THE IMPACT OF PERCEIVED RELATIVE DEPRIVATION ON HEALTH-RELATED OUTCOMES: MEDIATING ROLES OF LOCUS OF CONTROL AND LENGTH OF UNEMPLOYMENT & MODERATING ROLES OF DISPOSITIONAL OPTIMISM AND PERCEIVED SOCIAL SUPPORT

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ABSTRACT

THE IMPACT OF PERCEIVED RELATIVE DEPRIVATION ON HEALTH-RELATED OUTCOMES: MEDIATING ROLES OF LOCUS OF CONTROL AND LENGTH OF UNEMPLOYMENT & MODERATING ROLES OF DISPOSITIONAL OPTIMISM AND PERCEIVED SOCIAL SUPPORT

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Relative deprivation is a feeling that arises when individuals perceive a deficiency of a deserved outcome in themselves compared to others similar. Previous research suggested that since feeling relative deprivation leads to an unpleasant psychological state, this feeling deteriorates physical and psychological health. Unemployment can be regarded as a significant agent for the feeling of relative deprivation. The primary purpose of the present thesis was to investigate the relation between perceived relative deprivation and health outcomes among unemployed individuals. In this relation, mediating roles of locus of control and length of unemployment and moderating roles of dispositional optimism and perceived social support aimed to be explored. Before conducting the main study, Turkish adaptation study of the Personal Relative Deprivation Scale (PRDS) was performed, and Turkish version of PRDS was found as a reliable and valid measure with good psychometric properties. The main study was conducted with 402 unemployed participants. Results of the regression analyses showed that perceiving relative deprivation was related to worse physical and

psychological health. Findings of the mediation analyses indicated that externality in locus of control significantly mediated the relation between perceived relative deprivation and physical and psychological health; however, length of unemployment mediated this relation only for physical health. Regarding the protective roles of dispositional optimism and perceived social support, moderation analyses were not significant. The findings of the analyses were discussed based on the existing literature. Strengths, practical implications, limitations of the present study, and suggestions for future research were presented.

Keywords: Perceived Relative Deprivation, Health, Locus of Control, Dispositional Optimism, Perceived Social Support

ÖZ

ALGILANAN GÖRELİ YOKSUNLUĞUN SAĞLIK DURUMUNA ETKİSİ: KONTROL ODAĞI VE İŞSİZLİK SÜRESİNİN ARACI ROLLERİ & İYİMSERLİK EĞİLİMİ VE ALGILANAN SOSYAL DESTEĞİN DÜZENLEYİCİ ROLLERİ

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Göreli yoksunluk, bireylerin benzerlerine kıyasla kendilerinde hak ettikleri bir durumun eksikliğini algıladıklarında ortaya çıkan bir duygudur. Alanyazında daha önce yapılan araştırmalar, göreli yoksunluk duygusunun rahatsızlık verici bir psikolojik duruma yol açtığından, bu duygunun fiziksel ve psikolojik sağlığı bozduğunu ileri sürmüştür. İşsizlik, göreli yoksunluk duygusu için önemli bir etken olarak kabul edilebilir. Bu tezin birincil amacı, işsiz bireylerde algılanan göreli yoksunluk ile sağlık sonuçları arasındaki ilişkiyi araştırmaktı. Bu ilişkide kontrol odağı ve işsizlik süresinin aracı rolleri ile iyimserlik eğilimi ve algılanan sosyal desteğin düzenleyici rolleri araştırılmaya çalışılmıştır. Ana çalışma yapılmadan önce Bireysel Göreli Yoksunluk Ölçeği'nin (BGYÖ) Türkçe uyarlama çalışması yapılmış ve BGYÖ Türkçe versiyonu iyi psikometrik özelliklere sahip, güvenilir ve geçerli bir ölçek olarak bulunmuştur. Ana çalışma 402 işsiz katılımcı ile yürütülmüştür. Regresyon analizlerinin sonuçları, göreli yoksunluğu algılamanın daha kötü fiziksel ve psikolojik sağlıkla ilişkili olduğunu göstermiştir. Aracılık analizlerinin bulguları,

kontrol odağındaki dışsallığın algılanan göreli yoksunluk ile hem fiziksel hem de psikolojik sağlık arasındaki ilişkiye önemli ölçüde aracılık ettiğini göstermiştir; ancak işsizlik süresinin bu ilişkiye sadece fiziksel sağlık için aracılık ettiği bulunmuştur. İyimserlik eğilimi ve algılanan sosyal desteğin koruyucu rolleri ile ilgili olarak, moderasyon analizleri anlamlı bulunmamıştır. Çalışmanın bulguları mevcut literatür ışığında tartışılmıştır. Bu çalışmanın güçlü yönleri, pratik uygulama çıkarımları ve sınırlılıkları sunulmuş, gelecek araştırmalar için çeşitli öneriler verilmiştir.

Anahtar Kelimeler: Algılanan Göreli Yoksunluk, Sağlık, Kontrol Odağı, İyimserlik Eğilimi, Algılanan Sosyal Destek

To the dream of an equal world where everyone gets what they deserve

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CHAPTER 1

INTRODUCTION

"We will not know our own injustice if we cannot imagine justice. We will not be free if we do not imagine freedom. We cannot demand that anyone try to attain justice and freedom who has not had a chance to imagine them as attainable."

Ursula K. Le Guin

When evaluating our own position, do we only look at what we have, or do we define our standing by comparing ourselves with other people? According to social comparison theory, we compare ourselves with others to interpret our position among individuals; thus, judgment based on our absolute status in society is not enough (Festinger, 1954). At this point, it is essential to define with whom we compare ourselves. While making comparisons, do we anchor at better-off people, or those who are worse-off? Many scholars believe that making downward social comparisons leads individuals to feel safe and satisfied (Buunk & Gibbons, 2007). However, individuals tend to make more upward comparisons and the consequences of such comparisons are complicated. Making upward comparisons can motivate individuals to set goals for themselves by facilitating "upward drive" (Festinger, 1954), but it can also result in a negative affect (Marsh & Parker, 1984). The reason why we feel uncomfortable while making upward comparisons is described by the theory of relative deprivation. Feeling relatively deprived mainly depends on the understanding that one is in a disadvantaged position and that this disadvantage is not fair. After this realization, individuals believe that they deserve the better and begin to feel anger and resentment (Smith, Pettigrew, Pippin, & Bialosiewicz, 2012).

Unemployment can be considered as a significant agent for perceiving relative deprivation. If individuals recognize that similar others have a job, while they have not and believe that their unemployment results from an injustice, they may experience

relative deprivation (Walker & Mann, 1987). Under certain conditions, the discomfort arising from relative deprivation may cause self-improvement in some individuals; however, for some who cannot effectively cope with the negative emotional state, perceiving deprivation deteriorates their health (Crosby, 1976). Empirical findings concerning the association between relative deprivation and health have revealed that this path can be explained better by some mediating and moderating variables. First, perceiving lower personal control over the situations, in other words, having an external locus of control, causes individuals to believe that they are not capable of fighting with the injustice, which further worsens their health (Crawford & Naditch, 1970). Moreover, in the case of prolonged unemployment, the displeasure resulting from relative deprivation would be more prominent; thus, the longer the time spent unemployed, the more deteriorated the individuals become (Sheeran, Abrams, & Orbell,1995). Fortunately, particular factors might buffer the adverse impact of relative deprivation on health. Research has shown that optimistic individuals are less affected by the damaging effects of experiencing relative deprivation (Liu et al., 2017). Moreover, perceived social support, which is a well-studied protective factor during unemployment (Gore, 1978), can also be an essential protective factor in the process of coping with relative deprivation.

In the current study, the effect of experiencing relative deprivation on perceived health condition will be examined among an unemployed, higher educated sample. Moreover, in this association, mediating effects of locus of control and the duration of the unemployment will be explored. In addition to these mediator variables, the moderator roles of dispositional optimism and perceived social support in this path will be analyzed.

In the sections following the introduction, a literature review focusing on the studies on unemployment as an antecedent in experiencing relative deprivation and the pathway from relative deprivation to health condition will be presented. In that chapter, locus of control and the length of unemployment, which are possible mediating variables in this association, will also be reviewed. Moreover, how dispositional optimism and various sources of perceived social support could moderate the association between relative deprivation and health will be introduced.

1.1. Unemployment

1.1.1. Concept of Unemployment

Unemployment is a period when individuals of working age who do not have a working disability cannot find a job while making serious search attempts (OECD, 2021). To put it differently, International Labour Organization (2012) defines unemployment as "Unemployment occurs in a situation in which there is an excess of job seekers (labor demand) in relation to the actual number of available job offers (labor supply)" (pp. 4). There are several possible reasons of unemployment, such as financial crisis, economic recession, conflicting skills, or an interval resulting from changing jobs (Pettinger, 2019). Although unemployment is considered one of the significant social problems globally; in developing countries, unemployment poses severe challenges (Postel-Vinay, 2019). As a developing country, in Turkey, unemployment is regarded as one of the leading problems coming after financial problems (Istanbul Economics Research, 2020). Moreover, majority of citizens in Turkey think that the problem of unemployment will increasingly continue in following years (IPSOS, 2021). According to the Turkish Statistical Institute (2021), Turkey's unemployment rate among individuals above the age of 15 is 13.9%, which exceeds the average rate found across OECD countries (OECD, 2021). Among unemployed Turkish individuals, the rate of higher educated was reported as 14%, in fact, this makes Turkey the second country with the highest unemployment rate for higher educated people among OECD countries (Turkish Statistical Institute, 2021; OECD, 2021). Hence, unemployment in Turkey is a much greater concern compared to other OECD countries.

Unemployment has devastating consequences both at the country level and at the personal level. At the country level, it causes poverty among the unemployed and creates inequality. At the individual level, on the other hand, unemployment deteriorates the health condition of persons from multiple aspects (Brenner & Mooney, 1983). In the subsequent section, several theories on how unemployment worsens health will be reviewed.

1.1.2. Unemployment and Health

Unemployment does not only create financial difficulties for individuals; but it is also emotionally harassing. Unemployed individuals are labeled as loafers and useless persons; thus, they are devoid of the dignity given to employed ones in a society. Their self-esteem and self-identity are threatened as they are not employed (Goldsmith, Veum, & Darity Jr, 1997). To put it differently, both economic hardship and societal expectations place an emotional burden on the unemployed (Sümer, Solak, & Harma, 2012). According to Paul and Moser's (2009) meta-analysis, more than three hundred studies have revealed that unemployed individuals are under greater distress than employed ones. They reported higher levels of depression and anxiety and had more episodes of psychosomatic disorders. Negative affectivity in terms of sadness, helplessness, anger toward the society and self was found more among unemployed, also the unemployed felt more loneliness than their counterparts (Tiggemann & Winefield, 1984). Furthermore, unemployed people have been shown to have higher tendency to self-harming behaviors and commit suicide (Platt, 1984). Therefore, not being able to be a part of the labor market ruins individuals' psychological health. Besides psychological well-being, unemployment disturbs physical health, too. Many scholars hold the view that unemployment is a major source of physiological stress. Among the unemployed, the cortisol level was higher, making them more vulnerable to stress-related disorders (Arnetz et al., 1991). In the same manner, C-reactive protein, increased with stress, was found in more elevated levels among the unemployed, and that higher level of C-reactive protein caused inflammation, which in turn, may lead to serious diseases like diabetes and heart disorders (Janicki-Deverts, Cohen, Matthews, & Cullen, 2008). Moreover, unemployed individuals have been found to engage in more maladaptive health behaviors like drinking alcohol, using drugs, and smoking, which further destroy their physical health (Bartley, 1994). All in all, unemployment leads to both psychological and physical poor health.

In the literature, several theories are explaining how unemployment impairs health. These theories are based mainly on the deprivation of the benefits that employment provides namely: latent benefits (e.g., having a purpose in life), and manifest benefits (e.g., having a regular income). The most influential one, Jahoda's Latent Deprivation Model (1984), asserts that individuals gain some kinds of latent benefits from being

employed beyond manifest benefits. These latent benefits meet individuals' basic psychological needs. First, employed individuals have a time structure; that is, they have more purpose in using their time. Second, compared to the unemployed, employed individuals are more active in their daily lives, which helps to enhance their well-being. Third, having a job provides individuals with a broader social contact network. The fourth benefit is that being a part of an institution enables people to share a collective purpose with that community. Lastly, employment allows individuals to realize their status in society and define their self-identity. Thus, according to Jahoda, rather than manifest benefits, deprivation of latent benefits makes unemployed individuals' well-being worse. On the contrary, Fryer's Agency Restriction Model (1986) suggested that it is the deprivation of manifest benefits that worsens the unemployed people's well-being. The model reveals that economic difficulties and poverty are core reasons for unemployed individuals to experience psychological stress. Many studies have provided evidence for both models. However, Creed and Macintyre (2001) have posited that these two models are not superior to each other, and both deprivations of latent and manifest benefits should be considered to predict unemployed individuals' well-being.

The models described above focused on the effects of the deficiencies of benefits that employment provides. However, to examine the health-related consequences of unemployment, the focal point should be the feelings arise in response to the perceived deficiencies of those benefits. In other words, it might be more important to point out that how unemployed persons react to the lack of the opportunities brought by employment (Chen, 2015). For this reason, the current study will explore the issue of unemployment from the perspective of Relative Deprivation Theory. Therefore, the present study will shed light on the questions of whether unemployed individuals feel deprivation due to their unemployment and whether they perceive these deficiencies as injustice practices. The following section will review the theory of relative deprivation in the context of unemployment and health. Based on this theory, how the unemployed could be the subject to experiencing relative deprivation and its health-related consequences will be presented.

1.2. Relative Deprivation Theory

Relative deprivation is a feeling of discontent which occurs after a discrepant comparison with someone else, the past of the person, or the ideal self. In response to such comparisons, individuals notice a considerable discrepancy between what they have and what they deserve to have (Crosby, 1976). The theory also claims that the feeling of deprivation results from a subjective situation rather than an absolute position. Hence, under certain circumstances, those who are better off may feel worse than those who are actually worse off. This negative affect is more related to the feeling of being subjected to an unfair treatment. Therefore, as a result of such a comparison, people suffer from the feeling of injustice and experience anger and resentment (Smith, Pettigrew, Pippin, & Bialosiewicz, 2012).

The history of the relative deprivation theory dates back to World War II. The U.S. army's research department incidentally revealed that the better-off air personal reported more dissatisfaction than the worse-off military personal about the promotions they had received. Researchers concluded that since the air soldiers tended to compare themselves with the ones who had a similar position rather than those who were among worse-off military personal, they experienced a grievance in response to promotions (Stouffer, Suchman, DeVinney, Star, & Williams, 1949). As a post-hoc explanation, these researchers laid the foundations of relative deprivation theory. After a decade, Davis (1959) formulated the theory of relative deprivation by suggesting three premises. According to him, to experience relative deprivation, a person lacking something must perceive that another person who is similar to him/her possesses it, desire to have it, and feel have a right to own it. Runciman (1966) broadened this formulation by adding the fourth precondition. In addition to the three conditions suggested previously, he stated that a person must also feel it is possible to obtain the deficient object. Therefore, he highlighted that to perceive relatively deprived, the missing object must be attainable. Moreover, Runciman contributed to this theory by suggesting that relative deprivation could be experienced at two distinct levels: egoistical and fraternal. Egoistic relative deprivation occurs at the individual level when a person compares oneself with others; on the other hand, fraternal deprivation occurs when a person compares one's group with other groups. Crosby (1976) further enlarged the model by adding the fifth precondition. She claimed that in order to feel

relatively deprived, a person must not feel oneself as responsible for the lacking as well. Overall, five preconditions for experiencing relative deprivation were proposed, and it was considered that failure to meet any of these conditions prevents the occurrence of relative deprivation. The presence of these five preconditions causes individuals to realize that they are treated unfairly, and they do not obtain what they deserve. Hence, experiencing relative deprivation results in the feeling of anger and resentment.

According to Crosby's model (1976), the consequences of relative deprivation reflected in feelings, attitudes, or actions vary according to certain individual differences and environmental factors. To be more specific, fraternal relative deprivation results in either destructive acts against the society, such as terrorism (Issac, Mutran, & Stryker, 1980) or striving to improve the society (Morrison, 1971). On the other hand, the feeling of egoistic relative deprivation motivates some individuals to change the conditions and improve themselves to obtain what they deserve (Olson, Roese, Meen, & Robertson, 1995). However, for some, it causes them to experience symptoms of stress or engage in self-destructive behaviors (Adler, Epel, Castellazzo, & Ickovics, 2000). The stress symptoms and maladaptive behaviors further lead to poorer health conditions among individuals who are exposed to egoistic relative deprivation (Callan, Kim, & Matthews, 2015). The following section will examine the pathways between perceiving relative deprivation and its health-related consequences by providing a literature review.

1.2.1. Pathways from Relative Deprivation to Health

As mentioned previously, experiencing relative deprivation leads to worsening of psychological and physical health in multiple domains. A widely accepted explanation for this impact is that individuals who cannot cope effectively with the negative internal states as a result of perceiving deprivation experience stress symptoms (Adler & Stewart, 2010). The biological effects of stress on the body in the face of experiencing relative deprivation can be explained through "allostatic load." Normally, the human body keeps itself in balance, which is defined as allostasis, by secreting stress hormones against stressful life events. However, the persistent exposure to stress in the face of perceiving relative deprivation requires the body to

secrete more stress hormones; thus, the balance of the body impairs, which makes the body defenseless against diseases (McEwen & Stellar, 1993).

Dozens of research in the literature have focused on the negative impact of relative deprivation on health. Studies conducted both in western and eastern cultures provided evidence regarding the association between perceived egoistical relative deprivation and poor self-reported health. Experiencing relative deprivation lowers self-reported health, and this impact persists even after the effects of absolute income and status have been removed (Mishra & Carleton, 2015; Salti & Abdulrahim, 2016). Additionally, individuals experiencing relative deprivation apply more to hospitals for psychological disorders like depression and anxiety (Eibner, Sturm, & Gresenz, 2004). Moreover, a recent study has reported that the more the exposure to stress resulting from perceived relative deprivation has increased, the more symptoms of non-organic diseases such as irritable bowel syndrome and fibromyalgia have been predicted (Beshai, Mishra, Mishra, & Carleton, 2017). In parallel to these findings, Helgertz, Hess, and Scott (2013) examined the effect of relative deprivation on health by focusing on the sickness reports of working individuals. They indicated that the more the experiencing relative deprivation the less the absence of sickness within two-weeks period. This result implies that the probability of being sick lessens as the feeling of deprivation declines.

Furthermore, individuals may engage in risky behaviors to compensate for anger and resentment resulting from perceiving relative deprivation. In this way, they can obtain immediate rewards and avoid negative emotional states. After conducting a series of experiments, Callan, Shead, and Olson (2011) found that those who feel more relatively deprived took more risk in a gambling situation. Also, feeling relative deprivation affects the desire to involve in risky gambling through increased stress. Such a tendency towards risky and impulsive behaviors that operates through stress can further explain the health-related consequences of egoistical relative deprivation (Mishra & Meadows, 2017). Correspondingly, experiencing relative deprivation has been found positively associated with maladaptive health behaviors such as drinking alcohol, desire for being drunk, and tobacco use, which in turn, impair the health condition of individuals (Balsa, French, & Regan, 2013; Wu et al., 2020). Regarding risky and maladaptive health behaviors, the subjective experience of relative

deprivation has also been found to be related to obesity tendency. Research has revealed that feeling relative deprivation predicts certain obesity-related health behaviors, such as being physically less active, not consuming nutritious food like vegetables and fruits, not having breakfast, and not dieting (Elgar, Xie, Pförtner, White, & Pickett, 2016). Additionally, an experimental study demonstrated that individuals in the relatively deprived condition tend to put more food on their plate than those in the control condition, indicating a tendency for binge eating (Sim, Lim, Forde, & Cheon, 2018). By considering these results, it is reasonable to conclude that feeling relative deprivation drives people to engage in risky health behaviors, which negatively affect their health.

Feeling relatively deprived is also significantly associated with mortality rates even after controlling for absolute status. This finding highlighted the fact that the negative internal state of being treated unfairly and not obtaining what is deserved leads to severe consequences that can extend to death (Salti, 2010). More specifically, research has suggested that a critical amount of variance in cardio-vascular diseases related deaths can be explained via experiencing relative deprivation (Kondo et al., 2015).

In the next part, unemployment as a reason for experiencing relative deprivation will be examined, and possible health-related resultants of feeling deprived in the face of unemployment will be reviewed.

1.2.2. Unemployment as a Reason for Perceiving Relative Deprivation

As mentioned before, the feeling of relative deprivation depends primarily on the fulfillment of several preconditions. In order to feel anger against and resentment for the present status, individuals should make a comparison either with a similar other or their own past or their ideal self. As a result of this comparison, they should detect an undesirable discrepancy. The discrepancy should also be appraised as a deficiency that made them feel in a disadvantaged position. This inferior position resulting from the deficiency should also be perceived as unfair. In the face of this unfairness, individuals feel anger against and resentment about their current position, and they believe that they deserve better (Smith, Pettigrew, Pippin, & Bialosiewicz, 2012). Employment, in this context, might be this deficiency that unemployed individuals suffer. Thus, unemployment could be regarded as an antecedent variable for feeling relatively

deprived. As stated previously in the Latent Deprivation Model (Jahoda, 1984), unemployment is not just being deprived of a regular income but also experiencing the deficiency of five basic human needs. Moreover, the most prevalent element of relative deprivation that affects health has been found as going out regularly, which is one of the five benefits of employment specified in Jahoda's model (Stronks, van de Mheen, & Mackenbach, 1998). Therefore, it is plausible to infer that unemployment might be an important agent in experiencing relative deprivation.

In the literature, unemployment has been considered as a significant reason for experiencing relative deprivation, and the reactions toward this feeling were examined among the unemployed. Walker and Mann (1987) conducted a study among unemployed individuals to analyze their relative deprivation level and outcomes of that feeling. In their study, relative deprivation and the reactions were assessed for both personal and group levels separately. The evidence from this study has suggested that unemployed individuals experience more relative deprivation at both levels. Among the unemployed, as the group level relative deprivation increased, a positive attitude towards participating in protests increased. On the other hand, personal level of relative deprivation has been found to be associated with stress symptoms which measured in both behavioral outcomes of stress such as aches, nervousness, restlessness; and psychological outcomes such as anxiety and depression. Hence, unemployment can be a significant element for the feeling of relative deprivation at both group level and personal level (Walker & Mann, 1987). In a similar vein, Mishra and Carleton (2015) found that compared to the employed, unemployed individuals reported significantly higher perceived relative deprivation.

A recent study has posited that unemployed persons suffer more from relative deprivation, and as a result, they tend to participate in inconvenient ways of social action. As the relative deprivation increases, voting, a democratic reaction, decreases and more riots occur among the unemployed. Also, as the unemployment rate rises, the disparity between less deprived and more deprived increases, and those more deprived engage more in social protests (Grasso, Yoxon, Karampampas, & Temple, 2019). In the same vein, as an indication of relative deprivation, the unemployment rate has been found positively correlated with the level of terrorism within a country (Richardson, 2011). More specifically, in Northern Nigeria, where the unemployment

rate was high, as a reaction to feeling relative deprivation, more supporters of Boko Haram, an Islamic terrorist organization, resided (Agbiboa, 2013).

Moreover, feeling relative deprivation due to being unemployed has been found strongly associated with a poorer health profile (Subramanyam, Kawachi, Berkman, & Subramanyam, 2009). Sheeran, Abrams, and Orbell (1995) examined how employment status and various levels of social comparisons affect individuals' level of depressive feelings and self-esteem. For the individual level of social comparison, they utilized both interpersonal and intrapersonal comparisons. The results indicated that only for the unemployed, comparison between current self and past self is significantly correlated with depression scores and self-esteem scores. Additionally, among the unemployed, making more comparisons between oneself and others similar has been found strongly and positively associated with their depression level. The findings also demonstrated that as opposed to employed, unemployed ones discern the gap between their actual and desired selves thus, perceive a greater discrepancy between themselves and significant others. Therefore, they experience higher levels of relative deprivation than those who have a job.

To sum up, based on these findings, it can be drawn that unemployed individuals experience relative deprivation due to their job status. Also, as a reaction to the feeling of relatively deprived, unemployment leads to a worse health condition. Relevant research indicated that through some variables, the association between relative deprivation and health might be explained better. In the following sections, several factors that possibly play a mediating role in this relation will be examined.

1.3. Locus of Control

Deriving from Rotter's Social Learning Theory (Rotter, 1954), the phenomenon, locus of control, posited that individuals make attributions to the preceding factors of the occurrence of the events. The events following a person's specific behaviors or intentions strengthen the connection between the event and these behaviors; thus, it increases the perception of the person's own influence over the events. In line with the experiences acquired since infancy, individuals create a tendency to make causal attributions (Rotter, 1966). Locus of control refers to the attributions of responsibility or the reason for the occurrence of events (Lefcourt, 2013). If a person believes that

things that happen to one's life depend mostly on one's own antecedent actions, intentions, or personal characteristics, the person tends to have an internal locus of control (Rotter, 1966). Thus, individuals with an internal locus of control are inclined to perceive that the power and control over the situations are in themselves, and they believe they are active agents in control of their own life (Strikland, 1978). On the other hand, when the person appraises and believes that external sources, other than one's own, have more influence on the occurrence of the event, the person tends to have an external locus of control. The external sources attributed to causes of events could be destiny, chance, or powerful others beyond one's control (Rotter, 1966). The lower sense of personal responsibility in individuals with an external locus of control causes them to feel more passive and helpless over the situations that occurred to them. (Rotter, 1992).

Causal attributions of the control can shape the individuals' stress levels in the face of negative life events. Accordingly, since individuals with an internal locus of control feel they have more personal control over the situations, they are more adaptive to cope with negative conditions, thus reacting with lower stress levels (Johnson & Sarason, 1978). On the flip side, individuals with an external locus of control believe that things happen out of their control, and outside factors have more responsibility in the events' occurrence. Hence, as those individuals do not feel enough personal control over the situations, they have problems in adapting to negative life events, thus experiencing more stress and anxiety (Anderson, 1977; Johnson & Sarason, 1978). In parallel with these suggestions, it was reported that externals remembered more unfavorable feedbacks they have received, whereas internals put more effort to correct their mistakes in response to negative criticism (Phares, Ritchie, & Davis, 1968). Moreover, it was indicated that internals are better at using their knowledge actively and they have more effective strategies in problem-solving than externals (Strikland, 1978).

Moreover, it has been suggested that locus of control has a determining role in developing psychological disorders. Individuals with an external locus of control were inclined to be more anxious (Watson, 1967) and experienced more symptoms of depression (Burger, 1984). Furthermore, the differences in locus of control affect individuals' health behaviors. Having an internal locus of control was found associated

with engaging in more health-promoting behaviors in comparison to an external locus of control. It was further indicated that those with an internal locus of control have more tendency to not to smoke, be more able to reduce or quit smoking. They have been also found to adapt themselves better in sick-role behaviors, seek and have more information regarding their diseases, adhere more to their medical regimen, and use contraceptives in sexual intercourses consistently (Strudler-Wallston, & Wallston, 1978).

Within the scope of the present study, the locus of control will be discussed in the context of relative deprivation. In the next part, how locus of control can shape subjective experience of relative deprivation and reactions to that feeling will be addressed.

