta = -.26$, $p<.001$). However, when participation in CBO was added to the model in the second block there was no statistical significance found apart from the same values in the first block, F (5,175) = 8.87, $p < .001$). The R^2 value of both first and second blocks, .20 associated with these regression models suggest that the variables account for 20% of the variation in social wellbeing.

3.2.3 Mental wellbeing

The first of block of the analysis was found to be statistically significant F (4,176) = 8.35, $p < .001$, whereas the second block which included participation in CBOs was insignificant F (5,175) = 6.68 $p = < .001$). The significant variables were again contact ($\beta = .095$, $p<.04$) and discrimination ($\beta = -.20$, $p<.001$) The R^2 value of both first and second blocks, .16 associated with these regression models suggest that the variables account for 16% of the variation in social wellbeing.

3.2.4 Alcohol and substance

Both blocks of analysis were found to be statistically non-significant, F (4,176) = 1.61, p =.17, and F (5,175) = 2.05, p = .07, respectively.

Table 2: Hierarchical regression analysis on sexual health, social wellbeing, mental wellbeing, alcohol and substance use

	Sexual Health			Social Wellbeing			Mental Wellbeing			Alcohol and Substance Use		
Model	df	F	Sig.	df	F	Sig.	df	F	Sig.	df	F	Sig.
1	4 176	6.00	.000	4 176	11.15	.000	4 176	8.35	.000	4 176	1.61	.17
2	5 175	5.98	.000	5 175	8.87	.000	5 175	6.68	.000	5 175	2.05	.07

*1 Predictor: (Constant), Support, Discrimination, Out, Contact

*2 Predictors: (Constant), Support, Discrimination, Out, Contact, CBOcat

Chapter 4

DISCUSSION

This study looked at the effects of participating in LGBTI+ community-based organisations on alcohol and substance use, mental and social wellbeing, and sexual health of LGBTI+s in the northern part of Cyprus. It was hypothesized that active participation in LGBTI+ community-based organisations will be positively correlated with the mental well-being of LGBTI+s, that LGBTI+s who actively participate in a community-based organisation will report higher levels of social well-being, also that sexual health attitudes of LGBTI+s who participate in CBOs will be more positive, and finally, active participation in LGBTI+ community-based organisation will reduce alcohol and substance use for LGBTI+s. Out of all of these hypotheses, it was found that only the participation in community-based organisations had a significant effect on the reported sexual health of LGBTI+s in the northern part of Cyprus.

It is crucial to highlight the importance of wider social factors like socio-political, economic and legal contexts within a given society along with individual factors as a marker for sexual health for those who identify as a minority in terms of their gender identity, characteristics, expression and/or sexual orientation. It is well noted that health disparities for LGBTI+s are predominantly due to stigma, discrimination as well as lack of equality in access to civil rights based on sexual orientation and gender identity (Institute of Medicine, 2011). It should be reminded that any sexual identification is not inherently a risk for sexual health. Rather the scientific explanations should be criticised in that sexual behaviours such as anal sex

is a risk factor, however, the generalisation that “men who have sex with men” are more at risk is grounded in the notion that only gay or bisexual men engage in anal sex. Another criticism that is brought to public health workers and researchers is the overuse of the terms men who have sex with men and women who have sex with women. The phrasing of the sentences, though is understandable through historic medical terminology, perpetuates the erasure of same-sex relationships by narrowing it down to sexual behaviour and ignoring the cultural relevance and other underlying social factors that have previously been mentioned to influence the sexual health of the LGBTI+ community members (Young & Meyer, 2005). Looking through the Queer theoretical lens the subjective identification and the socio-collective dispositions gathers utmost importance against pseudo-scientific assumptions of objectified truths (Molacı, 2020). Thus, this understanding and way of explanation of risk categories fuels cis-heterosexist discourses within societies. This gives already prejudiced people more ammunition in attacking the LGBTI+ rights movements and preventing LGBTI+s from accessing sexual health services due to perceived and actual stigma. This further creates a cycle in which people, identifying as LGBTI+ or practising sexual behaviours that are not “acceptable” by social norms, are unable to access public health services in turn being more at risk of sexual health deficits. This, unavoidably also promotes a cis-heterosexist narrative that being an LGBTI+ comes with inherently and inevitably disrupted sexual health. Henceforth, it is of utmost importance to help reduce perceived discrimination in order to elevate the barriers in between attaining more positive sexual health attitudes for LGBTI+s.

