REPRODUCTION OF THE SOCIALITY OF YOUNG MIDDLE CLASS MEN AND WOMEN IN
THERAPIST-CLIENT RELATIONSHIP IN TURKEY

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ABSTRACT

REPRODUCTION OF THE SOCIALITY OF YOUNG MIDDLE CLASS MEN
AND WOMEN IN THERAPIST-CLIENT RELATIONSHIP IN TURKEY

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Therapeutic practice became popular in the last 20 years especially among younger
generations in Turkey. While concept of "therapy culture" was at the forefront of
the analyses, sociality of the direct relationship between therapist and client was
understudied in sociological literature. Based on in-depth interviews with four
therapists and nine young therapy clients, this study aims to understand how
therapeutic practice and the social is entrenched within their dyadic relationship.
By taking therapeutic experience of mostly white-collar clients between age of 23
and 35, the study asks how sociality of young middle class men and women, in
Turkey, is reproduced in therapy. The study shows that therapeutic practice has
three main functions that can be distinguished based on the legitimacy of the pain
that clients endure. In the case of young middle classes, the function of providing
support for the "weak" and "unfit" come to the fore while therapists and clients
construct the clinic as a safe zone in which clients can express their vulnerability.
Sociality of the clients become visible in recognition of oppressors within the
social surrounding of client and therapists' attentiveness to resources available to
client before and during the process. This sociality helps to form a partnership

between therapist and client, while another facilitating factor is similarity of their class backgrounds. Consequently, this partnership provide the main reference for the self-comfort that client would like to develop outside the clinic. Furthermore, referred vulnerabilities within this zone are experienced differently along the lines of gender.

Keywords: Therapist-client relationship, sociality, dyad, gender, middle class

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ÖZ

TÜRKİYE'DE TERAPİST-DANIŞAN İLİŞKİSİNDE ORTA SINIF GENÇ KADIN VE ERKEKLERİN SOSYALLİĞİNİN YENİDEN ÜRETİMİ

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Yüksek Lisans, Sosyoloji Bölümü

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Terapi uygulamaları Türkiye'de son 20 yılda özellikle genç kuşaklar arasında popüler hale gelmiştir. "Terapi kültürü" kavramı bugüne kadarki analizlerin çıkış noktasını oluşturan temel kavramken, terapist ile danışan arasındaki birebir ilişkinin toplumsallığı sosyolojik literatürde az çalışılmış bir konudur. Dört terapist ve dokuz genç danışan ile yapılan derinlemesine görüşmelere dayanan bu çalışma terapist ile danışan arasındaki ikili (dyadic) ilişkinin nasıl toplumsal hale geldiğini anlamayı hedeflemiştir. 23-35 yaşları arasında çoğunlukla beyaz yakalı olan danışanların terapi deneyimlerine dayanarak bu çalışma genç orta sınıf kadın ve erkeklerin sosyalliğinin terapi içerisinde nasıl yeniden üretildiği incelemektedir. Bu araştırmanın temel bulgusu terapinin, danışanın duygularının meşruiyeti üzerinden ayrışan, üç ana işlevi olduğudur. Orta sınıf gençler örneğinde, terapinin topluma uymayan ve duygusal olarak zayıf durumdakiler için destek sağlama işlevi ön plana çıkarken, hem danışanlar hem de terapistler terapi kliniğini danışanın zayıflıklarını rahatlıkla ifade edebileceği bir güvenli bölge olarak tahayyül etmektedir. Danışanın sosyalliği danışanın üzerinde baskı oluşturan etkenlerin fark edilmesi ve terapi öncesinde ve terapi sürecinde danışanın çevresinde bulunan kaynakların terapist tarafından dikkate alınmasıyla ortaya çıkmaktadır. Bu sosyallik temelinde terapist

ile danışan arasında bir ittifak kurulmaktadır. Bu ittifakın kolaylaştırıcı boyutlarından biri de terapist ve danışan arasındaki sınıfsal benzerliktir. Sonuç olarak, bu ittifak danışanın terapi sürecinde geliştirmek istediği sosyal çevresine olan uyumluluğunun ve rahatlığının referans noktasını oluşturmaktadır. Danışanın terapi kliniği içerisinde ifade ettiği tercih edilmiş zayıflıkları da toplumsal cinsiyet noktasında farklılaşmaktadır.

Anahtar Kelimeler: Terapist-danışan ilişkisi, sosyallik, ikili grup (dyad), toplumsal cinsiyet, orta sınıf

ACKNOWLEDGMENTS

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CHAPTER 1

INTRODUCTION

For some time now I hear from a lot of people whom I have chatted with, several young people in my entourage that they have been undergoing psychotherapy or they have already done in the recent past. Most of them claimed to have been through in mental breakdown, in a state of psychological crisis or simply in depression. As someone who spent a lot of time visiting psychiatry clinics, took anti-depressants and other medications since my early youth, my first reaction was very sympathetic of them. After all, I got into this career early and psychotic drugs were part of my life for a long time. I also have to tell that when I started studying on this topic I was also undergoing psychotherapy in a private institution for one and a half year. By the way of talking about these past memories, trying to name them in my long visits to the therapist, and outside the room forcing myself to think on what was going on in the clinic, by a lot of inside questioning, heavy research on the subject and reading a lot of books; therapeutic practice began to occupy an important part of my life. Therapy for me, hence, is a heavily personal matter. Yet, since the beginning of this journey I could also tell that this was not just a personal matter but was related to a web of social relationships, which include not only moral formations, social ties etc., and hence was itself social. These are the reasons that I jumped into this topic in the instant my advisor proposed it. As I read through the literature, I have also realized that there are poignant signs which show us that therapy is a widely acknowledged, popular phenomenon so that some scholars call it an ethos, or even a culture that does not only permeate psychology clinics but one which encompasses them and spans the social sphere entirely, including rational framework of political authorities or even our daily conversations.

My personal experience, in this picture, is just one side of the coin. As I stated, I began to hear from more and more people stories of how they find themselves in therapy room. Most of them were young women that are close to my age. Some of these women were well-educated people who try to stand on their own feet; some were already advanced in their careers and were real exemplaries of a success story. I have to note that a number of young men like myself, although not many, also were committing their effort to go see a psychologist. Furthermore, engagement with therapy for this generation was seen in a different light from earlier ones. From my anecdotal observations, I would say that just about 20 years a go, it was not easy for a majority of people in Turkey to claim in such a comfort that they have been seen a psychologist or psychiatrist. On the contrary, general reaction to people associated with mental clinics would be fear and contempt. Psychotherapy overall was not a popular practice and was associated with being psychotic or mentally ill.

While deliberating on my past, I also came to see that my story has a lot owing to the middle class culture of masculinity and the burden of social mobility. The way I struggled with the emotional damage of this past has had a decisive role in my life course. Similarly, I observed how gendered identities, ideals of feminine and masculine sentiments and hidden injuries and burdens of class (Sennett & Cobb, 1993) affect people around me, in their reasoning of going to see a therapist, the meaning and value they attached to the therapy and their approach to therapist-client relationship as a whole. This has led me to think that therapy is an arena where affects and moral sentiments are felt and lived out crosscutting social relations. Both people's willingness to go to the therapist and what they do in the process lead one to question how patterns of these stories relates to the social mechanisms. I came to see that therapy, in this sense, is an affective technology as the clients use it, and promotes social negotiations and pose challenges outside the clinic. Hence the process includes in itself dynamics of the social, especially social reproduction.

Another important factor of motivation for me was the sociological body of work that focuses on the psychosocial aspects of social relations of gender and class, especially studies of feminist sociologists like Adkins and Skeggs (2005) on affective dimensions and place of self-construction in social divisions along with Sayer's (2005) work on the role of emotions in the social reproduction and moral significance of these socially constituted emotions. While economic and cultural aspects of social divisions were at the center of discussion for a long time, these researchers took attention to affective dimension of the sociality, which inspired me to think about my therapeutic relationship and therapy in general in that light. I started to think that therapy is not just a psychological tool but can also be objected to sociological inquiry. Consequently, I designed the research and locate myself in the debate based on this premise.

My aim in this study, hence, is to understand and describe what role "the social" play in the private relationship between therapist and client, a practice common to many young middle class men and women who live in dense feelings such that they problematize themselves or their lives, people who try to find a way to dealing with what they feel as pressing and eager to articulate these emotions in a certain fashion.

1.1. Research Question

With that purpose, the main questions that my research attempts to deal can be described as follows: How is the sociality of middle class young men and women reproduced and/or reconstructed through the safe zone of the therapy-client relationship in Turkey?

For the purposes of this study, I take the client-therapist relation (or dyad) as a proxy for tools of clinical psychology. Although this question is wide and hard to deal with itself, it has two parts and it signals to a two-way relation. As I explain in

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later parts, this choice has both theoretical and methodological implications and brings detailed sub-questions. I am attaining to bypass some of those in literature review and the parts where I lay my assumptions. First part concerns therapists and the way they become a part of the therapeutic relationship. To locate better sociality of the therapist within its context, I first ask the question of:

1) How is the field of psychotherapy socially constructed and performed by psychotherapists?

Then, the focus comes to the actual process of sociation and social reproduction within the therapeutic process. In this regard, the study turn to the question of:

2) From therapists' perspective, which dynamics are shaping the sociality before, during and after therapy process?

As it is the case with therapists, clients' position within the relationship and how their - aged, classed and gendered- sociality come into play before, during and after the therapy process makes it necessary to ask similar questions for the second agent within the triad. Here, questions that I asked and answered are as follows:

1) How is therapy process socially constructed and performed by the clients?
2) What role sociality plays in client's decision to come to therapy, working of the process and reconstruction of client's selves during and after therapy?

Consequently, by bringing together therapist, client and the social within a triad, I provide a sociological analysis of the therapeutic relationship.

1.2. Assumptions

This thesis focuses on therapist-client relationship and an important challenge is to decide its limits. For the purposes of the study, I make a distinction between patients who are seeing treatment in a mental institution or under close surveillance of the doctors- generally labeled as "mental patients"— and people who decide to take therapy with their own decision— which was historically named as clients. While it is evident that the frontiers between two subsets are not clear-cut and transitions are possible, being a patient and a client are significantly socially different. Health professionals are more and more willing to accept former mental patients as health users (Crossley, 2001) while it is still possible to undergo treatment as a "patient" of the older paradigm. In this study, I am not paying specific care to the special circumstances of psychiatric treatment, as they require a wider and more different approach to the relations of power and discursive formations within. Hence what I take as therapy is a long-term relationship between people who willingly applied a clinic/ agreed its terms, and therapists with psychiatric or psychological expertise.

Second main problematic is about understanding therapy and its rising popularity while tracing the historical formations of being a therapy client in Turkey. It can be said that therapy is a new tool, an affective technology, in the negotiation of – gendered, raced, classed etc.- selves and its rising popularity has its debts to the efforts of both feminist and anti-psychiatry movements that came into play in the West. While women's demands were effective in the process of unbinding essentialist associations of hysteria and womanhood (Wright, 2008); fear and moral panic about mental troubles seem to be lessened in a similar fashion. These however do not point to a historical rupture. Conception of women and children as psychologically weak, for example, is still in vernacular. Similarly, being psychotically ill and seeing a therapist, are now discursively decoupled while the

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former can still be marginalized. On the other hand though, having ADHD or being coffee addict- both classified as mental diseases by DSM (The Diagnostic and Statistical Manual for Mental Disorders)- can even be considered as signals of following the "fashion". Analysis of similar historical changes in Turkey, however, necessitates an inquiry larger in scope than a master's thesis. In this study, drawing evidence from my anecdotal observations, I assume that a process of detachment has been recently happening in Turkey such that therapy became socially more acceptable and its mental illness connotations has weakened. Consequently, I delve directly into the discussion of what this new tool mean for people and how it encapsulates the social.

Since techniques introduced by psychology intersect with class and gender-making practices, I have to address that debate. Academic works on therapy are mostly blind to different dimensions of social divisions regarding gender and class along with their economic, cultural and symbolic dimensions. The fact that value and meaning of therapy can be different for the different members of the strata has had only limited attention. Middle and upper classes, for instance, have expectations like "not giving cheesy self-development advice" from their therapist showing cultural and symbolic significance of the process, while undergoing psychotherapy require an important amount of monetary and temporal investment and hence is inaccessible for lower classes except a marginalized outcast classified as psychotic patients by the state. On the other hand, television shows featuring psychologists or narrating self-development and recovery stories are widely popular and accessible to everyone; although they are generally associated with lower strata and working class. Eventually acknowledging the presence of the distinction within users of therapy is necessary. In this study, I assume a long-term therapeutic relation with a psychologist is a distinct and socially significant process that brings with itself a certain social type, especially women from middle-upper classes, and take this private relationship as the focus. Hence this thesis does not go into detail on what may be called as self-help or self-development media and literature, which were

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studied by many as part of a wider notion of popular culture.