1.3.1. Locus of Control and Perceiving Relative Deprivation

As stated before, Crosby (1976) identified the fifth precondition for perceiving relative deprivation. According to her, to experience relative deprivation, individuals should not feel personal responsibility over the situation. Based on this precondition, it can be claimed that if individuals do not feel any personal control over their conditions, they perceive their current position as unfair and feel resentment. In other words, they blame the outside factors such as the social system or the destiny for their disadvantage; thus, according to them, external sources form the basis of injustice (Crosby, 1976).

Crawford and Naditch (1970) proposed that the interaction of experiencing relative deprivation with the tendency for external or internal locus of control may produce various psychological and behavioral outcomes. According to them, individuals who feel highly deprived and have external locus of control are at highest risk. For these individuals, the discrepancy between what they aspire and what they have is great. In addition, they feel less control over the situations and feel powerless on the way to achieve their desired state. Therefore, they were defined as the psychologically most vulnerable individuals in Carwford and Maditch's model (1970). Their psychological phase was labeled as "discontent fatalism", and they were described as the most dissatisfied and hopeless individuals within the society. On the other hand, those with high relative deprivation and internal locus of control are at the phase of "discontent

activism". Although these individuals perceive a huge gap between their desired and current status, they believe that situations are under their own control, and they are able to alternate their current state. Hence, as active individuals, they provide change and transition within the society. Therefore, according to Crawford and Naditch's (1970) model, while experiencing relative deprivation, having an external locus of control impedes people from attaining their desired state, but the internal locus of control makes them feel able to change.

In line with these suggestions, Moore and Aweiss (2003) examined the effect of relative deprivation and the sense of control over the future expectations among middle eastern adolescents. They found that experiencing relative deprivation deteriorated the feeling of control more for the Arab and Palestinian adolescents, the relatively deprived ones, than that of relatively predominant Jewish adolescents. The diminishing sense of control further lowered the future expectations of the disadvantaged Arab and Palestinian adolescents. By the same token, Abrams, Linken, and Tomlins (1999) conducted a study to investigate whether perceived control would moderate the association between relative deprivation and feeling of disappointment among immigrant individuals. Findings indicated that relative deprivation resulted in more disappointment among individuals with a lower sense of control, while this effect was not significant for those with a higher sense of control.

Hence, the sense of perceived personal control, in other words, having an internal locus of control, was found to alleviate the unfavorable consequences of perceiving relative deprivation. In the following part, the length of unemployment, the second possible mediator factor in the association between relative deprivation and health condition will be reviewed.

1.4. The Effect of Length of Unemployment

Many studies have strongly proved the negative impact of unemployment on health condition. Moreover, researchers introduced some other variables to explain the relation between unemployment and deteriorated health better (Jin, Shah, & Svoboda, 1995). The duration of the unemployment has been considered as one of the most crucial factors in this association. It has been found that as time spent unemployed increases, self-reported physical health scores including bodily pain and physical

functioning declines in time (Stauder, 2018). Besides negatively affecting physical health, prolonged unemployment also damages the mental health of unemployed individuals. Hepworth (1980) revealed that as the duration of unemployment increases, individuals' self-reported well-being decreases, and their probability of developing a psychiatric disease rises. More specifically, long-term unemployed people require to devote longer time to tasks they used to complete in shorter time before (Álvaro, 1992, as cited in Sojo & Guarino, 2011).

In previous research, reactions to unemployment were categorized in four phases by time: being shocked, having optimistic thoughts, having pessimistic thoughts, and accepting unemployment as fate, respectively (Jahoda, Lazarsfeld, & Zeisel, 1971). In the literature examining the effect of duration of unemployment on health condition, researchers asserted three possible ways. The first view is that the longer the duration of the unemployment, the worse the health (Warr & Jackson, 1984). Another view proposed that when people experience a certain length of unemployment, this affects their health negatively, but after a certain point, no positive or negative change occurs in their health condition (Cook, Bartley, Cummins, & Shaper, 1982). The other view asserted that the impact of the duration of unemployment on worsening health condition could be curvilinear, meaning that initially, unemployment has a damaging effect on health, but after a specific time, the effect subsides by adapting to the situation (Kulik, 2001). Supporting this view, a curvilinear relationship between prolonged unemployment and psychological stress was observed in an unemployed Turkish sample. The evidence from this study posited that psychological stress increased as the duration of unemployment increased, but at a certain level, the stress started to drop (Bilgiç & Yılmaz, 2013). Although the superiority of any of these views over the others has not yet been proven, there might be a threshold for unemployment to deteriorate health. In other words, the destructive impact does not show itself immediately after being unemployed but increases exponentially after a particular time (Stauder, 2018). Furthermore, Janlert, Winefield, and Hammarström (2014) have suggested that it is also worth to look at the effect of accumulated time of being unemployed on health through conducting a longitudinal study. According to them, the cumulative duration of being unemployed adversely affects the health condition and health behaviors. Therefore, it can be inferred that each day spent as unemployed makes the health even worse.

Considering relative deprivation theory, Crosby (1976) proposed that if individuals continue to feel the lack of what they desire to have, the feeling of relative deprivation persists over time. Therefore, as a factor in experiencing relative deprivation, the continuity of being unemployed may cause to experience this feeling more. Sheeran, Abrams, and Orbell (1995) examined the role of length of unemployment in the relation between upward social comparisons and self-esteem. It was indicated that when a comparison is made between the self and a significant other, the longer the duration of unemployment, the more corrupted the self-esteem. Thus, within the context of upward social comparisons, the duration of the joblessness has a determining role in judgements about oneself.

Although experiencing relative deprivation due to unemployment has adverse impacts on health, individuals vary in the impact of that feeling on their health condition. Having certain personality traits or factors might play protective roles for some individuals. In the next part, the role of dispositional optimism, which is one of the possible buffering factors on this association, will be explored.

1.5. Dispositional Optimism

Dispositional optimism is a facet of personality, and it denotes having generally positive expectations regarding future. As opposed to pessimists, optimist individuals are more prone to believe that positive outcomes will happen (Scheier & Carver, 1987). It has been considered as a personality construct since optimism keeps its stability in long-term periods in one's life except for significant life experiences (Carver & Scheier, 2014).

A growing body of evidence has suggested that dispositional optimism is a strong determinant in predicting psychological wellbeing and physiological health. Optimist individuals react with less stress to negative life events; thereby, optimists are more capable of adapting themselves to situations psychologically (Nes & Segerstrom, 2006; Scheier & Carver, 1987). Concordantly, a series of experiments have revealed that optimism tendency could be a strong buffer in response to stressful conditions. It was further indicated that optimism promotes antibody activation and resists inflammation arising from stress response (Brydon, Walker, Wawrzyniak, Chart, & Steptoe, 2009). In connection with this finding, optimism has been found related with

stronger immune reactions (Segerstrom, 2006), lower cortisol levels in stressful situations (Jobin, Wrosch, & Scheier, 2014), and an increased sleep quality (Lemola et al., 2011). Moreover, dispositional optimism has been found to have a protective effect on the onset and the course of cardiovascular diseases (Boehm & Kubzansky, 2012). Being prone to optimism has been found associated with adaptive health behaviors as well. Optimist individuals are less likely to smoke, more likely to engage in regular exercise, and maintain a healthy diet (Carver & Scheier, 2014).

For the purposes of the current study, the functions of dispositional optimism will be examined in the context of relative deprivation. The following part will provide a literature review addressing this relation.

1.5.1. The Protective Power of Dispositional Optimism

Optimism may help individuals to cope with or alleviate the negative affect brought by perceived relative deprivation. Since optimistic individuals tend to believe that things will get better and good things will happen to them in the future (Scheier, Weintraub, & Carver, 1986), they might better cope with negative emotions such as anger and resentment that result from relative deprivation (Liu et al., 2017).

When people encounter a problem in their lives, their reaction to that problem is related to their resilience level. Resilience depends mainly on three factors, namely understanding the meaning of the situation, perceived control, and the level of optimism. After facing a stressful situation, individuals begin to adapt themselves cognitively by questioning the meaning of the event, assessing their perceived control, and trying to form positive or negative evaluations over the event. Finally, if they successfully grasp the meaning, feel sufficient control, and develop positive thoughts, they engage in behavioral actions to strengthen their self-esteem to deal with the stressful event (Taylor, & Brown, 1988; Powell & Self, 2004). It was reported that among the unemployed, those with lower levels of optimism had a diminished capacity of resilience, and experienced higher levels of depression (Sojo & Guarino, 2011).

In addition to resilience, individuals with a higher levels of optimism use more active ways of coping with stress, such as problem-oriented approaches, while those with lower levels of optimism use less adaptive strategies like avoidance coping (Scheier,

Weintraub, & Carver, 1986). A growing body of research has suggested that employing more avoidance coping is associated with poor health, whereas active coping strategies is related with a better health profile (Billings, Folkman, Acree, & Moskowitz, 2000). Thereby, having a higher source of optimism helps individuals to be oriented toward a healthier life. Lai and Wong (1998) conducted a study among unemployed Chinese women to understand whether having higher optimism in life would protect psychological health against joblessness. Their findings supported the protective power of dispositional optimism, indicating that less optimistic women were damaged more from being unemployed than their more optimistic counterparts.

More specifically, optimism's buffering role was examined in the relation between perceived relative deprivation and its negative consequences. Liu et al. (2017) posited that on social networking sites, experiencing relative deprivation caused individuals to experience symptoms of depression. However, this destructive effect of relative deprivation is alleviated for optimistic individuals. Optimists are less affected by the detrimental impact of relative deprivation, thus being optimistic has a buffering role in this relation. Furthermore, a study conducted with blind persons has demonstrated that the tendency for making upward social comparisons is inversely related with these persons' level of optimism. That is to say, having an optimistic nature may prevent individuals to engage in upward social comparisons which leads to negative emotional states (Ben-Zur & Debi, 2005).

Apart from dispositional optimism, the role of perceived social support, which is another possible protective factor, will be examined in the association between relative deprivation and health condition in the next part.

1.6. Perceived Social Support

According to Lazarus (1966), individuals experience stress when they evaluate a situation as threatening and do not have enough resources to cope. For decades, possible resources to help individuals to deal with negative life experiences have been analyzed. Social support may operate like a coping resource by providing a buffer to relieve stress. Evidence from both human and animal studies has shown that others' presence helps to decrease stress (Kaplan, Casser, & Gore, 1977). However, it is crucial to make the distinction between actual social network support and perceived

social support. A social network indicates a tangible social environment that can be detected and measured (Marsella & Synder, 1981). On the other hand, perceived social support refers to how persons appraise the support from their social environment and the impact of this support on these people (Caplan, 1974). This distinction underlines the fact that perceived social support does not mean the mere existence of acquaintances, but it means how the individuals feel about their accessibility under a stressful situation. Therefore, perceived social support is not related to the actual amount of support coming from social contacts, but it is related to the perception of the receiver who appraises the support (Procidano & Heller, 1983).

There is ample evidence that perceived social support has a buffering role in reducing undesired outcomes of stressful life events on psychological wellbeing and that in turn predict physiological disorders (Cohen & Wills, 1985; House, Landis, & Umberson, 1988). Moreover, feeling isolated from social connections has been found related with mortality rates (Berkman & Syme, 1979). Numerous studies have found that social support might decrease the possibility of the onset of various physiological disorders either through adapting a healthier lifestyle or improving the biological mechanisms or enhancing psychosocial environment. It was also indicated that perceived social support promotes positive emotional states and increases self-confidence (Cohen, 1988). Moreover, a higher perceived social support has been found associated with engaging in more adaptive health behaviors such as exercising regularly and maintaining a healthy diet (Riffle, Yoho, & Sams, 1989). Feeling the availability of social support may also prevent anxiety disorders and depression (Zhou, Zhu, Zhang, & Cai, 2013). Furthermore, the detrimental effects of occupational stress and hassles on psychological health were found lower for individuals with high perceived social support (LaRocco, House, & French, 1980).

The current research will explore the buffering effect of perceived social support in the association between experiencing relative deprivation and health condition among the unemployed. The next part will focus on perceived social support within the context of this relation.

1.6.1. The Protective Power of Perceived Social Support

Perceived social support may mitigate the adverse outcomes caused by relative deprivation. Feeling relatively deprived has been found positively associated with more episodes of depression and suicidal tendencies but negatively related to perceived social support (Zhang & Tao, 2013). In a similar vein, among college students, an inverse association between subjective level of relative deprivation and perceived social support was observed. As perceived social support increases, feeling of relative deprivation reduces. Higher social support perceivers have also been found to have better mental health outcomes than their counterparts (Smith, Ryan, Jaurique, & Duffau, 2020). In addition, a recent study conducted among school children showed that children who perceive more emotional support from their teachers had less adverse effects of relative deprivation on their sense of felt security (Xuan et al., 2021). Moreover, among the elderly who had increased feelings of relative deprivation, any kind of perceived social support affected their self-reported health positively. Also, while experiencing relative deprivation, the frequency of reporting symptoms of physiological and psychological disorders was found lower among those with higher perceived social support (Saito et al., 2014).

As stated before, to compensate for the negative affect arising from relative deprivation, individuals may engage in gambling-like activities that provide an immediate reward. Parallel to these findings, it was indicated that perceiving higher social support from peers can alleviate the feelings of relative deprivation and reduce the tendency of problematical gambling (Elgar, Canale, Wohl, Lenzi, & Vieno, 2018). Therefore, it can be concluded that perceiving higher levels of social support from acquaintances might protect individuals from the adverse feelings and behavioral outcomes arising from experiencing relative deprivation. Thus, in this way, perceived social support might buffer the health conditions of individuals who experience relative deprivation.

A large body of research have posited that perceiving higher social support could relieve the adverse outcomes brought by unemployment. Perceiving more social support was found associated with fewer depressive feelings (Crowe & Butterworth, 2016) and suicidal thoughts (Amissah & Nyarko, 2020) among the unemployed.

Unemployed individuals who perceived less social support had more problematic levels of cholesterol and complained more from the symptoms of several physiological illnesses, which describe a worse health profile (Gore, 1978). In parallel to these findings, Bilgiç and Yılmaz (2013) revealed that perceived social support decreases the psychological distress in unemployed individuals in Turkey.

1.7. Aims and Hypotheses of the Present Study

The literature review provided above demonstrated that experiencing relative deprivation has adverse impacts on individuals' health condition. Research has pointed out that unemployed individuals are deprived of both psychological needs and financial opportunities; also, unemployment has been considered as a significant antecedent for feeling relative deprivation. In the light of relevant literature, the pathways from experiencing relative deprivation due to unemployment to health were presented. There are very few studies in Turkish literature that examined the concept of relative deprivation, and no studies analyzing unemployment as an element in experiencing relative deprivation. Also, to best of our knowledge, no studies analyzing negative consequences of unemployment from the perspective of relative deprivation theory have been conducted.

The main purpose of the present study is to investigate whether experiencing relative deprivation can predict the health condition of unemployed individuals in Turkey. Moreover, some variables presented previously are expected to explain the association between relative deprivation and health among the unemployed better. Accordingly, the second purpose of the current study is to analyze whether the locus of control and the duration of the unemployment can mediate this association. Furthermore, some factors are expected to buffer this relation. Thereby, the third purpose is to examine whether dispositional optimism and social support perceived from multiple sources can be protective factors in the association between feeling relative deprivation and health condition among the unemployed.

Based on the aims mentioned above, it was hypothesized that (1) unemployed individuals who feel more relatively deprived would have worse (1a) physical and (1b) mental health. For possible mediating variables, it was expected that (2) locus of control would mediate the association between relative deprivation and both (2a)

physical and (2b) mental health. In other words, an increase in relative deprivation would predict higher externality in locus of control, which in turn, would predict a decrease in physical and mental health condition. It was also hypothesized that (3) the duration of unemployment would mediate this relationship. That is to say, an increase in relative deprivation would be associated with an increase in the length of unemployment, that would in turn predict worse (3a) physical and (3b) mental health. Regarding potential moderator variables, (4) dispositional optimism was expected to moderate the association between relative deprivation and health both (4a) physically and (4b) mentally. Accordingly, for individuals with higher dispositional optimism, feeling relative deprivation would have less impact on their physical and mental health than those with lower dispositional optimism. (5) Perceived social support was also hypothesized to moderate the relation between experiencing relative deprivation and (5a) physical and (5b) mental health among the unemployed. In line with this expectation, for individuals with higher perceived social support, feeling relatively deprived would affect their physical and mental health condition less negatively than those with lower perceived social support.

CHAPTER 2

STUDY 1: Turkish Adaptation, Validity and Reliability Study of Personal Relative Deprivation Scale

2.1. Method

The purpose of the first study was to translate Personal Relative Deprivation Scale (PRDS) into Turkish and analyze its psychometric properties to investigate whether the Turkish adaptation of PRDS is a valid and reliable measurement so that it can be employed in Turkish studies examining perceived relative deprivation. The validity and reliability study of the PRDS was conducted with university students. The method section will include detailed information regarding participants' sociodemographic characteristics, properties of scales used, and the procedure about how the study was conducted.

2.1.1. Participants

One hundred seventy-eight university students (M_{age} = 21.93, *SD* = 2.83, age range 18–43 years) participated in the first study. Students were announced that they would earn extra points for their voluntary participation. Data were collected via Qualtrics, an online questionnaire software. A great portion of the sample defined themselves as female (*n* = 139, 78.1%), and 36 of them (20.2%) defined themselves as males. One participant (0.6%) defined itself as non-binary, and two participants (1.1%) did not want to share information regarding their gender. Majority of the sample has resided for most of their lives in urban regions like metropolitans (*n* = 118, 66.3%) and cities (*n* = 35, 19.7%); whereas the remaining have spent most of their lives in rural regions like districts (*n* = 19, 10.7%), towns (*n* = 5, 2.8%), and villages (*n* = 1, 0.6%). A great portion of the sample assigned themselves to average (*n* = 104, 58.4%) financial status. Rest of them either consider themselves at low (*n* = 3, 1.7%), or below average (*n* =

31, 17.4%), or above-average financial status (*n* = 40, 22.5%). None of the participants described themselves in a high financial status.

Information about psychological and physiological disorders was also collected from the sample. Twenty-nine participants (16.3%) reported that they have at least one psychological condition. When asked about the kinds of treatments they have received, 8.4% (*n* = 15) of them reported having psychopharmacological treatments, 6.2% (*n* = 11) of them stated to receive psychotherapy. Two participants (1.1%) did not get any treatment, and one (0.6%) participant consulted alternative ways of treatment. Moreover, 9% of the sample (*n* = 16) reported suffering from at least one physiological disorder.

Table 1. *Demographic Characteristics of Participants*

Variables	*N*	%	*M*	*SD*
Gender				
Female	139	78.1		
Male	36	20.2		
Non-binary	1	0.6		
Unanswered	2	1.1		
Age			21.93	2.83
Residing area				
Village	1	0.6		
Town	5	2.8		
District	19	10.7		
City	35	19.7		
Metropolitan	118	66.3		
Financial status				
Low	3	1.7		
Below-average	31	17.4		
Average	104	58.4		
Above-average	40	22.5		
High	0	0		
Psychological disorder				
Yes	29	16.3		
No	149	83.7		
Physiological disorder				
Yes	16	9		
No	162	91		

2.1.2. Instruments

2.1.2.1. Demographic Information Form

The form was constituted to retrieve information regarding the social and demographic characteristics of the participants. They were asked to report their age, gender, residing area where they spent most of their life, and their perceived financial status. In addition to these variables, they were also requested to state their psychological and physiological disorders if they have any.

2.1.2.2. Personal Relative Deprivation Scale

Callan, Ellard, Shead, and Hodgins (2008) developed PRDS to assess self-reported individual level relative deprivation. The instrument aims to measure the degree of deprivation that individuals feel when they compare themselves with others similar. The scale originally consisted of 4 items, but it was revised to increase the measure's internal consistency, and one more item (I feel dissatisfied with what I have compared to what other people like me have) was added (Callan, Shead, & Olson, 2011). The 5–item PRDS is measured on 6–point Likert-type scale and response categories range from 1 (*strongly disagree*) to 6 (*strongly agree*). Higher scores demonstrate an increased experience of individual level relative deprivation. The original version of the PRDS indicated an acceptable internal consistency level (α = .78).

The Turkish adaptation of this scale was conducted within the scope of the current study. To ensure the convergent validity of the Turkish version of PRDS, Iowa-Netherlands Comparison Orientation Measure (INCOM) was employed. Thus, a significant positive correlation was expected between PRDS and INCOM, meaning that PRDS measures a related construct with what INCOM measures. In addition, to establish discriminant validity of the instrument, Marlowe Crowne Social Desirability Scale (MC-SDS) was utilized. Accordingly, a low or non-significant correlation was expected between PRDS and MC-SDS, indicating that PRDS does not aim to assess the construct which MC-SDS measure. Lastly, to ensure criterion validity, a scale measuring social comparison frequency was used.

2.1.2.3. Iowa-Netherlands Comparison Orientation Measure (INCOM)

So as to assess the level of social comparison orientation, Gibbons and Buunk (1999) developed INCOM. Assuming that the orientation for social comparison is a universal construct, the researchers analyzed INCOM in both American and Dutch samples. The measurement comprises 11 items rated on a 5–point Likert-type scale, and response alternatives are ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores obtained from this measure indicate a higher tendency for social comparison. According to the exploratory factor analysis, two factors emerged: ability (e.g., I always pay a lot of attention to how I do things compared with how others do things) and opinions (e.g., I often try to find out what others think who face similar problems as I face). However, since the correlation between the two factors was high (α = .79), the scale was used as a single-factor measurement tool.

INCOM was found to have a satisfactory level of internal consistency reliability with the Cronbach alpha coefficient .83 on average. Also, test-retest reliability was in an acceptable level (r = .71). The instrument's validity analyses demonstrated that INCOM have plausible construct, convergent, discrimination, and criterion validities. Significant correlations were found with social orientation disposition (r = .45, p < .001 for interpersonal orientation; r = .43, p < .001 for public self-consciousness), negative affectivity (r = .23, p < .01 for Dutch; r = .21, p < .01 for American), and neuroticism (r = .34, p < .001 for Dutch, r = .28, p < .001 for American), indicating a good convergent validity. On the other hand, a low correlation was observed with the need for cognition (r = -.12, p < .05) and social support (r = .13, p < .05), showing an acceptable level of discriminant validity. Furthermore, it was found that as the comparison orientation rose, comparison behavior also increased in daily practice suggesting that the criterion validity of the instrument was also competent.

The Turkish adaptation of INCOM was conducted by Teközel (2000). The scale was administered to university students fluent in both Turkish and English so that the difference between the two languages could be observed. Results indicated a high correlation (r = .87, p < .001), meaning that the Turkish version had similar content structure to the original one. In parallel to the findings regarding validity analysis of the original scale, the Turkish version also indicated satisfactory validity levels. The

Turkish INCOM demonstrated high internal consistency reliability (α = .82). For the current sample, Cronbach's alpha of INCOM was .79.

2.1.2.4. Marlowe-Crowne Social Desirability Scale (MC-SDS)

MC-SDS was developed by Crowne and Marlowe (1960) to detect the individuals' desire for social approval. It is a widely used instrument to eliminate the effect of social desirability bias from the research studies in psychology. The questionnaire contains 33 forced-choice items, and respondents are asked to decide whether the items are true or false for themselves. Eighteen sentences in the scale (e.g., Before voting I thoroughly investigate the qualifications of all the candidates) indicate higher social desirability when marked as true. On the other hand, the remaining fifteen items indicate lower desire for social approval (e.g., I like gossip at times) when marked as true, and in the scoring phase these items are coded reversely. The internal consistency reliability was found .88, and the test-retest reliability was found .89 (Crowne & Marlowe, 1960). Also, a significant and positive correlation between MC-SDS and Edward's Social Desirability Scale (r = .35, p < .01) indicated that MC-SDS has a good convergent validity. On the other hand, low and mostly non-significant correlations obtained between MC-SDS and subscales of Minnesota Multiphasic Personality Inventory (MMPI) supported the discriminant validity of the scale (Crowne & Marlowe, 1960). Özeren (1996) translated the scale into Turkish with a psychometrically acceptable level of internal consistency reliability (α = .67). For the present sample, the Cronbach's alpha was .75.

2.1.2.5. Social Comparison Frequency Scale (SCFS)

Demir (2017) created a 5–item scale to measure the frequency of social comparison by adapting the items previously used in relevant research. The measure is rated on a 5–point Likert scale and response alternatives range from 1 (*never*) to 5 (*always*). This scale was developed to determine how often people make social comparisons with others who are better or worse than themselves. Also, several domains for social comparisons were referred to, including friends, celebrities, and others similar to oneself. The internal consistency reliability coefficient was .77. The current sample yielded a good Cronbach's alpha for internal consistency (α = .72).

2.1.3. Procedure

After obtaining the ethical approval from the Institutional Review Board of Middle East Technical University, the translation procedure started. The items of the Personal Relative Deprivation Scale (PRDS) were translated into Turkish by four psychology graduate students (including the researcher of the current study) independently from each other. Next, the researcher and her advisor checked all four translations item by item and chose the most accurate and semantically most similar ones with the original scale. Then, a bilingual person translated the chosen items back into English. Lastly, the original and back translated sentences were crosschecked by the researcher and her advisor, and they finalized the Turkish version of the scale.

For conducting the reliability and validity study of the Turkish PRDS, permissions were obtained from either developers or adaptors of the employed scales. The present study was conducted with a sample of university students, since they were easily accessible. Therefore, the convenience sampling method was used for data collection. The teaching assistant announced the study by informing the students that they could earn extra points in enrolled courses for their voluntary participation. Data collected online via the Qualtrics survey platform. Students who accepted to participate were provided an informed consent form. Through this form, the anonymity of their participation was ensured, and they were reminded that they could close the survey page whenever they felt uncomfortable. After they confirmed the participation, they were asked to fill out first the Demographic Information Form and then the four inventories described above. To eliminate the carry-over effect, questionnaires were presented in a randomized order. The completion of the survey package lasted approximately ten minutes. At the end, they were asked to enter their ID number to earn extra points. When the filling process was over, participants were thanked for their participation, and an extra 2 points were added to their course averages.

To establish test-retest reliability, two months after the administration of the first study, those students were asked to participate in the subsequent one. Fifty participants from the first study accepted to participate in the second run. The same procedure in the first run was repeated to eliminate any confounding. They were again asked to

enter their ID number. In this way, the responses in the first and the second application could be matched for each participant.

2.2. Results

To examine psychometric properties of the Turkish version of the Personal Relative Deprivation Scale, first, the descriptive statistics for Turkish Personal Relative Deprivation Scale (PRDS) were analyzed. Then, an exploratory factor analysis was performed to investigate the factor structure of the scale. Next, the reliability analyses were conducted to test both internal consistency reliability and test-retest reliability. Finally, the validity of the scale was investigated for convergent, discriminant and criterion validities.

2.2.1. Descriptive Statistics for the Study Measures

Descriptive characteristics (mean, standard deviation, and score range) of Turkish version of PRDS, Iowa Netherland Comparison Orientation Measure (INCOM), Marlowe-Crowne Social Desirability Scale (MC-SDS), and Social Comparison Frequency Scale (SCFS) were presented in Table 2.

