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Examination of the Relationship Between Gender Roles of Mental Health Specialists and Levels of Sexual Myths and Homophobia

Melek Turan
Clinical Psycology (MA)

Kahraman Güler
Istanbul Aydın University, Psychology Department, Istanbul/Turkey

***Abstract*---**In this study, it is aimed to evaluate the approaches of mental health experts in terms of the relationship between gender roles, sexual myths and homophobia levels. For this purpose, experts working in the field of mental health; when they were evaluated in terms of their knowledge level on sexual orientation, professional experience and gender, the analysis of the detectability of a direct relationship with homophobia was made. The sample of the study consists of 300 experts working in the field of mental health. In the context of data collection tools in the research, "survey technique" was used. The form containing the voluntary consent of the participants and demographic information together, the “Gender Roles Scale” that measures the gender roles of individuals, the “Sexual Myths Scale” that detects sexual myths and the measures the level of homophobia "Hudson and Ricketts Homophobia Scale" were used. The data obtained in the study were analyzed with the SPSS analysis program. Within the framework of the findings, a moderate and negative relationship between Gender Roles Attitude Scale and Hudson and Ricketts Homophobia Scale scores, moderate and negative relationship between Gender Roles Attitude Scale and Sexual Myths Scale scores, Hudson and Ricketts Homophobia Scale and Sexual Myths Scale. A moderate and positive relationship was found between the scores. It has been reached that the mental health professionals have an egalitarian and modern attitude towards gender role, their belief in sexual myths is at a low level, their homophobia levels are at a low level.

***Keywords*---**gender roles, homophobia, sexual myths, mental health professionals.

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***Corresponding author**: Turan, M.; Email: melek-turan@hotmail.com*
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Extended Abstract

In this study, it is aimed to evaluate the approaches of mental health experts in terms of the relationship between gender roles, sexual myths and homophobia levels. For this purpose, experts working in the field of mental health; When they were evaluated in terms of their knowledge level on sexual orientation, professional experience and gender, the analysis of the detectability of a direct relationship with homophobia was made. The sample of the study consists of 300 experts working in the field of mental health.

Method

Within the framework of the data collection tools used in the research, the "survey technique" was used as a data collection tool. The participants were reached through social media and WhatsApp groups that include colleague solidarity, with the questionnaire created on the Google form. First, the Informed Consent Form was prepared. The data were taken with 4 different forms. The "Informed Voluntary Consent Form", in which the demographic information of the participants and voluntary consent were found together, the "Gender Roles Scale" that measures the gender roles of individuals, the "Sexual Myths Scale" that detects sexual myths, and the "Hudson and Ricketts Homophobia Scale" that measures the level of homophobia were used.

Results

The data obtained in the study were analyzed with the SPSS analysis program. Within the framework of the findings, a moderate and negative relationship between Gender Roles Attitude Scale and Hudson and Ricketts Homophobia Scale scores, moderate and negative relationship between Gender Roles Attitude Scale and Sexual Myths Scale scores, Hudson and Ricketts Homophobia Scale and Sexual Myths Scale A moderate and positive relationship was found between the scores.

Discussion

According to the findings obtained within the framework of examining the relationship between gender roles, sexual myths and homophobia levels of experts working in the field of mental health; It has been found that mental health professionals have an egalitarian and modern attitude towards gender role, their belief in sexual myths is at a low level, and their homophobia levels are at a low level. 72.7% of the participants are female and 27.3% are male mental health specialists. This data does not reflect the equal ratio in terms of gender distribution. Among the mental health specialists of the participants, 1.3% were psychiatrists, 24.7% were psychologists, and 74% were psychological counselors; The data of the sample group mostly includes the data of working psychological counselors. When we analyze the findings, there is a weak and positive relationship between age scores and Hudson and Ricketts homophobia scale, gender roles scale and sexual myths scale scores. There is a weak and positive relationship between Gender and Age scores. When we examine the data we have obtained, it has been found that the level of knowledge about sexual orientation of