1.3. Arguments

First and foremost, this thesis argues that therapy became an acceptable psychological device especially for certain part of the population, younger generation of men and women.

Secondly, the thesis asserts that therapy cannot just be seen as an individualistic endeavor- as it was mostly claimed from a white, middle/upper class and old male perspective- by attempting to decouple narratives that take individual as the basis, which is used as a social strategy, from the individualism as a structural characteristic that permeates the popular culture. I believe understanding the role of being able to narrate the self in therapeutic engagements also gives us a better sense about the location of the idea of individualistic self in the social sphere.

Following this, the thesis argues that therapeutic relationship in the form it became popular in Turkey, is not informed as an ethos by dividing relations of the social sphere, which makes it merely as a middle class tool for agents that are socially dispositioned with a certain self-value on which it is possible to invest and develop. Yet, these people come to therapy with a certain gender sensitivity evidenced by therapy's codification as a supporting and caring mechanism and also the percentage of women among therapy's practitioners and clients, and through performance of narrating their pain clients become able to gain moral authority over the matters that render them passive and faulty in the first place. Along with young middle class women, middle class men who feel themselves unable in a receiving end of a relationship of love and caring becomes therapy's users and create value out of the process by having the virtue of proper person of value.

In that sense, I suggest that sociality of the therapeutic practice matter not just because it reveals the role of dividing relations; of gender, race, class etc.; within the social sphere but because therapeutic relationship present itself as a way to furnish oneself with affective means that matter to people crosscutting social divisions. This happens because therapy makes sense both for young middle class women who suffered from oppression and finds herself in a passive social position as well as for men from similar backgrounds who have had trouble in engaging with their emotive self- which was not codified as a concern until recently. Hence therapeutic relationship acts a safe zone, which provides opportunity for middle class young men and women to reconstruct their selves, and adjust their social positions by making use of resources available within in their sociality.

Based on the arguments in the thesis one can also suggest determinant of the power relations within the therapy has not only its basis in the techniques used by therapists but also in the sociality of both clients and therapists, since therapy matters to both as strategic tool.

1.4. Significance of the Study

Although this research stems primarily from personal motivations, it grapples with important problems in the literature on both fronts regarding the social, and the therapy. There are three main discussions that my thesis engages with and how it attempts to contribute to them.

First problem regards to voice and the experience of the people who were part of a therapy process. Conceptualizations of therapy as a culture play down different interpretations of therapy by clients and its value within their life course. Researchers were quick to relate question of social ties and divisions of individual/ communitarian values to therapy and were successful in accounting for the moral implications of therapeutic ethos at large. There are also a number of works that

considers therapy's position within formations of dominance and inequality. Yet neither those nor the studies focusing on the social ties included ethnographic insights or patient's interpretations and positions. Therapist's evaluations about their own expertise are also largely absent from the literature. This study adds to the literature an interpretation and analysis of subjective experiences of the people undergoing therapy and therapists.

Secondly, studies of therapy are also to a large extent absent from the inquiries on social reproduction. While it was acknowledged that affections are an important aspect of social divisions (Adkins & Skeggs, 2005), a significant technology of affect and an arena of self construction- namely therapy- have taken only considerable attention. I also claim to serve to the purpose of bridging this gap.

Last but not the least, my work also seeks to contribute to the Turkish literature on psychosocial aspects of social divisions and on location of therapy within the social sphere. Both former (Mercan, 2018) and the latter had gathered little attention from academics. It is possible to see, when one makes a quick review of the literature, that therapy in Turkey is studied solely from psychological perspective and there are only a few sociological studies on the subject. While a number of cultural analysis inspired by Freud's concepts and psychoanalytic tradition found audience in circles of Turkish social science, therapy as a separate object of study do not have a place in that literature. This work aims to make a significant contribution to the literature by taking therapy and therapist-client relationship as an arena where the social is played out and strategies within the social are developed within the process. The thesis, hence, initializes new debates by making a relational sociological analysis of therapy in Turkey for the first time.

1.5. Theoretical Approach

There are two possible angles to theoretically approach the research problem at hand. First one is take therapeutic culture as the point of departure and design the study to make a thorough analysis on the social sphere within which the ethos is located in Turkish culture and to assess how therapy relates to cultural aspects of social relations as it was done in the literature. Second one is to take the theoretical focus as the sociality and to assess how different aspects within the process of social reproduction- be it economic, cultural or symbolic- become manifest – through affects, resources, values— via the safe zone provided by therapy.

This study adopts both positions alternatively and tries to take into account both theoretical perspectives. Yet, it nevertheless gives weight to second position and take the sociological framework that were developed by Simmel who used concepts like dyad and triad and developed certain social types to understand social formations within the relationships that takes place in the everyday. Simmel sees the process of sociation as constitutive of these formations, like triads, while these concepts go beyond to reveal the reproduction of sociality of the aforementioned types.

Based on their conceptualizations, I believe therapy can be seen in a constitutive relation with sociality; as clients' motivations and self-cognitions in the process are constructed from a social position. Hence, therapy's analysis may provide significant and important contributions to the study of the sociality for a certain group of population, young middle class men and women in our case. Furthermore, analyzing therapy from that lens is important because taking therapeutic culture as a place of manifestation for social relations reveals gendered and classed nature of therapy.

Accordingly, in the second chapter, I open up the premises of this theoretical perspective and lay out the conceptual toolbox that were used in this study.

1.6 Research Design

To answer my research questions, I needed to take a snapshot of changing value of therapeutic practice and dynamics of therapist-client relationship in a grand scheme of social relations. To serve this end, I designed an ethnographic study comprising in-depth interviews to collect the necessary data, which I analyzed and interpret qualitatively to understand how young, middle class male and female clients understand therapy, how they value it and locate it in their life course and social environment, and in which social surroundings other than the therapy clinic their process of feeling and narrating the emotions makes sense.

As it is the case with clients, I also asked therapists from different schools of clinical psychology about the rising popularity of therapy. After that, to reveal therapists' take on social forces active in the therapeutic relationship, I inquired experts on their classification and assessment of the clients before, during and after the process to see how people's social backgrounds, including different aspects like the symbolic, economic etc., could be effective.

The chosen methods, I assert, were best suited to bring together individual and social implications of therapy relationship. Accordingly, I prepared two interview questionnaires in compliance with my conceptualization and made some additional changes after pilot interviews to better able to capture sense and meaning created by participants. After preparing the final version of the question sheet, I took the ethical permission from the Middle East Technical University Human Subjects Ethics Committee (Appendix- A) to collect data between the dates May 20th 2019 and July 30th 2019. I mainly reached people from two biggest cities of Turkey, Ankara and İstanbul, and applied convenience sampling to reach interviewees.

Nine clients and four therapists were interviewed in total.

Finally, after the data collection process, a theoretically informed coding was used to analyze and group recurring patterns and emerging dynamics within this snapshot.

1.7 Limitations of the Study

There are some limitations to name in this study. First of all, therapeutic process is a delicate subject to conduct an interview on. Remembering about past troubles may have created a situation where participants felt shame or was reserved limiting the details about their story and their description of sentiments of the therapy process.

Nearly all of the participants had similar social and economic backgrounds to my own- they were middle class young people with a higher education degree. Furthermore, they were mostly living in big cities throughout their lives. In smaller cities and the countryside, conservatism may be stronger and this introduces whole new dynamics into psychotherapy. Patriarchy, with its more traditional formations, could also be felt stronger in those places. Thus, my study does not encapsulate therapeutic relationships that can be found in a rural setting. Also there is a group of young people— which goes to therapy— disposing a capital much larger in its economic dimension comparing to cultural one of which I was not able to capture the motivations.

Number of the therapists interviewed in this study is four, which may pose a limitation to my analysis, as the amount of the collected data is not quite plenty. Yet, since the data— coming from every expert— were intersecting at many points, this is not a significant limitation. Gender of therapists however might be considered as a bias, since all of the expert interviewees were women and they

happened to see mostly women clients.

Finally, as I only include in the thesis therapist-client relationship, I left out of the scope the people who never thought of going to a therapist, people who would like to go but did not until now and people who applied to other psychological tools. Considering these factors and the number of participants, representative power of the thesis is quite low.

1.8. Structure of the Study

In the literature section, I first introduce the concepts that were used in this study, like sociality, dyad and triad, and social reproduction to provide the reader with the framework on which my analysis is based on. Then, I lay out the sociological literature that aim to critique the place of therapy in American popular culture and show the ways in which therapy is entrenched with issue of morality in that body of work. In that part of the review, I take reader's attention to rise of the therapeutic ethos and how therapy has come to be seen as a culture. Lastly, critiques of psychiatric treatment, which can be seen as the precursor of the psychotherapy, and the ways in which therapy was conceptualized as an ideology within industrial capitalism, are other subjects of the section that deserve to be mentioned. In the last part, I talk about how therapeutic culture crosscuts relations of gender, class and race as factors that shape sociality of the client, and delve into the evidence provided by recent scholarship, which shows the ways therapy was adopted by different groups of audiences and its radical applications. In this part of the review, especially debates about the relationship between therapy and feminist movement, division of public/private spheres in therapy etc. are debated in more detail.

Third chapter focuses on the methodology of the study, specifically to the issues that I have faced and problems I had to o deal in the fieldwork. After laying out the methodological structure and connection of theoretical framework of the study to

two questionnaires I prepared, I provide a detailed story of the field to give the reader a better sense of the role participants played and how different pieces of data came together to make this work possible.

Fourth chapter lays out the findings that came out of the fieldwork and their analysis. As promised, I focus on how therapists socially construct the therapeutic ethos within the context of their relationship to the client. To understand this construction, the professional field within which therapists are located and how this relationship is positioned vis-à-vis therapeutic culture at large are also laid out. After that, evidence regarding therapist's conceptions about what makes therapeutic relationship and how it becomes a necessity in the first place are analyzed.

Second part of the fourth chapter comprises factors shaping client's sociality both from therapist's eyes and within the client's stories. First, I show the assumptions of therapist and then premises that bring clients therapy in the first place along with what resources and challenges surrounds clients and through what kind of dispositions. Finally, client's struggle to create value out of therapy and what this value means for their life stories as it was haunted by social pressures was demonstrated. This process, with the use of resources that take place within, constitutes the social within the triadic relationship.

In the conclusion, I discuss how findings of the study relate to literature and to major disputes in the field and lay out the contributions of my research to these social debates. I, then, finally turn to the question of how further studies would help to open up the discussion.

CHAPTER 2

LITERATURE REVIEW ON SOCIALITY AND THERAPY CULTURE

This literature review does both things together as it first tries to open up the conceptual toolbox used in this study and then later delves into further debates on how to understand therapy from a sociological standpoint.

The first difficulty to face when studying therapy from sociological perspective is messiness of the literature, through which one infers that there is no agreed upon definition of therapy or what constitutes "the therapeutic culture". Works on therapy, outside psychological literature, seem at first both few in number and narrow in depth in the sense that only recently studies seem to converse with each other. I believe the first reason for this is the fact that therapy means different things in different parts of the world. In U.S. and Western Europe therapy and therapeutic institutions are established for a long time and therapeutic culture as understood by critics seems to be an integral part of the American mass media and consumerist culture. Surely, therapy took more and earlier attention in these places. Rising popularity of the American culture in Turkey helped some of these critiques to arouse interest— although limited— among psychologists and cultural analysts inspired by Freud's concepts throughout 1990's, while we started to observe institutionalization and wider popularization of the therapy only recently, in the last two decades.

Second complication stems from therapy's position in that literature. While therapy is of interest, and meaning of therapeutic process matter within certain social arrangements; therapy's implications were narrowed down for the study of individualism and consumerism. Until recently, studying therapy made sense only

for cultural studies, which aimed to criticize these two models as integral parts of capitalism. Therapeutic culture in this sense was seen as a separate entity rather than being considered as having relation to issues and mechanisms wider in scope for studying the social. In this literature review, under the theoretical framework section, I try to open up space for such an analysis by showing the way construction of the therapeutic ethos can relate to the processes of sociation.