Table 2. *Descriptive Statistics for the Study Variables*

Variables	*N*	*M*	*SD*	*Min-Max (within the study)*	*Scale Range*
Perceived relative deprivation	178	17.43	4.55	5-27	5-30
Social comparison orientation	178	39.16	6.11	21-53	11-55
Social desirability	178	53.76	4.79	43-64	33-66
Social comparison frequency	178	19.91	4.03	7-35	7-35

Note. PRDS: Personal Relative Deprivation Scale; INCOM: Iowa-Netherlands Comparison Orientation Measure; MC-SDS: Marlowe-Crowne Social Desirability Scale; SCFS: Social Comparison Frequency Scale

2.2.2. Factor Analysis for Personal Relative Deprivation Scale

2.2.2.1. Exploratory Factor Analysis

In order to analyze the factor structure of PRDS, an exploratory factor analysis was conducted. Initially, a principal component analysis was administered. In terms of the factorability of the scale, three assumptions were checked. The sample size of the current study (N = 178) fitted the rule of thumb for the first assumption of the factor analysis. In addition, the Keiser-Meyer-Olkin (KMO) measure of sampling adequacy was found .66, which is above the suggested value. Additionally, Bartlett's test of sphericity ($\chi^2(10) = 330.89$, $p < .001$) proved that the items of PRDS are appropriate for factor analysis. Both eigenvalues and scree plot analysis offered a two-factor structure for PRDS. Eigenvalues for the extracted two factors were 2.51 and 1.39, and these factors explained cumulatively 78.06% of the variance. The component correlation matrix showed that these two factors were weakly correlated (r = .20). Since the inter-item correlations of PRDS were high, the analysis suggested an oblique (nonorthogonal) rotation method. According to the factor pattern matrix, three items (item 1, item 3, and item 5) were strongly loaded on the first factor, whereas two items (item 2 and item 4) were strongly loaded on the second factor (see Table 3). When the content of the items loaded on the factors was examined, it was concluded that items loaded on the first factor were about the negative feelings arising from experiencing relative deprivation. On the other hand, items loaded on the second factor were related to focusing on materialistic outcomes when comparing the self with others similar. Therefore, the exploratory factor analysis suggested a two-factor structure for Turkish PRDS: negative feelings and materialistic outcomes. Within the scope of the present thesis study, the total scale score was used.

Table 3. *Factors and Factor Loadings of the Personal Relative Deprivation Scale's Items*

	Factors	
	First factor	Second factor
Item 5	**.90**	.09
Item 3	**.89**	-.15
Item 1	**.83**	.09
Item 2	-.09	**.90**
Item 4	.12	**.85**

Note. Factor loadings in boldface indicate that respective items are loaded onto the factor in that column.

2.2.3. Reliability Analyses for Personal Relative Deprivation Scale

2.2.3.1. Internal Consistency Reliability

The Cronbach's alpha coefficient was calculated to analyze the internal consistency reliability among the items of the Turkish version of Personal Relative Deprivation Scale. The internal consistency reliability for the scale was found as .74, which is an acceptable value (Cortina, 1993).

2.2.3.2. Test-Retest Reliability

To analyze the test-retest reliability of the Turkish version of the Personal Relative Deprivation Scale, the study was administered twice with a two-month interval. The second run of the study was conducted to 50 voluntary participants from the first study. Pearson correlation analysis was performed to examine the test-retest reliability of the scale. For the Turkish version of PRDS, test-retest reliability coefficient was found to be .84 ($N = 50$, $p < .001$), which is a high reliability value (Cicchetti, 1994).

2.2.4. Validity Analysis for Personal Relative Deprivation Scale

Pearson zero-order correlation analysis was conducted to examine the validity of the Turkish version of the Personal Relative Deprivation Scale (PRDS). The validity of the scale was tested in terms of convergent, discriminant, and criterion validities. In terms of convergent validity, a significant correlation was expected between PRDS and a scale measuring a similar and relevant concept. For this purpose, PRDS was

correlated with the Iowa-Netherlands Comparison Orientation Scale (INCOM), the measure of social comparison orientation. As expected, a significant and positive correlation was obtained between PRDS and INCOM (r = .31, p < .001). That is, the individuals who perceive more relative deprivation are more likely to make social comparisons. Therefore, it can be concluded that the Turkish version of PRDS has a satisfactory convergent validity.

In terms of discriminant validity, PRDS was expected to have low or no association with the concept of social desirability, which is irrelevant to the concept of relative deprivation. With this aim, PRDS was correlated with Marlowe-Crowne Social Desirability Scale (MS-SDS). However, unexpectedly, the analysis showed that PRDS was correlated positively and significantly with MC-SDS (r = .30, p < .001). This result indicated that increased individual-level perceived relative deprivation was related to an increased tendency for social desirability. The unexpected correlation demonstrated that MC-SDS did not support the discriminant validity of Turkish PRDS.

For the criterion related validity of PRDS, a significant association of it with Social Comparison Frequency Scale (SCFS) was expected. Confirming the hypothesis, a positive and significant correlation was obtained between PRDS and SCFS (r = .30, p < .001). This expected result indicated that the more the individuals perceive personal relative deprivation, the more often they compare themselves with others. Table 4 presents the correlation coefficients between PRDS, and the measures employed to establish its validity.

Table 4. *Correlation Matrix between the PRDS and Validity Measures*

	1	2	3	4
1. PRDS	(.74)			
2. INCOM	.31**	(.79)		
3. MC-SDS	.30**	.33**	(.75)	
4. SCFS	.30**	.63**	.33**	(.72)

Note 1. *p < .05 (2-tailed), ** p < .01 (2-tailed)
Note 2. PRDS: Personal Relative Deprivation Scale; INCOM: Iowa-Netherlands Comparison Orientation Measure; MC-SDS: Marlowe-Crowne Social Desirability Scale; SCFS: Social Comparison Frequency Scale
Note 3. Scores in the parentheses represent the Cronbach's alpha values for the measures.

2.3. Discussion

The current study aimed to translate the Personal Relative Deprivation Scale (PRDS) into Turkish and examine its psychometric properties in terms of reliability and validity. Initially, the Turkish translation process was completed. Afterward, the exploratory factor analysis was conducted to analyze the factor structure of PRDS. Then, correlation analyses were run to investigate the psychometric properties (i.e., internal consistency and test-retest reliability, convergent, discriminant, and criterion-related validities) of the scale. In this part, the findings of the analyses will be discussed based on the relevant literature.

Primarily, exploratory factor analysis was performed for the Turkish version of PRDS. Results of the analysis indicated that a two-factor approach could be appropriate for the Turkish PRDS. Furthermore, when examining the contents of the items loaded on the factors, it was concluded that the scale could measure two diverse factors: negative feelings and materialistic outcomes. Within the scope of the present study, the total scale score was utilized.

In terms of reliability, the measure demonstrated an acceptable level of internal consistency reliability (α = .74). The Cronbach's alpha value was equal to the four-item version of the scale (Callan, Ellard, Shead, & Hodgins, 2008) and slightly lower than the value obtained from the five-item version of the original scale (α = .78) (Callan, Shead, & Olson, 2011). In order to investigate its test-retest reliability, the scale was readministered to a group of volunteers from the same sample at a two-month interval. Pearson correlation analysis showed that the Turkish version of PRDS has high test-retest reliability (r = .84, p < .001). This result indicated that the sample was likely to respond to the items in a similar fashion, even if the time intervened. Hence, the Turkish version of PRDS demonstrated high internal consistency and test-retest reliability to assess individual-level perceived relative deprivation.

So as to examine the validity of the Turkish version of PRDS, convergent, discriminant, and criterion-related validities were examined. In order to analyze the convergent validity of the scale, Iowa-Netherlands Comparison Orientation Scale (INCOM) was employed. Through INCOM, it was aimed to measure individuals' tendency in making comparisons in social settings. In a similar vein, PRDS has the

purpose of assessing the feelings and conclusions when individuals compare themselves with others similar. Therefore, since these two scales aimed to measure theoretically relevant constructs, a high positive correlation was expected between them. As expected, a significant and positive correlation was obtained between PRDS and INCOM. This result was congruent with previous findings. Callan, Kim, and Matthews (2015) also found that as the perceived relative deprivation increased, the tendency for social comparison increased. Since the positive and significant correlation obtained between INCOM and PRDS supported the convergent validity of the Korean PRDS (Kim, Kim, Suh, & Callan, 2018), for the current study, it was plausible to employ the INCOM to evaluate the convergent validity of the Turkish version of PRDS.

Marlowe-Crowne Social Desirability Scale (MC-SDS) was utilized to examine the discriminant validity of the Turkish version of PRDS. Since social desirability tendency and perceived relative deprivation appeared as theoretically unrelated constructs, no or very low correlation was expected between them. However, contrary to our expectation, a positive and significant correlation was obtained. That is to say, the higher the level of perceived personal relative deprivation, the greater the tendency for social desirability. This result should be evaluated with caution since it was not parallel to the previous findings. Olson, Roese, Meen, and Robertson (1995) pointed out that social desirability did not have any confounding impact on the findings regarding relative deprivation. Furthermore, INCOM, the scale used to ensure the convergent validity of the PRDS, had a weak relation with the concept of social desirability (Gibbons & Buunk, 1999). Therefore, based on these findings, a low or no correlation between social desirability and perceived personal level relative deprivation was anticipated in the present study. Although this was an unexpected result, the present study captured a notable finding for relative deprivation theory. In the literature, there have been different viewpoints regarding the concept of social desirability, which is the tendency to present oneself as a highly conforming person to social norms. The most common approach has been evaluated this tendency as a personality characteristic (Reynolds, 1982), meaning that some individuals are inclined to hide their negative sides, which are incongruent with the social norms. Another approach has suggested that there are some questions that individuals hesitate to answer unless they fully comply with the norms of the society; thus, social

desirability tendency increases when answering those types of questions (Phillips & Clancy, 1972). Since the feelings of discontent and grievance that occur after comparing oneself with someone similar are socially undesirable, social desirability and relative deprivation scores may have been significantly correlated in the present study. Therefore, by suggesting the significant relation between perceived relative deprivation and the tendency for social desirability, the current finding made an essential contribution to the literature. However, the discriminant validity of the Turkish version of PRDS could not be supported by the concept of social desirability since these two constructs were not found conceptually different from each other.

In order to evaluate the criterion-related validity of the PRDS, Social Comparison Frequency Scale was employed. Accordingly, a high and positive correlation was expected, indicating that the higher the perceived relative deprivation, the more frequently individuals make social comparisons. The finding obtained from the current study was consistent with the hypothesis. Therefore, the criterion-related validity of the Turkish version of PRDS was also proven.

All in all, despite the ill-defined findings regarding the discriminant validity, the scale demonstrated high reliability and high convergent and criterion-related validity. Thus, according to the present study's findings, it can be concluded that psychometric properties of the Turkish version of PRDS are suitable to be used in studies investigating personal level perceived relative deprivation. Although Özdemir, Tekeş, and Öner-Özkan (2019) developed a Turkish measure to assess the level of personal relative deprivation, they asked the respondents to determine the subject on which they felt relative deprivation. Therefore, they obtained diverse responses for the lacking subject. However, the current scale asked the respondents to evaluate the items by considering their feelings, thoughts, and attitudes in general. As a contribution to the previous study, the current study is of great importance since there was no existing scale in Turkish literature to measure personal level perceived relative deprivation as a predisposition.

CHAPTER 3

STUDY 2: Main Study

3.1. Method

The second study aimed to investigate whether experiencing relative deprivation is related to the health condition of unemployed individuals in Turkey. Moreover, in this relation, the mediating roles of locus of control and the length of unemployment were aimed to be explored. In addition to these purposes, the moderating roles of dispositional optimism and perceived social support were planned to be examined. Turkish version of PRDS, adapted into Turkish in the first study, was employed in this study. The method section will cover the participants' social and demographic characteristics, the psychometric properties of employed questionnaires, and the detailed description of the procedure about the administration of the study.

3.1.1. Participants

The second study was conducted with unemployed individuals in Turkey during the COVID-19 pandemic period. For the purposes of the present study, there were three main criteria to meet. Participants had to be aged between 20 and 45, and they had to be unemployed for at least six months. Also, they had to possess at least an associate degree or above. The announcement of the study was made on social media by emphasizing all these criteria. The study was administered online via Qualtrics survey system. Since the data were collected online, the study had a broad representation of the unemployed, higher educated individuals in various cities in Turkey.

Four hundred two unemployed individuals (M_{age} = 27.57, *SD* = 4.47, age range 21-45 years) participated in the second study. The sample consisted of 298 females (74.1%), 103 males (25.6%) and one non-binary person (0.2%). During the process of the study, 17.4% (*n* = 70) of the participants were married, 4.2% (*n* = 17) of them had a fiancée,

22.6% (*n* = 91) of them were single but in a relationship, and the remaining were single without a romantic relationship (*n* = 221, 55%). Three (0.7%) participants did not explain their romantic relationship status. Majority of the participants (*n* = 370, 92%) had no children, whereas 32 (8%) participants had at least one child (*M* = 1.63, *SD* = 0.75).

A great number of the participants reported that they have spent most of their life in an urban region like metropolitans (*n* = 212, 52.7%) or cities (*n* = 104, 25.9%), while the remaining resided for most of their life in rural areas like districts (*n* = 64, 15.9%), towns (*n* = 5, 1.2%), or villages (*n* = 17, 4.2%). Respondents were also asked about their monthly household income and the number of individuals living in the house. The monthly income per capita of the participants was calculated by dividing the reported range of monthly income by the number of people living at home. Then, according to the hunger and poverty line announced by the Confederation of Turkish Trade Unions, the actual income levels of the participants were determined (TÜRK-İŞ, 2021). The hunger line is the limit for monthly food expenditure for a balanced and adequate diet. The poverty line, on the other hand, is the monthly amount required for the expenses such as clothing, housing, transportation, health and education along with food expenses. For a family of four persons the hunger line was 2767 TL, and the poverty line was 9014 TL in 2021 (TÜRK-İŞ, 2021). The majority of the sample (*n* = 244, 60.7%) was between the hunger line and poverty line, 20.6% (*n* = 83) of the sample were below the hunger line, and 18.7% (*n* = 75) of them was above the poverty line.

Participants consisted of highly educated and job seeker unemployed individuals. More than half of the sample possessed a bachelor's degree (*n* = 287, 71.4%), and the remaining either had an associate degree (*n* = 16, 4%) or a master's degree (*n* = 94, 23.4%). Moreover, five participants (1.2%) had a doctoral degree. A great number of participants (*n* = 240, 59.7%) were enrolled in a graduate program either to obtain a bachelor's degree (*n* = 23, 5.7%), master's degree (*n* = 187, 46.5%), or a doctoral degree (*n* = 30, 7.5%). One hundred four participants (25.9%) reported that they had never worked before, whereas 74.1% (*n* = 298) of the sample reported that they were employed previously. Among those who previously employed, 34.6% (*n* = 139) of them worked in a job related to the education they received (M_{month} = 35.65, *SD* =

47.31), while the remaining (n = 159, 39.6%) worked in a temporary job they were not trained for (M_{month} = 19.7, SD = 27.11). Participants were also asked to indicate how long they have been unemployed on a scale with six-answer option in which the responses ranged from six months to more than five years. Of the participants, 167 (41.5%) have been unemployed for six months to one year, 108 (26.9%) for one to two years, 51 (12.7%) for two to three years, 33 (8.2%) for three to four years, 16 (4%) four to five years. Twenty-seven (6.7%) participants have been unemployed for more than five years.

Although majority of participants (n = 336, 83.6%) did not report any diagnosed psychological disorder, 66 (16.4%) participants reported that they had at least one. When asked what kinds of treatments they had received so far, 8% (n = 32) of them reported receiving psychopharmacological treatments, 3.5% (n = 14) of them reported getting psychotherapy, and 19 (4.7%) participants reported receiving no treatment. One participant reported to apply other ways of treatment. Also, 31 (7.7%) respondents reported suffering from a physiological disorder. The most frequently reported disorders were spinal disorders such as hernia (n = 3) and ankylosing spondylitis (n = 2), heart diseases (n = 3), and fibromyalgia (n = 2).

Table 5. *Demographic Characteristics of Participants*

Variables	*N*	%	*M*	*SD*	*Min-Max*
Age	402		27.57	4.47	21-45
Gender					
Female	298	74.1			
Male	103	25.6			
Non-binary	1	0.2			
Romantic relationship status					
Single	221	55			
In a relationship	91	22.6			
Engaged	17	4.2			
Married	70	17.4			
Other	3	0.7			
Having children					
Yes	32	8			
Number of children			1.63	0.75	1-4
No	370	92			

Table 5. *Demographic Characteristics of Participants (continued)*

Variables	*N*	%	*M*	*SD*	*Min-Max*
Residing area					
Village	17	4.2			
Town	5	1.2			
District	64	15.9			
City	104	25.9			
Metropolitan	212	52.7			
Economic level					
Below the hunger line	83	20.6			
Between hunger and poverty line	244	60.7			
Above the poverty line	75	18.7			
Graduated degree					
Associate degree	16	4.0			
Bachelor's degree	287	71.4			
Master's degree	94	23.4			
Doctoral degree	5	1.2			
Continuing further education					
Yes	240	59.7			
Bachelor's degree	23	5.7			
Master's degree	187	46.5			
Doctoral degree	30	7.5			
No	162	40.3			
Working previously			*month*		
Yes	298	74.1	27.13	38.66	1-240
Received education	139	34.6	35.65	47.31	1-240
Temporary job	159	39.6	19.7	27.11	1-180
No	104	25.9			
Length of unemployment					
6 months-1 year	167	41.5			
1 year-2years	108	26.9			
2 years-3 years	51	12.7			
3 years-4 years	33	8.2			
4 years-5 years	16	4			
More than 5 years	27	6.7			
Psychological disorder					
Yes	66	16.4			
No	336	83.6			
Physiological disorder					
Yes	31	7.7			
No	371	92.3			

3.1.2. Instruments

3.1.2.1. Demographic Information Form

To obtain information regarding the social and demographic characteristics of the participants, a 17–item form was developed. Participants' age, gender, romantic partnerships, parental status, and the number of children if they have any were asked. Regarding the socio-economic status of the participants, questions about the area of their residence where they have spent the most portion of their lives, the number of people living in the household, and the total monthly income of the household were directed. In terms of education status, respondents were asked questions about their last graduated degree, the graduation year, and whether they continue their education at the graduate level (master's or doctorate).

To collect information regarding the health conditions of the participants, they were requested to report whether they have any psychological or physiological disorders. Those participants diagnosed with a psychological disorder were asked what kind of treatment they have received so far. Participants with a physiological disorder were also asked which diseases they suffer from.

For the current study's purposes, all the participants were expected to be unemployed for at least six months. In the demographic information form, the respondents were questioned about how long they have been actively looking for a job. Additionally, they were requested to report whether they had been employed previously, and those who answered yes to this question were asked the duration of that job, and they were further questioned about whether this job was related to the field they were trained in. The form also included questions as follows: how often they check job postings, how serious they consider the problem of unemployment, and how controllable they think the problem of unemployment is (see Appendix C).

3.1.2.2. Personal Relative Deprivation Scale (PRDS)

PRDS, adapted to Turkish in the first study, was employed in the second study. Before filling in the form, the participants were asked to evaluate the items by considering their unemployment problem. As mentioned earlier, the 5–item PRDS was developed by Callan, Shead, and Olson (2011), with acceptable internal consistency reliability (α

= .78). The Turkish adaptation of PRDS yielded a good Cronbach's alpha (α = .74) and had a high test-retest reliability (r = .84) in two-months interval. The psychometric properties of the Turkish PRDS also demonstrated satisfactory results for the validity of the scale. The significant correlations between PRDS and INCOM (r = .31, p < .001) indicated that the Turkish version of PRDS has a good convergent validity. Moreover, the significant correlation between PRDS and SCFS (r = .30, p < .001) proved the criterion validity of the Turkish PRDS. For the current study, the Cronbach's alpha coefficient for internal consistency reliability was .74.

3.1.2.3. Locus of Control Scale (LCS)

Locus of Control Scale (LCS) was developed by Dağ (2002) to measure proneness for external or internal locus of control in individuals. The scale items were based mostly on widely used Rotter's Internal-External Locus of Control Scale (1966). Since the response method of the Rotter's scale is forced choice, it could be difficult for the participants to respond. For this reason, Dağ (2002) arranged the response alternatives in Likert-type format. The scale has 47 items with a 5–point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Twenty-two items were reverse coded. Higher scores obtained from the scale indicate a tendency for an external locus of control, whereas lower scores indicate a tendency for an internal locus of control.

In terms of convergent validity, LCS was correlated with Rotter's Internal-External Locus of Control Scale (r = .67, p < 001), Rosenbaum's Learned Resourcefulness Scale (r = -.39, p < .05), Symptom Check List–90 (r = .25, p < .05), and Paranormal Belief Scale (r = .46, p < .001). The significant correlations indicated that the Turkish version LCS has a satisfactory convergent validity to assess the construct of locus of control.

LCS had a high internal consistency reliability (α = .92) and yielded a high test-retest reliability in a four-week interval (r = .88, p < .001). As a result of the factor analysis, five factors emerged: personal control (α = .87) measured with 18 items (e.g., Bir insanın başına gelenler, temelde kendi yaptıklarının sonucudur), belief in chance (α = .79) measured with 11 items (e.g., Aslında şans diye bir şey yoktur), the meaningless of effortfulness (α = .76) measured with ten items (e.g., Bir çok hastalık insanı yakalar ve bunu önlemek mümkün değildir), belief in fate (α = .74) measured with three items

(e.g., Kaderin insan yaşamı üzerinde çok büyük bir rolü vardır), and belief in an unjust world (α = .61) measured with five items (e.g., İnsanın yaşamının alacağı yönü, çevresindeki güç sahibi kişiler belirler). For the current sample, the internal consistency reliability was found as .87, and for the subfactors of personal control, belief in chance, meaningless of effortfulness, belief in fate and belief in an unjust world it was found as, .86, .79, .78, .74, and .71, respectively.

3.1.2.4. Life Orientation Test (LOT)

The Life Orientation Test was developed by Scheier and Carver (1985) to assess dispositional optimism. The scale consists of 12 items evaluated on a 5–point Likert type scale and, response categories range between 1 (*strongly disagree*) to 5 (*strongly agree*). Four items (e.g., I always look on the bright side of things) were phrased in positive terms, another set of four items (e.g., I hardly ever expect things to go my way) were phrased in negative terms and they were also reverse coded. Additionally, other four items (e.g., It is easy for me to relax) were fillers excluded from the calculation. Higher scores obtained from the measure indicate a more optimistic tendency in life. The original version of LOT had acceptable internal consistency reliability (α = .76) and an adequate test-retest reliability in one-month interval (r = .79). Findings revealed that LOT had also satisfactory convergent and discriminant validity.

Turkish adaptation of LOT was conducted by Aydın and Tezer (1991). The psychometric properties regarding reliability were adequate for internal consistency reliability (α = .72) and test-retest reliability (r = .72, p < .001). A negative and significant correlation between the Beck Depression Inventory and LOT (r = -.56, p < .001) proved that the Turkish version of LOT had a good concurrent validity to assess dispositional optimism in Turkish samples. For the current study, Cronbach's alpha for internal consistency reliability was .83.

3.1.2.5. Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) was developed to assess perceived social support from three primary sources (Zimet, Dahlem, Zimet, & Farley, 1988). MSPSS is a self-report measure and comprises 12 items answered on a

7–point Likert type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores obtained from the scale indicate higher perceived social support. The instrument addresses three distinct sources of perceived social support, and each of these factors is measured with four items: family (e.g., My family really tries to help me.), friends (e.g., I can talk about my problems with my friends), and a significant other (e.g., There is a special person with whom I can share my joys and sorrows). The internal consistency reliability coefficients were high both for the total measure (α = .88) and for the factors of the family (α =.91), friends (α =.87), and significant other (α = .85). Additionally, test-retest reliabilities were .85 for the total measure, .72, .84, .75 for the family, friends, and significant other, respectively. Negative and significant correlations with depression and anxiety subscales of Hopkins Symptom Checklist (r = -.25, p < .01) indicated that the instrument also has a good construct validity (Zimet et al., 1988).

The scale was adapted into Turkish by Eker and Arkar (1995). The phrase "significant other" in the original version of the scale was modified with "a person out of family and friends such as a fiancée or neighbor" to clarify the significant other's description in the Turkish context (Eker, Arkar, & Yaldız, 2001). In terms of validity, positive and significant correlations between Perceived Social Support Scale (PSS) and MSPSS were obtained for the total measure (r = .61, p < .001), the family (r = .75, p < .001), and friends (r = .37, p < .01). In addition, MSPSS was correlated negatively and significantly with loneliness (r = -.63, p < .001), symptom checklist (r = -.58, p < .001), negative social relations (r = -.56, p < .001), and hopelessness (r = -.45, p < .001). All in all, Turkish MSPSS has satisfactory levels of validity. In terms of reliability, Turkish MSPSS yielded a high internal consistency reliability for the total measure (α = .89), family (α = .85), friends (α = .88), and significant other (α = .92). For the current sample, the total measure's internal consistency reliability was .91, and for the factors of family, friends and significant other Cronbach's alpha coefficients were .87, .85, and .74, respectively.

3.1.2.6. Short Form–36 Health Survey (SF–36)

SF–36, a self-report inventory, was designed by Ware and Sherbourne (1992) to assess health related quality of life. As its name suggested, it is a brief 36–item version of a

longer measure developed within the scope of Medical Outcomes Study (MOS). SF–36 is employed to evaluate health status from eight main health domains: (1) physical functioning, (2) social functioning, (3) role restriction in ordinary activities due to physical problems, (4) role restrictions in ordinary activities due to emotional problems, (5) psychological health, (6) vitality/fatigue, (7) bodily pain, and (8) general health. Higher order factor analysis showed that these domains measured two main broader components namely physical health (aggregation of domains 1, 3, 7, and 8) and mental health (aggregation of domains 2, 4, 5, and 6) (Ware, Kosinski, & Keller, 2011). The instrument consists of items answered both with Likert-type scale and with forced-choice format. Higher scores obtained from SF–36 indicate a better health condition. A following research revealed that the measure has internal consistency reliability coefficients ranging between .68 (social functioning) and .93 (physical functioning) across subscales. In terms of validity, findings from several studies revealed that SF–36 was significantly correlated with other health inventories (r = .40 or greater, p < .05) (Ware, 2000).

The Turkish adaptation study of SF–36 was conducted by Demirsoy (1999) among a university student sample. The internal consistency reliability of Turkish SF–36 was in satisfactory levels with Cronbach's alphas ranging between .75 (role restrictions due to emotional problems) and .90 (psychological health) across subscales. In a further study, for the similar subfactors of SF-36 and Nottingham Health Profile (NHP), higher correlations (ranging between r = -.44, p < .01 and r = -.65, p < .01) were obtained in between their similar subfactors than in between their dissimilar subfactors, meaning that Turkish version of SF-36 has a good construct validity (Koçyiğit, Aydemir, Fişek, Ölmez, & Memiş, 1999). For the current sample, the internal consistency reliability coefficients for physical functioning, social functioning, role restriction due to physical problems, role restrictions due to emotional problems, psychological health, vitality, bodily pain, and general health were .88, .68, .88, .86, .86, .84, .82, and .80, respectively. Also, for the physical health component, the Cronbach's alpha was found .90, and for the mental health component it was .88.