Looking more closely at the predictors of sexual health within this research it can be seen that contact with other LGBTI+s, familial and friend support and participating in community-based organisations had a positive effect, whereas

perceived discrimination negatively influenced it. These results clearly indicate the effects of active participation in CBOs as well as the role of social support in sexual health attitudes, while at the same time highlighting the adverse impact of perceived discrimination. Many studies within the literature highlight the inequitable disparities in access to health and negative influences of discrimination on the sexual health of LGBTI+s which are in line with the postulations of minority stress theory (Hegazi & Pakianathan, 2018; Pakianathan et al., 2016; Whitehead et al., 2016). The results are in line with the theorisation that cis-heteronormative practices disproportionately affect LGBTI+s in access to or maintaining sexual health. Thus, fostering environments without discrimination that enable normalisation of issues and conversations amongst minorities of sexual orientation and gender identity aids in the replenishment of sexual health for the local context. However, it should be noted that the participant distribution for the study was lacking adequate input of all LGBTI+s specifically trans participants as it predominantly consisted of gay cisgender men, bisexual cis-gender women, lesbians cis-gender women respectively. However, it is important to note the fact that studies show trans people being more disproportionally affected by sexual health issues, this comes from the fact that gender-affirming needs are mostly not met, both by the general public and also by health care workers (Eyler, 2013; Hegazi & Pakianathan, 2018). Thus, the fear of stigmatisation from health care workers puts a barrier in accessing health services specifically for trans and non-binary people (Whitehead et al., 2016). Therefore, it is suggested for further researchers to look into differences amongst all sexual orientations and gender identities in more depth to come to a more intelligible conclusion on the sexual health of LGBTI+s. More specifically, there is a need for research that looks at the sexual health of trans people living in the northern part of Cyprus in depth.

The results of this research illustrated that participation in community-based organisations does not have an effect on the social wellbeing of LGBTI+s as predicted. This finding is not supported by the literature which shows that especially for youth participation in such LGBTI+ organisations increases self-esteem and wellbeing (Fish et al., 2019). Other variables that were found to increase social wellbeing, within this research, are support from family and friends, positive mental wellbeing and sexual health. On the other hand, perceived discrimination was found to be a deterrent for the social wellbeing of LGBTI+s. This finding, in line with the minority stress theory, shows that distal and proximal stressors affect the LGBTI+s social wellbeing (Dentato, 2012). The discrimination that LGBTI+s face in the form of social isolation, physical, psychological and economical violence are all examples of distal stressors that are happening outside of themselves. These distal stressors become anticipated more often thus inducing additional stress, in turn fuelling the internalisation of cis-heterosexism, thus, leading up to concealment of LGTBI+ identity (Cole et al., 1996; Pennebaker, 1995). This creates a cycle of violence that is triggered by the "normative" sociocultural power institutions and reinforced by internal factors. The social wellbeing of LGBTI+s are constantly menaced by how the distal factors lead up to the proximal factors that create more negative self-perceptions. Inconsequently, this leads to the formation of detachment from the social world through alienation, exasperation and being defined by only one's gender identity, characteristics, expression and/or sexual orientation (Cass, 1996; Eliason, 1996). In contrast, social re-affirmative environments that boost social wellbeing was linked with also mental wellbeing in previous studies (Crocker & Park, 2004; Meyer, 2003). Thus, finding a link between social and mental wellbeing within this research indicates that the minority stress theorisation could be applied to the northern Cypriot case. However, participation in

community-based organisations did not have the expected relationship with social wellbeing.

Another variable that was hypothesised to be affected by active participation in community-based organisations was the mental wellbeing of LGBTI+s. The results clearly indicated that mental wellbeing increased with higher sexual health, social wellbeing, support, contact with other LGTBI+s and being out. Yet participation in community-based organisations was not found to have an effect on the mental wellbeing of LGBTI+s. The mitigating effect of community-based organisations on mental health is not met within this local context. This indicated that proximal stressors like internalised heterosexism (Kuerbis et al., 2017), as well as distal stressors of physical, psychological, economical violence and discrimination (Rosario et al., 2014), may not be adequately addressed to be resolved. In recently published series of studies published by Queer Cyprus Association (2021c, 2021b, 2021a) it has shown that LGBTI+s, in the northern part of Cyprus face disproportionate amounts of social, economic, physical and psychological violence not just from society at large but their close relatives, friends and family members. When LGBTI+s face such violence and victimisation the majority reported not seeking out professional help from institutions or even friends and families. Findings show that psychosocial and legal services that are provided by local authorities are not up to international human rights standards, thus, further victimising and subjecting LGBTI+s to unmonitored, unjustifiable human rights violations. These have led to a lack of trust in local authorities in implementing preventative policies and enabling access to psycho-social services that are provided. Also, it is worth mentioning that this lack of trust in local authorities, though not to the full extent, is reflected in the community-based organisations according to the findings (Queer Cyprus Association, 2021c). This concludes that intervention programs lack

the influence that participation in the community-based organisation could essentially have on social wellbeing negatively reflect on the mental wellbeing of LGBTI+s. The literature indicates the relationship that social and mental wellbeing has for LGBTI+s specifically with the minority stress theory. The social exclusion that LGBTI+s face due to their minority identity (Bagci et al., 2020b), as well as disparities in access to psycho-social services (Queer Cyprus Association, 2021c), puts a strain on mental wellbeing. It was found that 61% of the participants reported finding psychosocial services that are provided to be inadequate. This indicates that there should be amendments to the clinical settings in line with LGBTI+ affirmation as well as trainings to mental and physical health providers. Also, it is important to mention that there are no local legal texts in the northern part of Cyprus for regulating the field of psychology. Thus, service provision goes unchecked in terms of the quality and educational background of the provider. This lack of satisfaction in combination with the above-mentioned distrust of local authorities may have led LGBTI+s to develop and implement specific coping strategies that do not rely on the help of others. Thus, participation in community-based organisations may not be effective in resolving issues of mental wellbeing. However, this assumption needs to be based in more concrete and based on empirical data to better understand the coping strategies of LGBTI+s who live in the northern part of Cyprus. This could inform specific intervention programs to increase mental wellbeing, which could be implemented by CBOs such as QCA.