Psychiatric intervention, on the other hand, ignited major debates among social thinkers throughout the world. Researchers focused on the relations of power within which being a mental patient is located including doctor-patient relationship along with labeling and marginalization of the "ill". However, this body of literature did not give special praise to psychology and counseling, although it inspired later studies that focus on these properly.

In my review, I start with presenting the concepts that I adopt throughout the study and their relevance for analyzing therapeutic relationship. Then, a short summary of the cultural critique of therapy is presented including therapy's conceptualization as ideology. The debate on therapy's discursive power and significance of the historical moment that distinguished psychological counseling and therapy from psychiatric intervention comes next.

The review, then, focuses on studies that locate therapeutic space within the wider social sphere and discusses the factors that shape client's sociality in the process. In that part, the body of research that focus on radical therapeutic techniques also come to the fore. Furthermore, especially recent works on therapy that brought new insights to the debate were discussed. As such, I also try to reveal how changes in the conceptualization of therapy relate to this thesis. Finally in the last section of the review, the literature on the relation between gender and therapy was laid out.

2.1. Reproduction of the Sociality in Therapeutic Relationship: A Theoretical Framework

The thesis aimed to understand reproduction of the sociality of young middle class men and women in therapeutic relationship within the context of Turkey and to do it, asked the question of how in the dyadic relationship of therapist and client, the social -in the form of social pressure- enters the picture. As I discuss in the next section, although it seemed to connect the therapeutic ethos to the social formations within the global west, the concept of therapy culture locates therapy within a conception of culture spanning the masses; including in itself cultural currents like consumerism, individualism etc., and hence offers a wider perspective on its dynamics. To understand what this specific relationship socially mean, one has to place it within its specific context and pay special attention to what were neglected by this literature, like how therapist, client and the social are interrelated in the therapy process and beyond it. That is the reason that the main reference point in the thesis, in claiming this relationship as a dyad and revealing its sociality, is sociology of Georg Simmel along with his conceptualizations of dyad, triad and his social types. Simmel's understanding of sociality and sociation also resonates with relational understanding of the term in the works of Levinas (1993), Heidegger (2008) and Bauman (2009).

Hence; while it is based on specific definitions of the term developed in the literature, what I call "sociality" in this thesis has a specific sociological meaning. It signals to the set of social actions and inter-actions that produces certain social types. To understand our type, client, and her sociality the process of sociation, the concepts of dyad and triad and social reproduction in the triadic form has to be explained. For Simmel (1971), society is the process of sociation, which happens constantly in everyday interaction, as people are affecting and being affected within the their surroundings. According to this understanding, the social becomes a matter of scale in the sense when one looks too close to a fragment, individual comes to the fore and the social is not the object of the research, while enlarging

the focus makes the society visible. What makes the mediation between these two scales is, then, the sociation. That is why to understand the therapeutic relationship in a larger context of social forces, including global trend of consumerist culture or socioeconomic relations that took place within the country; one cannot conceive it only as a dyadic relation between therapist and client but has to include in the picture the social as the mediator.

Simmel suggests that a dyadic relation comprises the lowest possible number of two people to be maintained, as common sense also points out that the minimum number of two is the number in which a secret does no longer belong to only one side but also the highest possible number in which keeping that secret is possible. While for someone from outside, a dyadic relation may seem like functioning as independent and above the level of individuals that make it, the case is different for the participants. Rather, two sides feels like opposed directly by the other. The structure of the relation depends on the immediate presence of the other as if one ceases to exist it would end the dyad. That is the reason Simmel names it as a relationship, while he choses another word similar to interaction (die Wechselwirkung) when he talks about the social (Simmel, 1965).

Interaction, hence, makes the basis of the sociality of not only individuals in a dyad but also wider groups, communities, nations etc.; and reproduction of the social structure and autonomous collectives that are found in society happen only through interaction. Eventually; the smallest group that shows the emergence of the social, must comprise at least three elements and hence is called a triad.

The third party, in that picture, adds a new aspect to the relationship between the two and makes publicness possible and a new supra-personal level appears. In the case of family for instance, the romantic relationship between two people gains a social dimension when the concept of family enters and the process of marriage play out. After that point, a number of third parties from lawmakers to the people who support the wedding arrangements appear. Hence, dyadic models cannot

provide the basis for constructing the social as efficiently as triadic ones, which include the factors that make a partnership between the two possible.

While dyads have their own specific characteristics, inclusion of a third person totally changes that structure. Addition of a third element modifies the relation between the two such that their relationship has to now refer to it and to the new relationships that was formed with it. Internal cohesion of two, or any group including members more than two, is based on their attitude towards the third party. Mostly, this third element denotes a common enemy, a threat for their former relation, which brings the two closer. The relation between two becomes public within the triad and is now much more stable than the dyadic form (Simmel, 1965). In the case of therapy for instance, the common enemy can be someone from the client's past or someone who is actually present in his/her life while together with therapist, they explore what that person means for the client and form a partnership based on an agreement of this meaning. Dyadic relation between the client and therapist in this picture can still stay as subject of psychology, while triad includes the social. It is, thus, makes sense for our study of the relationship between client and therapist to make use of the triad as promised.

In order to do that, one can make use of the social types Simmel has used in his attempt to understand the fabric of the society at this larger level. Simmel developed a number of social types, such as the stranger, the mediator, and the poor etc. to conceive the structures that make up the society. Those types are social type due to the fact that in their relationship to others, they are located within a particular position and expected to behave accordingly. Special characteristic of these types, hence, stem from their specific social location. For instance, in Simmel's understanding (1965), stranger is someone who comes today and remains tomorrow. When defined as such, stranger gains a particular status within the community she enters meaning that her social location is assigned based on fact that she is not member of the group at the start. The place of stranger vis-à-vis the group she enters, hence, is formative of the interaction that takes place.

This relational understanding of the social can be used in imagining positions of the therapist and client and understanding the reproduction of the sociality of the client throughout the interaction that takes place before, during and after the process. As the position of the stranger is already formed even before she enters the group, positions of therapist and client are relationally defined at every stage. To think of therapist and client as a social types and a party to the aforementioned triadic relationship, one has to look at their social location vis-à-vis the other.

Consequently, one reaches an understanding of a triadic relationship that is based, first, on the prior social construction of the process within the sociality of the two types, then the sociation defined as the performances of the two in the clinic and the relation of this process to the factors that constitutes these types. First, mapping the characteristics of the practice of psychotherapy, as a professional field, is required to understand therapist's position in making the triad. Similarly; to see how client becomes a social type, client's reasons to come to therapy, namely how client constructs her life course before and during the process, is necessary. Client's conception of self and construction of life course are equivalents of what the structure of professional field is for the therapist. To look at the personal experience of both parties in the therapy room and hear about how they assess each other, by questioning difficulties and joys of the process and how they achieved a fit etc., can be the second step. Lastly, the actual process of finding specific cures for the client, in other words, what makes this relationship therapeutic has to be questioned. As these factors are inserted in the picture, the partnership between the two that reproduces sociality of clients becomes visible.

Before delving into the methodological implications of the framework presented in this section, I lay out what insights the literature on the analysis of the therapeutic process as a social construction offers. While these works provide some idea for understanding the sociality of the client they nevertheless treat therapy solely as a

symbolic construction. Yet, there are still illuminating points to pull off from this body of work. Next, regarding the factors shaping the sociality of the clients, I turn to studies that tried to locate therapeutic relationship within different social contexts in which classed, raced and gendered formations of the therapy come to fore.

One has to also look what sociality has meant for different scholars before going further into literature. The concept especially became prevalent among anthropologists in the 90's and gained popularity because it corresponded to a processual understanding of reality in the sense that processes that makes the social are formative of social structures. Rather than using static concepts of society and social rations or alternatively relying on the idea of social interaction which tend to treat the social as the product of the inter-action between the agents that preceded it. Simmel's understanding of sociation (1971) refers to the sociality in the same sense that the processes are formative of the social.

While different understandings about the term are in vernacular; philosophers, after Simmel, referred to the concept and revealed its usefulness to understand society. To start with, Levinas believed that sociality is a characteristic of the action as it is directed to a certain other. He uses the concept of self and asserts that "I" is located within a world of social economy through which autonomy of the person becomes possible when certain limitations are enforced on that self (Levinas 1993). Heideger (2008) also claimed that this type of sociality is a fundamental property of the social agency as he uses "being-with" to describe (being and time) it from a more holistic perspective.

Bauman, on the other hand, focuses on a more flexible community based concept when talking about the sociality, while Wittel's (2001) understanding of network-based sociality contrasted his position on the basis that people become social beings in an open structure of network connectivity rather than within the close formation of a community. Lastly, Bakthin referred to the concept as well by using

the notion of dialogical self to capture the transactual nature of sociality, yet he only put it to a phenomenological perspective (Cresswell and Baerveldt; 2001).

In all of the philosophical and sociological accounts, the concept was used as an umbrella term, which requires looking at certain social formations in understanding the social. The concept, hence, necessitates passing beyond a static concept of community and moving to a definition of the social based on shared beliefs, actions etc. As Bookman (2014) shows, social imaginaries including narratives about self and emancipation, for instance, are places that one can look if one attempts to understand it. Studies on formation of memory, especially collective memory, for instance also proved that when understood from a transactional perspective, memory and its historicity could be useful sub-concepts within the broader understanding of relationality and sociality.

The term enjoyed some popularity among psychologists although therapeutic frameworks do not refer to the concept. While constructivist approaches within the psychology, although seldom, talks about a processual understanding of sociality in the sense it was understood by sociologist and anthropologists, the term has its own place in social psychology and studies of the ethology and used to denote the relationship of people or animals to their social surrounding in that literature. While within the therapeutic context, be it psychological or sociological, the concept is rarely used; the study done by Duncan (2017), uses the concept of "psy-sociality" to refer to the type of sociality that is developed based on psychological concepts and practices of self-formation and self-work, and then shows how it is related to people's prior sociality in the context of therapeutic engagement of family constellations in Oxaca, which shows us that the concept of sociality can be effective in revealing the social processes within therapy.

Hence, to sum up, the framework at hand proves to be useful in looking at the therapist-client relationship because it includes in itself integrally an understanding of what makes dyadic relationships social.

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2.2. Perspective of Therapy as Culture and its Critiques

Conceptualization of therapy with a sociological lens, rather than its treatment as a medical practice based on psychology and psychiatry, has started and gathered attention in the academia with a body of literature that is heavily critical of it. In earlier criticisms therapy was accepted as a worldview (Rieff, 1966; Madsen, 2014), which attributed it a significant social power as a collection of comprehensive and consistent set of assumptions adopted to understand and explain inner worlds of people and social reality. The critics, around 1950's and 60's, understood therapy as an attempt by scientist to test and propagate their beliefs on human nature which was inspired formerly by most celebrated figure of the era, Freud, together with the works of his colleagues, and later affected by new psychological currents of their time like behaviorism. Similar to laboratory experiments of the hard sciences, psychiatric experts tested their insights and used techniques to understand and most importantly manipulate the human psyche using the social power of their science. While therapy was considered as a new invention coming from an independent body of scientists, psychologists and psychiatrists were depicted as agents of modernization who strongly believed in emancipatory power of Freudian psychology (Rieff, 1966).

Freudian worldview, as critics called it, assumed that human soul is naturally self-centered while society sets rules and boundaries to hedonistic desires of the individuals. A balancing mechanism called ego negotiates these two distinct bodies. On the one side, some critics believed that this view was threatening to social cohesion in the sense that human emancipation would not be achieved unless social stability was harmed (Rieff, 1966). One of the therapy's first critics, Philip Rieff, used the concept of positive "culture", a system of meanings attached to certain behavior in order to render that behavior agreeable to communal goals, to understand the historical change therapeutic practice signifies. Accordingly, while in the traditional settings healing of the ills of the soul was achieved by restoring

individual's commitment to society and being a good member of one's community means being a good and healthy man; the links connecting members to the community has been disintegrated with the advancement of capitalist industrial society and an understanding of private salvation became more plausible. Scholars that followed Rieff argued that opposing the clergy who maintained the order and set moral boundaries, therapists functioned to support the id in contrast to super-ego enforced by culture (1966). Experts' role in this picture, is to propagate autonomy and independence by exterminating fear, shame and guilt in a time where traditional authority loses its power vis-à-vis rising individuality (Casey, 2002; Gross, 1978). It is, I believe, important to note that these criticisms present also moral panic of their time vis-à-vis social changes throughout 19th and 20th centuries like erosion of traditional social ties, close connections between family members etc., which was also a presentation that laid out a certain framework for later analysis of the therapeutic and set an agenda.