the experts working in the field of mental health is in a more meaningful relationship with the level of homophobia, rather than the experience in the profession. There is a moderate negative significant relationship between gender roles and homophobia levels of mental health professionals. There is a moderate and positive relationship between Hudson and Ricketts Homophobia Scale and Sexual Myths Scale and sexual orientation scores. There is a moderate and negative correlation between Gender Roles Attitude Scale and Sexual Myths Scale scores. Most of the data subject to the research was collected from working psychological counselors. Therefore, generalizing the findings to all mental health professionals may not be the right approach. As a result of this study we have done, the fact that the primary preference of families in terms of both economic and transportation convenience is the psychological counselors working in the school guidance service, and the majority of the data we have obtained are psychological counselors, revealing the importance of the study. When the relationship between professional experience, age variable, sexual orientation knowledge level and homophobia levels is examined; It is predicted that as the level of knowledge increases, there will be a decrease in homophobic attitudes. For this reason, it is recommended that psychological counselors be more intensively involved in sexual education programs that include sexual orientation and respect for individual differences, and it is recommended to be supported by in-service trainings affiliated with the Ministry of National Education.

Introduction

Unlike the biological gender definition that separates people as men and women, gender; It is defined as a concept that includes all the complex features attributed to any culture. While sex is used in the case of hereditary and anatomical features that indicate that a person is male or female, "gender" is used to address both a cultural and social perspective of a man or woman, to consider the difference between these two parts and to describe the duties assigned to individuals independently of each other. The differences between men and women were examined within the scope of sociology until 1970. Thus, it was seen as a product of socialization and conceptualized in the style of gender roles. Gender roles; The attitudes and behaviors exhibited by men and women reveal their different duties and responsibilities. These "gender-related duties" that individuals have affect many layers of life, and separations arising from masculinity or femininity can come before people in all periods of life (Marshall, 1999; Ecevit, 2011).

“Gender roles are learned in the socialization process that starts with the birth of the baby. Children born biologically male and female learn norms and expectations appropriate to their gender. Thus, they adopt 'gender roles' and male and female identities (masculinity and femininity) in accordance with these norms and expectations” (Giddens, 2012). Gender means a communal position. Attitudes and activities are determined in a way that is specific to men and women. The individual is subjected to a classification starting from his/her birth, through his/her parents and those around him/her, and is brought up within the framework of the attitudes and principles expected from this class. He/she tends to learn about her environment within the framework of familiar and constructed roles. Differences in the products used by his parents, who are the closest among

the models he observed around him, the difference in their perfumes, their dissimilar clothing styles, etc. It leads to the emergence of an understanding of gender, albeit incomplete, in the child (Lott ve Maluso, 2002).

People in the community regulate their attitudes and behaviors according to the society in order to adapt to the expectations of the society and the conditions of the society. The conditions and expectations in the society are defined as "social norm". The reasons why people take care to adapt to social norms are to be seen as a different individual in the society; exclusion, be ignored, stigma, etc. They do not want to be exposed to attitudes. For example, people in a society, lesbian, gay, etc. exclusion, contempt, etc. towards individuals. Having negative tendencies affects the excluded people psychologically to a great extent. This situation causes lack of self-confidence, depression, social phobia, etc. in individuals. can cause psychological disorders.

The World Health Organization (WHO) explains the concept of sexuality as an undeniable part of the individual (Sahbaz, 2017). Although it is very important for individuals, sexuality, which cannot be mentioned clearly, is positioned in the inner world of people in a "mythical and closed" way. The situation that is intended to be expressed with the term sexual myth is the assumptions that people consider to be true about sexuality, which are mostly inaccurate, contain exaggerations and do not bear scientific proof. Even if the sexuality models learned are the same, “sexual myths” affect individuals in different degrees and types (Sahbaz, 2017; Simsek, 2015). General acceptances and judgments about sexuality differ from society to society. It is seen that there are regional differences in sexuality in the same society. It is one of the other observed cases that there are differences in judgments and behaviors related to sexual matters "according to individual, education, family structure, gender and age". The prevalence of negative sexual teachings indicates that individuals may have grown up in a normative environment. These factors increase the number of individuals who do not have education on sexuality, are inexperienced, have insufficient knowledge of the other sex, have low self-confidence, and have exaggerated desires and discourses. This system has a serious effect on the formation of various sexual dysfunctions (Aydin, 2012). Sexual myths, which are in a very important position in the formation of sexual problems and the increase of problems, have an important place in the acquisition of sexual identity of individuals (Aydin, 2012).