3.1.3. Procedure

Prior to data collection, first, the ethical approval for the current study was obtained from the Institutional Review Board of Middle East Technical University. Also, so as to use the scales described above, permissions were obtained from the authors who developed or adapted the scales. Data were collected online through Qualtrics online survey system. The current study was announced via several social media platforms such as Facebook, LinkedIn, and Twitter. Individuals who met the criteria and volunteered to participate were provided an informed consent form. Through this form, participants were informed about the purposes of the present study and confidentiality for their participation. They were also informed regarding their right to leave the study whenever they feel uncomfortable. After their consent was obtained, participants were asked to complete the Demographic Information Form first and then the five inventories. The questionnaires were presented in a randomized order to eliminate the carry-over effect. Completion of the questionnaire package took approximately 20 minutes. When the filling out process was over, all participants were thanked for their participation, debriefed briefly about the study, and provided the researcher's contact information for their further questions.

3.2. Results

The purpose of the second study was to test the main study's hypotheses. For this aim, first, descriptive statistics of the current study's measures were analyzed. Then, a regression analysis was conducted to examine the association between perceived relative deprivation and health outcomes. Next, a series of mediation analyses were performed to investigate the roles of locus of control and length of unemployment in the relation between perceived relative deprivation and health status. Lastly, to explore the protective roles of dispositional optimism and perceived social support in the same relation, a series of moderation analyses were run. All of the analyses were conducted via IBM SPSS (Statistical Package for Social Sciences) version 25.

3.2.1. Preliminary Analyses

Before running the preliminary analyses, the data were screened for missing values. No missing values were found. Then, the data were examined to test the assumption

of normality. For the composite scores of Personal Relative Deprivation Scale (PRDS), Locus of Control Scale (LCS), Life Orientation Test (LOT), MSPSS (Multidimensional Scale of Perceived Social Support) and its family, friends and significant other subscales, and physical and mental health subscales of SF-36, the normality test was performed. In terms of skewness and kurtosis, values for the measures in the present study were in between -2 and +2, which was the acceptable range (Trochim & Donnelly, 2006). After examining skewness and kurtosis values, standardized values of the composite scores of the measures were analyzed for the outlier analysis. Since the standardized scores of two participants were not in the range of -3.29 and +3.29 for the Locus of Control Scale (LCS), they were excluded from the dataset.

For the questions directed in the demographic information form, participants (N = 402) perceived their unemployment problem as highly severe (M = 4.77, SD = .59, range = 1−5), but still controllable (M = 2.92, SD = 1.26, range = 1−5). Regarding job seeking frequency, participants' frequency of looking at job postings was above the average (M = 3.74, SD = 1.29, range = 1−5).

3.2.2. Descriptive Statistics for the Study Measures

So as to examine the descriptive characteristics of the employed measures and their subscales, mean values, standard deviations, minimum and maximum values obtained within the present study and their score range were analyzed for Perceived Relative Deprivation Scale (PRDS), Locus of Control Scale (LCS), Life Orientation Test (LOT), Multidimensional Scale of Perceived Social Support (MSPSS) and its family, friend and significant other subscales, and Short Form-36 and its physical and mental health subscales. The results of the analysis are presented in Table 6.

Table 6. *Descriptive Characteristics of the Study Measures*

Variables	*N*	*M*	*SD*	*Min-Max (within the study)*	*Scale Range*
Perceived relative deprivation	402	19.06	5.34	5-30	5-30
Locus of control	402	130.50	18.70	69.09-194.11	47-235
Length of unemployment	402	2.26	1.50	1-6	1-6
Dispositional optimism	402	14.59	6.26	0-32	0-32
Perceived social support	402	55.38	18.64	12-84	12-84
Family	402	16.72	8.19	4-28	4-28
Friends	402	19.88	6.59	4-28	4-28
Significant other	402	18.78	6.29	4-28	4-28
Health condition					
Physical health	402	1512.61	395.70	275.73-2100	0-2100
Mental health	402	603.79	279.23	393.53-905.52	0-1400

3.2.3. Bivariate Correlations among the Study Variables

Pearson zero-order correlation analysis was conducted to examine the bivariate correlation coefficients among the study measures, namely PRDS, LCS, length of unemployment, LOT, MSPSS, subscales of MSPSS, and subscales of SF-36. The results indicated that perceived relative deprivation was positively and significantly correlated with externality in locus of control (r =.26, p < .001) and length of unemployment (r =.17, p < .01); while it was negatively and significantly correlated with dispositional optimism (r = -.40, p < .001), the global score of perceived social support (r = -.27, p < .001) and its family (r = -.16, p < .01), friends (r = -.33, p < .001) and significant other (r = -.26, p < .001) subscales. Perceived relative deprivation was also negatively and significantly correlated with physical health (r = -.23, p < .001) and mental health (r = -.37, p < .001) subscales of SF-36. One of the mediator variable of the present study, externality in locus of control, was found to be negatively and significantly correlated with dispositional optimism (r = -.30, p < .001), the total score of perceived social support and its significant other (r = -.10, p < .05) subscale. Externality in locus of control was also negatively and significantly correlated with physical health (r = -.22, p < .001) and mental health (r = -.21, p < .001) subscales of

SF-36. The other mediator variable, length of unemployment was negatively and significantly correlated with dispositional optimism (r = -.11, p < .05), the full scale of perceived social support (r = -.14, p < .001) and its family (r = -.12, p < .05), friends (r = -.13, p < .05) and significant other subscales (r = -.13, p < .05). Length of unemployment was also found negatively and significantly correlated with the physical health subscale of SF-36 (r = -.19, p < .001). One of the moderator variable of the current study, dispositional optimism, was found as positively and significantly correlated with the total score of perceived social support (r = .25, p < .001), and its family (r = .14, p < .01), friends (r = .30, p < .001) and significant other subscales (r = .25, p < .001). Moreover, dispositional optimism was correlated positively and significantly with physical health (r = .20, p < .001) and mental health (r = .51, p < .001) subscales of SF-36. The other moderator variable of the present study, global perceived social support, was found to be correlated positively and significantly with its family (r = .88, p < .001), friends (r = .83, p < .001) and significant other (r = .96, p < .001) subscales. The total scale of perceived social support was also positively and significantly correlated with physical health (r = .23, p < .001) and mental health (r = .30, p < .001) subscales of SF-36. Family subscale of perceived social support was found as positively and significantly correlated with friends (r = .49, p < .001) and significant other subscales (r = .79, p < .001) of the same scale. Family subscale was also found to be correlated positively and significantly with physical health (r = .18, p < .001) and mental health (r = .21, p < .001) subscales of SF-36. Another subscale of perceived social support, friends support, was found to be correlated positively with significant other subscale of perceived social support (r = .77, p < .001), and physical health (r = .23, p < .001) and mental health (r = .31, p < .001) subscales of SF-36. The other subscale of perceived social support, significant other subscale, was found as positively and significantly correlated with physical health (r = .21, p < .001) and mental health (r = .29, p < .001) subscales. Furthermore, physical health subscale of SF-36 was found to be correlated significantly and positively with the mental health subscale of the same scale (r = .44, p < .001) (see Table 7).

Table 7. *Pearson Correlation Coefficients for the Study Measures*

Variable	1	2	3	4	5	6	7	8	9	10
1. Perceived relative deprivation	(.74)									
2. Locus of control	.26***	(.87)								
3. Length of unemployment	.17**	.07	(–)							
4. Dispositional optimism	-.40***	-.30***	-.11*	(.83)						
5. Perceived social support	-27***	-.10*	-.14**	.25***	(.91)					
6. Family support	-.16**	-.07	-.12*	.14**	.88***	(.87)				
7. Friends support	-.33***	-.10	-.13*	.30***	.83***	.49***	(.85)			
8. Significant other support	-.26***	-.11*	-.13*	.25***	.96***	.79***	.77***	(.74)		
9. Physical health	-.23***	-.22***	-.19***	.20***	.23***	.18***	.23***	.21***	(.90)	
10. Mental health	-.37***	-.21***	-.06	.51***	.30***	.21***	.31***	.29***	.44***	(.88)

Note 1. * $p < .05$ (2-tailed), ** $p < .01$ (2-tailed), *** $p < .001$ (2-tailed).
Note 2. Scores within the parentheses represent Cronbach's alpha coefficients of the respective scales and sub-scales.

3.2.4. Regression Analysis

In order to test whether perceived relative deprivation significantly predicted participants' scores in physical and mental dimensions of health conditions, a regression analysis was planned to perform. Since significant associations were obtained between the age of the participants and their physical (r = -.11, p < .05) and mental (r = .11, p < .05) health scores, age was analyzed as a control variable in this analyses. Thus, a hierarchical regression analysis was run to ensure that the relation between perceived relative deprivation and health outcomes was not affected by the effect of age. In order to rule out its possible confounding effect, age was entered in the model first; then, on the next step, perceived relative deprivation was added to the model. This analysis was conducted separately for both of the dependent variables, i.e., physical and mental health. Findings indicated that age was accounted for 1% variance in physical health (F(1, 400) = 4.89, p < .05), and 1% variance in mental health (F(1, 400) = 5.12, p < .05) scores significantly. As age increased, the physical health decreased (B = -4.46, SE = .21, p < .05, 95% CI [-.88, -.05]), but mental health increased (B = .52, SE = .23, p < .05, 95% CI [.07, .98]). When the second predictor, perceived relative deprivation, was included in the model, a significant change occurred in both physical health (ΔF(1, 399) = 22.52, p < .001 with ΔR^2 = .05) and mental health (ΔF(1, 399) = 63.38, p < .001 with ΔR^2 = .14). The results of the analyses showed that even after ruling out the effect of age, an increase in perceived relative deprivation significantly predicted a decrease in physical health (B = -4.06, SE = .86, p < 001, 95% CI [-5.74, -2.38]) and a decrease in mental health (B = -7.17, SE = .90, p < 001, 95% CI [-8.94, -5.40]). Therefore, the first hypothesis, unemployed individuals who perceived more relative deprivation would have worse health outcomes, was supported by the findings of these hierarchical regression analyses.

3.2.5. Mediation Analyses

A series of mediation analyses were conducted to investigate the mediator roles of locus of control and the length of unemployment in the association between perceived relative deprivation (IV) and health condition (DV). In the first mediation model, the mediating role of locus of control in the relation between perceived relative deprivation and health condition was tested separately for physical and mental health

dimensions. In the other mediation model, the mediating role of the length of unemployment in the association between perceived relative deprivation and health condition was investigated separately for both physical and mental dimensions of health. All the mediation models were performed by entering age as a control variable to rule out its possible confounding impact. The mediation analyses were run by using PROCESS macro (model 4) for IBM SPSS (Hayes, 2018).

3.2.5.1. Mediating Role of the Locus of Control in the Relation between Perceived Relative Deprivation

A mediation analysis was performed to examine whether the association between perceived relative deprivation and health condition is mediated by locus of control. The physical and mental dimensions of health were investigated separately to test this mediation model. Age was added to the model as a control variable. The result of the analysis indicated that the path from perceived relative deprivation to the locus of control; in other words, the direct effect of perceived relative deprivation on locus of control was positive and significant (B = .10, SE = .02, p < .001, 95% CI [.06, .13]), indicating that participants scoring higher on perceived relative deprivation were more likely to have an external locus of control. The paths from locus of control to physical health (B = -8.10, SE = 2.34, p < .001, 95% CI [-12.70, -3.49]) and mental health (B = -6.54, SE = 2.48, p < .01, 95% CI [-11.42, -1.67]) were also significant, showing that an increase in external locus of control predicted lower scores in physical and mental health. Similarly, the direct effect of perceived relative deprivation on physical health (B = -3.28, SE = .87, p < .001, 95% CI [-5.00, -1.57]) and mental health (B = -6.54, SE = .92, p < .001, 95% CI [-8.36, -4.72]) was found negative and significant, indicating that participants scoring higher on perceived relative deprivation had lower scores on physical and mental health dimensions. The significance of the indirect effect was calculated with 5000 bootstrap samples, and the indirect effect of perceived relative deprivation on physical health was mediated by the locus of control; it was negative and significant (B = -.78, SE = .24, 95% CI [-1.30, -.33]). Also, the indirect effect of perceived relative deprivation on mental health through the locus of control was found negative and statistically significant (B = -.63, SE = .27, 95% CI [-1.22, -.14]). That is, the mediating role of locus of control on the association between perceived relative deprivation and both physical and mental health was found significant even after

controlling for age. Thus, an increase in relative deprivation predicted higher externality in the locus of control, which in turn predicted a decrease in both mental and physical health dimensions. Therefore, these mediation analyses supported both 2a and 2b hypotheses of the present study (see Figure 1 and Figure 2).

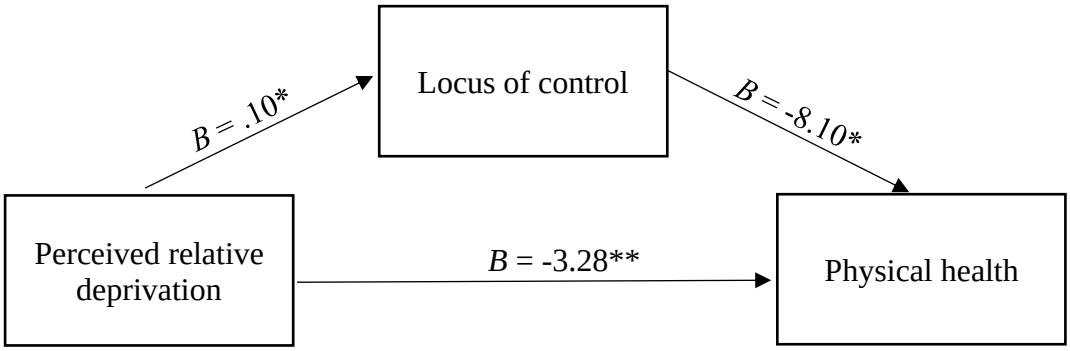

Figure 1. The mediating role of locus of control in the relation between perceived relative deprivation and physical health
Note. *$p < .001$
Note 2. Unstandardized regression coefficients are presented.

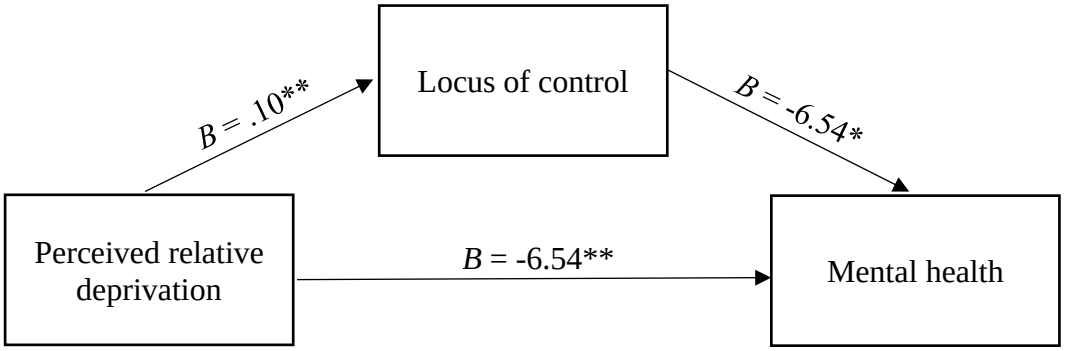

Figure 2. The mediating role of locus of control in the relation between perceived relative deprivation and mental health
Note. *$p < .01$, **$p < .001$
Note 2. Unstandardized regression coefficients are presented.

3.2.5.2. Mediating Role of the Length of Unemployment in the Relation between Perceived Relative Deprivation and Health Condition

A mediation analysis was run to investigate the mediating role of the length of unemployment in the relation between perceived relative deprivation and health condition. So as to examine this model, physical and mental health dimensions of health condition were tested, respectively. Age was still included as a control variable in these analyses. Findings indicated that the path from perceived relative deprivation to the length of unemployment was positive and significant (B = .26, SE = .06, p < .001, 95% CI [.13, .38]), meaning that an increase in perceived relative deprivation was significantly associated with an increase in the length of unemployment. Also, the direct effect of the length of unemployment on physical health was found negative and significant (B = -1.55, SE = .67, p < .05, 95% CI [-2.86, -.23]), indicating that as the duration of unemployment increased, participants' physical health worsened. However, the direct effect of the length of unemployment on mental health was not found significant (B = -.54, SE = .71, p = .44, 95% CI [-1.93, .85]). The direct effect of the perceived relative deprivation on physical health (B = -3.66, SE = .87, p < .001, 95% CI [-5.37, -1.96]) and mental health (B = -7.03, SE = .92, p < .001, 95% CI [-8.83, -5.22]) was negative and significant. In order to test the significance of the indirect effect, 5000 bootstrap samples were used. The indirect effect of the length of unemployment on the association between perceived relative deprivation and physical health was found significant (B = -.40, SE = .22, 95% CI [-.88, -.04]), while this indirect effect was not found significant for mental health dimension even if 10000 bootstrap samples were utilized (B = .14, SE = .19, 95% CI [-.56, .21]). That is, the length of unemployment had a significant mediating role in the association of perceived relative deprivation with physical health, but not with mental health. That means that even after the effect of age was controlled for, an increase in perceived relative deprivation was associated with an increase in the duration of unemployment, which in turn predicted worse physical health outcomes. Therefore, while hypothesis 3a was supported, hypothesis 3b was rejected (see Figure 3 and Figure 4).

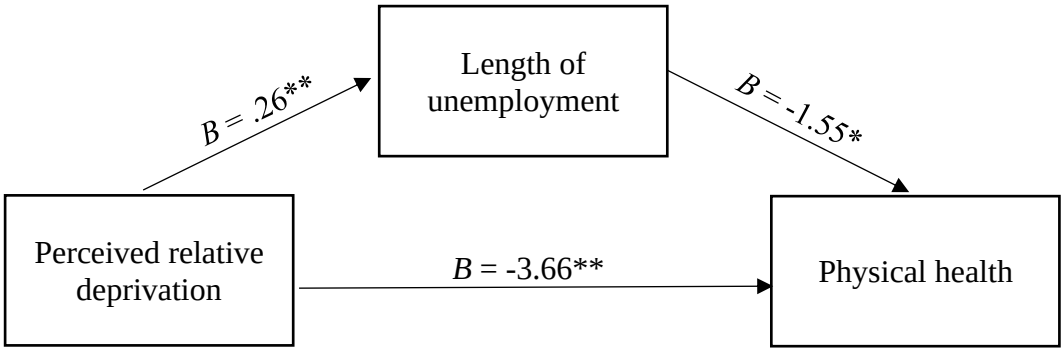

Figure 3. The mediating role of the length of unemployment in the relation between perceived relative deprivation and physical health
Note. *p < .05, **p < .001
Note 2. Unstandardized regression coefficients are presented.

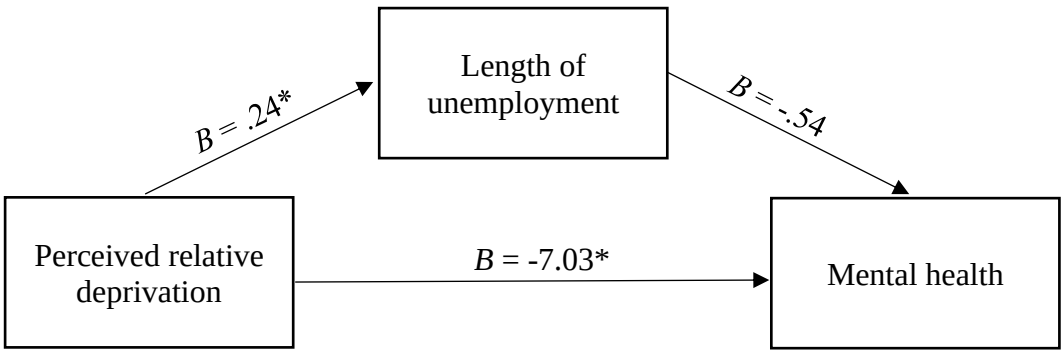

Figure 4. The mediating role of the length of unemployment in the relation between perceived relative deprivation and mental health
Note. *p < .001
Note 2. Unstandardized regression coefficients are presented.

3.2.6. Moderation Analyses

A series of moderation analyses were conducted to reveal the moderating roles of dispositional optimism and perceived social support in the association between perceived relative deprivation (IV) and health outcomes (DV). In the first moderation model, the moderating role of dispositional optimism in the mentioned relation for both physical and mental health scores was tested. In the other moderation model, the moderating role of perceived social support and its subscales (family, friends, and significant other) were examined in this association for both physical and mental

health dimensions as the outcome variables. In all these analyses, age was included as a covariate variable to rule out its possible confounding effect. The moderation analyses were performed by using PROCESS macro (model 1) for IBM SPSS (Hayes, 2018). The summary of the findings for the moderation analyses was presented in Table 8.

3.2.6.1. Moderator Role of the Dispositional Optimism in the Relation between Perceived Relative Deprivation and Health Condition

Moderation analyses were performed to investigate the moderating role of dispositional optimism in the association between perceived relative deprivation and health outcomes. The analyses were run separately for both physical and mental health dimensions. The possible confounding effect of age was ruled out by adding it as a control variable. Findings revealed that the overall models for physical health ($F(4, 397) = 9.58$, $p < .001$, with $R^2 = .30$) and mental health ($F(4, 397) = 42.48$, $p < .001$, with $R^2 = .30$) were statistically significant. That is, these three predictors and the control variable predicted 30% variance in physical and 30% variance in mental health dimensions. However, the interaction terms were not found significant for both physical ($B = -1.55$, $SE = 1.03$, $p = .13$, 95% CI [-3.57, .47]) and mental health ($B = -1.48$, $SE = .99$, $p = .14$, 95% CI [-3.44, .47]) outcomes. The results indicated that the association between perceived relative deprivation and health condition (both physical and mental dimensions) was not moderated by dispositional optimism. In other words, this association was not significantly different for participants high on optimism compared to low on optimism. Therefore, the hypotheses 4a and 4b were not supported.

3.2.6.2. Moderator Role of the Perceived Social Support in the Relation between Perceived Relative Deprivation and Health Condition

The moderating role of perceived social support and its dimensions was investigated in the relation between perceived relative deprivation and health outcomes. Age was included as a control variable in all these models. Analyses were performed separately for both physical and mental health dimensions. For the total scale of perceived social support, results indicated that the overall models were significant for both physical health ($F(4, 397) = 10.14$, $p < .001$, with $R^2 = .09$) and mental health ($F(4, 397) =$

24.20, $p < .001$, with $R^2 = .20$). This result showed that these predictors and the control variable were accounted for 9% variance in physical and 20% variance in mental health. However, the interaction terms were not significant neither for physical health ($B = -.08$, $SE = .55$, $p = .89$, 95% CI [-1.16, 1.01]) or mental health ($B = 3.34$, $SE = .57$, $p = .59$, 95% CI [-.79, 1.47]) dimensions. Similarly, for the family subscale of perceived social support, the overall model was significant in predicting physical health ($F(4, 397) = 8.85$, $p < .001$, with $R^2 = .08$), and mental health ($F(4, 397) = 21.10$, $p < .001$, with $R^2 = .18$). However, any significant interaction term was not obtained neither for physical health ($B = -.04$, $SE = .20$, $p = .92$, 95% CI [-.87, .78]) or mental health ($B = -.07$, $SE = .44$, $p = .87$, 95% CI [-.79, .94]). As on the family subscale, for the friends subscale of perceived social support, although the overall model was significant for both physical ($F(4, 397) = 10.12$, $p < .001$, with $R^2 = .09$) and mental health ($F(4, 397) = 23.30$, $p < .001$, with $R^2 = .19$) dimensions, the interaction terms were not found significant neither for physical health ($B = -.31$, $SE = .52$, $p = .55$, 95% CI [-1.34, .71]) or mental health ($B = .06$, $SE = .54$, $p = .91$, 95% CI [-1.00, 1.13]). As in other subscales, for the significant other subscale of perceived social support, although the overall models were found significant in predicting both physical health ($F(4, 397) = 9.51$, $p < .001$, with $R^2 = .09$) and mental health ($F(4, 397) = 24.00$, $p < .001$, with $R^2 = .19$), any significant interactions were obtained neither for physical health ($B = .03$, $SE = .54$, $p = .95$, 95% CI [-1.03, 1.09]) or mental health ($B = .54$, $SE = .56$, $p = .33$, 95% CI [-.55, 1.64]). The findings of these analyses indicated that the moderating role of perceived social support with its three subscales is not significant, meaning that the association between perceived social support and both health outcomes, i.e., physical and mental, was not significantly different for the participants high on perceived social support and low on perceived social support. Hence, the fifth hypothesis (5a and 5b) of the present study was not supported by the findings of these moderation analyses.

Table 8. *Summary of the Findings for the Moderation Analyses*

Independent Variable	Moderator Variable	Dependent Variable	Moderation Effect	Confidence Interval
Perceived relative deprivation	Dispositional optimism	Physical health	No	Not significant
Perceived relative deprivation	Dispositional optimism	Mental health	No	Not significant
Perceived relative deprivation	Perceived social support	Physical health	No	Not significant
Perceived relative deprivation	Perceived social support	Mental health	No	Not significant
Perceived relative deprivation	Perceived social support from family	Physical health	No	Not significant
Perceived relative deprivation	Perceived social support from family	Mental health	No	Not significant
Perceived relative deprivation	Perceived social support from friends	Physical health	No	Not significant
Perceived relative deprivation	Perceived social support from friends	Mental health	No	Not significant
Perceived relative deprivation	Perceived social support from a significant other	Physical health	No	Not significant
Perceived relative deprivation	Perceived social support from a significant other	Mental health	No	Not significant

3.3. Discussion

The primary purpose of the current study was to investigate the association between perceived personal-level relative deprivation and health outcomes among a sample of unemployed individuals living in Turkey. Furthermore, in this association, the mediating roles of the locus of control and the length of unemployment, and the protective (moderator) roles of dispositional optimism and perceived social support were aimed to be explored. For these purposes, initially, Pearson correlation analysis was performed to screen the linear relations among the study measures. Then, a regression analysis was run to explore the relation between perceived personal-level relative deprivation and physical and mental health outcomes. Next, a series of mediation analyses were conducted to examine the mediating roles of the locus of control and the length of unemployment in this association. Finally, a series of moderation analyses were run to find out the moderator roles of dispositional optimism and perceived social support in the relation between perceived relative deprivation and health outcomes.

In this section of the chapter, after summarizing the findings regarding the correlation analysis among the study measures, the main findings of the regression, mediation, and moderation analyses will be discussed in the light of the relevant literature. Afterward, practical implications regarding the current study's results and the strengths and importance of the present study will be outlined. Finally, limitations of the current study and suggestions for future research will be presented.

3.3.1. Findings Regarding the Correlations among the Study Measures

According to the results of the correlation analyses, perceived relative deprivation was negatively correlated with physical and mental health. That is, as perceived personal-level relative deprivation increased, both physical and mental health got poorer. These findings were congruent with the previous research, indicating the deteriorating effect of relative deprivation on health. Across many studies in the literature, the inverse correlation between relative deprivation and physical and mental aspects of health has been revealed (Eibner, Sturm, & Gresenz, 2004; Mishra & Carleton, 2015). Moreover, perceived relative deprivation was positively correlated with the externality in locus of control. This finding was also consistent with the past research, indicating that

feeling less self-control over the situations was related to perceiving more relative deprivation (Mishra & Novakowski, 2016). Perceived relative deprivation was also found as positively correlated with the length of unemployment. Although no existing study has examined this relation between perceived relative deprivation and the duration of unemployment, this finding could be supported by the previous suggestions. According to Crosby's relative deprivation model (Crosby, 1976) the length of time that others in the person's immediate environment possess what the person desires may affect the degree of perceived relative deprivation. Furthermore, as this duration increases, the person becomes constantly aware of the lack, and it nourishes the feeling of discontent and grievance resulting from relative deprivation (Crosby, 1976). In the current study, having a job was regarded as what an unemployed person desires to have. Therefore, it is reasonable for the feeling of relative deprivation to increase as the length of time spent as unemployed increases.