Around the same period, Freudian psychotherapy was also under attack by feminists who claimed that Freud's ideas were both supremacist- as they only apply to and concern themselves with modern western society- and masculinist in their approach to sexuality in the sense that they put the emphasize on penis and sees it as a form of power (Benjamin, 1998; Moskowitz, 2008). These movements also gathered support from detailed scientific studies of the period on sexuality. I do not delve into specifics of this debate in this part, as the section titled "Therapy, Gender and Feminism" tries to address the discussion on how feminisms understood and used therapy.

Rather recently, scholars added a new dimension to the idea depicting therapy as a signal of declining social cohesion and the rising individual morality. First, the concept of "worldview" left its place entirely to "culture", while the main points of the analysis remained the same. Therapy, from there on, was considered an ethos - a set of underlying beliefs, sentiments and practices - which has a distinct place in

popular culture, especially the American culture in our case (Ehrenberg, 2016). Rather than being a process that was mainly formed and enforced by therapists' agency, it came to be treated as a commodity produced for and consumed by a general mass of people. It became so prevalent that rising new media- like television shows and the popular magazines- felt the need to create content- like personal counseling pages, recovery from trauma stories etc. - especially targeted to sell it while people also started to make sense of all the events of the everyday like birth, death or parenting by referring to a vulnerable, sensible self that the therapeutic ethos assumed (Furedi, 2004). This also points to an early break in the analysis of therapy, since from there on it had to address a broader phenomenon. Hereafter, therapeutic culture was not confined to the clinic; indeed the relationship between client and therapist had only little chance to be the main subject of analysis. On the contrary, a larger set of beliefs and practices having a basis in people's conceptions and emotional psyche enjoyed being at center of analysis and researchers started to use concepts like "the psychological society' (Gross, 1978), and 'therapy culture' (Furedi, 2004; Imber, 2004) to conceive it.

In that era, critics continued to focus on the so-called dark side of therapy by making visible how it "renders people passive", presupposes vulnerability and has no place for guilt or responsibility (Furedi, 2004; Sommers, 2005). However with a twist, therapy were now deemed guilty of not being sufficiently individualistic. Rather than suggesting an openly individualistic conception of self, which can be assertive; it created a culture of victimhood, enforced a distinction of the villain and the good, enabling short-cut explanations without much responsibility on the self. Therapeutic language was not only a language of individuality, however, since along with their personal issues people also started to interpret major catastrophes or crisis etc. within the framework of resilience and vulnerability provided by the ethos. Critics like Furedi claimed that the real danger was the constant sense of lack and weakness that therapy brings to both individual and social questions (2004).

After this first wave of theorizations, the idea that therapy encourages people to harmonize with their individual environment came to be seen as plausible and therapeutic ethos started to get new criticisms. While new therapeutic techniques appeared and the paradigm for mental cure started to shift through drug based treatments, making critique of therapy as a popular culture became more plausible. The most important escalation point was still therapeutic techniques' and language's appearance in television shows and printed media, which feature psychologists or self-help storytellers, along with increasing publication of personal recovery stories.

Therapy in that light was also conceptualized as an ideological tool within the 20th century consumerist and individualist popular culture. Even the analyses that did not directly relate to therapeutic ethos, but that are critical of these cultural trends– like that of Richard Sennett's- paid respect to the subject. Lasch was one of the first people to propagate a critique and he asserted that therapy could be linked to a historical trend of professionalization and bureaucratization not only present in public sphere but also in the private realm (Culture of Narcissism (1979) and Minimal Self (1984)). In doing so, he referred to a concept psychologists frequently used, narcissism, to describe the general mental state of consumerism. But he believed this was not just a cultural trend in and of itself and provided in great detail the story of how it became possible for therapists to take advantage of the self-absorption of the modern person and capitalize on the psychological weakness to which people were born in modern times making them even more self-absorbed. As the arrangements surrounding professional field of psychology became heavily subjected to market conditions, the practice itself became questionable (Lasch, 1984).

To conceive the cultural aspect in this arrangement, Sennett put forward the idea that with ascendancy of consumerism, and hence a form of narcissistic self, general framework of the public arguments was narrowed down to inner worlds of people

(2003). Intimacy and authenticity became the most important criteria even in the public realm and increased interest in one's self, leaded to decreasing value of social questions to the favor their individual effects. Personal bonds to family and friends started to matter more than anything else and public sphere is coded as emotionless which means for every problem people started to turn to their personal surroundings as intimacy can solve it all. But Sennett was not directly associating therapeutic ethos with his claims. Rather those claims were used by therapy's critiques to place it under the private end of the distinction and to support the idea that it detaches people from politics.

Cloud, for example, used concepts of hegemony and ideology, as Antonio Gramsci used them, to draw a picture of how therapy was ripping off the political agency as a type of rhetoric that renders individual the sole responsible for change. As Anthony Giddens suggested (1992), therapy functions to promote conformity with social order, because it converts outrage to rage and political energy to life planning. Its power comes from its appearance as a ready made solution for pain and suffering and that is the reason it was often deployed as a main response to social conflict even regarding social issues of race, class, and gender. The main argument summarizing this radical disapproval was her following words: "At moments of political anger or disaffection, rebellion is possible, but therapeutic discourse effectively translates resistance into "dis-ease" and locates blame and responsibility for solutions in the private sphere."(Cloud, 1997) In a similar manner, Whalen suggested (1996) that the ethos was used as a tool to handle class and racial conflict. It acted similar to other worker management initiatives, such as Total Quality Management for instance, in consenting workers to be self-actualized and develop sympathy for their bosses' interests by demanding from them individual responsibility to overcome hardships like decreasing wages.

While these criticisms also give therapeutic ethos a role in the participation of political agents to public debates, they left little or no place for different

interpretations of therapy. Nor social sphere that makes up therapist, client and outsiders (people who do not go to therapy) and the dynamics of this triad was considered to be of having central importance. Furthermore, the way engagement with private realm in therapeutic practice gets in the way of advocacy is mostly unexplained while public and political were deemed identical.

Another popular assertion within studies mentioned above is the existence of a historical trend of "emotionalization", which is directly related to therapeutic ethos. On the one hand, the term refers to appearance and wider use of new narratives and other discursive tools to describe emotions; on the other hand it refers, as a consequence of this, to popularization of a romantic vision that takes sum of a person's emotions as the person herself. While Sennett believes intimacy became the rule (2003), Furedi asserted (2004) that therapy holds emotions such as vulnerability, pain and hurt as 'good' while 'strong' emotions such as rage or 'political' emotions such as anger are pathologized. In that body of work, therapeutic ethos' effect of depoliticizing was connected to domestication of affects, which render domesticity along with the affective being exclusive to politics. Furthermore, when one looks at the main pamphlet for therapeutic practice, DSM (The Diagnostic and Statistical Manual for Mental Disorders), the text assumes the self as a place of multiple entities including other aspects than emotions. Under those conditions, coming to conclusion that the ethos is based on directing the emotions to a certain projected state would itself be an ambitious statement. Masculinist tendencies of this public/private distinction were also criticized elsewhere (Mcload and Wright, 2009).

Another way to approach therapy, like a number of scholars attempted, was to conceptualize it as a salvation offering religion (Bellah et. al., 1985 ; North, 1972 ; Berger, 1965). According to this view, therapy is both a byproduct and a driver of the new worldwide religion of liberal individualism. In that light, Bellah and others (1985) proposed to treat ethos of individuality and therapy as the first and major

form of salvation offering narrative centered on the inner world while it was possible to also adopt secondary and complementary ethos for maintaining loyalty to communal goals. Basing their analysis on the distinction of individualism/ collectivism, they conceived therapy as a new language added to people's repertoire. It does not, as in other critiques, pose a threat to older forms of social bonding, but it became the most prevalent habit of the heart. From a historical perspective, however, therapeutic ethos may not represent a distinction point. It actually draws similarities to ethos of companionship and friendship as traditional forms of "governing" personal troubles, specifically harm or damage (Gabriel, 2015). Although the way people conceive harm has changed in the west from a god given conception of pain that must be accepted and lived to a curable health problem and two types of pain, physical and psychological were differentiated in the process; therapy, in theory, need not to be based on curing the pain altogether. Pain throughout history was not seen as a public issue itself most of the time, although public debates had always have connections to personal troubles in one way or another (Gabriel, 2015). Therapeutic ethos in that sense is both a form of public intervention to the pain and suffering and a form of private relationship between therapist and client.

Some researchers, while acknowledging the moral implications of therapeutic ethos, were inspired by Foucault's work on mental illness and conceived therapy as a discourse through which agents prompt to create subjectivities (Lerner & Zbenovich, 2013; Matza, 2012 ; Rose, 1998 ; Salmenniemi, 2017). The inspiration mainly came from both Foucault's work on madness and medical institutions. In Mental Illness and Psychology, Foucault (2008) showed how the socially constructed concept of mental illness was the technology, that marginalized were disciplined. The newly arising bourgeois society of the 17th and 18th centuries have founded the idea, which in turn made for them easier the –intervene and regulate – social sphere. Since the revolutions of the 18th century freed the other marginalized groups- like the poor and people with disability for instance - only the

mad were left as condemned and subjected to older forms of surveillance. New impoverished working class was now normalized with a therapeutic intervention instead of being subjected to criminalization.

One must, however, be vary of the term "freed" I used above since Foucault does not simply say that this new attempt to cure the poor- and then later the insane- does not mean liberation. Therapy as a discourse is, indeed, continued to construct mental weakness as an abnormality. But rather than disciplinary power, scientific method was the tool that made it possible to intervene and govern (1987). While from Foucault's position, therapeutic can be seen as a discourse and its relation to power can be the basis of the analysis, his ideas on the care for the self took researchers' attention to active participation of the mad subject to his/her constitution. An important attempt at applying these insights to therapeutic discourse is the account presented by Nikolas Rose (1990 and 1998) who tried to investigate ways in which it created new subjectivities by letting people to identify a self that is based on the categories such as co-dependence, seen unhealthy, and in-dependence which is deemed healthy and preferable. This showed that psychotherapy should not merely be understood as oppressive as it also makes a certain kind of subjectivation possible. People now were deemed "obliged to be free" in the sense that having a lifestyle and consuming one's own choice of products made people feel as creative subjects in the making of them-selves. Consequently adoption of a new morality of autonomy, psychic health, individual liberty and their expansion through the market mechanisms freed techniques of self-regulation and care from the state governance and its disciplinary institutions. Therapy was, for a long time, applied and supported by state, as a tool to govern populations (Nolan, 1998; Polsky, 1991). But now, it was people themselves who made the diagnosis and leave themselves willingly o the hands of the experts to be governed through the promotion of 'lifestyle', with the obligation to shape a life through individual choice of their consumption (Crossley, 2003). Similar analysis followed taking our attention to possibilities for constitution of the self that

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therapeutic culture created in the post-soviet Russia (Salmenniemi, 2017). As frameworks that were available in Soviet communist regime disappeared, therapeutic approaches were adopted, under the name of mobilizing the country to heal from its traumatic past, to create the new individualist consumer citizen (Lerner & Zbenovich, 2013; Matza, 2012).

What those studies show is the fact that myth of individuality took precedence and dominated entire social sphere forcing a relationship of one's self to everything else as objects connected to that self. Therapeutic ethos was part of the myth and forced the individual agency to be the sole power in any narrative. The dilemma, however, in this analysis is the idea that individual agency can always be forced. While going to therapy may be understood as a form of consumption in itself, I believe it may also depict a picture of consumption as limiting to self, or limiting to psyche as a concept freed from the self. Yet, research also showed that mental illness as a category become much more acceptable after 1990's as years of efforts by mental patients and activism of anti-psychiatry movement leaded the changes in the field of mental health through conversion of mentally ill as marginalized populations -needed to be treated for the good of public- to mental health users (and consumers) (Crossley, 2003).