There were no effects of participation in community-based organisations on alcohol and substance use for LGBTI+s. Also, when looking at other variables within the research there were no correlations that could be identified in the prediction of alcohol and substance use with contact, being out, perceived discrimination and

support from family and friends. However, the literature is clearly illustrating that the prevalence of alcohol and substance use in LGBTI+s is higher than their cis-heterosexual counterparts and the prevalence of use can be mitigated by community-based organisations (Burgard et al., 2005; Fish et al., 2019; Meyer, 2003; Pakianathan et al., 2016; Roxburgh et al., 2016; Stueve et al., 2002). There might be several factors for this result to be inconsistent with the previous studies within the literature. The major limitation in this assumption was that the LGBTI+ community had a similar process of using alcohol and substances as a defence mechanism to alleviate the socio-political oppression. All previously mentioned studies link alcohol and substance use with the theorisation of minority stress, in that, when distal and proximal stressors affect social and mental wellbeing prevalence of alcohol and substance use increases. Yet, such findings could not be supported with the current research, thus, indicating a differential analysis should be done to understand the cultural implications for the LGBTI+ community in the northern part of Cyprus. Also, the historic gay bar culture of most western societies which has provided a safer environment for socialisation as well as the chemsex practices due to internalised heterosexism and the mainstreaming of gay dating apps might not be relevant for the local context. It can very well be inconsequential for the reality of LGBTI+s living in the northern part of Cyprus.

Even though the current study focused on identifying the effects of community-based organisations for LGBTI+s other variables were found to affect the main dependent variables used within this research. Throughout the current study contact with LGBTI+s, support from family and friends and being out were found to affect the main dependent variables apart from alcohol and substance use. In addition to having found these variables' positive effect, discrimination was found to have a negative influence on them. These findings are in line with the above-mentioned literature

which suggests the minority stress theory's postulation of social factors and internal psychological factors are at an interplay in predicting social and mental wellbeing as well as sexual health of LGBTI+s. Contact with LGBTI+s help reduce the negative attitudes and prevent the internalisation of cis-heterosexist values that are imposed upon the LGBTI+s by the dominant social norms. Contact in combination with support helps serve as a preventative measure in need of identity concealment through affirmative socialisation processes. This could be postulated to create an environment in which "non-conventional" sexual health becomes less of a stigma, thus, influencing the sexual health attitudes of LGBTI+s. However, the negative influence of perceived discrimination should be kept in mind in understanding how these variables could potentially affect one another. Because the researcher didn't check for income level, looked at the employment status of the participants and only 10 % was unemployed thus it was not included in the research as a control variable.

Indications of the above-mentioned variables clearly illustrate the need for implementing specifically developed intervention programs that highlight the intersectional values of the LGBTI+ community in its core with values of social affirmation. These could range from regularised socialising events with the participation of diverse members in terms of their backgrounds as well as encouraging meaningful engagement, as well as thematic discussions that centralise coming out processes, mental wellbeing challenges and sexual health of LGBTI+s. Formatting of such intervention programs that promote intersectionality, social support and foster non-discriminatory environments should aid community-based organisations in sustainably-grown communities with better mental and social wellbeing as well as sexual health.

However, considering these above-mentioned variables' effects, the current study could have found active participation in community-based organisations to be a mitigating factor in ensuring an increase in social and mental wellbeing, sexual health and a decrease in alcohol and substance use. However, there could be several factors that might have been the limitation of this study in terms of the assumptions and methodology. First of all, the sample group was limited which affected the power of the analysis, thus, further studies with bigger sample groups could potentially reach a different conclusion.

Another limitation could be the timing of the research data collection. Since the data collection stage happened throughout the Covid-19 pandemic, socialising events such as parties, picnics, thematic discussions, movie nights etc, had either been suspended or limited in line with the safety measures all around the world. These events in themselves bring people from different backgrounds together who share a common intersecting social identity of being LGBTI+, thus, enabling a social environment for participants to meaningfully engage and have contact with different people. This engagement creates feelings of connectedness and a sense of belonging free of judgement thus fostering healthier construction of self-perception and identity exploration (Kimberlé Crenshaw, 2021; Fish et al., 2019). The development of identity and comprehension taking place at such an intersectional and socially affirmative environment not only enables contact with other outgroups (i.e., gender, sexuality, ethnicity, religion, disability, etc.) but also empowers LGBTI+s to question the cis-heteronormative power institutions to look at from subjective realities rather than the status quo provided by disproportionately dominant norms (Santos & Toomey, 2018). A recent study by Salerno (Salerno et al., 2020) and colleagues show that during the pandemic LGBTI+s have been disproportionately affected in terms of

their wellbeing. Also, it could be considered that the social needs of the LGBTI+s living in the northern part of Cyprus are not met, thus, should be researched in further detail to be able to implement strategies that promote social wellbeing.