The first psychological definitions of the concept of homophobia were tried to be made by establishing a relationship between homophobia characterized by a mental disorder and irrational fears of homosexuals / homosexuality. In this context, in recent analyzes similar to other types of phobia, this situation is considered as having thought disorders (Herdt & Van der Meer, 2003; Goregenli, 2004’ten as cited in Sah, 2012). Lorde explained homophobia in 1978 as “fear of love for someone of one's own gender and therefore hating when he sees this feeling in others” (Baird, 2004). According to Fernald (1995), the term "homophobia" is seen as a problem in more than one respect; first of all, the concept of “phobia” makes reference to the fact that prejudice against homosexuals is an irrational fear and a form of pathology (Goregenli, 2004). It triggers judgments against LGBT people and causes these to occur in the form of exclusionary attitudes in the form of “fear, hatred, verbal and/or physical violence

and threats" (Sakalli-Ugurlu and Ugurlu, 2004). Studies have found that these negative judgments manifest themselves "at home, at school, in peer groups and in the whole society" (Goregenli, 2004; Herdt ve Van der Meer, 2003; Sakalli Ugurlu ve Ugurlu, 2004; Polimeni et al., 2000).

While the majority of LGBTQ-oriented individuals struggle with prejudice and discrimination by the society and the social stress experienced in this direction, it is considered extremely important that the mental health field does not lead to a prejudice and stress environment dominated by a pathologizing and heteronormative perspective (Yuksel, 2016). Considering the negative attitudes towards homosexual individuals in society and the more frequent use of mental health services by homosexual individuals than heterosexual individuals, it is thought that the possible homophobic attitudes of mental health professionals towards homosexual individuals and the results that can be seen in line with these attitudes will be very important. Many studies conducted in the world indicate that mental health professionals have heterosexist and homophobic attitudes towards homosexual individuals, depending on different time and sample groups (Garfinkle & Morin, 1978 as cited in Tuna,2019). In line with this information, in this research study, it is aimed to evaluate the approaches of experts working in the field of mental health in terms of the relationship between gender roles, sexual myths and homophobia levels.

Method

Data collection tools

In the context of data collection tools used in the research, "survey technique" was used as a data collection tool. The participants were reached through social media and WhatsApp groups that include colleague solidarity, with the questionnaire created on the Google form. First of all, the Informed Consent Form was prepared. The data were taken with 4 different forms. The "Informed Voluntary Consent Form", in which the demographic information of the participants and voluntary consent were found together, the "Gender Roles Scale" that measures the gender roles of individuals, the "Sexual Myths Scale" that detects sexual myths, and the "Hudson and Ricketts Homophobia Scale" that measures the level of homophobia were used.

Informed voluntary consent form

It is a form containing personal information about the participant's personality. In this form, the individual's gender, age, education, employment status, occupation, year in the profession, family structure, level of acquaintance with LGBTIQ individuals, providing counseling services to LGBTIQ individuals in his professional life, sexual orientation knowledge level, etc. there are questions.

Gender roles scale

The Gender Roles Scale (TGRS) was developed by García-Cueto et al. (2015). The scale consists of 20 items to determine the egalitarian attitudes of the participants. It has a one-dimensional and 5-point Likert type rating (1 = I totally

disagree, 5 = I totally agree). The high scores of the participants indicate that they have an egalitarian attitude towards “gender roles”. The Turkish validity and reliability of the scale was developed by Bakioğlu and Türküm. The internal consistency coefficient is 0.99 (Bakioğlu & Turkum, 2019). A value of 0.83 was determined as the Cronbach Alpha internal consistency coefficient for this study.