Some critics complained about consequences of this trend and increasing use of therapeutic language and confessional narratives. Some even use the term "fashion" to describe two widely accepted genres of self-help and recovery, asserting that recovery groups and reality shows using confessional style -like "Oprah Show"- assumed that pain and suffering are always relative and terms like "dysfunctional family" became an empty signifier due to heavy and faulty use (Kaminer, 1993). As we infer from other studies, similar terminologies like "being emotionally abused or depressed" also saw inflationary use in the last few decades (Furedi, 2004, Brown, 1995). While still maintaining a belief in scientific power of psychotherapy, these claims makes it possible to stay skeptical of the popular

connotations of the ethos. The value and the originality of these arguments lies in their illustration of a middle/upper class consciousness about the distinction between therapy based on proper psychological descriptions and its faulty adaptations based on self-help and recovery stories. As recovery stories and personal growth statements became a part of the popular culture and gave place more and more to the disadvantaged groups- that nonetheless always seem to miss- or un-represented- therapy's proper and improper uses has come to be a matter to be distinguished. The works that take our attention to that distinction and studies that open the discussion to radical therapeutic practices are, however, subjects of the next section.

2.3. Factors Shaping the Sociality of Therapists and Clients

Studies thus far took therapy as an ethos embedded in popular culture, operating with certain assumptions and codes, and they tried to look what it meant for social cohesion and conflict along with its moral implications in transition to modern capitalist society. It is possible to infer, until that point on what social dimensions therapeutic discourse can be located and what type of limits or possibilities it brings to the action. One can also acknowledge how therapeutic discourse can be effective in producing consent in late-capitalism. However, the way social agents' social constructions and actual performances reproduces the process is understated in that body of literature. These works, hence, remained far from capturing the entire diversity of actions and interpretations of the people who undergone therapy. This section focuses on studies that attempted to bridge this gap by looking at the ways in which therapy was entangled with the different social factors that may be effective in that reproduction, like dimensions of class, race and gender of the client. Alternative interpretations of therapy that were invented and applied by therapists themselves also gain ground in some of the works.

First and foremost, among the studies that take therapy as a discourse, there exist a plethora of research focusing on the readership of the self-help genre and creative adoptions of the ethos. Lichterman (1992), for instance, showed how a middle-class audience reads and interprets self-help books in a complex manner and uses that body of literature to locate "personhood" in a social context. A middle class culture of flexibility and openness was present in those interpretations such that while therapeutic narratives' consumers from middle class backgrounds stay skeptical about the ambitious claims of self-help literature, they treat it as an alternative explanation in understanding, naming and dealing with their pain, suffering, stress etc. vis-à-vis the hardships of life- ranging from occasional unavailability of life choices to loosing a loved person. Therapeutic techniques are used as a way to become able to juggle between different narratives to avoid lifestyle choices or "mindsets" that might lead them to more pain and stress. The most valuable aspect that both theoretical and practical readers among the middle class buyers of therapeutic advise, was finding the words to describe their personal troubles, which rendered negotiation of the pain easier for that part of the population.

Similarly, following Lasch and Foucault's arguments, Donzelot asserted (1979) that psychological knowledge and decreasing power of patriarchy made it to "conquer" family and govern populations while his created a distinction along the lines of social class. Others following this idea claimed that therapy's intervention to family and private life worked as a tool to support middle class who had the power to decide when and where they could start and end therapy. Furthermore, while therapeutic intervention was already normal and useful to those classes whose cultural attitudes it accorded; it was a method of normalization for marginalized populations (Chriss, 1999; Donzelot, 1979; Polsky, 1991).

As these accounts show, the idea that therapeutic engagements identify a certain social characteristic for clients and hence bring with itself a certain type of

educated person was evident from the start. While applications of therapy became become popular in the 1960's people started to see that language of therapy, especially psychotherapy, was complicated and even could be illegible for the interpretation of an uneducated population (Bernstien, 1964). Freud himself claimed that coming to psychotherapy assumes a certain level of self-consciousness (2015).

Studies also show that assumptions of self-help literature, which has stronger associations with American individualism than therapeutic ethos at large, were questioned by readers- especially by people from lower parts of the social strata. Women and African-American readers of self-help, for instance, are not all convinced by optimism of popular self-help narratives (Grodin, 1991). Neither Working class women are eager to blindly accept individualist implications of the self-development stories and were skeptical about the concept of independent self. Those stories were consumed as a genre of literature similar to popular romance books, but not as texts that provide guidance (Wright, 2009). Nor the way people interpret and follow spiritual literature and self-help stories is blind-fold and uniform. This was showed by pointing out to how people who read spirituality literature and therapeutic culture's heavy critics share a sense of alienation within capitalist modernity and use these narratives, spirituality and radical criticism, to negate its oppressive effect although those two narratives seem illegible for each other (Bender, 2015). Nevertheless, inquires on therapy and self-help that assume a passive audience were refuted showing the ways in which interpretations of the therapeutic ethos intersect with gendered, classed and raced identities.

A number of studies, however few, presented a revisionist take on therapy by including in their treatment its radical applications. As soon as therapy started to gain popular attention, a movement of radical therapy appeared in the U.S. claiming that "therapy means change not adjustment", advocating for "a therapy for a better world". This radical branch was associated with social movements of

60's and 70's and gathered supporters in big cities of the U.S. Its proponents argued that conventional psychotherapy ignored power relations and social inequalities. Instead of designing a deliberate agenda to counter this though, pointing to that ignorance and developing alternative techniques alongside was the main strategy of the movement. One technique, for instance, was applying group therapies where psychiatrist himself or herself was also treated as a patient and acted as a facilitator rather than a counselor (Satter, 2015).

Although they differed in their applications, radical therapeutic approaches agreed on the idea that mental problems have a social basis and therapy has to address these social issues for emancipation. This move also included discursive strategies like adopting the word "sanity" to describe anti-war and anti-poverty politics while sometimes insanity, as its opposite, were given a new meaning as "listening to one's reason in the face of hardships of everyday life", hardships that were thought to prepared by the contemporary capitalist society. These movements also heavily opposed uses of therapy as a social service to heal the wounds of the poor, claiming that it would act as a soft form of control and conceiving it as a very important matter that cannot be left to therapeutic applications that were based on psychology's mainstream popular forms (Staub, 2015).

In stories similar to that of Lafargue clinic for instance, that appeared in 1950's Harlem aiming to reach to the African-American population living nearby, one also sees how therapy was, and can potentially be, understood and practiced in relation to social issues of racism and racial inequality. Clinic operated in order to diminish the psychological burden of racism and oppression on the disadvantaged people, Afro-Americans, and attempted to relocate psychological problems as the result of social mechanisms- specifically as the intersections of race, class and power relations. Founders of the clinic refuted the essentialist framework of "cultural difference" that became a proxy for "race", which psychiatric approach of the time adopted. The aim was not only provide cheap therapy sessions but also to take an

active part in black people's struggle with the inequality and discrimination (Mendes, 2015).

Different adoptions of therapy's concepts like trauma were also used to narrate the pains of apartheid era political violence. In that case therapy, again, did not only to serve the purpose of healing but its adoption in storytelling acted as a form of social bonding and exchange mechanism (Colvin, 2018). Other researcher also showed concept's adoption as a way to deal and narrate oppression without leaving aside its founding conditions, by narrating the story of colonization as an offensive and severe process that traumatized the culture and psyche of the colonized (Bennett and Kennedy 2003, Saunders and Aghaie, 2005).

We have shown studies that take our attention to divisions within therapeutic practice along the lines of class and race. Therapy's relation to the gender order was nevertheless the most prolific line of this discussion among the others. Since the beginning, therapeutic ethos has been associated with private realm and discussed together with issues of sexuality, intimacy etc. Around the same era, another party to these debates was feminist movement who problematized the division between private and public realm and association of these realms with women and men respectively. Therapy, in the literature, is a modern narrative, which replaced traditional norms in regulating relations within family and the emotional environment. Contrary to the older forms of familial morals, it does not serve to hold family together or even ensure economic survival of the family members but aims to negate the repression and strain that the burden of the close relationships, familial and kinship norms, put into the individual (Moskowitz, 2008). In that sense, historical conditions that have led to the emergence of therapy can also be conceived to pave the way for feminist movements, especially second wave feminism. During 60's and 70's, feminist movements in the global west aimed at revolutionizing the norms regarding women's sexuality and familial duties while therapeutic practice, especially its Freudian proponents, was also in an

attempt to dissect sexuality with reference to relations within family (Illouz, 2008). This resemblance in focus leaded to crosscutting of therapeutic ethos and feminist movements. While it sometimes meant cooperation, it nevertheless created some contestations.

Although they diverge in their interpretations of individual, different perspectives on therapeutic agree on the power of personal change narrative. The individual, either with her own responsibility- this was called self development- or with help from others- this was called emancipation or liberation- was seen as able to change and develop a better, healthier self which made psychology and therapy plausible for feminist goals. Perspectives that were inclined to see subject of therapy as an oppressed individual due to the incessant strain coming from the clash of societal expectations and individual desire for intimacy could be found in the circles of therapeutic practice.

For some, a partnership arose from founding myths of psychology itself. According to the argument, psychology as a science has focused on people's need for intimacy. Likewise, therapeutic practice considered lack of intimacy as a reason for psychological disorders. For that reason, therapy's intersection with feminism was expected from the start, because marriages traditionally differentiated positions of wife and husband and hence they were not social scenes that produce intimacy which can only be achieved when two independent and equally valuable individuals offer their authentic self to each other (Illouz, 2008).

Traditionally, family has been an institution primarily concerned with reproduction and survival of its members, and these members should have possessed different powers in order for family to achieve that goal. Yet, modern family was formed in order to maximize emotional satisfaction of its members. This was explained by some (Illouz, 2008) as the result of the separation between sexuality and reproduction; while it was also believed feminist activists played their part. In any

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case, a trend of individualization – and detraditionalisation (Giddens, 1992) – was a main driver in both birth of therapy and feminists movements and their alliance.

Another point common to both approaches was the necessity of conflict. Conflict within the family was a new, modern invention and therapeutic ethos was one of its strongest supporters. Therapeutic matrix did not place familial relations in a good and bad axis; rather therapeutic ethos comprised in itself an inclination to question the family with an individual gaze. As this critical rationality got stronger family, and intimacy, became a matter of choice (Brown, 1995). With a difference in their unit of analysis, therapeutic practice based it on the individual entities while feminism tended to consider family as a system of its own comprising unequal relationship of men and women, the dispute in both of these moments was centered on problematization of family relations – including sexuality, parenthood, husband-wife relationships etc. Researchers tracked the historical process that relates modern individualistic norm of emotional satisfaction, which became dominant but not yet fully achieved in the marriage, to therapeutic models. Applications based on Freud gained credit by their virtue of going first in rejecting older paradigm regarding women's sexuality and with each blow to family, the were approved. Yet, family as the prime intuitional arrangement proved to be resistant and approaches based on Freud lost credit with time (Illouz, 2008).

From there on, therapeutic approaches included both more traditional conservatist arguments and radical ones using them adaptively following historical trends and needs; of the typical clients of their time, client as the consumer becoming the model mental health was constituted (Madsen, 2014). This even led, from time to time, to blaming of the victim as some interpretations of therapeutic found women guilty for lacking interest in their own individuality and authentic self (Moskowitz, 2008). Critics claimed that such applications of therapeutic have seen individual in a social vacuum assuming an ideal autonomy from birth. Misogynistic tone in these

applications made feminists critical of some strands of therapy and especially self-help literature as a genre.

Another important arena for both feminism and therapy was popular culture in which therapy as an ethos was located. Similar debates about therapy's relation to popular culture followed in the case of feminism as women used mass media with magazines, newspapers and television shows to create the founding myths necessary for constitution of modern woman. Some claimed that being a consumer was a fundamental aspect of the type and conceived therapy as a new commodity offering ready-made narratives to women without really providing insight to their women selves (Simonds, 1992). Self-help genre was analyzed in that light, as an ideology offering essentialist explanations of womanhood to women. Tendency to treat recovery stories and self-help narratives as a panacea for social problems was criticized and blamed for preventing social action (Faludi, 2006; Lowney, 1999; Simonds, 1992; Swan, 2008).