Implications of such findings are the need for developing and implementing strategic intervention programs. This program should focus on fostering and flourishing the social wellbeing of LGBTI+s in acceptance and intersectional environments. Social wellbeing plays an integral part in establishing better mental health outcomes thus fostering positive sexual health attitudes as well as mitigating alcohol and substance use. In line with the Queer theory's postulation, the effects of domination and oppression of cis-heteronormativity on the gender identity, expression and characteristic and sexual orientation of diverse people are rooted in socio-political institutions. Thus, the stressors outlined by the minority stress theory have an exasperated negative impact on LGBTI+s. However, affirmative intersectional socialization environments enable the sense of not only belonging but being more than one's own social identity. Therefore, such re-structuring of activities as well as wellbeing focused approaches would help build a healthier and stronger community in the northern part of Cyprus.

It could be drawn out that there is a need for further studies to map the queer history of Cyprus and how LGBTI+s have been socialised and affected by different cis-heterosexist power dynamics throughout the decades as well as social and technological advances. Such empirical data could help in identifying the unique needs of LGBTI+s in the northern part of Cyprus in terms of coping strategies developed as well as understanding the culturally relevant cis-heteronormative power dynamics that influence the socio-political dispositions of the LGBTI+ community. It is also worth mentioning that the motivation for participating in such community-based

organisations could potentially influence the effects of the participation. Motivation studies show how intrinsic motivation should be understood in its collective sense of meaningfulness, commitment and engagement, thus, making it a possible denominator in understanding how participation in CBOs is on more of a deeper level (Chalofsky & Krishna, 2009)

Overall, apart from sexual health, the other main variables of the study (mental and social wellbeing, alcohol and substance use) were not influenced by participation in LGBTI+ community-based organisations in the northern part of Cyprus. These results could be influenced by the pandemic as mentioned earlier as a limitation of the study. Also, it is important to mention the fact that there is currently one community-based organisation based in the northern part of Cyprus which have only recently started to provide psycho-social and legal services (for almost four years now) and the CBO itself was only established fourteen years ago. Thus, the effectiveness of such services and how socialisation processes of Queer Cyprus Association happen should be examined further. Such further examination could potentially help identify the divergence from the literature on effects of CBO participation for LGBTI+s as well as formatting the scope of community-building efforts to help foster an environment for LGBTI+, specifically youth, to increase their social and mental wellbeing as well as mitigate the prevalence of alcohol and substance use.

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APPENDICES

Appendix A: Key Words

Cis-gender	Someone whose assigned gender at birth matches their gender identity
Heteronormativity	The concept which assumes heterosexuality to be the norm of human sexuality
Cis-normativity	The concept which centralises the idea that being cisgender is the norm
Homonegativity	Term used to describe any negative attitude, and behaviour based on prejudice due to someone's same-sex attracti

Appendix B: Informed Consent Form

Psikoloji Bölümü
Doğu Akdeniz Üniversitesi
Gazimağusa, Kuzey Kıbrıs Türk Cumhuriyeti
Tel: +(90) 392 630 1389 Fax: +(90) 392 630 2475
Web: http://brahms.emu.edu.tr/psychology

LGBTİ + ların Sosyal Tutumları

Sevgili katılımcı,

Lütfen katılmayı kabul etmeden önce bu araştırma ile ilgili aşağıdaki bilgileri dikkatlice okumak için birkaç dakikanızı ayırın. **Herhangi bir zamanda, çalışma ile ilgili bir sorunuz varsa, lütfen daha fazla bilgi sağlayacak araştırıcıya sormaktan çekinmeyin.**

Bu çalışma, **Doğukan Gümüşatam** tarafından **Prof. Dr. Şenel Hüsnü Raman** gözetiminde yürütülmektedir. **Bu araştırma LGBTİ+ların günlük hayatlarında karşılaştıkları olası sorunları ve sosyal tutumlarını ele almayı amaçlıyor.** Çalışmanın tamamlanması **15 dakikadan** fazla sürmemelidir.

Tabii ki, bu araştırmaya katılmak zorunda değilsiniz ve katılmayı reddetmekte özgürsünüz. Ayrıca, çalışmadan herhangi bir noktada herhangi bir sebep göstermeksizin geri çekilebilirsiniz. Bu durumda, tüm cevaplarınız yok edilecek ve araştırmalardan çıkarılacaksınız. Çalışmaya katılmayı ve tamamlamayı kabul ederseniz, tüm cevaplar ve anketler **gizli** tutulacaktır. Tanımlayıcı bilgileriniz anketinizin geri kalan bölümünden ayrı ve güvenli bir şekilde saklanacaktır. Veriler çalışmadan sonra en fazla altı yıl boyunca saklanacaktır. Veriler analiz edildiğinde, bulguların bir raporu yayınlanmak üzere sunulabilir.

Gönüllü katılımınızı belirtmek için lütfen aşağıdaki onay formunu doldurun.