Sexual myths scale

The Sexual Myths Scale was developed by Zehra Golbasi et al (2016).The scale consists of 28 items in a 5-point Likert type (I totally agree = 5 points, I somewhat agree = 4 points, I am undecided = 3 points, I disagree = 2 points, I completely disagree = 1 point). Participants score the statements in the scale from 1 to 5. The validity and reliability of the scale were made in Turkey. In the study conducted by Golbasi et al., the Cronbach Alpha coefficient was found to be 0.91 and the test-retest reliability coefficient to be 0.814.

Hudson and ricketts homophobia scale (HRHS)

The Homophobia Scale is a 25-item scale developed by Hudson and Ricketts (1980) in order to detect behaviors towards homosexual people. In the study, the Turkish version of the scale with 24 items adapted by Sakalli and Ugurlu (2001) was used. The scale was found to have high reliability with its original Cronbach Alpha =.90 (Hudson & Rickett, 1980) and the Turkish version with Cronbach Alpha = .94 (Sakalli & Ugurlu, 2001). In the scale, participants were asked to rate each item (1 =strongly disagree to 6 = strongly agree). High scores from the scale indicate a high level of homophobia. The total score was found by reversing items 5, 6, 8, 10, 11, 13, 17, 18, 23 and 24 in the scale. By calculating the median (median) value of the total score achieved, the participants were divided into two in terms of low and high homophobia levels in line with the median score found.

Data analysis

After the data were transferred to the SPSS 25 program, the analyzes were started. Kurtosis and skewness values were checked to determine the distribution normality. If the values for kurtosis and skewness are in the range of ±3, it can be accepted that there is a normal distribution (Kalayci, 2009). Accordingly, there are studies that accept the upper limit of the kurtosis value as ± 7 (Bollen, 1998).

Results

Table 1
Findings related to demographic variables

		n	%
Sex	Female	218	72.7
	Male	82	27.3
	Total	300	100.0
Job	Psychiatrist	4	1.3
	Psychologist	74	24.7
	Psychological	222	74.0

	counselor		
	Total	300	100.0
Working Status	Unemployed	38	12.7
	Employed	262	87.3
	Total	300	100.0
The family structure you grew up in	Large Family	61	20.3
	Nuclear Family	239	79.7
	Total	300	100.0
Have you ever met an LGBTIQ individual before?	Yes	210	70.0
	No	90	30.0
	Total	300	100.0
Have you had any LGBTIQ clients in your professional life?	Yes	112	37.3
	No	188	62.7
	Total	300	100.0
Level of knowledge about sexual orientation	Insufficient	49	16.3
	Partially Sufficient	142	47.3
	Sufficient	109	36.3
	Total	300	100.0

72.7% of the participants were female and 27.3% were male. 1.3% are psychiatrists, 24.7% are psychologists, 74% are psychological counselors, 12.7% are not working, 87.3% are working. 20.3% of them were brought up in the extended family structure, and 79.7% of them were brought up in the nuclear family. 70% met a person with LGBTIQ, 30% did not. 37.3% of them had LGBTIQ clients in their professional life, 62.7% of them did not. The knowledge level of 16.3% of the participants on sexual orientation issues was insufficient, 47.3% partially sufficient and 36.3% sufficient.

Table 2
Descriptive Statistics for Age and Professional Experience

	n	Min	Max	$\bar{X}$	Ss.
Age	300	24	55	35.79	8.44
Professional Experience	300	1	31	11.65	7.86

The mean age of the participants ($\bar{X}$=35.79, SD=8.44) was the youngest age 24 and the oldest 55 years old. The average professional duration ($\bar{X}$=11.65, SD=7.86) is at least 1 year and at most 31 years.