Moreover, as perceived personal-level relative deprivation increased, the level of dispositional optimism decreased. As stated in the study of Özdemir, Tekeş, and Öner-Özkan (2019), higher personal level relative deprivation was associated with a lower tendency for optimism. It was also found that the level of perceived personal relative deprivation was negatively correlated with perceived social support with its all subscales. Consistent with this finding, Mishra and Carleton (2015) reported a significant negative association between feeling relative deprivation and perceived social support, indicating that more deprived individuals perceived less social support. Furthermore, among the subscales of perceived social support, the strongest negative correlation was obtained for the friends subscale. This finding sounds logical, since the items of the Personal Relative Deprivation Scale were designed to measure how the persons felt when they compared themselves to others similar. Therefore, the highest correlation could be attributed to the fact that respondents may have thought of their friends when asked to consider persons similar to them. Therefore, as the perceived social support from friends decreased, the degree of perceived relative deprivation increased.

In the present study, externality in the locus of control was found to be negatively correlated with dispositional optimism and the full scale of perceived social support and its significant other subscale. These findings were also parallel to the past research.

According to several studies, individuals with an external locus of control were less likely to be optimistic (Guarnera & Williams, 1987; Peacock & Wong, 1996). Moreover, it was pointed out that as the externality in locus of control increased, individuals reported lower levels of perceived social support (VanderZee & Buunk, 1997). The present study also revealed that the externality in locus of control was negatively correlated with physical and mental health. That is to say, the more the externality in locus of control, the worse the unemployed individuals' health profile. These findings were also in line with the previous studies. Individuals with an external locus of control were found to engage in risky health behaviors more (Strudler-Wallston, & Wallston, 1978). Also, individuals with a higher external locus of control had more negative physical health symptoms (Gore, Griffin, & McNierney, 2016). More specifically, Dağ (2002) found that increased externality in the locus of control was associated with having more psychiatric symptoms.

Length of unemployment was found as negatively correlated with dispositional optimism. That is, the more time spent as unemployed, the less the optimistic tendencies of the individuals. This finding was supported by the previous research. In a study optimism tendency was found to be negatively related to the duration of unemployment, and it was concluded that optimism, as a source of resilience, could erode over time (Sojo & Guarino, 2011). Length of unemployment was also negatively associated with the full scale of perceived social support and its three subscales. This result was parallel to previous suggestions, implying that perceived accessibility and quality of social support may decline over time during unemployment. The stressful life events experienced during the period of unemployment, and the tensions in interpersonal relationships caused by unemployment, especially within the family, could be demonstrated as the reasons for this result (Atkinson, Liem, & Liem, 1986). In the same manner, a negative correlation was reported between the length of unemployment and perceived social support (Maslić-Seršić, 2006). Moreover, a negative correlation was obtained between the length of unemployment and the physical health scores of the participants. This finding was consistent with the previous research, suggesting that the longer the unemployment, the higher the accumulated psychological stress, which led to a decline in physical health (Stauder, 2018).

The results of the correlation analysis demonstrated that dispositional optimism was positively correlated with the full scale and the three subscales of perceived social support. This association was congruous with the previous findings. Many scholars have found that a greater tendency for optimism was associated with higher perceived social support (Özdemir, Tekeş, and Öner-Özkan, 2019; Weber, Puskar, & Ren, 2010). Furthermore, a positive correlation was obtained between dispositional optimism and physical and mental health. That is, as the tendency for optimism increased, the health profile improved. Parallel to this result, previous studies have reported that higher dispositional optimism is related to improved physical (Carver & Scheier, 2014) and mental (Scheier & Carver, 1987) aspects of health.

Lastly, positive correlations were obtained between the global scale and the subscales of perceived social support and physical and mental health scores. It is a widely held view that perceiving others' support aids individuals in promoting better health (Zimet, Dahlem, Zimet & Farley, 1988). Accordingly, positive associations have been found between perceived social support and physical (Bassi et al., 2021) and mental dimensions of health (Xu, Li, & Yang, 2019).

3.3.2. Regression Analysis

Although many scholars have revealed the adverse effect of relative deprivation on health-related outcomes, no study has investigated this relation among the unemployed. The current study examined this relation among the unemployed and hypothesized that the relative deprivation experienced due to unemployment would negatively affect physical and mental dimensions of health. Before running the regression analysis, the possible confounding effects of descriptive variables on the dependent variable of the current study were explored. Accordingly, it was found that age was significantly and positively correlated with physical health but negatively correlated with the mental health. In line with this finding, Ware et al. (1995) stated that as age increased, self-reported physical health scores decreased while mental health scores increased. A longitudinal research further supported this finding by indicating that physical health declines with age, but mental health either stays stable or improves over time (Hopman et al., 2006). Therefore, in order to rule out the possible confounding impact of age on the findings, age was included as a control

variable in the analysis. Accordingly, two hierarchical regression analyses were performed to assess the relation between perceived personal-level relative deprivation and health outcomes. Results of the present study were in line with the hypothesized direction, showing that an increase in the perceived relative deprivation predicted a decrease in both physical and mental health conditions of the unemployed, even if the effect of age was controlled. The adverse impacts of being unemployed on mental and physical health have been widely investigated with a growing body of research (Paul & Moser, 2009), and present findings concurred well with these previous studies. Eibner and Evans (2005) have proposed that the health outcomes of individuals depend on the characteristics of the persons with whom they compare themselves. If the reference persons are better off than the individuals themselves, it leads to a stressful experience for the individuals and worsens their health. Parallel to these suggestions, they found that increased experience of relative deprivation predicted increased mortality rates, deteriorated self-reported health, increased tendency for being overweight, and risky health behaviors such as smoking and doing less physical activity (Eibner & Evans, 2005). In a similar vein, it was reported that perceived personal-level relative deprivation worsened individuals' physical and mental health above and beyond other factors such as age, gender, and absolute income (Mishra & Carleton, 2015). Therefore, in the present study, considering unemployment as an antecedent for perceiving personal level relative deprivation was quite plausible to examine the association between relative deprivation and health conditions. Thus, considering the neglected area of research in the literature, the results of the present study unveiled the significance of perceived relative deprivation due to unemployment in predicting both the physical and mental health status of the unemployed.

3.3.3. Mediation Analyses

In order to investigate the mediating roles of the locus of control and length of unemployment in the association between perceived personal-level relative deprivation and health outcomes, a series of mediation analyses were performed. The findings of these analyses will be discussed in the following sections.

3.3.3.1. Findings Regarding the Mediating Role of the Locus of Control

The results of the mediation analysis exploring the mediating role of the locus of control in the association between perceived relative deprivation and health outcomes supported our hypothesis (H_2). Therefore, an increase in the perceived relative deprivation was found as associated with higher externality in the locus of control, which predicted worse physical and mental health outcomes. That is to say, feeling relatively deprived when comparing oneself with others similar led to deteriorated physical and mental health, but this effect was explained better with the mediating impact of the externality in the locus of control among the unemployed.

In her model of relative deprivation, Crosby (1976) suggested that as a prerequisite to feeling relative deprivation, one should not feel a personal responsibility for what one lacks. In other words, external sources such as the authority figures, powerful others, chance, or fate should be considered as responsible for the injustice so that the person feels relative deprivation. Despite limited in number, a few studies examined the association between the sense of control and relative deprivation. Brehm and Cohen (1959) conducted an experiment to test whether cognitive dissonance occurred when experiencing relative deprivation in a highly personal choice situation. They found that individuals reported greater satisfaction to relieve the dissonance occurring due to two contradictory feelings, i.e., feeling high personal control and relative deprivation. However, if individuals felt less personal control over the situation, higher relative deprivation led to lower satisfaction. Hence, they showed that a diminishing sense of control in a situation where relative deprivation occurred causes more discontent. In a similar vein, Mishra and Novakowski (2016) posited that having lower self-control was correlated with higher perceived relative deprivation. Moreover, it has been previously suggested by the past research that the externality in locus of control is associated with worsened health behaviors, including less exercising, having a poorer diet, more smoking, and alcohol consumption (Cobb-Clark, Kassenboehmer, & Schurer, 2014; Steptoe & Wardle, 2001). Individuals with an external locus of control are also at higher risk of experiencing psychological problems (Dağ, 2000; Gore, Griffin, & McNierney, 2016). Hence, the diathesis for the external locus of control was suggested to harm both physical and mental health.

Therefore, parallel to these previous findings in the literature, in the present study, feeling less personal control over the situations was expected to mediate the association between perceived relative deprivation and health outcomes. The results of the current analysis were in line with the hypothesized direction and proved the mediating role of locus of control. The expected finding was in line with an inference mentioned earlier. Whitehead et al. (2016) posited that the effect of the sense of control on health could not be examined without considering the social status of the individuals. According to them, individuals in lower social status have fewer resources, such as financial situation, power or knowledge to control their own fates, which makes them feel more helpless to have a say in their own lives. Feeling powerlessness and less personal control over their own destinies causes them to experience more stress, which in turn, leads to health problems. Moreover, lower perceived control invokes maladaptive coping strategies with stress, leading to risky health behaviors like smoking and alcohol consumption (Whitehead et al., 2016). On the other hand, it has been well established that unemployment causes individuals to experience financial hardships, which in turn, decreases their health-related wellbeing (Fryer, 1986). Therefore, considering that 81.3% of the current sample lived below the poverty line, the present study addressed the influence of social position on the relation between locus of control and health outcomes.

Although the effect of locus of control has been previously suggested, the current study is the first study to directly examine the path between perceived relative deprivation and locus of control. In addition, the mediating role of sense of control in the relation between relative deprivation and health outcomes has been tested for the first time. More importantly, in the context of relative deprivation, these pathways to health outcomes were examined for the first time in an unemployed sample. Therefore, the findings of this analysis can shed light on future studies and these paths can be examined on different samples to make more generalized conclusions.

3.3.3.2. Findings Regarding the Mediating Role of the Length of Unemployment

The results of the mediation analysis, which investigated the mediating role of the duration of unemployment in the relation between perceived relative deprivation and health outcomes, supported hypothesis 3a but rejected hypothesis 3b; the path between

the length of unemployment and mental health scores did not yield a significant relation. Hence, an increase in perceived relative deprivation was associated with an increase in the duration of unemployment, which predicted a decrease in physical but not mental health scores. This account should be approached with some caution because there have been distinct views about the effect of the length of unemployment on health outcomes.

Parallel to the expectation, the path between perceived relative deprivation and the length of unemployment yielded a positive and significant result. As aforementioned, in the literature, no study examined this direct relation. However, Crosby (1976) suggested that the continued absence of the desired object would intensify the feelings of relative deprivation. If the person's acquaintances find a job, the desire to have a job will be more salient; thus, the discontent and grievance will be more prominent. In the measure of perceived relative deprivation, individuals were asked to evaluate their feelings resulting from comparing themselves with others similar by considering their unemployment. Therefore, it was reasonable to expect that the longer the period of unemployment, the more intensified the feelings of relative deprivation.

Many scholars have suggested that since unemployed individuals are deprived of the benefits of employment including, having a time structure (Jahoda, 1984), the opportunity for using and improving skills (Warr, 1978), and earning money (Fryer, 1986), the unemployed are more vulnerable to experience physical and mental health problems. Accordingly, the main view about unemployment duration is that health will continue to deteriorate as the length of time being unemployed increases (Warr & Jackson, 1984). Many findings in the literature agree with this view of linear association. Increased duration of unemployment was found negatively related to psychological wellbeing (Chen et al., 2012; Maslić-Seršić, 2006). Additionally, Stauder (2019) reported that physical health worsened after a certain period spent as an unemployed. Likewise, among the long-term unemployed, being underweight was found more prevalent, which suggests a rise in weight problems as unemployment duration increases (Hughes & Kumari, 2017). Furthermore, in a study investigating the health conditions of the unemployed in Greece, it was found that compared to the short-term unemployed, long-term unemployed individuals had lower self-reported physical health and reported more signs of depression (Latsou & Geitona, 2020).

Consistent with these previous findings, in the present study, the path between the length of unemployment and physical health was found negative and significant, meaning that the longer the duration of unemployment, the worse the physical health. Therefore, in the current study, the length of unemployment significantly mediated the association between perceived relative deprivation and physical health.

On the other hand, there is another prevalent view in the literature regarding the effect of the duration of unemployment on health. It has been suggested that reactions to unemployment varies over time, i.e., the shock phase, optimistic phase, pessimistic phase, and the phase of regarding unemployment as a destiny (Jahoda, Lazarsfeld, & Zeisel, 1971). Accordingly, an adaptation process to unemployment has been proposed by several researchers. In their meta-analysis, Paul and Moser (2009) have suggested that the length of unemployment and mental health scores might not show a linear relation. It was stated that mental health level rose towards the end of the first year of unemployment, and after some ups and downs, it stabilized in the third year of unemployment. Similarly, Warr and Jackson (1987) reported that although the psychological health of the unemployed was still lower than that of the employed, the decline in psychological health during the unemployment did not persist for long. They also asserted that individuals show three kinds of patterns of adaptation to unemployment, i.e., productivity, resigned adaptation, and despair (Warr & Jackson, 1987). In a similar vein, De Witte, Hooge, and Vanbelle (2010) stated that the long-term unemployed may not show a steady decline in their mental health, the fall would stop at a certain level. They also found that compared to the short-term unemployed, the long-term unemployed had lower levels of commitment to finding a job and decreased job search behavior; thus, they showed an adaptation to unemployment conditions. Hence, as proposed earlier, the reason for the unexpected finding for the path between the length of unemployment and mental health could be the adaptation to unemployment over time.

There could be some other factors that may prevent the unemployed from declining mental health scores. For instance, having financial support may be effective in relieving the distress of financial hardship due to unemployment (Finlay-Jones & Eckhardt, 1984). Another factor could be related to the ways in how they evaluate their problem of unemployment. In the present study, despite respondents evaluated their

unemployment problem as highly severe (M = 4.77, SD = .59, range = 1−5), they apprised it still controllable (M = 2.92, SD = 1.26, range = 1−5). Also, the present sample reported looking at job postings quite often (M = 3.74, SD = 1.29, range = 1−5). Based on their responses, it can be concluded that, on average, respondents did not lose their hope to find a job. It has been suggested that hope for control might reduce the adverse impact of unemployment on psychological health (Frese & Mohr, 1987). The other factor could be that individuals might have attributed the long duration of unemployment to increasing rates of unemployment in all areas and all around the world caused by the pandemic conditions (Blustein et al., 2020). As unemployment has affected many people due to the pandemic, individuals might have normalized their status; thus, their mental health might have protected from deterioration despite prolonged unemployment. Therefore, this unexpected finding of the current study could be explained by these factors, which might be the coping resources with stress caused by prolonged unemployment.

The present study is of great importance as it investigated the mediating role of the length of unemployment in this relation for the first time. The findings validate the usefulness of the length of unemployment as a mediating variable in predicting physical health. The present study provides considerable insight into the effect of the duration of the lacking subject in experiencing relative deprivation on physical health. Since no existing study has examined these pathways, the current study's findings may form a basis for further studies investigating these variables among diverse samples.

3.3.4. Moderation Analyses

So as to explore the moderating roles of the dispositional optimism and perceived social support in the relation between perceived personal-level relative deprivation and health outcomes a series of moderation analyses were conducted. Findings regarding these analyses will be discussed in the subsequent parts.

3.3.4.1. Findings Regarding the Moderating Role of the Dispositional Optimism

The results of the moderation analysis, in which the protective role of optimism tendency in the association between perceived relative deprivation and health-related outcomes was tested, were not in line with our expectations; thus, we rejected the

fourth hypothesis of the study. Accordingly, although a positive association was revealed between dispositional optimism and physical and mental health scores, dispositional optimism was not buffering against the adverse effects of perceived relative deprivation on physical and mental health. Therefore, individuals with high levels of optimism did not have better health outcomes than those with lower levels of optimism, neither physically nor mentally.

This unexpected finding regarding the moderating role of dispositional optimism can be explained by previous studies in the literature. Although many studies have demonstrated the health-promoting effect of optimism such that individuals with high optimism have fewer heart diseases (Boehm & Kubzansky, 2012), lower cortisol levels (Jobin, Wrosch, & Scheier, 2014), and better immunity (Segerstrom, 2006), optimism may not continue as protective in all circumstances. In the context of unemployment, several studies have proven the decline in dispositional optimism during unemployment. It was reported that as the period of unemployment increased, the level of optimism reduced (Mutambara, Makanyanga & Mudhovozi, 2018). Similarly, Sojo and Guarino (2011) reported the inverse association between the length of unemployment and optimism. Thus, it can be inferred from these findings that the tendency for optimism may diminish as individuals cannot find a job and remain unemployed. Since one of the criteria for participating in the present study was to be unemployed for at least six months, many of the participants may have experienced a decline in their level of optimism to protect them from the harmful effects of relative deprivation. In fact, in the current study, a significant and negative correlation was obtained between the length of unemployment and dispositional optimism. Therefore, the unexpected finding is not particularly surprising given the previous findings and the current correlation that the length of unemployment period might have reduced the level of dispositional optimism. Hence, dispositional optimism became insufficient to buffer the unemployed individuals from the negative impacts of relative deprivation on their health.

The reason for this rather contradictory result is still not entirely clear, but the unexpected finding regarding the moderating role of dispositional optimism underlines the intensity of the feeling of relative deprivation. In other words, the adverse impact of relative deprivation on health was so strong that the tendency for optimism was not

enough to relieve it. Moreover, we cannot rule out that the length of unemployment might have influenced the level of dispositional optimism. Prior to the present study, the moderating role of dispositional optimism in the association between perceived relative deprivation and health outcomes has not been examined yet. Therefore, the current findings could be influential in further research to examine the buffering role of dispositional optimism in this association by controlling the effect of the duration of unemployment.

3.3.4.2. Findings Regarding the Moderating Role of the Perceived Social Support

The results of the moderation analysis performed to examine the buffering role of perceived social support in the association between perceived relative deprivation and health outcomes led us to reject our hypothesis (H_5). That is to say, neither the full scale nor the family, friends, or significant other subscales of perceived social support protected individuals from the adverse effects of perceived relative deprivation on health. Even though perceived social support and its three subscales correlated positively with physical and mental health, it could not alleviate the impact of relative deprivation feeling. Hence, individuals with higher perceived social support did not differ significantly from those with lower perceived social support in terms of their physical and mental health conditions while experiencing relative deprivation.

In the literature, although the buffering role of perceived social support has been well examined within the context of unemployment, there are some findings that have indicated a decline in social support over time in the course of the unemployment period. Atkinson, Liem, and Liem (1986) argued that during unemployment, interpersonal relationships might suffer primarily due to financial hassles the unemployed experience. As a result of the meetings with the unemployed conducted at regular time intervals, they demonstrated that as the duration of unemployment increases, the perceived quality of the marriage and even the frequency of social contact decreases. By the same token, Kurt (2006) pointed out that unemployed individuals in Turkey may not be able to participate in social activities due to financial concerns and may gradually withdraw from social interactions due to the shame of unemployment. Thus, this results in a decline in actual and perceived social ties. In a

similar vein, Bilgiç and Yılmaz (2013) stated that perceived social support could not buffer the association between the duration of unemployment and psychological distress. Furthermore, in the present study, it was found that as the length of unemployment increased, perceived relative deprivation increased but perceived social support decreased. Thereby, it might be that as the duration of unemployment increases, the feelings of discontent and grievance resulting from perceived relative deprivation might have outweighed the degree of perceived social support. Thus, the buffering effect of perceived social support might have faded such that it cannot prevent health from worsening due to perceived relative deprivation. Therefore, the surprising finding of the current study might be justified with the effect of the duration of unemployment.

Additionally, in the period of unemployment, from whom the social support comes, and the way of support is perceived are also cardinal to detect the effect of perceived social support. It was reported that for the unemployed females, the most positive support was perceived from their unemployed friends like themselves (Rife, 1995). As mentioned earlier, when measuring perceived relative deprivation, respondents were asked to compare themselves with others similar to them. In the present study, in terms of perceived relative deprivation, the strongest negative correlation was obtained from the friends' support subscale. Hence, another reason for the puzzling finding might be that if the friends of the unemployed person have a job, it may have increased the perceived relative deprivation, which may have overshadowed the protective effect of the perceived support from friends.

All in all, the findings of the moderation analysis did not support the fifth hypothesis of the current study. In the literature, no study has examined the protective role of perceived social support in the association between perceived relative deprivation and health outcomes. Thus, the current study's finding regarding the moderating role of perceived social support should not be accepted as the final conclusion. The possible confounding effect of unemployment duration should not be overlooked. Subsequent studies should take into account the eroding effect of the period of unemployment when examining the protective role of perceived social support.

3.3.5. Evaluation of the Findings in Light of the Relative Deprivation Theory

According to relative deprivation theory, individuals evaluate their current status by comparing themselves with others similar. As a result of such comparisons, if they notice a deficiency of a deserved outcome in themselves, feelings of anger, discontent, and resentment may arise. Therefore, individuals think that they deserve better outcomes and feel relative deprivation (Smith, Pettigrew, Pippin, & Bialosiewicz, 2012). Previous studies have pointed out that the feeling of relative deprivation worsens the health conditions of the individuals (Mishra & Carleton, 2015; Salti & Abdulrahim, 2016). In the present study, unemployment was considered as a deficiency in perceiving relative deprivation. In accordance with the theory's claims, feeling more relative deprivation was found to be related to deteriorated physical and mental health among unemployed individuals. In her relative deprivation model, Crosby (1976) argued that for the feeling of relative deprivation to arise, individuals should perceive little or no personal responsibility for the deficiency. Parallel to this suggestion, in the current study, an increase in perceived relative deprivation was found to be related to an increase in the externality in locus of control, which in turn predicted worse mental and physical health outcomes. The theory also claimed that as the period elapsed without the desired state increases, the feeling of relative deprivation might deepen (Crosby, 1976). Accordingly, the current study revealed that an increase in perceived relative deprivation was associated with the length of unemployment, which predicted worse physical health.

Regarding the moderation analyses, results did not support the protective roles of dispositional optimism and perceived social support in the relation between perceived relative deprivation and health outcomes. For the current study, the main explanation for the failure of their buffering roles was provided by the claims of the theory of relative deprivation. As aforementioned, Crosby (1976) emphasized the potential role of the duration of the deficiency in intensifying the feeling of relative deprivation. In the present study, negative and significant relations were obtained between the length of unemployment and both dispositional optimism and perceived social support. Therefore, it was considered that the adverse effects of feeling relative deprivation on health might have increased over time and overshadowed the impacts of potential protective factors.

All in all, considering both supported and unsupported hypotheses of the current study, the findings of the analyses corresponded well with the suggestions of the theory of relative deprivation.

3.3.6. Practical Implications of the Present Study's Findings

The current study's findings shed light on the impact of perceived relative deprivation due to unemployment on health-related outcomes in Turkey. In addition, the effects of locus of control, the length of unemployment, dispositional optimism, and perceived social support were examined. Based on all these findings, several suggestions for practical implementations will be provided in the rest of this part.

Olson, Roese, Meen and Robertson (1995) have suggested that the more qualified the individuals for obtaining desired outcomes, the more they feel to deserve the outcome; thus, they feel more relative deprivation when they do not obtain the outcome. In a similar vein, Richardson (2011) has stated that higher educated individuals are more likely to experience relative deprivation due to unemployment since they have high expectations regarding their social status. Thus, they experience more frustration and discontent, which causes them to feel unfairly treated by policymakers. The present sample consisted of unemployed individuals with higher education degrees. Accordingly, after many years of education and all the expectations from higher education, it is reasonable for them to feel more deserving of being hired. Relative deprivation is an injustice-related feeling that arises when the disadvantaged position is viewed as unfair (Smith, Pettigrew, Pippin, & Bilalosiewicz, 2012). In the present study, it was found that perceived relative deprivation was associated with deteriorated physical and mental health among the unemployed. Moreover, the present study's findings emphasized the negative impact of the length of unemployment on health outcomes and on the degree of perceived relative deprivation. Given such a large and growing number of the unemployed in Turkey (Turkish Statistical Institute, 2021), recruitment procedures should be regulated by law to prevent any injustice practices. Accordingly, merit and equality must be ensured to avoid individuals from falling into any sense of injustice. Moreover, social policymakers should consider the outcomes of perceived relative deprivation, and legal arrangements should be made to sanction the recruiters who are hiring unfairly. Perception of injustice can be reduced through

more transparent recruitment processes. In addition, the perceived scarcity may inflate the feeling of relative deprivation (Richardson, 2011). Accordingly, priority should be given by the government to increase the variety and number of job opportunities for highly educated individuals.

The current study has revealed that unemployed individuals with an external locus of control face worse physical and mental health outcomes. Free psychotherapy sessions can be organized for unemployed individuals by the government. In these sessions, their locus of control can be questioned, and psychoeducation can be given to them to develop a more internal locus of control. Moreover, in the present study, dispositional optimism was found to be positively correlated with the physical and mental health scores. Clinical psychologists might conduct their therapies by considering this finding. Perceived social support was also found positively associated with physical and mental health. Particularly, Rife (1995) suggested that the most positive social support was perceived from unemployed friends. Therefore, municipalities or social policymakers can provide accessible environments for the unemployed to engage in social activities with each other. In this way, they can both improve their social contact networks, which decrease during unemployment, and they might also perceive more social support.

All in all, the findings of the current study have promising implications for several courses of actions to ease the hassles experienced during the unemployment. Policymakers have a lot of work to do to make the unemployment experience less distressing, make hiring processes fairer, and increase job opportunities. In addition, brain drain, which is defined as the migration of skilled labor to more developed countries, has been one of the most serious ongoing problem in developing countries like Turkey (Karataş & Ayyıldız, 2021). The practical implications mentioned above and increasing optimism or internal locus of control among the unemployed can also help to reduce brain drain rates.

3.3.7. Strengths of the Present Study

To the best of our knowledge, the present study is the first study to investigate the association between perceived relative deprivation and health-related outcomes among an unemployed sample. Also, in the literature, no existing study has examined the

mediating roles of locus of control and the length of unemployment in this relation. Moreover, the protective roles of dispositional optimism and perceived social support in this association were tested for the first time in the current study. Therefore, the current study made a unique contribution to the literature examining the relative deprivation theory.

Unemployment has become one of the most important problems of Turkey with the effect of the COVID-19 pandemic. Considering the high rate of the young population in Turkey, a higher unemployment rate may lead to a social crisis (Bağlı, 2020). By revealing the factors that predict the health conditions of the unemployed, the present study illuminated a significant problem that the unemployed faced. Considering the unemployment and health problems experienced by individuals with higher education, the results of the present study reveal the most fundamental struggle faced by the growing young population in our country.