ONAM FORMU
Araştırma Başlığı: LGBTİ + ların Sosyal Tutumları

Araştırmacının Adı: Doğukan Gümüşatam
Araştırmacının e-posta adresi: (dogukan.gumusatam@gmail.com)

Lütfen her bir bildirimi kabul ettiğinizi onaylamak için kutuları işaretleyin.

1. Bu çalışma için bilgi sayfasını okuduğumu ve anladığımı onaylıyorum ve herhangi bir soru sorma fırsatım oldu.
2. Katılımımın gönüllü olduğunu ve çalışmadan istediğim zaman açıklama yapmadan çekilebileceğimi biliyorum.
3. Bu çalışmaya katılmayı kabul ediyorum.

_____ _____
Tarih İmza

Bu çalışmanın etik davranışı hakkında endişeleriniz varsa, lütfen Doğu Akdeniz Üniversitesi Psikoloji Bölümü & Araştırma ve Etik Komitesi adına Yrd. Doç. Dr. Çığır Kalfaoğlu, yazılı olarak endişelerinizi detaylı olarak açıklayınız (cigir.kalfaoglu@emu.edu.tr).

Appendix C: Barpit-Alcohol and Substance Use Scale

BAPİRT-ALKOL ve MADDE ÖLÇEĞİ

Lütfen aşağıdaki maddeleri dikkatlice okuduktan sonra karşılarında bulunan yanıtlardan size en çok uyanın üzerine X işareti atarak seçiniz.

Son altı ay içerisinde ne sıklıkla alkol kullandınız?	Hiç kullanmadım veya ayda 1-3 kereden fazla değil	Haftada 1-5 kez	Hemen hemen her gün
Son altı ay içinde, alkol içtiğinizde bir günde ne kadar içerdiniz? Ortalama olarak söyleyebilir misiniz? Aşağıdakine göre günlük standart içki miktarını hesaplayıp, yanıtı öyle yazınız Bir kadeh şarap = Bir standart içki Yarım duble rakı veya votka veya cin veya viski vb= Bir standart içki Bir büyük kutu bira= 1,5 standart içki	Hiç veya 1-2 standart içkiye kadar	3-4 standart içki	5 standart içkiden fazla
Son altı ay içinde, bir seferde (6 kadeh şarap veya 3 duble rakı veya dört kutu büyük bira) veya daha fazla içme sıklığınız ne kadardır? Parantez içindeki standart içki cinsini daha önceki soruda verdiği yanıta göre belirleyiniz.	Hiç veya ayda birden az	Ayda 1-3 kez	Haftada bir veya daha fazla
Gündüz saatlerinde de alkol kullandığınız zamanlar oldu mu? Ne sıklıkla?	Hiçbir zaman	Bazen	Çok sık
Aileniz veya çevreniz sizin çok fazla alkol kullandığınızdan endişeleniyor muydu? Ne sıklıkla?	Hiçbir zaman	Bazen	Çok sık
Alkol kullandığınız için aile ziyaretleri, hobiler, sosyal ilişkiler gibi hayatınızdaki başka etkinliklerden vazgeçtiğiniz oldu mu?	Hiçbir zaman	Bazen	Çok sık
Son bir yıl içinde ne sıklıkta [madde] kullandınız?	Hiçbir zaman	Enazbirkez	Üçten fazla kez
[Maddeyi] kestiğinizde veya azalttığınızda bazı sorunlar ortaya çıktı mı? (örneğin uykusuzluk, terleme, sinirlilik, huzursuzluk, titreme vb)	Hiçbir zaman	Bazen	Çok sık
[Madde] kullandığınız için hayatınızdaki başka etkinliklerden vazgeçtiğiniz oldu mu? (örneğin aile ziyaretleri, hobiler, sosyal ilişkiler vb)	Hiçbir zaman	Bazen	Çok sık
[Madde] kullanmak beden veya ruh sağlığınızı olumsuz yönde etkiledi mi?	Hiçbir zaman	Bazen	Çok sık
[Madde] kullanmanız, az sonra sayacağım yaşam alanlarından birisi üstünde olumsuz etkileri oldu mu? Aile ilişkilerinizde? Arkadaşlarınızla olan ilişkilerinizde? Eğitim hayatınızda? İş hayatınızda?	Hiçbir zaman	Bazen	Çok sık
Gündüz saatlerinde de [madde] kullandığınız oldu mu?	Hiçbir zaman	Bazen	Çok sık

Appendix D: Warwick-Edinburgh Mental Wellbeing Scale

Warwick-Edinburgh Mental İyi Oluş Ölçeği

Lütfen aşağıdaki maddeleri okuyup karşılarında size uygun olan seçeneği işaretleyiniz.