Table 3
Findings of Correlation Analysis

	1	2	3	4	5	6	7	8	9	10	11
1. Gender Roles Attitude Scale	1										
2. Hudson and Ricketts	-.539**	1									

Homophobia Scale										
3.Sexual Myths Scale	-.627**	.640**	1							
4.Sexual Orientation	-.548**	.688**	.788**	1						
5.Gender	-.616**	.468**	.787**	.525**	1					
6.Age and Sexuality	-.236**	.239**	.560**	.168**	.422**	1				
7.Sexual Behaviour	-.327**	.298**	.623**	.245**	.483**	.610**	1			
8.Masturbation	-.313**	.479**	.683**	.605**	.345**	.266**	.368**	1		
9.Sexual Violence	-.409**	.386**	.742**	.494**	.475**	.349**	.483**	.503**	1	
10.Sexual Relation	-.343**	.289**	.653**	.318**	.399**	.404**	.419**	.352**	.568**	1
11.Sexual Satisfaction	-.359**	.296**	.567**	.266**	.332**	.267**	.333**	.345**	.445**	.631**	1

***p<0.01, *p<0.05 Test used: Pearson Correlation Test*

When the findings were examined, there was a moderate and negative correlation between the Gender Roles Attitude Scale and Hudson and Ricketts Homophobia Scale (r=-.539, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Myths Scale (r=-.627, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Orientation (r=-.548, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Gender (r=-.616, p<0.01) scores; Weak and negative correlation between Gender Roles Attitude Scale and Age and Sexuality (r=-.236, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Behavior (r=-.327, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Masturbation (r=-.313, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Violence (r=-.409, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Relationship (r=-.343, p<0.01) scores; There is a moderate and negative relationship between Gender Roles Attitude Scale and Sexual Satisfaction (r=-.359, p<0.01) scores.

When we analyzed the findings, there was a moderate and negative correlation between Gender Roles Attitude Scale and Hudson and Ricketts Homophobia Scale (r=-.539, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Myths Scale (r=-.627, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Orientation (r=-.548, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Gender (r=-.616, p<0.01) scores; Weak and negative correlation between Gender Roles Attitude Scale and Age and Sexuality (r=-.236, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Behavior (r=-.327, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Masturbation (r=-.313,

p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Violence (r=-.409, p<0.01) scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Relationship (r=-.343, p<0.01) scores; There is a moderate and negative relationship between Gender Roles Attitude Scale and Sexual Satisfaction (r=-.359, p<0.01) scores.

Table 4
The Prediction of Sexual Myths on Homophobia

	B	*SH*	*β*	*t*	*p*
(Constant)	0.86	0.17		5.03	0.000*
Sexual Orientation	0.14	0.01	0.64	14.70	0.000*
Sexual Behaviour	0.10	0.04	0.11	2.53	0.012*
Sexual Satisfaction	0.06	0.03	0.09	2.00	0.046*
R=.71 *R^2=.49*					
F=98.05 *p=0.000*					

**p<0.05 Test used: Multiple Linear Regression Analysis*

Stepwise was chosen as the preferred method when establishing the regression model. With this method, while the model is being built, the subscales that do not predict the regression model are eliminated and the most appropriate regression model is obtained. When we examine the table of findings, it is seen that the variables of sexual orientation, sexual behavior, and sexual satisfaction predict homophobia dependent variable (*R=.71, R^2=.49, p<0.05*). The independent variables in the model explain 49% of the total variance in the homophobia dependent variable. The relative order of effect according to beta is; sexual satisfaction (*β=.09*), sexual behavior (*β=.11*), sexual orientation (*β=.64*). It was determined that the subscale of sexual orientation, sexual behavior, and sexual satisfaction had a positive effect on the homophobia scale. According to the findings, it was determined that the variable that most explains homophobia is the independent variable of sexual orientation.

Table 5
Prediction of Gender Roles on Homophobia

	B	*SH*	*β*	*t*	*P*
(Constant)	5.58	0.23		23.91	0.000*
Gender Roles Attitude Scale	-0.04	0.00	-0.54	-11.05	0.000*
R=.54 *R^2=.29*					
F=122.13 *p=0.000*					

**p<0.05 Test used: Multiple Linear Regression Analysis*

Enter was chosen as the preferred method when setting up the regression model. With this method, while the model is being built, the independent variable in the regression model is directly added to the model and the regression model is obtained. When the table of findings is analyzed, it is seen that the independent variable of the gender roles attitude scale predicts the dependent variable of

homophobia (*R=.54, R^2=.29, p<0.05*). It has been determined that the gender roles attitude scale has a negative effect.