The present study revealed rather striking findings regarding the conditions of the unemployed. Although the impact of perceived relative deprivation on health outcomes has been well examined, there are very limited studies conducted in Turkey, and none of them were conducted in a sample of the unemployed. One of the most remarkable results of the current study was that perceived relative deprivation adversely affected the physical and mental health of the unemployed. Moreover, the present study provides considerable insight into the effect of externality in locus of control on health-related outcomes in the context of perceiving relative deprivation due to unemployment. The current study's findings were also of great importance in revealing the impact of the length of unemployment. To date, no study has examined before the effect of length of unemployment on health outcomes within the impact of perceived relative deprivation. Therefore, the current study made a significant contribution to the literature on unemployment. Moreover, although the moderation analyses did not yield significant results, the current study contributed to the relevant literature by presenting the impacts of dispositional optimism and perceived social support.

In economics, Gini coefficient is utilized to assess the inequality of income distribution in a country, and it is also used to detect the level of relative deprivation (Yitzhaki,

1979). If the coefficient is close to zero, it indicates that the income is more evenly distributed within the country ("Gini index", 2006). Accordingly, a higher coefficient indicates an increase in income inequality and relative deprivation. In Turkey, Gini coefficient was found as .41 in 2020, which is regarded as a high value indicating the inequality in income distribution (Turkish Statistical Institute, 2021). More specifically, this value shows that the highest income group received the 47.5% of the entire income, while the lowest income group received only the 5.9% of it. Therefore, the present study is of great importance as it was conducted in Turkey, one of the countries where relative deprivation can be observed most apparently.

Furthermore, despite all the COVID-19 precautions, the present study reached a high number of participants, which increases the power of the present study. Also, as the data collected online, the sample included participants from almost all cities of Turkey. Therefore, the generalizability of the findings could be another strength of the current study. Last but not least, the findings of the present study pointed out highly critical problems and suggested several important implications which may affect the sociopolitical arrangements in Turkey.

3.3.8. Limitations and Directions for Future Research

The current study has a few shortfalls that need to be considered. First of all, although the sample size was large enough and included only higher education graduates, the sample was not homogenous in terms of the graduated department and university. Although this factor increased the generalizability of the findings, the diversity of graduated departments and universities could be a confounding effect since it might have made a difference in their actual chance of being hired. Moreover, Sümer, Solak and Harma (2012) have suggested that the level of perceived future employability has a significant impact on the well-being of the unemployed. Therefore, future studies should take the variation among the sample and the level of perceived employability into account and test whether there will be any significant difference in the findings.

Another downside of the current study could be related to its methodology. A longitudinal rather than a cross-sectional design would be more appropriate to examine the effect of unemployment length. Thus, in further researches, the hypotheses of the current study should be tested in a longitudinal study. Moreover, since the data were

based on self-reported responses, it is plausible that particular concerns such as social desirability might have influenced the findings. Also, in online surveys based on self-reported questionnaires, the dropout rate of participants during the trial was relatively high (Hoerger, 2010), which might have negatively affected the power of generalizability of the findings. Given participants' concerns and high dropout rates, experimental designs conducted in laboratory environments could be implemented in subsequent studies to obtain more reliable and representative findings.

Inevitably, the COVID-19 pandemic might have influenced the current study's findings. The pandemic period might have increased unemployment and have a confounding effect on physical and mental health outcomes. Therefore, a replication of the present study should be made after the effects of the pandemic have subsided.

It is undeniable that the limitations mentioned above could have influenced the presented findings; thus, the picture is still incomplete. Future research should consider all these potential downsides of the current study. Although most of the pathways and relations were tested for the first time in the current study, these findings could be a framework for the following researchers to obtain more powerful effects and remarkable results.

3.3.9. Conclusion

The current study demonstrated the adverse impacts of perceived relative deprivation on physical and mental health outcomes among the unemployed. Moreover, the mediating role of locus of control was investigated in this association. Accordingly, an increase in perceived relative deprivation predicted an increase in the externality in locus of control, which in turn, predicted a decrease in physical and mental scores. Moreover, the length of unemployment was found to mediate the association between perceived relative deprivation and physical health among the unemployed. In other words, an increase in perceived relative deprivation was positively related to the unemployment duration, which led to a decline in the physical health scores of the unemployed.

The findings of the present study shed light on the factors affecting the health-related outcomes of the unemployed. As it is the only study in which these variables are

examined in the context of perceived relative deprivation and among the unemployed, the present study made a unique contribution to the literature and opened doors for further studies. Also, the current study's findings were very promising for social policymakers to make legal arrangements which would improve the well-being of the unemployed. Accordingly, several suggestions for practical implications, which will be beneficial in easing the difficulty of the unemployment period, were presented. Despite its strengths, the protective roles of dispositional optimism and perceived social support were not found in the current study. Also, there are a few shortcomings regarding the homogeneity of the sample and a lack of control for possible confounding variables. Following studies should consider all the ups and downsides of the present study and be conducted among diverse samples to expand the generalizability of the findings.

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APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
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27 OCAK 2021

Konu : Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi : İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof.Dr. Özlem BOZO ÖZEN

Danışmanlığını yaptığınız İrem Berna GÜVENÇ'in "Algılanan Göreli Yoksunluğun Bireyin Sağlık Durumuna Etkisi: Kontrol Odağı ve İşsizlik Süresinin Aracı Rolleri & İyimserlik Eğilimi ve Algılanan Sosyal Desteğin Düzenleyici Rolleri" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **010-ODTU-2021** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof. Dr. Mine MISIRLISOY
İAEK Başkanı

B. INFORMED CONSENT FORM

ARAŞTIRMAYA GÖNÜLLÜ KATILIM FORMU

Bu araştırma, ODTÜ Psikoloji Bölümü yüksek lisans öğrencisi ve araştırma görevlilerinden İrem Berna Güvenç tarafından Prof. Dr. Özlem Bozo Özen danışmanlığında Yürütülmektedir. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Araştırmanın amacı, üniversite mezunu ve en az 6 aydır iş arayan katılımcıların genel sağlık durumlarını yordayan faktörlerle ilgili bilgi toplamaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz, sizden 5 adet ölçek doldurmanız beklenmektedir. Yaklaşık olarak 15-20 dakika sürmesi öngörülen bu çalışmada sizden ölçeklerdeki ifadeleri size en uygun şekilde değerlendirmeniz beklenmektedir.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük temelinde olmalıdır. Ankette, sizden kimlik veya kurum belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak, sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayımlarda kullanılacaktır. Sağladığınız veriler gönüllü katılım formlarında toplanan kimlik bilgileri ile eşleştirilmeyecektir.

Katılımınızla ilgili bilmeniz gerekenler:

Anket, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkmakta serbestsiniz.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Anket sonunda, bu çalışmayla ilgili sorularınız cevaplanacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Psikoloji Bölümü araştırma görevlilerinden İrem Berna Güvenç (e-posta: bernag@metu.edu.tr) ile iletişim kurabilirsiniz.

☐ ***Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.***

C. DEMOGRAPHIC INFORMATION FORM

Demografik Bilgi Formu

1. **Yaşınız: _____**
2. **Cinsiyetiniz: _____**
3. **Medeni halinizi nasıl tanımlarsınız?**

   Bekar, romantik ilişkisi yok **( )** Bekar, romantik ilişkisi var **( )**

   Sözlü/Nişanlı **( )** Evli **( )**
4. **Çocuğunuz var mı?** Evet **( )** Hayır **( )**

   Cevabınız <u>evet</u> ise kaç tane çocuğunuz var belirtiniz. _____
5. **Hayatınızın çoğunu nerede yaşayarak geçirdiniz?**

   Köy **( )** Kasaba **( )** İlçe **( )** Şehir **( )** Büyükşehir **( )**
6. **En son mezun olduğunuz eğitim seviyesi nedir?**

   Ön lisans **( )** Lisans **( )** Yüksek lisans **( )** Doktora **( )**
7. **Mezuniyet yılınız nedir? _____**
8. **Şu an bir okula kayıtlı olup eğitiminize devam ediyor musunuz?**

   Evet **( )** Hayır **( )**

   Cevabınız <u>evet</u> ise eğitiminize devam ettiğiniz seviye nedir?

   Lisans **( )** Yüksek lisans **( )** Doktora **( )**
9. **Daha önce bir işte çalıştınız mı?**

   <u>Evet</u>, eğitimini aldığım alanla ilgili bir işte çalıştım **( )**

   <u>Evet</u>, ama eğitimini almadığım geçici bir işte çalıştım **( )**

   <u>Hayır</u>, çalışmadım **( )**

   Cevabınız <u>evet</u> ise çalışma sürenizi ay cinsinden belirtiniz. _____
10. **Ne kadar süredir aktif olarak iş arıyorsunuz?**

    6 ay–1 yıl**( )** 1 yıl–2 yıl**( )** 2 yıl–3 yıl**( )** 3 yıl–4 yıl**( )** 4 yıl–5 yıl**( )**

    5 yıldan uzun**( )**

11. Hanenizde siz dahil yaşayan kişi sayısını belirtiniz.

Yalnız yaşıyorum **( )** 2 **( )** 3 **( )** 4 **( )** 5 **( )** 6 **( )** 7 **( )** 8 **( )** 9 **( )** 10 **( )**

10 kişiden fazla **( )**

12. Hanenizin toplam aylık geliri ne kadardır?

1000TL'den daha az **( )** 1000TL–3000TL**( )** 3000TL–5000TL**( )**

5000TL–7000TL**( )** 7000TL–10000TL**( )** 10.000TL–15.000TL**( )**

15.000-20.000 **( )** 20.000 TL'den fazla **( )**

13. Ne sıklıkla iş ilanlarına bakıyorsunuz?

1 **( )** 2 **( )** 3 **( )** 4 **( )** 5 **( )**

Neredeyse hiç ----------Orta sıklıkla----------Neredeyse her gün

14. İşsizliğin ne kadar <u>ciddi</u> bir sorun olduğunu düşünüyorsunuz?

1 **( )** 2 **( )** 3 **( )** 4 **( )** 5 **( )**

Hiç ciddi değil----------Orta ciddiyette----------Çok ciddi

15. İşsizliğin ne kadar <u>kontrol edilebilir</u> bir sorun olduğunu düşünüyorsunuz?

1 **( )** 2 **( )** 3 **( )** 4 **( )** 5 **( )**

hiç kontrol edilemez ----------biraz kontrol edilebilir ----------tamamen kontrol edilebilir

16. Herhangi bir psikolojik rahatsızlığınız var mı?

Evet **( )** Hayır **( )**

Cevabınız <u>evet</u> ise bu rahatsızlık nedeni ile nasıl bir tedavi gördünüz/görüyorsunuz?

Psikolojik tedavi **( )** İlaç tedavisi **( )** Diğer (*belirtiniz*): _____

17. Herhangi bir fiziksel rahatsızlığınız var mı?

Evet **( )** Hayır **( )**

Cevabınız <u>evet</u> ise bu rahatsızlık nedir? _____

D. PERSONAL RELATIVE DEPRIVATION SCALE
(ADAPTED FORM)

Aşağıda, kişilerin bazı durumlar karşısındaki duygu, düşünce ve tutumlarını belirten ifadeler verilmiştir. Lütfen her cümleyi dikkatlice okuyunuz ve yaşadığınız **işsizlik sorununu göz önünde bulundurarak** size en uygun seçeneği işaretleyiniz.

1. **Kesinlikle katılmıyorum**
2. **Katılmıyorum**
3. **Biraz katılmıyorum**
4. **Biraz katılıyorum**
5. **Katılıyorum**
6. **Kesinlikle katılıyorum**

1. Sahip olduklarımı, bana benzer diğer insanların sahip olduklarıyla kıyasladığımda kendimi yoksun hissederim.	1	2	3	4	5	6
2. Kendimi, bana benzer diğer insanlarla kıyasladığımda ayrıcalıklı hissederim.	1	2	3	4	5	6
3. Bana benzer diğer insanların refah içinde olduğunu gördüğümde içerlerim.	1	2	3	4	5	6
4. Sahip olduklarımı, bana benzer diğer insanların sahip olduklarıyla karşılaştırdığımda kendimi oldukça varlıklı hissederim.	1	2	3	4	5	6
5. Sahip olduklarımı, bana benzer diğer insanların sahip olduklarıyla karşılaştırdığımda tatminsizlik hissederim.	1	2	3	4	5	6

E. IOWA-NETHERLANDS COMPARISON ORIENTATION MEASURE (ADAPTED FORM)

Çoğumuz zaman zaman kendimizi başka insanlarla karşılaştırırız. Bu karşılaştırmalar, bazen hislerimizi; bazen görüşlerimizi; bazen yeteneklerimizi; bazen de içerisinde bulunduğumuz durumu başka insanlarınkilerle karşılaştırmak biçiminde olabilir. Bu şekilde karşılaştırmalar yapmanın iyi ya da kötü bir yanı yoktur. Bazı insanlar bunu daha çok yapar; bazıları ise daha az. Biz, sizin kendinizi diğer insanlarla ne sıklıkta karşılaştırdığınızı öğrenmek istiyoruz. Bunun için aşağıda yer alan her bir ifadeye ne derecede katıldığınızı karşısındaki seçeneklerden uygun olanını işaretleyerek yanıtlayınız.

1. **Kesinlikle katılmıyorum**
2. **Katılmıyorum**
3. **Kararsızım**
4. **Katılıyorum**
5. **Kesinlikle katılıyorum**

1. Yaptığım şeylerin diğer insanların yaptıklarıyla karşılaştırıldığında nasıl olduğuna her zaman çok dikkat ederim.	1	2	3	4	5
2. Çoğu zaman sevdiğin insanların (kız/erkek arkadaşım, ailemden kişiler vb.) yaptıkları şeyleri nasıl yaptıklarıyla, diğer insanların nasıl yaptıklarını karşılaştırırım.	1	2	3	4	5
3. Bir şeyi ne kadar iyi yaptığımı bilmek istediğimde, yaptığım şeyi diğer insanların yaptıklarıyla karşılaştırırım.	1	2	3	4	5
4. Ne kadar sosyal birisi olduğum konusunda (sosyal becerilerim, popülerliğim vb.) kendimi sık sık diğer insanlarla karşılaştırırım.	1	2	3	4	5
5. Hayatta ne durumda olduğumu asla başkalarının durumlarına göre değerlendirmem.	1	2	3	4	5
6. Kendini sık sık başkalarıyla karşılaştıran birisi değilimdir.	1	2	3	4	5
7. Hayatta ne kadar başarılı olduğum konusunda çoğu zaman kendimi başka insanlarla karşılaştırırım.	1	2	3	4	5
8. Diğer insanlarla karşılıklı görüş ve deneyimlerimiz hakkında konuşmaktan çoğu zaman zevk alırım.	1	2	3	4	5
9. Çoğu zaman, benim karşılaştığım sorunlara benzer sorunlarla karşılaşmış kişilerin ne düşündüğünü öğrenmeye çalışırım.	1	2	3	4	5
10. Bir konuda daha fazla şey öğrenmek istersem, o konuda başka insanların ne düşündüğünü öğrenmeye çalışırım.	1	2	3	4	5
11. Benimkine benzer bir durumda başka insanların ne yapacağını bilmek her zaman hoşuma gider.	1	2	3	4	5

F. MARLOWE CROWNE SOCIAL DESIRABILITY SCALE (ADAPTED FORM)

Aşağıdaki cümleler, insanların davranış ve duygularındaki farklılıkları araştırmak amacıyla hazırlanmıştır. Bu cümlelerden sizin durumunuza uyanlar için D (doğru) harfini; uymayanlar için ise Y (yanlış) harfini yuvarlak içine alınız. Lütfen her cümleyi içtenlikle işaretlemeye çalışınız. Teşekkür ederiz.

1. Her işimi önceden planlarım.	D	Y
2. Her zaman başkalarına karşı düşünceli davranırım.	D	Y
3. Çoğu kez kendi çıkarımı tanıdıklarımın çıkarından üstün tutarım.	D	Y
4. Otobüste yer verebileceğim yaşlıları bazen görmezlikten gelmişimdir.	D	Y
5. Bazen tanıdıklarımı kendi amaçlarım için kullandığımı hissediyorum.	D	Y
6. Arkadaşlarımın başarılarından bazen rahatsızlık duyarım.	D	Y
7. Yardıma ihtiyacı olan birinin durumunu hiçbir zaman görmezlikten gelmedim.	D	Y
8. Bazen toplum yararını gözetmeden hareket ediyorum	D	Y
9. Sevmediğim birinin başarısı bile beni sevindirir.	D	Y
10. Nefret ettiğim kimse olmadı.	D	Y
11. Yardım ettiğim kişilerden hiçbir zaman karşılık beklemem.	D	Y
12. Eleştirilmeye sinirlendiğim zamanlar oluyor.	D	Y
13. Temizliğimi hiçbir zaman ihmal ettiğimi hatırlamıyorum.	D	Y
14. Bazen hoşgörülü davranamıyorum	D	Y
15. Her zaman suçumu kabul eder ve açıkça söylerim.	D	Y
16. Bazı işleri baştan savma yaptığım olur.	D	Y
17. Her düşünceyi tarafsız olarak değerlendiririm.	D	Y
18. Birinin gülünç duruma düşmesi beni her zaman üzer.	D	Y
19. İyi bilmediğim hiçbir konuda fikir ileri sürmem.	D	Y
20. Hiç kimseyi küçümsemedim.	D	Y

G. SOCIAL COMPARISON FREQUENCY SCALE

SOSYAL KARŞILAŞTIRMA SIKLIĞI ÖLÇEĞİ

Lütfen, kendinizi belirtilen farklı kişilerle karşılaştırma sıklığınızı işaretleyiniz. Kendinizi (yeteneklerinizi, düşüncelerinizi, başarılarınızı, başarısızlıklarınızı veya görünüşünüzü) ne sıklıkla aşağıdaki kişilerle karşılaştırırsınız?

	Asla	Nadiren	Bazen	Sıklıkla	Her zaman
…arkadaşlarımla	1	2	3	4	5
…ünlü kişilerle	1	2	3	4	5
…benden daha iyi durumda olan insanlarla	1	2	3	4	5
…benden daha kötü durumda olan insanlarla	1	2	3	4	5
…benden **çok** daha iyi durumda olanlarla	1	2	3	4	5
…benden **çok** daha kötü durumda olanlarla	1	2	3	4	5
…bana benzer kişilerle	1	2	3	4	5

H. LOCUS OF CONTROL SCALE

KONTROL ODAĞI ÖLÇEĞİ

Bu anket, insanların yaşama ilişkin bazı düşüncelerini belirlemeyi amaçlamaktadır. Sizden, bu maddelerde yansıtılan düşüncelere ne ölçüde katıldığınızı ifade etmeniz istenmektedir.

Bunun için, her maddeyi dikkatle okuyunuz ve o maddede ifade edilen düşüncenin sizin düşüncelerinize uygunluk derecesini belirtiniz. Bunun için de, her ifadenin karşısındaki seçeneklerden sizin görüşünüzü yansıtan kutucuğa bir (X) işareti koymanız yeterlidir. "Doğru" ya da "yanlış" cevap diye bir şey söz konusu değildir.

1. **Hiç uygun değil**
2. **Pek uygun değil**
3. **Uygun**
4. **Oldukça uygun**
5. **Tamamen uygun**

1. İnsanın yaşamındaki mutsuzlukların çoğu, biraz da şanssızlığına bağlıdır.	1	2	3	4	5
2. İnsan ne yaparsa yapsın üşütüp hasta olmanın önüne geçemez.	1	2	3	4	5
3. Bir şeyin olacağı varsa eninde sonunda mutlaka olur	1	2	3	4	5
4. İnsan ne kadar çabalarsa çabalasın, ne yazık ki değeri genellikle anlaşılmaz.	1	2	3	4	5
5.İnsanlar savaşları önlemek için ne kadar çaba gösterirlerse göstersinler, savaşlar daima olacaktır.	1	2	3	4	5
6. Bazı insanlar doğuştan şanslıdır.	1	2	3	4	5
7. İnsanlar ilerlemek için güç sahibi kişilerin gönlünü hoş tutmak zorundadır.	1	2	3	4	5
8. İnsan ne yaparsa yapsın, hiçbir şey istediği gibi sonuçlanmaz.	1	2	3	4	5
9. Birçok insan, rastlantıların yaşamlarını ne derece etkilediğinin farkında değildir.	1	2	3	4	5
10. Birçok insanın halen ciddi bir hastalığa yakalanmamış olması sadece bir şans meselesidir.	1	2	3	4	5
11. Dört yapraklı yonca bulmak insana şans getirir.	1	2	3	4	5

12. İnsanın burcu hangi hastalıklara daha yatkın olacağını belirler.	1	2	3	4	5
13. Bir sonucu elde etmede insanın neleri bildiği değil, kimleri tanıdığı önemlidir.	1	2	3	4	5
14. İnsanın bir günü iyi başladıysa iyi; kötü başladıysa da kötü gider.	1	2	3	4	5
15. Başarılı olmak çok çalışmaya bağlıdır; şansın bunda payı ya hiç yoktur ya da çok azdır.	1	2	3	4	5
16. Aslında şans diye bir şey yoktur.	1	2	3	4	5
17. Hastalıklar çoğunlukla insanların dikkatsizliklerinden kaynaklanır.	1	2	3	4	5
18. Talihsizlik olarak nitelenen durumların çoğu yetenek eksikliğinin, ihmalin, tembelliğin ve benzeri nedenlerin sonucudur.	1	2	3	4	5
19. İnsan, yaşamında olabilecek şeyleri kendi kontrolü altında tutabilir.	1	2	3	4	5
20. Çoğu durumda yazı-tura atarak da isabetli kararlar verilebilir.	1	2	3	4	5
21. İnsanın ne yapacağı konusunda kararlı olması, kadere güvenmesinden daima iyidir.	1	2	3	4	5
22. İnsan fazla bir çaba harcamasa da, karşılaştığı sorunlar kendiliğinden çözülür.	1	2	3	4	5
23. Çok uzun vadeli planlar yapmak her zaman akıllıca olmayabilir, çünkü birçok şey zaten iyi ya da kötü şansa bağlıdır.	1	2	3	4	5
24. Birçok hastalık insanı yakalar ve bunu önlemek mümkün değildir.	1	2	3	4	5
25. İnsan ne yaparsa yapsın, olabilecek kötü şeylerin önüne geçemez.	1	2	3	4	5
26. İnsanın istediğini elde etmesinin talihle bir ilgisi yoktur.	1	2	3	4	5
27. İnsan kendisini ilgilendiren birçok konuda kendi başına doğru kararlar alabilir.	1	2	3	4	5
28. Bir insanın başına gelenler temelde kendi yaptıklarının sonucudur.	1	2	3	4	5
29. Halk, yeterli çabayı gösterirse siyasal yolsuzlukları ortadan kaldırabilir.	1	2	3	4	5
30. Şans ya da talih hayatta önemli bir rol oynamaz.	1	2	3	4	5
31. Sağlıklı olup olmamayı belirleyen esas şey insanların kendi yaptıkları ve alışkanlıklarıdır.	1	2	3	4	5
32. İnsan kendi yaşamına temelde kendisi yön verir.	1	2	3	4	5
33. İnsanların talihsizlikleri yaptıkları hataların sonucudur.	1	2	3	4	5
34. İnsanlarla yakın ilişkiler kurmak tesadüflere değil, çaba göstermeye bağlıdır.	1	2	3	4	5
35. İnsanın hastalanacağı varsa hastalanır; bunu önlemek mümkün değildir.	1	2	3	4	5

36. İnsan bugün yaptıklarıyla gelecekte olabilecekleri değiştirebilir.	1	2	3	4	5
37. Kazalar, doğrudan doğruya hataların sonucudur.	1	2	3	4	5
38. Bu dünya güç sahibi birkaç kişi tarafından yönetilmektedir ve sade vatandaşın bu konuda yapabileceği fazla bir şey yoktur.	1	2	3	4	5
39. İnsanın dini inancının olması, hayatta karşılaşacağı birçok zorluğu daha kolay aşmasına yardım eder.	1	2	3	4	5
40. Bir insan istediği kadar akıllı olsun, bir işe başladığında şansı yaver gitmezse başarılı olamaz.	1	2	3	4	5
41. İnsan kendine iyi baktığı sürece hastalıklardan kaçınabilir.	1	2	3	4	5
42. Kaderin insan yaşamı üzerinde çok büyük bir rolü vardır.	1	2	3	4	5
43. Kararlılık bir insanın istediği sonuçları almasında en önemli etkendir.	1	2	3	4	5
44. İnsanlara doğru şeyi yaptırmak bir yetenek işidir; şansın bunda payı ya hiç yoktur ya da çok azdır.	1	2	3	4	5
45. İnsan kendi kilosunu, yiyeceklerini ayarlayarak kontrolü altında tutabilir.	1	2	3	4	5
46. İnsanın yaşamının alacağı yönü, çevresindeki güç sahibi kişiler belirler.	1	2	3	4	5
47. Büyük ideallere ancak çalışıp çabalayarak ulaşılabilir.	1	2	3	4	5

I. LIFE ORIENTATION TEST (ADAPTED FORM)

Aşağıda 12 cümle verilmiştir. Her cümleyi dikkatle okuyarak beşli ölçek üzerinde size uygun olan dereceyi işaretleyiniz. 'Doğru' ya da 'Yanlış' cevap söz konusu değildir. Yardımlarınız için teşekkür ederiz.

0. **Kesinlikle katılmıyorum**
1. **Katılmıyorum**
2. **Kararsızım**
3. **Katılıyorum**
4. **Kesinlikle katılıyorum**

1. Ne olacağının önceden kestirilemediği durumlarda hep en iyi sonucu beklerim.	0	1	2	3	4
2. Kolayca gevşeyip rahatlayabilirim.	0	1	2	3	4
3. Bir işimin ters gitme olasılığı varsa muhakkak ters gider.	0	1	2	3	4
4. Her şeyi hep iyi tarafından alırım.	0	1	2	3	4
5. Geleceğim konusunda hep iyimserimdir.	0	1	2	3	4
6. Arkadaşlarımla birlikte olmaktan hoşlanırım.	0	1	2	3	4
7. Yapacak bir şeylerimin olması benim için önemlidir.	0	1	2	3	4
8. İşlerin istediğim gibi yürüyeceğini neredeyse hiç beklemem.	0	1	2	3	4
9. Hiçbir şey benim istediğim yönde gelişmez.	0	1	2	3	4
10. Moralim öyle kolay kolay bozulmaz.	0	1	2	3	4
11. Her türlü olayda bir iyi yan bulmaya çalışırım.	0	1	2	3	4
12. Başıma iyi şeylerin geleceğine pek bel bağlamam.	0	1	2	3	4

J. MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT (ADAPTED FORM)

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemek için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söyleneni sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz.

1. İhtiyacım olduğunda yanımda olan özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

2. Sevinç ve kederimi paylaşabileceğim özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

3. Ailem bana gerçekten yardımcı olmaya çalışır.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

4. İhtiyacım olan duygusal yardımı ve desteği ailemden alırım.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

5. Beni gerçekten rahatlatan özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

8. Sorunlarımı ailemle konuşabilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

10. Yaşamımda duygularıma önem veren özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

11. Kararlarımı vermede ailem bana yardımcı olmaya isteklidir.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

12. Sorunlarımı arkadaşlarımla konuşabilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

K. SHORT FORM-36 (ADAPTED FORM)

YÖNERGE: Bu tarama formu size sağlığınızla ilgili görüşlerinizi sormaktadır. Bu bilgiler sizin nasıl hissettiğinizi ve her zamanki faaliyetlerinizi ne rahatlıkla yapabildiğinizi izlemekte yardımcı olacaktır. Lütfen bütün soruları belirtildiğini şekilde cevaplayın. Eğer bir soruyu ne şekilde cevap vereceğinizden emin olamazsanız, lütfen o cevaba en yakın olanı işaretleyin.