	Hiç katılmıyorum	Katılmıyorum	Biraz katılıyorum	Katılıyorum	Tamamen katılıyorum
1. Gelecekle ilgili iyimserim.	1	2	3	4	5
2. Kendimi işe yarar (faydalı) hissediyorum.	1	2	3	4	5
3. Kendimi rahatlamış hissediyorum.	1	2	3	4	5
4. Diğer insanlara karşı ilgiliyim.	1	2	3	4	5
5. Farklı işlere zaman ayırabilecek enerjim var.	1	2	3	4	5
6. Sorunlarla iyi bir şekilde başa çıkabilirim.	1	2	3	4	5
7. Açık ve net bir biçimde düşünebiliyorum.	1	2	3	4	5
8. Kendimden memnunum.	1	2	3	4	5
9. Kendimi diğer insanlara yakın hissediyorum.	1	2	3	4	5
10. Kendime güveniyorum.	1	2	3	4	5
11. Kendi kararlarımı kendim verebiliyorum.	1	2	3	4	5
12. Sevildiğimi hissediyorum.	1	2	3	4	5
13. Yeni şeylere karşı ilgiliyim.	1	2	3	4	5
14. Neşeli hissediyorum.	1	2	3	4	5

Appendix E: Social Wellbeing Scale

Sosyal İyi Olma Ölçeği

Lütfen aşağıdaki maddeleri okuyup karşılarında size uygun olan seçeneği işaretleyiniz.

(1) *Kesinlikle Katılmıyorum* **(2)** *Önemli ölçüde katılmıyorum* **(3)** *Çok az katılmıyorum* **(4)** *Kararsızım* **(5)** *Bazen Katılıyorum* **(6)** *Önemli ölçüde katılıyorum* **(7)** *Kesinlikle katılıyorum* anlamına gelmektedir.							
1.Dünya bana fazla karmaşık geliyor.	1	2	3	4	5	6	7
2. Kendimi hiçbir gruba ait hissetmiyorum.	1	2	3	4	5	6	7
3. Bana iyilik yapan insanlar karşılığını beklemezler.	1	2	3	4	5	6	7
4. Dünyaya katabileceğim değerli bir şeyler var.	1	2	3	4	5	6	7
5. Dünya herkes için daha iyiye gidiyor.	1	2	3	4	5	6	7
6. Kendimi çevremdeki insanlara yakın hissediyorum.	1	2	3	4	5	6	7
7. Yaptığım şeylerin çevreme hiçbir yararı yok.	1	2	3	4	5	6	7
8. Dünyada neler olup bittiğine anlam veremiyorum.	1	2	3	4	5	6	7
9. Hiçbir toplumsal ilerleme olmuyor.	1	2	3	4	5	6	7
10. İnsanlar diğer insanların sorunlarını umursamıyorlar.	1	2	3	4	5	6	7
11.Çevremdeki insanlar benim için bir rahatlık kaynağıdır.	1	2	3	4	5	6	7
12. Yaşadığım çevrede olacakları tahmin edebilmek benim için çok zor değildir.	1	2	3	4	5	6	7
13. İçinde bulunduğum toplum benim gibi insanları için yeterince ilerlemiyor.	1	2	3	4	5	6	7
14. İnsanların nazik olduğuna inanıyorum.	1	2	3	4	5	6	7
15. Topluma katkı sağlayacak önemli bir şeyim yok.	1	2	3	4	5	6	7

Appendix F: Sexual Health Scale

Cinsel Sağlık Ölçeği

Cinsel hayatınızla ilgili özel sayılabilecek sorular soracağız. Cevaplarınızın gizli kalacağını hatırlatıp, içtenlikle cevap vermenizi rica ederiz.

1. Hiç cinsel ilişkiye girdiniz mi?
    a. Evet
    b. Hayır

2. İlk cinsel ilişkinizi yaşadığınızda kaç yaşınızdaydınız?
    a. Hiç cinsel ilişki yaşamadım
    b. 11 yaşında ya da daha genç
    c. 12 yaşında
    d. 13 yaşında
    e. 14 yaşında
    f. 15 yaşında
    g. 16 yaşında
    h. 17 yaşında
    i. 18 yaşında veya daha sonra

3. Hayatınız boyunca kaç kişiyle cinsel ilişkiye girdiniz?
    a. Hiç cinsel ilişki yaşamadım
    b. 1 kişi
    c. 2 kişi
    d. 3 kişi
    e. 4 kişi
    f. 5 kişi
    g. 6 kişi veya daha fazla

4. Son 3 ay içinde kaç kişiyle cinsel ilişkiye girdiniz?
    a. Hiç cinsel ilişki yaşamadım
    b. Cinsel ilişki yaşadım ama son 3 ay içerisinde değil
    c. 1 kişi
    d. 2 kişi

e. 3 kişi
f. 4 kişi
g. 5 kişi
h. 6 kişi veya daha fazla

5. En son cinsel ilişkiye girmeden önce alkol veya uyuşturucu kullandınız mı?
    a. Hiç cinsel ilişki yaşamadım
    b. Evet
    c. Hayır

6. En son cinsel ilişkide bulunduğunuzda, siz veya partneriniz prezervatif kullandınız mı?
    a. Hiç cinsel ilişki yaşamadım
    b. Evet
    c. Hayır