To counter the arguments about therapy's partnership to women's movement, researchers claimed that the alliance was basically a child of the second wave feminism, which was originated and carried on by white middle class women (Becker, 2005). First and foremost, feminist scholars also criticized Freudian approach due to its conception of personhood and self based on independence, autonomy etc. that were masculinist ideals of their time (Chodorow, 1989). The role psychological knowledge plays in power relations were also a matter of concern (Becker, 2005). They interpreted therapy's characteristics that confirm existing social inequalities as another tool aimed at managing and controlling women. While feminist critics was mostly concerned with psychological knowledge and its applications which were considered to personalize the public by putting forward emotions and women's inner psyche (Kitzinger, 1996), some have convicted use of psychiatric applications and the category of mental illness as the actual process through which oppression of women in patriarchy have been

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retained with the power of science as an institution. (Chesler, 2005; Showalter, 1998). A misogynist understanding of "women with hysteria" in psychology and psychiatric practice has been prevalent for a long time; while women's unhappiness was defined from a medical perspective by the way of psychiatric diagnoses and prescription of psychotic drugs. (Blum and Stracuzzi, 2004).

There were, on the other side, accounts that underlined emancipatory and empowering potentials of therapeutic approaches, from the therapy process itself to the larger meaning of the ethos, by igniting performances of speaking out troubles and helping to develop discursive capacities to link private and public. Therapy, despite seeming like a personal narrative, could help women to raise public voice. The argument here, stemming from Giddens' conception of reflexive modernization, was that moral implications of traditional understandings about gender and private life could potentially become questionable by accounts that women provide about themselves (Giddens, 1992; Scanzoni, 2000; Weeks, 1997) Rather than limiting the repertoire of making politics, confessions of affects can actually work the other way around and create new public debates (Elliot, 2004).

In this regard, with two illuminating works, Wright focuses on the context of Australia- and tries to understand the ways in which therapy and therapeutic tools were used by women to render their private sentiments public and legitimize their pain (2008 and 2009). Her claims about the adoption of the ethos are illustrative: "The voices of women, children, migrants, people with disabilities, those from sexual minority groups and indigenous Australians were publicly articulated and formally documented. A comprehensive picture of widespread emotional pain and suffering in the personal domain emerged, making public experiences of distress, fear and abuse that had hitherto been largely hidden." (Wright, 2009).

Confessional narrative's role in this process was underlined by a number of studies (Mandziuk, 2001; Rose, 2004; Ahad, 2015) . In the U.S. of 1950's, for instance, a

magazine called "Confessions" offered therapeutic space for African-American and working classes women. Rather than a place of counseling, the magazine became a medium for the assuage of the feelings of isolation, insecurity and inadequacy for black and working class women. While the dominant narrative was in line with adherence to conventional mores of marriage and family, stories themselves opened up a space for sexuality and expression of behaviors that are considered inappropriate and amoral, showing the ways in which gender roles and family arrangements are remade within the American working class. These confessions were therapeutic in the sense that black, queer and working class sexualities were rendered enunciable and acceptable in the psyche of the readers and confessors (Ahad, 2015).

Benjamin (2001), similarly, interviewed twenty-eight women in England and investigated how therapeutic discourse shape women's negotiation with their husbands through introduction of new feeling rules in 1970's. While until that date expression of anger was considered taboo for women and engaging into conflict in marriage was seen in a negative light, therapeutic discourse took a turn to encourage expression of feelings of all sorts. These scholarships have shown that this expression, putting these unnamed feelings into a narrative, renders the pain, suffering and silence that women have long been experiencing visible and how these women were able to rename it as it deserves- emotional repression and violence- instead of using concepts like hysteria.

All in all, looking at the diverging and intersecting points of feminism and therapeutic applications does not answer the question of what would happen to therapy after third wave feminism in which experiences of women from different ends of the social spectrum became visible and new divisions within feminist politics were formed. The question that if therapy is just an old ally for feminism or if the relation between the two continued in different a manner, remains also to be asked and answered. We have seen, thus far, that historical transformation of

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mental patient to mental health user can help us to locate these new formations within feminist movement and gender order. If we include in the picture the fact that therapeutic culture is always performed from a classed position, which means while some people experience it as part of the popular culture others establish long-term commitments of trust with the experts, locating therapy as a psychosocial tool within the social sphere becomes even more urgent. With these considerations, the thesis now turns to the analysis to reveal the role of sociality as a whole, including aspect of gender, class and age alike, in the therapeutic relationship.

CHAPTER 3

METHODOLOGY

3.1. Research Design

As the literature shows, therapy was first understood as a culture and critics tried to entangle how it works either by looking at the popular media or how the audience interpreted it. Later on, with the effort of feminist scholars, historical methods were also added to the repertoire to reveal its ties to gender relations. There were, however, only a limited number of studies that tried to open up the black box of therapy itself by talking to therapists. Neither therapy clients were treated from a different perspective than the one, which considered them audiences of self-help literature and therapeutic content. This study takes therapy as a culture imagined and lived by social agents that are active in the making of therapeutic relationship, including both the way they conceive and perform therapy process. The main concern is to map the social sphere where the web of relations in the therapeutic process is actually lived out. This could only be achieved through hearing "experiences and the words, voice and lives of the participants", especially when gendered and classed codifications are at stake (Skeggs, 2001). Hence, an ethnographic study was best suited to gather and analyze the data. This choice helps to understand clients' experiences from their own perspective and argue against the old and masculine gaze (Mattley, 2006), which is prevalent in some of the critics on therapeutic ethos.

Technically, equivalent psychological techniques to therapy or narrative-based forms of support- varying from group counseling to literature and media on self-help-which could make sense for people from different social strata, could be

included in the study to achieve this end. Yet, such a design would require a longer process and larger resources which passes beyond the scope a of a master's thesis. Furthermore, the effect therapeutic ethos occupy has popular culture is comparatively small in Turkish context, than the U.S. and Europe where it was originally studied. This makes the overlooked part of therapeutic culture, the process itself, a more suitable object of study for the thesis and a good starting point to make general inferences.

Data collection process was approved by METU Institute of Social Sciences Ethical Comittee, and took up 5 months to finish. Expert respondents were first selected by convenience and snowballed to a number of four. Client participants of the thesis were chosen among people who have already undergone or have been undergoing therapy, people who claim that therapy has had an important impact to their lives. At the beginning of the study, I did not expect to see this number of people in my immediate surrounding who has done it. Due to the conditions of the field, because therapists are hard to find and set up a meeting with, I ended up having more respondents as clients, in total nine, than therapists. Using my own therapeutic past as a gateway, I have reached clients and hear about their own stories. Both the emphasis of therapists on the middle classness of the clients and the fact that respondents of the study have similar life conditions to my own made the central focus of the thesis the urban middle class. Thus, as stated in the introduction, this study does not cover therapeutic experience of a large group of people, who continue their treatment with only medication, which may constitute the majority of the therapy experience for working classes.

As in many other ethnographic studies, a rich amount of data was collected, which literature suggests using qualitative inquiry to analyze. To sum up, data collected with in-depth interviews within the ethnographic field study comprise most of the material, which were analyzed with a theoretically informed coding procedure.

3.2. Research Procedure: Forming the Questionnaire

When topics include intimate details of participant's life, in-depth interviews are most appropriate whose discretion provides the comfort that participants need (Madriz, 2000). Hence, this study is based on in-depth interviews with both therapists and clients. Two separate sets of questions were used to gather the data that will answer two subsets of research questions. Neither of these questionnaires was designed totally stemming from the literature, since what researchers have done so far was mostly to investigate self-help books or personal recovery stories that were written for a broader public. As stated earlier, this does not capture the totality of the therapeutic culture. Moreover, such an approach reproduces the consumer/producer (or the supplier and the audience) distinctions within the therapeutic ethos, and has the danger of leaving gender and class out of the picture.

Consequently, first part of the questionnaire prepared for experts were formed to reveal trends in the field and the way therapists relate to these trends and locate themselves vis-à-vis their profession which helped me to see what distinguishes the ethos in a one-to-one therapeutic relationship from therapy in popular culture and the effect of the latter on the former. The move to differentiate the two also forced therapists to consider the boundaries of being a professional and laid out how the field, within which psychotherapist work in Turkey, is socially constructed.

In formation of questionnaire, therapists were considered both as agents that make therapeutic ethos and experts that are able to objectively draw conclusions from client's experiences. Hence, in the second part, dynamics of therapeutic engagement and therapists' evaluations about client demographics, ranging from what they look at when they first meet a client to types of clients that they think are most common and interesting, were questioned. Analysis of the expert interviews was more descriptive and aimed at understanding the ethos through their eyes. Accordingly coding procedure followed the themes that emerged from the data.

Emerging themes were, in order, "Establishment and transformation of the therapeutic field in Turkey" which laid the conditions of being a therapist. After that, analysis focused on the answers that can be classified as frameworks that make social construction of therapeutic ethos. Hence "therapy as a safe zone of support" appeared as the main themes regarding therapists' positions. Lastly, the analysis turns back to sociality of client from therapists' eye and reveals the role of this sociality within the process. Therapists' expectation of perseverance, willingness for self-development and use of the resources available to the client was analyzed in the next part.

Next questionnaire, which was prepared for the client interviews, concerns second subset of research questions and aims to delve on what make people a therapy client, how they are their positioned as a social agent within the process along with the role of their gendered and classed personhood. The way clients create value out of therapy is an integral part of this mediation. A good way of obtaining this was to capture opportunities and challenges therapy posed for their life strategies. People understand their life in narrative forms through which they locate their everyday experiences (Maynes et. al. 2008), in our case the experience of therapeutic relationship. In that regard, both life stories and life course perspective gained importance for the research and helped to put accounts told by participants into a framework through which one can interpret clients' agency before, during and after therapy.

These experiences was positioned in their certain social context in the sense they are not only individually meaningful, but are also illustrative of the locations of clients within the social sphere (Plummer, 2009). Experiences within a life course and the way they are constructed and recounted not only show participant's valuations, about their affects and personhood, and but also how they depend on relationships of gender, ethnicity and class etc. (Elder et. al., 2003). Questions on participants' life course also served the purpose of introducing researcher and

participant to each other. How respondents might have alternatively expressed similar concerns in another media, namely possibilities of alternative agencies, were also at stake in this part of interviews.

While first part focused on affective aspects of participants' past and the resources within their range in their early lives, interviews continued with clients' experience of therapy, which was rather recent. To analyze how problematization of their life course and therapeutic process is located within their sociality Simmel's conceptions of dyad, triad and sociation (1965) was used. From this position, the relations between therapist and client along with the position of the latter within that relation cannot be socially understood by only focusing on their face-to-face interaction and a third element is embedded in the process which means sociality of clients spans their interactions within the everyday. Consequently, next set of question focused on the story of therapeutic engagement with what happened both inside and outside clinic. Difficulties that clients faced and practical gains therapy provided were questioned along with the clients' feeling in the process. I also paid attention to economic, social and emotional resources that therapy clients mobilized to make therapy a worthwhile effort as it can be understood as an investment on oneself on which both a considerable amount of money and time is spent.

Lastly, to put back therapy in a larger picture, questions turned to find the proper place of therapy in client's life course after their engagement with the therapist. In both stages, respondents were also provoked to think about therapy in moral terms. Accordingly, they were asked if one should advise people to go therapy and who should benefit from it the most, why etc. These insights and respondent's valuations as a whole became indicators of the classed and gendered formations within the therapeutic ethos.

3.3. Research Procedure: Story of the Field

Field research has launched with the idea of using therapist's accumulated knowledge on classed and gendered forms of suffering together with their first hand field expertise on what distinguishes therapy as a profession. My first assumption was that because they have seen many examples and had a lot to say when it comes to the way psychological issues were problematized, therapist could form original insights and had a valid idea about the conditions within which their clients were socially located. Especially after reading such insights from writer/psychiatrists, like Engin Geçtan for instance (2016), I expected to find some similarities to what this literature provides, and what therapist could tell. While reading those books, I came to see that therapists could offer, with the advantage of being in the field, grounded insight on affective formations within the social realm to a sociologist like me, who mostly sit in the office and who sure have not the grasp of the psychic lives of people as they do.