Table 6
Prediction of Gender Roles on Sexual Myths

	B	*SH*	*β*	*t*	*P*
(Constant)	80.65	2.58		31.23	0.000*
Gender Roles Scale	-0.59	0.04	-0.63	-13.91	0.000*

R=.63 R^2=.39
F=193.35 p=0.000
**p<0.05 Test used: Multiple Linear Regression Analysis*

Enter was chosen as the preferred method when setting up the regression model. With this method, while the model is being built, the independent variable in the regression model is directly added to the model and the regression model is obtained. When we examine the table of findings, it is seen that the independent variable of the gender roles attitude scale predicts the dependent variable of sexual myths (*R=.63, R^2=.39, p<0.05*). The independent variable in the model explains 39% of the total variance in the dependent variable of sexual myths. It has been determined that the gender roles attitude scale has a negative effect.

Discussion

In this section, the findings obtained within the framework of examining the relationship between gender roles, sexual myths and homophobia levels of experts working in the field of mental health are discussed according to the main problem of the research and the order of the sub-questions to be answered. It has been discussed and interpreted in relation to the theoretical literature and empirical studies.

Is there a significant relationship between gender roles and homophobia levels of professionals working in the field of mental health?

There is a moderate and negative correlation between Gender Roles Attitude Scale and Hudson and Ricketts Homophobia Scale scores. When the table of findings was evaluated, it was seen that the independent variable of the gender roles attitude scale predicted the dependent variable of homophobia. It has been determined that the gender roles attitude scale has a negative effect on homophobia. In most of the studies, the relationships between negative attitudes towards LGBT individuals and homophobia with gender differences, traditional gender roles, sexism, social relations with LGBT individuals, social superiority orientation, attribution, friendship, authoritarianism, age, religiousness and education level variables (Anderson, 2004; Polimeni et al., 2000; Ratcliff et al., 2006; Sakalli-Ugurlu, 2006; Sakalli Ugurlu & Ugurlu, 2004). Accordingly, for example, sexism and excessive adoption of gender roles (Davies, 2004), authoritarianism (Franzoi, 2003), social superiority orientation (Whitley, 1999), essentialist beliefs (Goregenli, 2004), extreme religiosity and low education level

(Herek et al., 1988) found a significant relationship between negative attitudes towards LGBT individuals and homophobia.

Another finding seen in the studies carried out is that women have lower levels of homophobia than men (Anderssen, 2002; Herek, 1988; Kite & Whitley, 1996; Lock & Kleis, 1995). In terms of gender differences in studies conducted in Turkey, similar to studies conducted abroad, it was found that women generally exhibit more positive attitudes towards homosexuals than men (Cirakoglu, 2006; Guney et al., 2004; Sakalli, 2002a; Sakalli & Ugurlu, 2001). Men with a high level of religiosity; traditional and conservative ones; those who have little social contact and acquaintance with homosexual individuals; sexist individuals; it can be said that those who have traditional attitudes towards gender roles and those who make causal attributions about the controllability of homosexuality exhibit more homophobic attitudes than others. It is stated that there are prejudices and negative attitudes towards homosexuals in Turkey. These negative attitudes can occur in cognitive (for example, not conforming to the person's point of view), emotional (for example, sadness and anxiety about the individual's situation) or behavioral (for example, efforts to discourage the individual from their current situation) (Camgoz & Orta, 2018).

Research findings examining whether university students' gender, gender roles and whether both variables have an effect on the level of homophobia show that university students' homophobia scores differ significantly in terms of gender and gender role. According to the research findings, the scores of men and those with masculine gender roles on the homophobia scale were found to be significantly higher. However, it was determined that the common effect of gender and gender role did not play a significant role on homophobia (Sanberk, Celik, & Gok, 2016). Sarac & Toprak (2017) found that there is a relationship between male athlete identities of male participants and their total attitude scores towards lesbians and gays. Karaca (2018) determined that there is a positive relationship between the attitudes of individuals with heterosexual orientation towards the female gender role and their attitudes towards the male gender role, the attitudes towards the traditional gender role, the attitudes towards the gender role in marriage, and the avoidant attachment tendency. In his research, Kara (2019) examined the relationship between gender roles and homophobia in university students. A positive correlation was found between the gender roles and sub-dimensions of the low homophobia group and the high homophobia group. When the literature is examined, it has been found that there is a positive and significant relationship between the gender roles of professionals working in the field of mental health and homophobia levels in parallel with the data obtained.