7. Genel olarak, cinsel ilişki sırasında ne sıklıkta prezervatif kullanıyorsunuz?

1	2	3	4	5
Hiç bir zaman kullanmıyorum				Her zaman kullanıyorum

8. Hayatınız boyunca kiminle cinsel ilişkiye girdiniz?
    a. Atanmış cinsiyeti kadın
    b. Atanmış cinsiyeti erkek
    c. Her ikiside

9. Sizi aşağıdakilerden hangisi en iyi tanımlar?
    a. Heteroseksüel
    b. Gay veya Lezbiyen
    c. Biseksüel
    d. Cinsel yönelimimi farklı şekillerde tanımlıyorum
    e. Cinsel yönelimimi tanımlamıyorum
    f. Cinsel yönelimim hakkında emin değilim

10. Cinsel sağlık/üreme sağlığı ile ilgili herhangi bir eğitim aldınız mı?
    a. Evet
    b. Hayır
    c. Evet ise kimde/nerede aldığınızı lütfen belirtiniz…….

11. Cinsel sağlık/üreme sağlığı bilgi düzeyinizi yeterli buluyor musunuz?

1 2 3 4 5

Oldukça yeteriz buluyorum Oldukça yeterli buluyorum

12. Cinsel sağlık/üreme sağlığı eğitimi almak ister misiniz?

1 2 3 4 5

Kesinlikle istemezdim Kesinlikle isterdim

13. Cinsel sağlığınızla ilgili herhangi bir sorun yaşadınız mı?
    a. Evet
    b. Hayır

14. Evet ise, ne kadar sıklıkla sorun yaşıyorsunuz?

1 2 3 4 5

Oldukça az Oldukça çok

15. Cinsel sorun yaşasanız bunu kime anlatırdınız? (Birden fazla seçenek işaretleyebilirsiniz)
    a. Anne
    b. Baba
    c. Arkadaş
    d. Kardeş
    e. Eş/Sevgili
    f. Sağlık personeli
    g. Öğretmen
    h. Diğer….

Kesinlikle katılmıyorum Kesinlikle katılıyorum

23. Cinsel yakınlığım olan bir kişinin cinsel yolla bulaşan enfeksiyonlardan herhangi birine yakalanmış olduğunu duysaydım bunu önemsemez, ilişkime devam ederdim.

1 2 3 4 5

Kesinlikle katılmıyorum Kesinlikle katılıyorum

24. Cinsel yakınlığım olan bir kişinin cinsel yolla bulaşan enfeksiyonlardan herhangi birine yakalanmış olduğunu duysaydım bunu tedavisi için ona destek olurdum.

1 2 3 4 5

Kesinlikle katılmıyorum Kesinlikle katılıyorum

Appendix G: Demographic Information Form

Demografik Bilgi Formu

Doğum Tarihi: ..... Cinsel Yönelim: _____ Cinsiyet Kimliği: .....

1. Eğitim durumunuzu belirtiniz.
    a. Okuma yazma biliyor ama diploması yok
    b. İlkokul mezunu
    c. Ortaokul mezunu
    d. Lise mezunu
    e. Üniversite mezunu
    f. Yüksek lisans/doktora mezunu
2. Çalışma durumunuzu belirtiniz.
    a. Tam zamanlı bir işte çalışıyor
    b. Yarı zamanlı bir işte çalışıyor
    c. İşsiz
    d. Emekli
    e. Öğrenci
3. Şu an herhangi bir romantik partneriniz var mı?
    Evet Hayır
4. Ne kadar süredir birliktesiniz? _____ ay _____ yıl

Şimdi fiziksel sağlığınız ile ilgili birkaç soru soracağız:

5. Şu an herhangi bir fiziksel rahatsızlık ile yaşıyor musunuz? (ör. Yüksek tansiyon, diyabet, vs.)

Evet Hayır

6. Yaşıyorsanız tedavi alıyor musunuz?

Evet Hayır

7. Daha önce Cinsel Yoldan Bulaşan bir Enfeksiyon geçirdiniz mi?
    Evet Hayır
8. Şu an herhangi bir Cinsel Yoldan Bulaşan bir Enfeksiyon ile yaşıyor musunuz?
    Evet Hayır
9. Ne sıklıkla Cinsel Yoldan Bulaşan Enfeksiyonlar testi yaptırıyorsunuz?
    1 2 3 4 5
    Hiç bir zaman Çok sık

Şimdi ise size akıl sağlığınız ile ilgili sorular soracağız. Kimisi akıl sağlığı yerine ‘ruh sağlığı’ da diyor.

10. Şuanda herhangi bir akıl sağlığı sorununuz (örneğin depresyon, kaygı, travma bozukluğu gibi) var mı?
    Evet Hayır
11. Şuan yaşadığınız akıl sağlığı sorunu için herhangi bir ilaç alıyor musunuz?
    Evet Hayır
12. Evet ise, ne kadar zamandır kullanıyorsunuz? _____ay ____yıl
13. Şu anda bir terapiste gidiyor musunuz?
    Evet Hayır
14. Evet ise, ne kadar zamandır gidiyorsunuz? _____ay ____yıl
15. Terapistinizden memnun musunuz?