With this idea in mind, I started to think about the ways of reaching therapists and ask them to share their perspective both on the profession and their field experience. Gaining access in ethnographic research is not an easy matter and involves provisioning possible obstacles along with making plans to overcome them. Yet a lot of times it also depends on sheer luck (Van Maanen and Kolb, 1985). While there were a number of therapists in my university entourage, my own therapist works in a sizable clinic near the business district of the city. At the beginning, I thought that my current relationship with those experts would be the site that I could find the respondents and furthermore my therapist accepted to be a key informant. Counting both the experienced therapists in that big establishment and the respondents in my entourage, I could reach to the necessary number fast enough. But when it came to convince other experts to participate to an interview, despite my therapist's great efforts none of them volunteered presenting their workload as the excuse. All of the therapists working in that clinic were well-

known psychologists who charge prices that are above certain average and it is not hard to imagine that their time is valuable. They had a very long list of clients who are waiting for the first session and while those clients could only see therapists after waiting for months, me seeing them for an interview seems like a burden on their part. Even though I was willing to pay their regular fee for sessions, I wasn't able to get their attention. That has led me towards to therapists in my entourage that are more willing to talk but less experienced than the ones in that clinic. I made the first interview with a friend of mine and she became a key informant in finding and helping to arrange other expert interviews in this study.

The role I expected to play, in our conversations, was the one of the curious colleague expecting to be enlightened by expertise; and as the interviews proceed, I was hoping to partner with them in forming a gendered and classed map of therapeutic ethos. To fulfill this promise, therapists did not need to tell the specific stories of clients. Rather the aim was to conceive their assumptions, first impressions and conclusions they drew about clients, and especially the context within which stories they hear could be placed. Evident as it is, I did not aim in this thesis to provide analysis of power relations within which therapist-client relationship operates. Rather the purpose was to dig deeper on the sociality, including gendered and classed formations, of this relationship, which form only a friction— yet an important one— of the therapeutic culture. Likewise, before going to the field, my expectation was to see a middle class partnership or at least a class based agreement between clients and therapists. This suggests that moral implications of the dynamics of power within the client-therapist dyad would matter less than their social positions. Yet the normativity of this dyad posed itself as an obstacle since the first interview. I have worked and dealt with authority figures in my previous studies and found ways to tackle their challenges. While I thought the fact that the authority figures are closer to my expertise and social position this time would make the interviews go smoother, it did not exactly go as expected.

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The gatekeeper that I faced during the expert interviews was therapists' work ethic. The questions I asked them about experiences of clients were not always received with welcome even though the demand was to generalize the most frequent examples with made up stories or to use typologies terms that psychologist generally form through their first impressions. Rather therapists considered these questions as if they were directed to obtain actually-lived stories that must never leave the therapy room and abstained from making those experiences public even by abstracting them. My aim is neither to blame therapists, nor stigmatize them as guardians of a private sphere or as apolitical agents. Some of those therapists were actively taking part in feminist movements and all of them were supporting the cause. They were typically engaged politically and were enthusiastic advocates who leaked the social energy they accumulated in the therapy room to feminist struggle, by taking place in women's organizations, in the commissions that aim to prevent sexual abuse in the academia etc. Hence, I cannot charge my offenses about gender blindness of interviews to vocational bias or to the supposed lack of political disinterestedness in the therapeutic field. One of these therapists even told me that she had chosen this job especially because she wanted to be an active part of women's struggle and being in therapy room is a good way of battling against patriarchy from the ground. Despite that, their work ethic continued to treat genderedness of the process as the elephant in the room. In all of the interviews, therapists' reflexes to use vocational insights only for therapeutic purposes became visible. With fear of being sexist, therapists hesitated to talk about their approach to the matters of gender. They were varying in their translation of client's stories to the outside world even in a depersonalized and abstract narrative form. Their approaches to socio-economic status of clients were no different. Although they laid out occasionally how they distinguish clients, they always tried to keep the framework that treats every client as a special and independent individual purified from the effects of social process. Considering the tendency to codify therapeutic ethos as individualistic in the literature, this was expected. But as the interviews go,

I started to gather stories about the outside sources that two agents use in the process, as a social aspect.

The fact that I was a male researcher and a junior one at that also contributed to sketchiness of communication as I had difficulties to ask more questions about gender or probe the questions that I already asked in ways to force my participants to respond. Moreover, since experts could only offer me limited time, every interview took one hour and I was not allowed to pass that, this escalated my hesitation to probe and get a more detailed and nuanced opinion. I wanted, of course, to be closer allies and wished our partnership would last. Yet their older age and experience vis-à-vis my position aggravated my feeling of powerlessness. Their concerns about the work ethic and timing of the interview passed on to me and combined with the willingness to not force too much the respondent, discouraged me while in moments that I gathered some courage to probe, I generally get short and neutral answers. Despite all these shortcomings, these experiences that may at first seem infertile offered me rich material about social dynamics of therapy. I even had the chance to chat with some of therapists off the record and they did not hesitate to share their knowledge from the topics like history of their practice to how DSM became fashionable and how therapist, like themselves, understand the terms that were laid out in the manual. The times that I found the chance to talk experts outside the interviews become another important site for this study.

Nevertheless, data coming from therapists was not comprehensive enough in understanding clients' experiences and how their actions are part of the therapeutic ethos and the fieldwork needed a turn at that point. One option was to try by-pass the work ethic by changing the questions and the second one was to expand the field study by including for whom therapy matters the most, the clients. In the beginning of the study, the idea was to limit interviews to the experts only and consider clients' experience as a secondary alternative site. But since that

alternative became a necessity, a new set of questions regarding clients were formed and the second stage of the field took start.

My plan was to talk and partner with the clients who are taking or have had previously taken therapy. Due to my previous experience as a therapy client, my new role in this site would be to side with respondents and be part of the study in equal terms. I was surrounded by a lot of young people thanks to my age and my profession and to my surprise I found out that a lot people in my entourage were undergoing therapy or have had therapeutic engagement with a psychologist/ psychiatrist recently. In finding participants, mentioning the subject of the study around friends and relatives became a key to introduce me to people who were interested to share and talk about their experiences. I was surprised because personally, even though there were a lot moments that made me think to go to a clinic and establish a long term therapeutic relationship with a psychologists, I did not do that until 2016; as my prior experience in psychiatry clinics and years of drug-based therapy made me hopeless and skeptical about it. Like a lot of the respondents, I did not have the necessary economic means to do that either until my late 20's.

While my role as an insider made it much easier to realize this plan, as interviews followed I felt like I developed a deeper sense into the lives of therapy clients. This led me to adopt a sympathetic stance and created an environment similar to that of the therapy room. Participants, during the course of the interview, were comfortable and willing to share their experience and a middle class partnership was, in the interview room this time, formed in that sense. At that point, I was the one who put obstacles to myself in arranging and completing these interviews due of the emotional turbulence and depressive situation I was in during that period and number of participant could easily increase to a higher number if it were otherwise.

The meeting settings, unlike the experts that were interviewed in a closed and quiet environment, have varied from promenades in the woods to sitting and chatting in cafes. I believe this made both sides more relaxed and participant started to see me, after a while, as someone to whom they can share more intimate stories. As I saw the parallelism with my own life in the stories they told, observed similar emotional dispositions to the ones that I have and showed how I felt to participants, I could feel that these conversations were becoming more than just interviews. In the interviews with therapists, the distance was always there and it was bi-directional. In most of the client interviews, we became a shoulder to cry on for each other through sharing of stories, although what participants propounded was disproportionate to that of I did. All in all, clients in the study were generally eager to show how they have come to the decision of going to therapist, how their problems required a struggle to begin with etc. Accordingly while I mainly listen and leave myself to the narratives induced by the questions, I sometimes diverted questions to directions imposed by the stories.

Yet, not all of the interviews followed the same pattern. Our partnership hugely rested on similarity of routes that participants and their families have taken. Migration to a big city and being new to establish an economically stable life was our main story line. When stories diverged, as in the case of two male participants who live as the heir of their wealthy parents, the language we talked started to differ. In those moments, my role as a companion/friend turned to the one of "admirer", who approved and claimed respondents' witty comments and curiosity about his complicated psychic self.

As a side note, since the recorder did not pose a problem for any of the respondents, I took notes only when it seemed absolutely necessary in order not to interrupt face-to-face interaction. I would also like to say that I am grateful to everyone who has been part of this study either as a respondent or as gatekeepers, agents etc.

3.4. Characteristics of the Respondents

There were two groups of respondents, first one comprising experienced therapists with a psychology background and the second including clients who have been undergoing or already undergone therapy in the near past. These two groups can be seen as parts of similar social environments since both were chosen thanks to their convenience for the researcher. Regarding the first group, the average time five interviewed therapists passed in the field, as a clinical practitioner was about 10 years the least experienced having five years of practice and the most experienced having 13. While the lack of depth in their knowledge about the field posed problems along with the strong work ethic that impeded mentioning anything about client profiles, bringing limitations to the collection of necessary data as stated, their aspirations about the profession provided new and unexpected data to work with.

All of the experts in the study were graduates from established universities of Turkey, mostly with honors degrees. As regulated by the state it is compulsory to complete the college with a degree in psychology and finish a masters program on clinical psychology to get a practitioners license. All participant experts in the research had the necessary degrees. Only one of them had the experience to work in a state hospital while other three saw clients in their own office throughout their careers. This was also a factor that limits, for them, the chance of making comparisons and comments about socioeconomic status of clients. An important distinction, however, appeared when it comes to the school of psychology therapists follow and apply in their practice. Analytic or psychodynamic school and behavioral approaches to therapy constituted two main strands that expert identify themselves with, while some of them claimed to have used techniques from both schools alternatively according to client's needs.

All of the expert interviewees were women, which may cause a bias for the study. But since women dominate the field, this was rather an obligation than a choice. There is only little number of men working as a clinical psychologist and unfortunately there were none in my entourage. Yet, I believe this limitation offers insights about the structure of the affective realm within which therapy relationship is played out. The meaning and implications of this gender bias is discussed in the next chapter.

Experts in the study are all working in private clinics at the moment with fellow therapists and their offices are in a fancy district of the city where famed psychiatrists and psychologists offer their services. The district is located near to upper and upper-middle class neighborhoods and mostly accessible to that part of population. To be acknowledged as a therapist in Turkey, however, clinical psychologist and psychiatrists need to successfully complete a period of internship before starting their private practice, where sessions are free or very cheap. Since this period takes six to twelve months and therapists do not want their efforts to be inconclusive, they continue to see those clients a while after their internship ends. Some of them claimed to have done or have been doing therapy sessions with cheap prices in state institutions from time to time thanks to support programs funded by state. Seeing clients from a wider audience, who would not be able to come to clinic otherwise, is also considered as a gateway to gain experience and more insight about the practice. Yet, these clients form only a very limited portion of their clientele. All of the experts have also undergone compulsory therapeutic sessions as a client in the beginning of their career and this is used to test their own their mental health and give them the opportunity to sit in the other chair in the room.

Like it is the case with experts, client participants of the study were all chosen according to their convenience and they snowballed into a number of nine, composed of five women and four women. They all had been graduated from at

least high school or a higher institution; most of them holding degrees from prestigious colleges and the two of them still pursing undergraduate studies. Nearly all participants needed to work in full time jobs to make their living and they were typical examples of what C. Wright Mills calls "white collar" workers (2002) in clerical positions within the service sector (sometimes as a junior manager in the state or private sector) or alternatively in creative industries.

Client respondents were aged between 23 and 36 years old, but they were not presented in this study as a generation in the sociological sense nor they were considered from a perspective as part of the youth. Yet, this age limitation brought some implications. As young adults, clients in the study in that part of their lives do not have access to wide range of economic resources and their work and career is an important part of their identities. While the consequences of this was discussed in the analysis section, it is important to note here that this study can only capture meaning and uses of therapy for a specific cohort among which the practice became popular. Rather than presenting a historical trend and looking at how therapeutic practice gained popularity in the near past, the thesis aims to provide an analysis of the social dynamics of therapy relationship. Yet, it still uses the wide range of analysis, ranging from the ones that focus on presentation of emotions in the public to the studies that work changes mental health paradigms, which treat ascendancy of therapeutic as a signal of historical trend.

Respondents of the study live either in İstanbul or Ankara. It is also important to note that they have little or no intention of moving to a different place. Some of them, however, were relocated to their original towns for a short period of time but found themselves in the city again with the lack of jobs available to them in those places. The historical trend of rural to urban migration takes its part in the story. With only one exception, participants were the first or second generation in their familial lines that had come and established their life in a big city.

Despite the differences, clients' stories mostly shared a sense of struggle. Either participants themselves or their parents are exemplary social mobility workers, trying to secure a life where only limited life opportunities can be found. Their stress seems to have been increasing with career aspirations and self- expectations. As they are in a relatively early stage in life, the lack of prestige and self-respect that they sometimes feel poses itself as s problem. Yet, objectively, participants are not the part of the precarious youth in the sense of having lower life chances. This stress is rather a general feeling vis-à-vis the ambiguity, among respondents. The table below summarizes the paths that the life, and professional experience, of my respondents have taken prior to our conversation.