Is there a significant relationship between sexual myths and homophobia levels of professionals working in the field of mental health?

Moderate and positive correlation between Hudson and Ricketts Homophobia Scale and Sexual Myths Scale scores; Moderate and positive correlation between Hudson and Ricketts Homophobia Scale and Sexual Orientation scores; Weak and positive correlation between Hudson and Ricketts Homophobia Scale and Sexual Behavior scores; A weak and positive correlation was found between Hudson and Ricketts Homophobia Scale and Sexual Satisfaction scores. When

the table of findings was examined, it was seen that the variables of sexual orientation, sexual behavior, and sexual satisfaction predicted the dependent variable of homophobia. The independent variables in the model explain 49% of the total variance in the homophobia dependent variable. The relative order of effect according to beta is; sexual satisfaction, sexual behavior is in the form of sexual orientation. It was determined that the subscale of sexual orientation, sexual behavior, and sexual satisfaction had a positive effect. According to the findings, it was determined that the variable that most explains homophobia is the independent variable of sexual behavior.

150 people, 78 randomly selected male and 72 female, participated in the research conducted by Sahbaz (2017) to examine the effect of sexual myths on sexual dysfunction and anxiety. The research concluded that there is a positive relationship between the effect of sexual myths on sexual dysfunction and anxiety. Vural & Temel (2010) included 36 couples in the experimental group and 35 couples in the control group in their study to investigate the effect of sexual myths on the prediction of sexual satisfaction. Diker (2017) studied the relationship between women's belief in sexual myths and sexual knowledge levels and sexual dysfunction of self-esteem. As a result of the research, it was determined that there is a significant relationship between female sexual dysfunctions and adult women's self-esteem, belief in sexual myths and sexual knowledge levels. It has been found that as sexual dysfunctions increase, self-esteem decreases and the likelihood of sexual dysfunction increases as sexual myths are believed.

Mental health professionals' having sexual myths does not only negatively affect their own sexual health. At the same time, when he conveys inaccurate information to his clients during therapy, it may endanger the sexual health of his clients. Although sexual education enables individuals to realize their sexual myths, it also has a therapeutic feature. It allows mental health professionals to examine their own ideas and beliefs. Another important issue is that sexual education can guide the experts in order to answer the questions asked by the client in a scientific way and in the most accurate way.

Is there a significant relationship between gender roles of mental health professionals and sexual myths?

Common beliefs and attitudes about sexuality constitute sociocultural differences. This situation sometimes shows regional changes in sexuality even within the same culture. These changes may differ from person to person, according to education, family structure, gender and age, in terms of sexual attitudes and beliefs. Inadequate sexual education paves the way for the spread of sexual myths and for individuals to grow up in a normative environment. It is a major factor in the occurrence of sexual dysfunctions in people who are ignorant about sexuality, inexperienced, do not know the opposite sex and themselves, have low self-confidence, exaggerated expectations and exaggerated expressions (Aydin, 2012).

In the study conducted to determine the ideas of education faculty students on gender equality in Turkey, it was found that teacher candidates have negative

attitudes towards gender, and this negative attitude was also affected by the time they were in education faculty. In other words, it was concluded that as the grade level increases, it contains more negative opinions (Erdol et al., 2019). In the same study, it was determined that students studying in English Language Teaching and Psychological Counseling and Guidance departments had more egalitarianism and tolerance in gender issues than students studying in different departments. This is explained by the fact that the educational program consists of content that can directly or indirectly raise information and awareness about gender equality, such as respect for individual differences, unconditional acceptance, gender equality, etc. In another study, it was found that the students of the Counseling Department were more tolerant of their attitudes towards different identities, especially gender, than the students in other departments. This is explained by the thought that the education they receive supports their attitudes such as empathy, respect and unconditional acceptance (Yazici & Budak, 2017).