1	2	3	4	5
Hiç memnun değil				Çok memnun

Son olarak ise cinsel yöneliminiz ve/veya cinsiyet kimliğinizle ilgili sorular soracağız:

16. Kaç kişiye cinsel yöneliminiz ve/veya cinsiyet kimliğinizi açıkladınız?

1	2	3	4	5
Oldukça az kişiye	Az	Ne az ne çok	çok	Oldukça çok

17. Cinsel yöneliminiz ve/veya cinsiyet kimliğiniz ile ilgili olarak aileniz tarafından desteklendiğinizi düşünüyor musunuz?

1	2	3	4	5
Hiç bir zaman desteklenmiyorum				Çok sıklıla destekleniyorum

18. Cinsel yöneliminiz ve/veya cinsiyet kimliğiniz ile ilgili olarak arkadaşlarınız tarafından desteklendiğinizi düşünüyor musunuz?

1	2	3	4	5
Hiç bir zaman desteklenmiyorum				Çok sıklıla destekleniyorum

19. Cinsel yöneliminiz ve / veya cinsiyet kimliğiniz nedeniyle genel olarak ayrımcılığa maruz kalıyor musunuz? (Evet ise, iş yeri, okul ve ev olarak lütfen belirtiniz)

1	2	3	4	5
Hiç bir zaman				Çok sıklıkla

20. Cinsel yöneliminiz ve / veya cinsiyet kimliğiniz nedeniyle iş yeri ayrımcılığa maruz kalıyor musunuz?

1	2	3	4	5
Hiç bir zaman				Çok sıklıkla

21. Öğrenci iseniz, cinsel yöneliminiz ve / veya cinsiyet kimliğiniz nedeniyle okulunuzda ayrımcılığa maruz kalıyor musunuz?

1	2	3	4	5
Hiç bir zaman				Çok sıklıkla

22. Cinsel yöneliminiz ve / veya cinsiyet kimliğiniz nedeniyle ev ortamında ayrımcılığa maruz kalıyor musunuz?

1 2 3 4 5

Hiç bir zaman Çok sıklıkla

Son olarak LGBTİ+ sivil toplum örgütlerine katılımınız ile ilgili sorular soracağız.

Herhangi bir LGBTİ+ sivil toplum örgütüne üye misiniz?

Evet Hayır

Evet ise, LGBTİ+ sivil toplum örgütünün ismini belirtiniz: _____

Herhangi bir LGBTİ+ sivil toplum örgütününün aktivitelerine ne derecede katılıyorsunuz?

1 2 3 4 5

Hiç bir zaman Çok sıklıkla

Bir LGBTİ+ sivil toplum örgütünün herhangi bir komitesinde aktif rol alıyor musunuz?

1 2 3 4 5

Hiç aktif değil Çok aktif

Evet ise rolünüzü belirtiniz: _____

Kendinizi herhangi bir LGBTİ+ sivil toplum örgütüne ait hissediyor musunuz?

1 2 3 4 5

Hiç ait hissetmiyorum Oldukça ait hissediyorum

Kendinizi herhangi bir LGBTİ+ sivil toplum örgütüne bağlı hissediyor musunuz?

1 2 3 4 5

Hiç bağlı hissetmiyorum Oldukça bağlı hissediyorum

Kaç tane samimi, dost diyebileceğiniz LGBTI+ arkadaşınız var?

1 2 3 4 5

Oldukça az Oldukça çok

Appendix H: Debrief Form

Doğu Akdeniz Üniversitesi
Eastern Mediterranean University
"Uluslararası Kariyer İçin"
"For Your International Career"
Psikoloji Bölümü / Department of Psychology

Psikoloji Bölümü
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Katılımcı Bilgi Formu

'**LGBTİ + sosyal tutumları'** başlığı altında yürütülen bu çalışmaya katıldığınız için teşekkür ederim. Araştırmanın amaçlarını ve hedeflerini açıklamayı amaçlayan aşağıdaki bilgileri okumak için birkaç dakikanızı ayırınız. Araştırma ile ilgili sorularınız varsa, aşağıda iletişim bilgileri olan araştırmacıyla iletişim kurabilirsiniz.
LGBTİ+ların akıl sağlık, sosyal iyilik halleri, alkol ve madde kullanımı ve cinsel sağlık gibi konularda cis-heteroseksüellere kıyasla daha fazla risk taşıdığını göstermketedir (Hegazi & Pakianathan, 2018, (Bostwick et al., 2010; Burgard et al., 2005; Cochran et al., 2003; Cochran et al.,2011; Gilman et al., 2001; Hatzenbuehler, 2009, Bagci et al., 2020, Burgard et al., 2005; Johnson et al., 2008; Northridge et al., 2007; Roxburgh et al., 2016). Bu araştırmada ise **risk faktörü oluşturan bu değişkenlerin LGBTİ+ topluluk temelli kuruluşlara katılım ile nasıl etkileneceğini araştırarak**, genişletiyoruz.

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Araştırmaya yaptığınız değerli katkıdan ve katılımınızdan dolayı teşekkür ediyorum.
Saygılarımla,
Doğukan GÜMÜŞATAM.