1-Genel sağlık durumunuz hakkında aşağıdaki tanımlardan hangisi doğrudur?
Mükemmel **[ ]** Çok iyi **[ ]** İyi **[ ]** Fena değil **[ ]** Kötü **[ ]**

2-Geçen seneyle karşılaştırıldığında, şimdi sağlığınızı nasıl değerlendirirsiniz?
Bir yıl önceye göre çok daha iyi----------**[ ]**
Bir yıl önceye göre daha iyi----------**[ ]**
Hemen hemen aynı----------**[ ]**
Bir yıl önceye göre daha kötü----------**[ ]**
Bir yıl önceye göre çok daha kötü----------**[ ]**

3-Aşağıdakiler normal olarak gün içerisinde yapıyor olabileceğiniz bazı faaliyetlerdir. Şu sıralarda sağlığınız size bu faaliyetler bakımından kısıtlıyor mu? Kısıtlıyorsa ne kadar?

FAALİYETLER	Evet, oldukça kısıtlıyor	Evet, biraz kısıtlıyor	Hayır, hiç kısıtlamıyor
a.) Kuvvet gerektiren faaliyetler, örneğin ağır eşyalar kaldırmak, zor sporlarla uğraşmak			
b.) Orta zorlukta faaliyetler, örneğin masa kaldırmak, süpürmek, yürüyüş gibi hafif spor yapmak			
c.) Çarşı-Pazar torbalarını taşımak			
d.) Birkaç kat merdiven çıkmak			
e.) Bir kat merdiven çıkmak			
f.) Eğilmek, diz çökmek, yerden bir şey almak			
g.) Bir kilometreden fazla yürümek			
h.) Birkaç yüz metre yürümek			
i.) Yüz metre yürüme			
j.) Yıkanmak ya da giyinmek			

4- <u>Geçtiğimiz bir ay (4 hafta)</u> içerisinde işinizde veya diğer günlük faaliyetlerinizde <u>bedensel sağlığınız nedeniyle</u> aşağıdaki sorunların herhangi biriyle karşılaştınız mı?

	Evet	Hayır
a) İş ya da iş dışı uğraşlarınıza **verdiğiniz zamanı** kısmak zorunda kalmak		
b) Yapmak istediğinizden **daha azını** yapabilmek (bitmeyen projeler, temizlenmeyen ev vb gibi…)		
c) Yapabildiğiniz iş türünde ya da diğer faaliyetlerde kısıtlanmak		
d) İş ya da diğer uğraşları yapmakta zorlanmak		

5- <u>Geçtiğimiz bir ay (4 hafta)</u> içerisinde işinizde veya diğer günlük faaliyetlerinizde <u>duygusal problemleriniz nedeniyle</u> (üzüntü ya da kaygılı olmak gibi) aşağıdaki sorunların herhangi biriyle karşılaştınız mı?

	Evet	Hayır
a) İş ya da iş dışı uğraşlarınıza **verdiğiniz zamanı** kısmak zorunda kalmak		
b) Yapmak istediğinizden **daha azını** yapabilmek (bitmeyen projeler, temizlenmeyen ev vb gibi…)		
c) Yapabildiğiniz iş türünde ya da diğer faaliyetlerde kısıtlanmak		
d) İş ya da diğer uğraşları her zaman dikkatlice yapamamak		

6- <u>Son bir ay (4 hafta)</u> içerisinde bedensel sağlığınız ya da duygusal problemleriniz, ailenizle, arkadaşlarınızla, komşularınızla ya da diğer gruplarla normal olarak yaptığınız sosyal faaliyetlere ne ölçüde engel oldu?

[ ]	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Hiç	Biraz	Orta derecede	Epeyce	Çok fazla

7- <u>Geçtiğimiz bir ay (4 hafta)</u> içerisinde ne kadar <u>bedensel</u> ağrılarınız oldu?

[ ]	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Hiç	Çok hafif	Hafif	Orta hafiflikte	Aşırı derecede	Çok aşırı derecede

8- <u>Son bir ay (4 hafta)</u> içerisinde, <u>ağrı</u> normal işinize (ev dışında veya ev işi) ne kadar engel oldu?

[ ]	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Hiç olmadı	Biraz	Orta derecede	Epey	Çok fazla

9-Aşağıdaki sorular geçtiğimiz bir ay (4 hafta) içerisinde kendinizi nasıl hissettiğinizle ve işlerin sizin için nasıl gittiği ile ilgilidir. Lütfen, her soru için nasıl hissettiğinize en yakın olan cevabı verin.

1. **Her zaman**
2. **Çoğu zaman**
3. **Epeyce**
4. **Arada sırada**
5. **Çok ender**
6. **Hiçbir zaman**

Geçtiğimiz 4 hafta içindeki sürenin ne kadarı:

a) Kendinizi hayat dolu hissettiniz?	1	2	3	4	5	6
b) Çok sinirli bir kişi oldunuz?	1	2	3	4	5	6
c) Hiçbir şeyin sizi neşelendiremeyeceği kadar moraliniz bozuk ve kötü oldu?	1	2	3	4	5	6
d) Sakin ve huzurlu hissettiniz?	1	2	3	4	5	6
e) Çok enerjiniz oldu?	1	2	3	4	5	6
f) Mutsuz ve kederli oldunuz?	1	2	3	4	5	6
g) Kendinizi bitkin hissettiniz?	1	2	3	4	5	6
h) Mutlu ve sevinçli oldunuz?	1	2	3	4	5	6
i) Yorgun hissettiniz?	1	2	3	4	5	6

10- <u>Geçtiğimiz bir ay (4 hafta) içerisinde</u>, bu sürenin ne kadarında <u>bedensel sağlığınız ya da duygusal problemleriniz</u>, sosyal faaliyetlerinize (arkadaş, akraba ziyareti gibi) engel oldu?

[ ] Her zaman **[ ]** Çoğu zaman **[ ]** Bazen **[ ]** Çok ender **[ ]** Hiçbir zaman

11- Aşağıdaki her bir ifade sizin için ne kadar DOĞRU ya da YANLIŞ?

	Kesinlikle doğru	Çoğunlukla doğru	Bilmiyorum	Çoğunlukla yanlış	Kesinlikle yanlış
a) Başkalarından biraz daha kolay hastalandığımı düşünüyorum.					
b) Ben de tanıdığım herkes kadar sağlıklıyım.					
c) Sağlığımın kötü gideceğini sanıyorum.					
d) Sağlığım mükemmeldir.					

L. DEBRIEFING FORM

KATILIM SONRASI BİLGİ FORMU

Bu araştırma daha önce de belirtildiği gibi ODTÜ Psikoloji Bölümü araştırma görevlilerinden İrem Berna Güvenç tarafından yüksek lisans tezi kapsamında Prof. Dr. Özlem Bozo Özen danışmanlığında yürütülmektedir. Bu araştırmada temel olarak, üniversite mezunu işsiz bireylerde algılanan birey odaklı göreli yoksunluğun bireylerin genel sağlık durumlarını nasıl etkilediği; ayrıca göreli yoksunluk ve sağlık durumu arasındaki ilişkide kontrol odağı ve işsizlik süresinin aracı rolleri, iyimserlik eğilimi ve algılanan sosyal desteğin ise düzenleyici rolleri incelenecektir.

Göreli yoksunluk bireylerin kendilerini benzer durumdaki kişilerle karşılaştırdığında, mahrumiyet hissettikleri bir durumdur. İlgili literatür birey düzeyinde göreli yoksunluk yaşamanın kişinin öznel iyi oluşu olumsuz yönde etkilediğini ortaya koymuştur. İşsizlik ise literatürde araştırmacıların göreli yoksunluk hissetmek için belirttiği koşullara uygun bir çıktıdır. Bu bilgiler temelinde göreli yoksunluk seviyeleri yüksek olan işsiz durumdaki üniversite mezunu bireylerin genel sağlık durumlarının göreli yoksunluk yaşamayan işsiz durumdaki bireylerden daha kötü olması beklenmektedir. Ayrıca araştırma kapsamında işsizlik süresinin uzunluğunun ve dış kontrol odağı baskınlığının göreli yoksunluk ile genel sağlık durumu arasında birer aracı değişken olabileceği hipotez edilmiştir. Bunların yanı sıra, göreli yoksunluk yaşayan işsiz bireylerde algılanan sosyal destek seviyesi daha yüksek olan veya iyimserlik eğilimi daha yüksek olanların genel sağlık durumlarının daha iyi olacağı beklenmektedir.

Bu çalışmadan alınacak ilk verilerin Mayıs 2021 sonunda elde edilmesi amaçlanmaktadır. Elde edilen bilgiler sadece bilimsel araştırma ve yazılarda kullanılacaktır.

Çalışmanın sağlıklı ilerleyebilmesi ve bulguların güvenilir olması için çalışmaya katılacağını bildiğiniz diğer kişilerle çalışma ile ilgili detaylı bilgi paylaşımında bulunmamanızı dileriz.

Bu araştırmaya katıldığınız için tekrar çok teşekkür ederiz.

Araştırmanın sonuçlarını öğrenmek ya da daha fazla bilgi almak için aşağıdaki isme başvurabilirsiniz.

Arş. Gör. İrem Berna Güvenç (E-posta: bernag@metu.edu.tr)

Çalışmaya katkıda bulunan bir gönüllü olarak katılımcı haklarınızla ilgili veya etik ilkelerle ilgi soru veya görüşlerinizi ODTÜ Uygulamalı Etik Araştırma Merkezi'ne iletebilirsiniz.
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M. TURKISH SUMMARY / TÜRKÇE ÖZET

ALGILANAN GÖRELİ YOKSUNLUĞUN SAĞLIK DURUMUNA ETKİSİ: KONTROL ODAĞI VE İŞSİZLİK SÜRESİNİN ARACI ROLLERİ & İYİMSERLİK EĞİLİMİ VE ALGILANAN SOSYAL DESTEĞİN DÜZENLEYİCİ ROLLERİ

1. GİRİŞ

1.1. İşsizlik

1.1.1. İşsizlik Kavramı

İşsizlik, çalışma engeli olmayan çalışma çağındaki bireylerin, iş bulmak için uğraştığı ancak bulamadığı dönemdir (OECD, 2021). Hem 15 yaş üstü bireyler hem de yüksek eğitimli bireyler için yüksek işsizlik oranlarıyla Türkiye'de işsizlik, diğer OECD ülkelerine kıyasla daha büyük bir endişe kaynağıdır (OECD, 2021; TÜİK, 2021).

İşsizlik ülke düzeyinde yoksulluğa neden olmakta ve eşitsizlik yaratmakta, bireysel düzeyde ise kişilerin sağlık durumunu olumsuz etkilemektedir (Brenner ve Mooney, 1983).

1.1.2. İşsizlik ve Sağlık

Toplumda işsiz bireyler aylak ve işe yaramaz kişiler olarak etiketlenir; dolayısıyla çalışan bireylere verilen saygınlıktan yoksundurlar ve özsaygıları tehdit altındadır (Goldsmith, Veum, ve Darity Jr, 1997). İşsizler, çalışanlara kıyasla daha fazla stres yaşayıp daha fazla psikolojik rahatsızlık bildirmişlerdir (Paul ve Moser, 2009). Ayrıca, öfke (Tiggemann ve Winefield, 1984), kendine zarar verme davranışları (Platt, 1984) işsizlerde daha fazladır. İşsiz bireylerdeki yüksek kortizol seviyesi onları hastalıklara

karşı daha savunmasız hale getirir (Arnetz ve ark., 1991). Ayrıca, işsizlerde alkol, uyuşturucu ve sigara kullanımı daha fazladır (Bartley, 1994). Sonuç olarak, işsizlik hem psikolojik hem fiziksel sağlığı olumsuz yönde etkiler.

Hem Jahoda'nın Örtük Yoksunluk Modeli (1984) hem de Fryer'ın modeli (1986) çalışanların sahip olduğu çeşitli avantajlardan mahrum kalmanın işsizlerin sağlığını olumsuz etkilediğini savunmuş olsa da işsizliğin sağlıkla ilgili sonuçlarının incelenmesinde yoksunluğun nasıl algılandığı önemlidir (Chen, 2015). Bu nedenle, mevcut çalışma işsizlik sorununu Göreli Yoksunluk Teorisi perspektifinde inceleyecektir.

1.2. Göreli Yoksunluk Teorisi

Göreli yoksunluk, kişinin kendini bir başkasıyla, geçmişiyle veya ideal benlikle karşılaştırmaları sonucunda ortaya çıkan bir hoşnutsuzluk hissidir. Bu karşılaştırmalar sonucunda, bireyler sahip oldukları ile hak ettikleri arasında önemli bir farklılık algılarlar (Crosby, 1976).

Göreli yoksunluk hissetmek için, kişinin eksikliğini hissettiği şeye başkasının sahip olduğunu algılaması, ona sahip olmayı istemesi ve sahip olma hakkının olduğunu hissetmesi gerekir (Davis, 1959). Ayrıca, kişi eksik nesneyi elde etmenin mümkün olduğunu hissetmeli (Runciman,1966) ve kendini bu eksiklikten sorumlu hissetmemelidir (Crosby, 1976). Bu beş ön koşulun varlığı, bireylerin hak ettikleri konumda olmadıklarını fark etmelerine neden olur ve öfke ve kırgınlık duygusuyla sonuçlanır (Smith ve ark., 2012).

Grup düzeyinde göreli yoksunluk ya terörizm gibi yıkıcı eylemlerle (Issac, Mutran ve Stryker, 1980) ya da toplumu iyileştirme çabasıyla (Morrison, 1971) sonuçlanır. Bireysel düzeyde göreli yoksunluk ise bazılarını hak ettiklerini elde etmek için koşulları değiştirmeye ve kendilerini geliştirmeye motive ederken (Olson, Roese, Meen ve Robertson, 1995), bazıları için stres yaşamalarına veya kendine zarar verici davranışlarda bulunmalarına neden olur (Adler, Epel, Castellazzo ve Ickovics, 2000). Psikolojik stres ve olumsuz davranışlar, göreli yoksunluğa maruz kalan bireylerde sağlık sorunlarına yol açar (Callan, Kim ve Matthews, 2015).

1.2.1. Göreli Yoksunluk ve Sağlık Arasındaki İlişki

Göreli yoksunlukla baş edememek bireylerin stres yaşamalarına neden olur (Adler ve Stewart, 2010). Göreli yoksunluk karşısında sürekli strese maruz kalmak vücudun daha fazla stres hormonu salgılamasını gerektirir, bu da vücudu hastalıklara karşı savunmasız hale getirir (McEwen ve Stellar, 1993).

Göreli yoksunluğun sağlık üzerinde olumsuz etkisi vardır (Mishra ve Carleton, 2015; Salti ve Abdulrahim, 2016). Göreli yoksunluk yaşayan bireyler daha fazla depresyon ve anksiyete bildirmişlerdir (Eibner, Sturm ve Gresenz, 2004). Ayrıca, göreli yoksunluk sonucunda stres arttıkça, organik olmayan hastalıklar (örn: irritabl bağırsak sendromu ve fibromiyalji) daha fazla bildirilmiştir (Beshai, Mishra, Mishra ve Carleton, 2017).

Bireyler göreli yoksunluktan duygusunu telafi etmek için anında ödül alabilecekleri riskli davranışlarda bulunabilirler. Göreli yoksunluk arttıkça kumar oynanırken alınan riskler artar (Callan, Shead ve Olson, 2011). Ayrıca göreli yoksunluk, alkol alma ve tütün kullanımı gibi davranışlarla (Balsa, French ve Regan, 2013; Wu ve ark., 2020) ve obezite eğilimiyle (Elgar, Xie, Pförtner, White ve Pickett, 2016) pozitif ilişkilidir. Göreli yoksunluk ölüm oranlarıyla da önemli ölçüde ilişkilidir (Saltı, 2010).

1.2.2. Göreli Yoksunluk Algılamanın Bir Nedeni Olarak İşsizlik

İşsiz bireylerin hem kişisel hem de grup düzeyinde daha fazla göreli yoksunluk yaşarlar (Walker ve Mann, 1987). İşsizler arasında grup düzeyinde göreli yoksunluk arttıkça, protestolara katılmaya yönelik olumlu tutum artmıştır. Öte yandan, göreli yoksunluk işsizlerde daha fazla stres belirtileriyle ilişkilidir (Walker ve Mann, 1987). Ayrıca, çalışanlara kıyasla işsizler daha yüksek göreli yoksunluk bildirmişlerdir (Mishra ve Carleton, 2015).

İşsizlerin başkalarıyla daha fazla kendini kıyaslaması depresyon ile pozitif ilişkili bulunmuştur. Ayrıca, işsizlerin gerçek ve istenen benlikleri arasındaki farkı daha çok algıladığını ve çalışanlardan daha fazla göreli yoksunluk yaşadıkları bildirilmiştir (Sheeran, Abrams ve Orbell, 1995).

1.3. Kontrol Odağı

Kontrol odağı olayların meydana gelmesindeki nedensel atıflarla ilgilidir (Rotter, 1954). Kişiler, olayların çoğunlukla kendi eylemlerine, niyetlerine veya özelliklerine bağlı olduğuna inanıyorsa, içsel kontrol odağına sahip olma eğilimindedirler (Rotter, 1966). Bu bireyler, kontrolün kendilerinde olduğuna ve kendi hayatlarını kontrol eden aktif failler olduklarına inanırlar (Strikland, 1978). Öte yandan, kader, şans veya güçlü diğerleri gibi dış kaynakların olaylar üzerinde daha fazla etkiye sahip olduğuna inanan bireyler dış kontrol odağına sahip olma eğilimindedir (Rotter, 1966). Sorumluluk duygusunun düşük olması, bu bireylerin daha pasif ve çaresiz hissetmelerine neden olur. (Rotter, 1992).

İç kontrol odağına sahip bireyler, olumsuz koşullara daha düşük stres seviyeleri ile tepki vermektedirler (Johnson ve Sarason, 1978). Dış kontrol odağına sahip bireyler ise olumsuzluklar karşısında daha fazla stres ve kaygı yaşarlar (Anderson, 1977). İçsel kontrol odağına sahip olmak, daha olumlu bir sağlık profili ile ilişkili bulunmuştur (Strudler-Wallston ve Wallston, 1978).

1.3.1. Kontrol Odağı ve Göreli Yoksunluk

Crosby'ye göre (1976) göreli yoksunluk yaşamak için bireylerin durumla ilgili kişisel sorumluluk hissetmemeleri gerekir. Yaşadıkları dezavantajlı durum için dış etkenleri sorumlu tutmaları halinde mevcut konumlarını adaletsiz olarak algıladıkları ve kırgınlık hissettikleri söylenebilir (Crosby, 1976).

Crawford ve Naditch'e göre (1970), dış kontrol odağına sahip bireyler istediklerine ulaşma yolunda daha az kontrol hissettikleri ve kendilerini güçsüz hissettiklerinden göreli yoksunluk karşısında en yüksek risktedirler. Bu nedenle, Carwford ve Maditch'in modelinde (1970) "hoşnutsuzluk kaderciliği" olarak tanımlanmış ve toplumdaki en mutsuz ve umutsuz bireyler olarak nitelendirilmişlerdir.

Moore ve Aweiss (2003) göreli yoksunluk hissinin kontrol duygusunu azalttığını ve azalan kontrol duygusunun, dezavantajlı ergenlerin gelecekteki beklentilerini daha da düşürdüğünü bulmuşlardır. Benzer şekilde, göreli yoksunluğun, daha düşük kontrol duygusuna sahip bireylerde daha fazla hayal kırıklığına yol açtığı bulunmuştur (Abrams, Linken ve Tomlins, 1999).

1.4. İşsizlik Süresi

İşsizlik süresi arttıkça, fiziksel sağlığın zamanla azalır (Stauder, 2018). Uzun süreli işsizlik ruh sağlığına da zarar vermektedir. İşsizlik süresi arttıkça bireylerin iyilik halleri azalır ve psikiyatrik bir hastalığa yakalanma olasılıkları artar (Hepworth, 1980).

İşsizlik süresinin sağlık durumu üzerindeki etkisini inceleyen literatürde, üç görüş öne sürülmüştür. İlk görüş, işsizliğin süresi uzadıkça sağlığın daha kötü olduğu yönündedir (Warr ve Jackson, 1984). Başka bir görüş, belirli bir süre işsizlik yaşamanın sağlığı olumsuz etkilediğini, ancak belirli bir noktadan sonra sağlık durumlarında değişiklik olmadığını savunur (Cook, Bartley, Cummins ve Shaper, 1982). Diğer görüş, başlangıçta işsizliğin sağlık üzerinde olumsuz etkisi olduğunu, ancak bir süre sonra duruma uyum sağlanarak etkisinin azaldığını ileri sürmüştür (Kulik, 2001).

Crosby (1976), sahip olmak istenilen şeyin eksikliği devam ederse, göreli yoksunluk hissinin artarak devam edeceğini savunur. Dolayısıyla işsiz kalmanın sürekliliği göreli yoksunluğun artmasına neden olabilir. Sheeran, Abrams ve Orbell (1995) yukarı yönlü sosyal karşılaştırmalar sonucunda daha uzun işsizlik süresinin daha düşük benlik saygısıyla ilişkili bulmuştur.

1.5. İyimserlik Eğilimi

İyimserlik eğilimi gelecekle ilgili olumlu beklentilere sahip olmayı ifade eder (Scheier ve Carver, 1987). İyimserliğin psikolojik iyilik hali ve fiziksel sağlığı öngörmede güçlü bir belirleyici olduğu bulunmuştur. İyimser bireyler olumsuz olaylara daha az stresle tepki verirler ve koşullara psikolojik olarak daha fazla uyum sağlayabilirler (Nes & Segerstrom, 2006; Scheier ve Carver, 1987). İyimserlik, daha güçlü bağışıklık (Segerstrom, 2006) ve daha düşük kortizol seviyeleri (Jobin, Wrosch ve Scheier, 2014) ile ilişkili bulunmuş olup kardiyovasküler hastalıklar üzerinde koruyucu bir etkiye sahiptir (Boehm ve Kubzansky, 2012).

1.5.1. İyimserlik Eğiliminin Koruyucu Rolü

İyimseler gelecekle ilgili olumlu beklentileri olduğundan (Scheier, Weintraub ve Carver, 1986), göreli yoksunluktan kaynaklanan olumsuz duygularla daha iyi başa çıkabilirler.

İyimserlik seviyesi düşük olan işsizler, daha yüksek düzeyde depresyon yaşarlar (Sojo ve Guarino, 2011). Ayrıca, iyimserler stresle daha aktif başa çıkma yollarını kullanırken, daha az iyimser olanlar, kaçınma gibi daha uyumsuz stratejiler kullanırlar (Scheier, Weintraub ve Carver, 1986). Böylece iyimserlik, daha sağlıklı bir yaşamı öngörür. İyimserliğin koruyucu rolü, göreli yoksunluk bağlamında incelenmiştir. Liu ve arkadaşları (2017), sosyal paylaşım sitelerinde göreli yoksunluk yaşamanın depresyon belirtilerine yol açtığını öne sürmüşlerdir. Ancak göreli yoksunluğun olumsuz etkisi iyimser bireylerde daha düşük bulunmuştur.

1.6. Algılanan Sosyal Destek

Algılanan sosyal destek kişilerin sosyal çevrelerinden aldıkları desteği nasıl değerlendirdikleriyle ilgilidir (Caplan, 1974). Algılanan sosyal destek, stresli yaşam olaylarının psikolojik iyi oluş üzerindeki istenmeyen sonuçlarını azaltmada koruyucudur (Cohen ve Wills, 1985). Algılanan sosyal desteğin, daha sağlıklı bir yaşam tarzına uyum sağlayarak veya biyolojik mekanizmaları geliştirerek çeşitli fiziksel sorunların ortaya çıkma olasılığını azaltabileceği bulunmuştur (Cohen, 1988; Riffle, Yoho ve Sams, 1989).

1.6.1. Algılanan Sosyal Desteğin Koruyucu Rolü

Algılanan sosyal destek, göreli yoksunluktan kaynaklanan olumsuz sonuçları azaltabilir. Göreli yoksunluk, depresyon ve intihar eğilimi ile pozitif, algılanan sosyal destek ile negatif ilişkilidir (Zhang ve Tao, 2013). Benzer şekilde, öğretmenlerinden daha fazla destek algılayan çocukların, göreli yoksunluğun hissedilen güven duygusu üzerindeki olumsuz etkilerinin daha az olduğunu göstermiştir (Xuan ve ark, 2021). Göreli yoksunluk duyguları artan yaşlılarda, algılanan sosyal destek, sağlık durumunu olumlu yönde etkilemiştir (Saito ve ark. 2014).

1.7. Mevcut Çalışmanın Amacı ve Hipotezleri

Çalışmanın temel amacı, Türkiye'deki işsizlerde göreli yoksunluk ve sağlık durumu arasındaki ilişkiyi araştırmaktır. Bu ilişkide kontrol odağının ve işsizlik süresinin aracı rolleri ve iyimserlik eğilimi ve algılanan sosyal desteğin koruyucu rollerini incelemek diğer amaçlardır.

Bu amaçlardan hareketle aşağıdaki hipotezler oluşturulmuştur:

H_1: Göreli yoksunluk arttıkça (1a) fiziksel ve (1b) mental sağlık kötüleşecektir.

H_2: Kontrol odağının göreli yoksunluk ve sağlık ilişkisine aracılık etmesi beklenmiştir. Buna göre göreli yoksunluktaki artış, dış kontrol odağıyla ilişkili olacaktır, bu da (2a) fiziksel (2b) ve mental sağlığı azaltacaktır.

H_3: İşsizlik süresinin göreli yoksunluk ve sağlık ilişkisine aracılık etmesi beklenmiştir. Yani, göreli yoksunluktaki artış, işsizlik süresindeki artışla ilişkili olacaktır, bu da (3a) fiziksel ve (3b) mental sağlığı düşürecektir.

H_4: İyimserlik eğiliminin göreli yoksunluk ve sağlık ilişkisinde düzenleyici rol oynaması beklenmiştir. Yani, daha iyimser bireyler göreli yoksunluk karşısında (4a) fiziksel ve (4b) mental sağlık açısından daha az iyimser olanlarla farklılaşacaklardır.

H_5: Algılanan sosyal desteğin göreli yoksunluk ve sağlık ilişkisinde düzenleyici rol oynaması beklenmiştir. Buna göre algılanan sosyal desteği yüksek bireyler göreli yoksunluk karşısında (4a) fiziksel ve (4b) mental sağlık açısından algılanan sosyal desteği düşük olanlarla farklılaşacaklardır.

2. ÇALIŞMA 1: Bireysel Göreli Yoksunluk Ölçeği'nin Türkçe Uyarlama, Geçerlilik ve Güvenirlik Çalışması

2.1. Yöntem

İlk çalışmanın amacı, Bireysel Göreli Yoksunluk Ölçeği'ni (BGYÖ) Türkçe'ye uyarlayıp psikometrik özelliklerini analiz etmek ve BGYÖ'nün geçerlilik ve güvenilirliğini araştırmaktır.

2.1.1. Katılımcılar

Bu çalışma, yaşları 18 ve 43 arasında değişen, çoğu kadın, 178 üniversite öğrencisi ile yürütülmüştür. Çoğunluk yaşamlarının büyük bölümünü büyükşehirlerde geçirdiğini

belirtmiş, yine büyük çoğunluk ekonomik düzeyini orta olarak bildirmiştir. Örneklemin büyük bölümü herhangi bir fiziksel veya psikolojik rahatsızlığı olmadığını belirtmiştir.