Examining the table of findings, it was found that people who are strongly committed to gender roles believe more in sexual myths. The independent variable in the model explains 39% of the total variance in the dependent variable of sexual myths. It has been determined that the gender roles attitude scale has a negative effect. Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Myths Scale scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Orientation scores; Moderate and negative correlation between Gender Roles Attitude Scale and Gender scores; Weak and negative correlation between Gender Roles Attitude Scale and Age and Sexuality scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Behavior scores; Moderate and negative correlation between Gender Roles Attitude Scale and Masturbation scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Violence scores; Moderate and negative correlation between Gender Roles Attitude Scale and Sexual Relationship scores; A moderate and negative relationship was found between Gender Roles Attitude Scale and Sexual Satisfaction scores.

Conclusion and Recommendations

According to the findings obtained within the framework of examining the relationship between gender roles, sexual myths and homophobia levels of experts working in the field of mental health; It has been found that mental health professionals have an egalitarian and modern attitude towards gender role, their belief in sexual myths is at a low level, and their homophobia levels are at a low level. 72.7% of the participants are female and 27.3% are male mental health specialists. This data does not reflect the equal ratio in terms of gender distribution. Among the mental health specialists of the participants, 1.3% were psychiatrists, 24.7% were psychologists, and 74% were psychological counselors; The data of the sample group mostly includes the data of working psychological counselors. When we analyze the findings, there is a weak and positive relationship between age scores and Hudson and Ricketts Homophobia Scale, Gender Roles Scale and Sexual Myths Scale scores. There is a weak and positive relationship between Gender and Age scores. When we examine the data we have obtained, it has been found that the level of knowledge about sexual orientation of

the experts working in the field of mental health is in a more meaningful relationship with the level of homophobia, rather than the experience in the profession.

There is a moderate negative significant relationship between gender roles and homophobia levels of mental health professionals. There is a moderate and positive relationship between Hudson and Ricketts Homophobia Scale and Sexual Myths Scale and sexual orientation scores. There is a moderate and negative correlation between Gender Roles Attitude Scale and Sexual Myths Scale scores. Most of the data subject to the research was collected from working psychological counselors. Therefore, it is thought that it would not be a correct approach to generalize the findings to all mental health professionals. When the studies conducted in Turkey are examined, it is seen that the studies on the homophobia level, gender roles and sexual myths of mental health professionals are limited. However, Human Rights, in its report published in 2008, states that LGBTI individuals encounter unpleasant attitudes not only from citizens but also from mental health professionals. In the written report, it was stated that homosexuality is not a disease according to medicine, but despite this, 50% of the participants were pressured to go to a psychologist or psychiatrist. Some of the participants who applied to a psychologist or psychiatrist were faced with the negative attitudes of the relevant specialist (27%, the specialist saw homosexuality as a disease, 45% had insufficient knowledge about homosexuality, 24% forced the client to be heterosexual, 24% forced the person to take medication despite his/her reluctance). This research report shows that mental health professionals also display homophobic attitudes. When families encounter a situation outside the norms determined by social conditions or when their children experience existential diversity, they first apply to mental health professionals. It is important for the client that the mental health professional exhibits an objective attitude and has up-to-date information about sexual orientation. As a result of this study, which was carried out in this direction, the fact that the primary preference of families in terms of both economic convenience and ease of transportation is the psychological counselors working in the school guidance service and the majority of the data we obtained consists of psychological counselors, shows the importance of the study. When the relationship between professional experience, age variable, sexual orientation knowledge level and homophobia levels is examined; It is predicted that as the level of knowledge increases, there will be a decrease in homophobic attitudes. For this reason, it is recommended that psychological counselors be more intensely involved in sexual education programs that include sexual orientation and respect for individual differences and should be supported by in-service trainings affiliated to the Ministry of National Education.

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