2.1.2. Veri Toplama Araçları

Mevcut çalışmanın verileri, Demografik Bilgi Formu, araştırmacı tarafından Türkçe'ye çevrilen Bireysel Göreli Yoksunluk Ölçeği (Callan, Ellard, Shead, ve Hodgins, 2008; Callan, Shead, ve Olson, 2011), Iowa Netherlands Karşılaştırma Yönelimi Ölçeği (Gibbons ve Buunk, 1999; Teközel ,2000), Marlowe-Crowne Sosyal İstenirlik Ölçeği (Crowne ve Marlowe, 1960; Özeren, 1996) ve Sosyal Karşılaştırma Sıklığı Ölçeği (Demir, 2017) aracılığıyla toplanmıştır.

2.1.3. İşlem

ODTÜ İnsan Araştırmaları Etik Kurulu'ndan onay alındıktan sonra Bireysel Göreli Yoksunluk Ölçeği'nin (BGYÖ) maddeleri çeviri-geri çeviri yöntemiyle Türkçe'ye uyarlanmıştır.

Veriler Qualtrics platformunda çevrimiçi toplanmıştır. Katılımcılara önce Bilgilendirilmiş Onam Formu sunulmuş, ardından Demografik Bilgi Formu ve dört ölçek rasgele bir sırayla sunulmuştur. Yaklaşık 10 dakika süren çalışma karşılığında öğrenciler ekstra iki puan kazanmışlardır.

Test-tekrar test güvenilirliğini ölçmek için ilk katılımdan iki ay sonra gönüllü 50 katılımcıyla aynı çalışma tekrar yürütülmüştür.

2.2. Sonuç

Çalışmada kullanılan ölçeklere ait betimleyici istatistikler Tablo 2'de görülebilir.

2.2.2. Bireysel Göreli Yoksunluk Ölçeği'nin Faktör Analizi

2.2.2.1. Açıklayıcı Faktör Analizi

Örneklem büyüklüğü (N = 178), Kaiser-Meyer-Olkin (KMO) katsayısı (.66) ve Barlett Küresellik Testi ($\chi^2(10) = 330.89$, $p < .001$) ölçeğin faktör analizine uygun olduğunu göstermiştir. Analiz iki faktörlü bir yapı önermiştir. Birinci faktöre yüklenen maddeler

(madde 1, 3 ve 5) göreli yoksunlukla ilgili oluşan negatif hisleri, ikinci faktöre yüklenen maddeler (madde 2 ve 4) karşılaştırma sonucunda somut varlıklara odaklanmayı ifade etmiştir (Table 3). Mevcut tez kapsamında ölçeğin toplam puanı esas alınmıştır.

2.2.3. Bireysel Göreli Yoksunluk Ölçeği'nin Güvenilirlik Analizleri

Ölçeğin Türkçe formunun iç tutarlılık katsayısı .74'tür. İki ay arayla sağlanan test-tekrar test güvenilirlik katsayısı yüksektir (N = 50, r = .84, p < .001).

2.2.4. Bireysel Göreli Yoksunluk Ölçeği'nin Geçerlilik Analizi

Iowa-Netherlands Karşılaştırma Yönelimi Ölçeği ile BGYÖ arasındaki pozitif ve anlamlı ilişki BGYÖ'nün yakınsak geçerliliğini desteklemiştir. Marlowe-Crowne Sosyal İstenirlik Ölçeği ile BGYÖ arasında elde edilen pozitif ve anlamlı ilişki ölçeğin ayrıştırıcı geçerliliğin bu ölçekle sağlanamadığını göstermiştir. Kriter geçerliliği ise Sosyal Karşılaştırma Sıklığı Ölçeği ve BGYÖ arasındaki pozitif ve anlamlı korelasyon ile sağlanmıştır (Tablo 4).

2.3. Tartışma

Ölçeğin Türkçe formunun iç tutarlılık değeri (α = .74), orijinal formundan (α = .78) çok az düşüktür (Callan, Ellard, Shead, ve Hodgins, 2008). Yüksek test-tekrar test güvenilirliği ölçeğin araya zaman girse bile tutarlı bir şekilde cevaplandığını göstermiştir.

Yakınsak geçerlilik için ölçeğin Korece versiyonunda da Iowa-Netherlands Karşılaştırma Yönelimi Ölçeği kullanılmıştır (Kim, Kim, Suh, ve Callan, 2018). Ölçeğin ayrıştırıcı geçerliliğinin sosyal istenirlik kavramıyla sağlanamamasına sebep olarak göreli yoksunluğun toplumsal olarak istenmeyen bir his olması gösterilebilir (Phillips ve Clancy, 1972). Kriter geçerliliği için sosyal karşılaştırma sıklığı, göreli yoksunluk ile pozitif ilişkili bulunmuştur. Sonuç olarak ölçeğin Türkçe formu yüksek psikometrik özellikler göstermektedir.

3. ÇALIŞMA 2: ANA ÇALIŞMA

3.1. Yöntem

Bu çalışmada mevcut tezin hipotezlerin test edilmesi planlanmıştır.

3.1.1. Katılımcılar

Çalışma Türkiye'de yaşayan 402 işsiz bireyle yürütülmüştür. Katılımcıların 20 ve 45 yaş arasında olması, en az altı aydır işsiz olup iş aramaları ve en az ön lisans mezunu olmaları gerekmektedir. Katılımcıların yarıdan fazlası kendini kadın olarak tanımlamıştır. Katılımcıların çoğu romantik ilişkisi olmayan bekâr bireylerdir ve büyük çoğunluğu çocuk sahibi değildir.

Örneklemin çoğunluğu hayatlarının büyük çoğunluğunu büyükşehirlerde geçirmiştir. TÜRK-İŞ'in (2021) belirlediği açlık ve yoksulluk sınırlarına göre, katılımcıların büyük çoğunluğu açlık ve yoksulluk sınırları arasında yaşamaktadır.

Büyük çoğunluk lisans derecesinde üniversite mezunudur. Katılımcıların yarıdan fazlası lisansüstü seviyesinde eğitimlerine devam etmektedir. Büyük bir kesim daha önce bir işte çalıştığını bildirmiştir. İşsizlik süresi altı aydan beş yıldan fazla bir sürede değişmekteyken, çoğu katılımcı altı ay-bir yıl süresince işsiz olduğunu belirtmiştir. Katılımcıların çoğunluğu herhangi bir psikolojik ve fiziksel rahatsızlıklarının olmadığını bildirmiştir (Tablo 5).

3.1.2. Veri Toplama Araçları

Mevcut çalışma için veriler Demografik Bilgi Formu, ilk çalışmada Türkçe'ye uyarlanan Bireysel Göreli Yoksunluk Ölçeği (Callan, Shead ve Olson, 2011), Kontrol Odağı Ölçeği (Dağ, 2000), Yaşam Yönelimi Testi (Aydın ve Tezer,1991; Scheier ve Carver, 1985), Çok Boyutlu Algılanan Sosyal Destek Ölçeği (Eker ve Arkar, 1995; Zimet, Dahlem, Zimet ve Farley, 1988) ve Kısa Form-36 (Demirsoy, 1999; Ware ve Sherbourne, 1992) kullanılarak elde edilmiştir.

3.1.3. İşlem

ODTÜ İnsan Araştırmaları Etik Kurulu'ndan etik izin alındıktan sonra veri toplama işlemine başlanmıştır. Çalışma sosyal medya sitelerinde duyurulup veriler Qualtrics platformu ile çevrim içi toplanmıştır. Katılımcılara öncelikle Bilgilendirilmiş Onam Formu gösterilmiş, ardından Demografik Bilgi Formu ve rasgele bir sıralamayla beş ölçek sunulmuştur. Çalışma yaklaşık 20 dakika sürmüştür, sonunda Katılım Sonrası Bilgi Formu gösterilerek araştırma hakkında bilgi verilmiştir.

3.2. Sonuç

Normallik analizi sonucunda iki katılımcı analizlerin dışında tutulmuştur. Demografik Bilgi Formundaki sorulara göre, katılımcılar işsizlik sorununu çok ciddi ama kontrol edilebilir olarak değerlendirirken iş ilanlarına bakma sıklıkları ortalamanın üstündedir. Kullanılan ölçeklere ilişkin betimleyici analizler Tablo 6'da sunulmuştur.

3.2.3. Çalışmanın Değişkenleri Arasındaki Korelasyonlar

Araştırmada kullanılan değişkenler arasındaki ikili korelasyonlara ait bilgiler Tablo 7'de incelenebilir.

3.2.4. Regresyon Analizi

Yaş, sağlıkla ilişkili bulunduğundan, hiyerarşik regresyon analizine kontrol değişkeni olarak eklenmiştir. Analizin birinci adımı yaş arttıkça fiziksel sağlığın düştüğünü, mental sağlığın yükseldiğini göstermiştir. Analizin ikinci adımında göreli yoksunluk eklenmiş ve yaşın etkisi kontrol edilse bile göreli yoksunluğun fiziksel ve mental sağlıkta anlamlı bir düşüşü öngördüğü bulunmuştur. Bu bulgu ile çalışmanın birinci hipotezi desteklenmiştir.

3.2.5. Aracı Değişken Analizleri

Kontrol odağı ve işsizlik süresinin, göreli yoksunluk ve sağlık arasındaki ilişkideki aracı rollerini incelemek üzere bir dizi aracı değişken analizi, yaş değişkeni kontrol altına alınarak PROCESS (model 4) aracılığıyla IBM SPSS'te uygulanmıştır (Hayes, 2018). Göreli yoksunluk ve fiziksel ve mental sağlık arasındaki ilişkide dış kontrol odağının dolaylı etkisi anlamlı bulunmuştur. Böylece çalışmanın ikinci hipotezi

desteklenmiştir. İşsizlik süresinin göreli yoksunluk ve fiziksel sağlık arasındaki ilişkideki dolaylı etkisi anlamlı bulunurken, göreli yoksunluk ve mental sağlık arasındaki dolaylı etkisi anlamlı bulunamamıştır. Yani hipotez 3a desteklenirken, hipotez 3b reddedilmiştir.

3.2.6. Moderasyon Analizleri

İyimserlik ve algılanan sosyal desteğin göreli yoksunluk ve sağlık arasındaki ilişkideki düzenleyici rollerini incelemek üzere bir dizi moderasyon analizi, yaş kontrol değişkeni olarak eklenip PROCESS (model 1) aracılığıyla IBM SPSS'te uygulanmıştır (Hayes, 2018). Bu ilişkide iyimserlik eğilimi ve algılanan sosyal desteğin toplam puanı ve alt ölçeklerinin anlamlı düzenleyici rolleri bulunamamıştır. Böylece çalışmanın dördüncü ve beşinci hipotezleri desteklenmemiştir.

3.3. Tartışma

3.3.1. Değişkenler Arasındaki Korelasyonlara Dair Bulgular

Göreli yoksunluk arttıkça fiziksel ve mental sağlık azalmıştır. Bu bulgu önceki araştırmalarla uyumludur (Eibner, Sturm ve Gresenz, 2004; Mishra ve Carleton, 2015). Ayrıca, geçmiş araştırmalarla tutarlı olarak (Mishra ve Novakowski, 2016) göreli yoksunluk, kontrol odağındaki dışsallık ile pozitif ilişkilidir. Göreli yoksunluk işsizlik süresi ile pozitif ilişkilidir. Eksikliği hissedilen şeye sahip olunamayan sürenin uzunluğu göreli yoksunluk hissini arttırabilir (Crosby, 1976). Bu nedenle mevcut çalışmada işsizlik süresi arttıkça göreli yoksunluğun artması tutarlıdır.

Önceki bulgulara paralel olarak (Özdemir, Tekeş ve Öner-Özkan, 2019), göreli yoksunluk arttıkça, iyimserlik düzeyi düşmektedir. Ayrıca göreli yoksunluk, algılanan sosyal destek ile negatif ilişkilidir. Mishra ve Carleton (2015) göreli yoksunluk seviyesi daha yüksek olan bireylerin daha az sosyal destek algıladığını belirtmiştir.

Kontrol odağındaki dışsallık, iyimserlik ve algılanan sosyal desteğin toplam puanı ve önemli diğerleri alt ölçeği ile negatif ilişkilidir. Dış kontrol odağına sahip bireylerin iyimser olma olasılıkları daha düşüktür (Guarnera & Williams, 1987; Peacock & Wong, 1996). Ayrıca, kontrol odağındaki dışsallık arttıkça, bireylerin algılanan sosyal destek düzeylerinin düştüğü belirtilmiştir (VanderZee ve Buunk, 1997). Mevcut

çalışmada kontrol odağındaki dışsallık fiziksel ve mental sağlık ile negatif ilişkilidir. Dışsal kontrol odağına sahip bireylerin riskli sağlık davranışlarına giriştikleri (Strudler-Wallston ve Wallston, 1978), fiziksel (Gore, Griffin ve McNierney, 2016) ve psikolojik sağlıklarının (Dağ, 2002) daha kötü olduğu bulunmuştur.

İşsizlik süresi, iyimserlik ve algılanan sosyal destekle negatif ilişkilidir. Sojo ve Guarino (2011) iyimserliğin işsizlik süresince azalabileceğini savunmuştur. İşsizlik sürecindeki stres ve özellikle aile içinde oluşan gerilimler algılanan sosyal destekle olan negatif ilişkinin nedeni olarak gösterilebilir (Atkinson, Liem ve Liem, 1986). Ayrıca, Stauder'in (2018) bulgusuna paralel olarak işsizlik süresi fiziksel sağlık ile negatif ilişkilidir.

Önceki bulgularla (Özdemir, Tekeş ve Öner-Özkan, 2019; Weber, Puskar ve Ren, 2010) uyumlu olarak iyimserlik, algılanan sosyal destekle pozitif ilişkilidir. Ayrıca, iyimserlik ile fiziksel ve mental sağlık pozitif ilişkilidir. Literatüre göre daha yüksek iyimserlik, daha iyi fiziksel (Carver ve Scheier, 2014) ve mental (Scheier ve Carver, 1987) sağlığı öngörür.

Algılanan sosyal destek ve fiziksel ve mental sağlık arasında pozitif korelasyonlar elde edilmiştir. Başkalarının desteğini algılamanın, bireylerin sağlığını olumlu etkilediği yaygın bir görüştür (Zimet, Dahlem, Zimet ve Farley, 1988).

3.3.2. Regresyon Analizi

Önceki bulgulara paralel olarak (Ware ve ark., 1995) yaş değişkeni fiziksel sağlıkla negatif, mental sağlıkla pozitif ilişki bulunmuştur. Analizlere göre, göreli yoksunluktaki artış, yaşın etkisi kontrol edilse bile hem fiziksel hem de mental sağlıktaki azalışla ilişkilidir. İşsizliğin mental ve fiziksel sağlık üzerindeki olumsuz etkileri sunulmuştur (Paul & Moser, 2009). Eibner ve Evans (2005), bireylerin sağlıklarının kendilerini karşılaştırdıkları kişilerin özelliklerine bağlı olduğunu öne sürmüşlerdir. Kıyaslanan kişilerin daha iyi durumda olması, bireylerin stres yaşamasına yol açar ve sağlıklarını kötüleştirir. Sonuçlar işsizlerin sağlık durumlarını öngörmede işsizliğe bağlı algılanan göreli yoksunluğun önemini göstermiştir.

3.3.3. Aracı Değişken Analizleri

3.3.3.1. Kontrol Odağının Aracı Rolüne İlişkin Bulgular

Crosby'ye (1976) göre, göreli yoksunluk hissinin oluşması için dezavantaj hakkında otorite figürleri, şans veya kader gibi dış kaynaklar sorumlu görülmelidir. Kontrol duygusu ile göreli yoksunluk arasındaki ilişkide benzer sonuç bulunmuştur (Brehm ve Cohen, 1959). Benzer şekilde, Mishra ve Novakowski'ye göre (2016) daha düşük öz kontrol daha yüksek göreli yoksunluk ile ilişkilir. Ayrıca, kontrol odağındaki dışsallığın, kötüleşen sağlık davranışlarıyla ilişkili olduğu bulunmuştur (Cobb-Clark, Kassenboehmer ve Schurer, 2014; Steptoe ve Wardle, 2001). Dış kontrol odağına sahip bireylerin psikolojik sorun yaşama riski de daha yüksektir (Dağ, 2000; Gore, Griffin ve McNierney, 2016).

Mevcut çalışma, göreli yoksunluk ile kontrol odağı arasındaki yolu doğrudan inceleyen ve kontrol odağının göreli yoksunluk ile sağlık ilişkisindeki aracılık rolünü inceleyen ilk çalışmadır.

3.3.3.2. İşsizlik Süresinin Aracı Rolüne İlişkin Bulgular

İşsizlik süresinin göreli yoksunluk ile fiziksel sağlık arasında aracı rolü anlamlı bulunurken, mental sağlık için anlamlı bulunamamıştır. İşsizlik süresinin sağlık üzerindeki etkisi hakkında genel görüş işsizlik süresi arttıkça sağlığın kötüleşeceği yönündedir (Warr ve Jackson, 1984). İşsizlik süresi arttıkça fiziksel sağlığın düştüğünü (Stauder, 2019), kilo problemlerinin arttığını (Hughes ve Kumari, 2017) gösteren çalışmalar bu görüşü destekler.

Mental sağlık için desteklenmeyen hipotezin sebebi işsizliğe alışma süreci olabilir. Paul ve Moser (2009) işsizlik süresi ve sağlık arasındaki ilişkinin lineer olmadığını savunmuştur ve mental sağlığın işsizliğin birinci yılından sonra yükselmeye başladığını, bir süre sonra sabitlendiğini bulmuşlardır. Warr ve Jackson (1987) işsizlerin psikolojik sağlığının düşük olduğunu ancak bu düşüşün uzun sürmediğini öne sürmüşlerdir. İşsizliğin nasıl algılandığı da bu noktada önemlidir. Mevcut katılımcılar işsizliği çok ciddi ancak kontrol edilebilir bir sorun olarak değerlendirmiş olup iş arama sıklıkları ortalamanın üstündedir. Buna göre, katılımcılar iş bulma konusunda umutlarını kaybetmemiştir denebilir. Frese ve Mohr (1987) kontrol

umudunun işsizliğin psikolojik sağlık üzerindeki etkisini azaltabileceğini bulmuştur. Ayrıca, COVID-19 nedeniyle artan işsizlik, kişilerin uzun süren işsizliklerini normalleştirmelerine sebep olup, mental sağlıklarını korumuş olabilir. Mevcut çalışmanın beklenmeyen sonucu bu açıklamalarla desteklenebilir.

3.3.4. Moderasyon Analizleri

3.3.4.1. İyimserlik Eğiliminin Düzenleyici Rolüne İlişkin Bulgular

İyimserlik ile sağlık arasındaki pozitif ilişkiye rağmen, iyimserlik, göreli yoksunluğun sağlık üzerindeki olumsuz etkilerine karşı koruyucu bulunamamıştır.

Çeşitli çalışmalar, işsizlik sürecinde iyimserliğin azaldığını kanıtlamıştır (Mutambara, Makanyanga ve Mudhovozi, 2018; Sojo ve Guarino, 2011). Mevcut katılımcılar en az altı aydır işsiz olduklarından, katılımcıların çoğu, zamanla iyimserlik seviyelerinde bir düşüş yaşamış olabilir. Nitekim mevcut çalışmada, işsizlik süresi ile iyimserlik arasında anlamlı ve negatif bir ilişki bulunmuştur. Bu nedenle, önceki bulgular ve mevcut korelasyon göz önüne alındığında, iyimserliğin koruyucu etkisinin yetersiz kalması şaşırtıcı değildir.

İyimserliğin koruyucu etkisinin bulunamaması göreli yoksunluk hissinin yoğunluğunun altını çizmiştir. İşsizlik süresi kontrol edilerek iyimserliğin bu ilişkideki etkisi yeniden araştırılmalıdır.

3.3.4.2. Algılanan Sosyal Desteğin Düzenleyici Rolüne İlişkin Bulgular

Algılanan sosyal destek ve üç alt boyutu, fiziksel ve mental sağlıkla pozitif ilişkili olmasına rağmen, göreli yoksunluğun sağlık üzerindeki olumsuz etkisini hafifletmekte yeterli olmamıştır.

Mevcut çalışmada, işsizlik süresi arttıkça göreli yoksunluğun arttığı, algılanan sosyal desteğin ise azaldığı bulunmuştur. Literatürde bazı bulgular işsizlik dönemi boyunca algılanan sosyal desteğin zamanla azaldığına işaret etmiştir. Atkinson, Liem ve Liem (1986), işsizlik süresince, kişilerarası ilişkilerin özellikle maddi zorluklar nedeniyle zarar görebileceğini savunmuştur. Kurt (2006), Türkiye'deki işsizlerin maddi kaygılar nedeniyle sosyal faaliyetlere katılamayabileceklerini ve işsizlik utancından dolayı

sosyal etkileşimlerden çekilebileceklerini vurgulamıştır. Bilgiç ve Yılmaz (2013) da algılanan sosyal desteğin işsizlik süresiyle psikolojik stres arasındaki ilişkiyi tamponlayamadığını belirtmişlerdir. Dolayısıyla, algılanan sosyal desteğin koruyucu etkisi, göreli yoksunluk nedeniyle sağlığın kötüleşmesini engelleyemeyecek şekilde azalmış olabilir.

3.3.6. Mevcut Bulgularla İlgili Pratik Uygulama Çıkarımları

Yüksek eğitimli kişiler yüksek sosyal statü beklentileri olduğundan işsizlik nedeniyle daha fazla göreli yoksunluk yaşayabilirler (Richardson, 2011). Mevcut örneklem, yükseköğrenim almış işsiz bireylerden oluşmaktadır; dolayısıyla katılımcıların işsizlikleri sebebiyle haksızlık hissetmeleri tutarlıdır. Türkiye'deki artan işsizlik göz önüne alındığında (TÜİK, 2021), adaletsizlikleri önlemek için işe alım prosedürleri kanunla düzenlenmelidir. Adaletsizlik oluşmaması için liyakat ve eşitlik sağlanmalıdır. Ayrıca politika yapıcılar, göreli yoksunluğun sonuçlarını dikkate almalı ve liyakatsiz işe alım yapan görevlilere yaptırım uygulayacak düzenlemeler yapmalıdır. Daha şeffaf işe alım süreçleri ile adaletsizlik algısı azaltılabilir. Ayrıca algılanan kıtlık, göreli yoksunluğu arttırabilir (Richardson, 2011). Yüksek eğitimli bireylere yönelik iş olanaklarının çeşitliliğini ve sayısını artırmaya devlet tarafından öncelik verilmelidir.

İşsiz bireylerin içsel kontrol odağı geliştirmelerine yönelik ücretsiz psikoterapi seansları düzenlenebilir. Klinik psikologlar terapilerini iyimserlik ve algılanan sosyal destekle ilgili bulguları dikkate alarak yürütebilirler. Rife (1995), en olumlu sosyal desteğin işsiz arkadaşlardan algılandığını bulmuştur. İşsizlerin birbirleriyle sosyal faaliyetlerde bulunup sosyal ağlarını geliştirebilecekleri erişilebilir ortamlar sağlanabilir.

Bulgular, işsizliğin yarattığı zorlukları azaltacak umut verici çıkarımlara sahiptir. Ayrıca, yukarıda bahsedilen uygulamalar Türkiye'nin ciddi sorunlarından biri olan beyin göçü (Karataş ve Ayyıldız, 2021) oranlarını azaltmaya yardımcı olabilir.

3.3.7. Çalışmanın Güçlü Yönleri

Bu çalışma, işsiz bir örneklemde göreli yoksunluk ile sağlık arasındaki ilişkiyi araştıran ilk çalışmadır. Literatürde bu ilişkide kontrol odağının veya işsizlik süresinin

aracılık rolünün incelendiği herhangi bir çalışmaya rastlanmamışken, iyimserlik ve algılanan sosyal desteğin koruyucu rolleri ilk kez test edilmiştir. Bu nedenlerle, ilgili literatüre benzersiz bir katkı sağlanmıştır.

Bu çalışma, işsizlerin sağlık durumlarını öngören faktörleri ortaya koyarak önemli sorunlara ışık tutmuştur. Bu çalışmanın sonuçları ülkemizde artan genç nüfusun karşılaştığı mücadeleyi ortaya koymaktadır.

En dikkat çekici sonuçlardan biri, göreli yoksunluğun işsizlerin sağlıklarını olumsuz yönde etkilemesidir. Ayrıca, dış kontrol odağının ve işsizlik süresinin sağlık üzerindeki etkisine ilişkin bulgular ilham vericidir. Moderasyon analizleri anlamlı olmamasına rağmen iyimserlik ve algılanan sosyal desteğin etkilerini sunarak işsizlik literatürüne önemli bir katkı sağlanmıştır.

Türkiye'de 2020 yılında Gini katsayısı .41 bulunmuştur ve bu değer gelir dağılımındaki eşitsizliği ve yüksek göreli yoksunluğu göstermektedir (TÜİK, 2021; Yitzhaki, 1979). Bu çalışma, göreli yoksunluğun en belirgin şekilde görüldüğü ülkelerden biri olan Türkiye'de yapılmış olması nedeniyle büyük önem taşımaktadır.

Örneklem büyüklüğü ve verilerin Türkiye'nin birçok şehrinden toplanması çalışmanın temsil gücünü arttırmaktadır. Bulgular kritik sorunlara işaret etmiş ve Türkiye'deki sosyo-politik düzenlemeleri etkileyebilecek önemli çıkarımlar sunmuştur.

3.3.8. Çalışmanın Sınırlılıkları ve Gelecek Araştırmalar için Öneriler

Çalışmanın güçlü yönleri olduğu gibi dikkate alınması gereken eksiklikleri de vardır. Örneklem mezun olunan bölüm ve üniversite açısından homojen değildir. Bu faktör kişilerin işe alınma ihtimallerinde fark yaratmış olabileceğinden sonuçları etkileyebilir. Ayrıca Sümer, Solak ve Harma (2012), algılanan gelecekteki istihdam edilebilirlik seviyesinin işsizlerin refahı üzerinde etkisi olduğunu savunmuşlardır. Gelecekteki çalışmalar örneklem varyasyonunu ve algılanan istihdam edilebilirlik düzeyini dikkate almalıdır.

İşsizlik süresinin etkisini incelemek için kesitselden ziyade boylamsal çalışmalarla hipotezler test edilebilir. Sosyal istenirlik gibi kaygılar ve çevrim içi çalışmalardaki yüksek bırakma oranları (Hoerger, 2010) göz önüne alındığında, sonraki çalışmalar

laboratuvar ortamlarında yürütülüp daha güvenilir ve genellenebilir bulgular elde edilebilir.

COVID-19 salgını işsizliği artırmış ve sağlık sonuçlarına yansımış olabileceğinden bulguları etkilemiş olabilir. Bu nedenle, pandeminin etkileri azaldıktan sonra bu çalışmanın bir tekrarı yapılmalıdır.

Gelecekteki araştırmalar, mevcut çalışmanın sınırlılıklarını dikkate almalıdır. Sunulan ilişkilerin çoğu bu çalışmada ilk kez test edilse de gelecekteki araştırmalar için bir çerçeve oluşturmuştur.

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