Clients			
Pseudonym	**Gender**	**Age**	**Story**
Yeşim	W	23	Yeşim is the second child to parents who migrated from a small town to a big city. She claimed to have difficulties in her romantic relationships to men and a resulting depression after a break-up drove her to therapy. She works in casual jobs around school and sometimes performs as a musician in small gigs to pay for college whose therapy service she benefits from.
İrem	W	34	İrem is a research assistant in university. As she lost her father at young age and lived under the responsibility to support her mother, she also needed support herself. After spending a lot of time in new age spiritual movements in her youth, she "restored faith in science" and found a suitable psychiatrist to talk about what she has been going through. She thinks, though, this was a one-time thing and her condition, both economically and emotionally, is better now.
Gaye	W	31	Although she graduated from a reputable university, in the beginning of her career Gaye questioned her qualities as she was constantly insulted by one of her male seniors leading her to a depression. While she partly relates the hardships of this process to her bad relationship with the early divorced parents, with the encouragement of a trusted friend she started therapy, a process she gained confidence in her work.
Su	W	30	Su believes that moving to a big city and studying in one of the most reputable schools in Turkey was the most important breaking point of her life. There, she realized, she needed to assert herself, her needs and desires, better and started therapy through which she became able to consider herself more valuable making her more relax in both intimate and casual relationships that she now started to enjoy.
Feride	W	28	As her father left his mother after she was diagnosed with heart disease, Feride had to take a lot of responsibility early in her life. After starting college, she joined feminist associations and restoration of her mother's health also helped her to recover economically. She, then, started to work in an NGO while pursuing a master's degree. At that point in her life, she needed to go to therapy both to talk about the former hardships within her family and the rape she had to endure in high school in order to be able to express her sexuality better.

Ahmet	M	25	Ahmet is working in a university and due to both economic loses his family endured in his childhood and living under strain because of the bullying that he experienced in school, he was anxious and discontent. As he started to become economically more able he decided to go see a therapist, which also led him to discover and share his queer sexuality.
Mehmet	M	36	Mehmet is working in a reputable position within a state institution and enjoys its economic benefits. While he is the son of two reputable, yet emotionally distant, doctors; that distance made him emotionally detached and he needed to go to a therapist to express himself better in his intimate relationships, something he believes he achieved.
Can	M	25	After his parents were separated and he lost his mother at an early age, Can lived a lone yet economically stable life as he inherited certain wealth. This led him to live an adventurous life in which he became addicted to adrenaline leading him to therapy clinic as he suffered from this also in his relationship to women. After therapy ended, he wanted to continue because he enjoyed the process and felt like he knew himself better.
Hakan	M	29	Hakan is currently working as cashier while he is still searching for work as a teacher, the field he was trained in university. A few years back, after loosing one of his close friends in front of his eyes, he lived an acute trauma and since pills did not work, he needed to take psychotherapy. This process, he believes, led him to deal better with hardships he faces as he became more gallant and blissful.

Table 1: Stories of Clients

Therapists		
Pseudonym	**Experience**	**Story**
Serra	8 years	Serra had not have the idea to become a therapist when she started to study psychology. After graduation she did not what to while doing a masters and becoming clinician seemed like a good idea due to increasing popularity of profession and expanding job opportunities. Besides, as she participated to feminist associations in college and started to get familiar with the stories of women from different social backgrounds and thought that becoming a therapist and working with women in clinic would also contribute to the feminist cause. After she offered her service in a university for a few years, she passed to a private clinic while she still volunteers and sees one or two clients a week for a low price.
Cemre	13 years	Cemre, is an experienced psychotherapist who worked both in state hospitals and private clinics. After graduation, she was immediately offered a job in a new rehabilitation program within a state hospital and she took the job while continuing her masters'. The program was targeted to young people and after five years spent there, she married and moves to a small town in the western part of Turkey in which she opened one of the first private psychotherapy clinics. She, then, was divorced and moved back to the big city to finally open her place in the district where most reputable therapists were found. She combines different schools of therapeutic practice and offers her service to people from different ages.
Berna	11 years	Berna wanted to be psychotherapist in her young age, yet did not have the necessary requirements to get accepted to a medical program. Psychology looked like and alternative way to become a therapist and she get into a good school to achieve that goal. She, now, has a stable position within the university that she holds since the start of her career and mostly sees young people in the clinic. That led her to specialize in that branch while she sometimes accepts people of older age. Similarly, she makes use of the techniques of different schools of therapy while psychodynamic approach is her main specialty.

Melda	5 years	Melda has completed two major degrees while working as a costume designer in movie sets, something she did since very young age. As she experienced stories of burnout in the workplace, she started to get interested in this process and followed her major in psychology in the master's to become a clinician. While she now mostly sees people of young age at the start of their career, she mainly practices psychodynamic approach and because of this, therapeutic processes that she is in take longer time.

Table 2: Characteristics of Therapists

All in all, factors like having a difficult childhood, or living with a queer sexual identity for instance, are integral parts of their therapeutic engagements. I also show in the next part that clients' social background works like safety net to assure that not only personal childhood traumas or relationship troubles but also stresses of working in middle class flexible jobs are assisted with social and economic means these same positions provide. All of the participants agreed that: "everyone needs therapy but unfortunately not everyone can afford it". How their concern has led them to therapy and how they conceived and constructed the process, along with the insights coming from therapists, are the subjects of the next chapter.

CHAPTER 4

SOCIALITY IN RELATION TO THERAPY DYNAMICS

After data collection process, a theoretically informed coding procedure was adopted to analyze the material. In the first section, considering the axes within which therapeutic field is placed; I lay out the specific location of psychotherapy and therapeutic relation in the professional field of mental health. Interviews show that while on the one hand therapists express dissatisfaction about the lack of regulation in their profession, that heteronomy, experienced as lack of regulation and ethical incapability, in the field gives them ability to direct and control the therapeutic relationship in the case of middle class young clients.

Regarding the social construction of the therapeutic ethos, both experts' claims about the ethical codes and necessary regulations and the basic assumptions they held regarding what is going on before during and after therapy process were presented and analyzed. When we add the clients' perspective to the picture, the basic assumptions and the common understanding that set the stage for the therapeutic relationship, hence the social within the triad[1], starts to become clear and lays the basis for later analysis regarding the social dynamics making the process.

Second section, accordingly, includes implications of aforementioned construction from both client's and therapist's perspective. It provides the analysis of stories about the decision to go to therapy clinic and the process after. Social aspects of being in need of psychological help and looking for support, like gender and class,

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[1] Social is used in the sense that clients socially problematize their pain and make it legitimately acknowledged within that sociality.

shows how the client's resources and environments shape and make therapy work as the last part of the triad.

In that section, while stories about what happens before therapeutic engagement and then the actual process spent in the therapy room take precedence, one also need to look at what is happening outside the clinic to make the sociality visible. As a consequence, an important theme of the section concerns the resources clients mobilize in that part of their therapeutic engagement and finally how they value the process thereafter.

4.1. Establishment and Transformation of the Therapeutic Field in Turkey and Therapists' Perspective

Looking at the history of psychotherapeutic practice in Turkey, it is possible to observe that while therapy clinics were very small in number until 1990's, both the private enterprises of psychiatry and therapeutic practice based on psychology gained popularity around that era. In the website of the foundation that unites psychologists around Turkey, the year 1997 was presented as a turning point since the foundation was recognized as a "non-governmental organization working fort he good of public" by the state. When we look at profession's history, the earthquake of 1999 marks the actual turning point in giving psychotherapist the role of public agents working for the good of people. The profession, which therapist believe that was neglected for a long time, is acknowledged after an important number of psychologists were sent to the area that were affected by the earthquake in the name of providing relief to survivors (TPD website, 2020) as efforts of the therapists in the process was highly appreciated. Historically, psychology and psychoanalysis was already treated as a panacea for social issues especially a cure for the painful process of modernization of Turkey. But, that area was always contested (Soyubol, 2018) and had not had the effect of therapeutic

perspective's direct intervention to an event that people agreed upon was a public crisis.

While the number of psychologists that are registered to the umbrella foundation bringing together most of the expert in the country were very low, after the therapist intervened to earthquake by providing psychosocial support and codification of therapy as a cure for social trauma, number of professional psychotherapist in the foundation quickly rose in 2000's, as near 2500 psychologists graduate each year, while there were around 1000 psychologists registered as clinician in 2012 (TPD website) and it seems like the number will grow even more. The fact that new universities appear and psychology departments enjoy a historical popularity also supports the trend. As it is the case with the global West (Furedi, 2004), in case of a crisis that concern public, the language of the therapeutic is more easily adopted since similar frameworks were also mobilized in events like Soma accident in which people found themselves within a wide network of psychological expert and state agents.

This transformation also reflects a global trend of what was called in literature "therapeutic turn", "ascendency of therapy" etc. by scholars (Madsen, 2014). Similar to this observed popularity of therapy applications in U.S. and outside (Furedi, 2004; Madsen, 2014), there is an increasing trend in the number of people coming to therapy according with the anecdotal evidence. Therapist in my study who have been working in the field from five to fifteen years all claimed that in the last decade, in last five years especially, there has been a "visible increase" in the demand to the service they provide and they claim that this change is not only reflected in number of people who knock the door of clinic but also in the place that therapy and therapeutic practice occupies in both traditional and social media, and its popularity.

Serra, while working as a therapist, also pursues her PhD in public communication and social media and she believes there exist a feedback loop as therapy's popularity and its existence in social media feed each other. As Melda suggests: "people started to see that one does not need to be considered as a crazy person to look for support".

Yet, there are only a few official regulations regarding who can be a therapist, and there is no definition of the profession accepted by the state. Therapists often complain about this heteronomy, like lack of regulation and consider it as a downside for the profession. This also provides opportunities for anyone who is willing to satisfy the demand for therapy. It is easy for people who are not officially therapists, or who does not have enough competence despite having the compulsory masters degree, to abuse this situation to gain economic benefit from the popularity of the need for support.

Cemre is a psychotherapist who has seen clients both in state institutions and in her own private clinic, which is located in the neighborhood where most prestigious therapist, including both psychologists and psychiatrists offer their service. While therapists agree on the idea that popular media, including social, visual or printed media alike, render therapy as something doable without feeling shame and therapy is nevertheless represented as a viable option to consider in cases of emotional pain and suffering; normalizing- in Cemre's words- "a process which should already be normal anyway", they are not content with overall representation of the profession in the media- especially in television shows and soap operas- because they think that fictional therapists usually violate ethic codes. Experts see there a caricature of the profession rather than seeing what really happens when clients come to clinic. Accordingly, therapists in the study like Ayşe, Cemre and Melda, believe that only therapists who are not competent enough show up in television programs. These shows, they claimed, are usually used as way to draw more people to the private clinics. Cemre even asserted to have been presented by such an offer, to pay a

certain amount of money to be presented as a professional expert in the news of a broadcast. This example illustrates that therapeutic applications already formed a network wider than the scope of the direct relationship between therapist and client, while the main frameworks used by therapists—including in itself the tactics to make therapeutic practice worthwhile— were not limited to a shared understanding of pain and suffering.

This requires therapists to prove their value vis-a-vis new and unwanted entrants while it also gives them the advantage of setting the norms for the field. All of them stated their dissatisfaction from therapist who market themselves on television and other media and lack of ethic incapability in the field. They think an ethical enforcement is necessary to avert the harm to clients, who suffer from therapy's popularization even more then therapists. Better experts are not the ones who appear in the shows, this is rather an abuse of the profession and shame for the therapist who has done it. The way to become a good professional and play the game, hence, is a combination of expertise and a long-term engagement requiring also a willingness by the client to take part in the process. Consequently, while experts wait for an intervention by the state to regulate the profession by controlling credibility and capabilities of therapists so that they could claim the barriers to entry for their field; this situation creates a distinction and makes it difficult for clients to choose properly between available therapists. This issue is problematized both by therapists and clients as "the fit" matters.

The analysis turns at this point to social construction of therapeutic engagement by therapists and clients in order to answer the first part of the research questions in both subsets. Following the establishment of the profession, therapeutic practice in Turkey serves three functions. First one is, as it was the case in the earthquake of 1999, to intervene in situations of "crisis" and social issues. Second one is to provide support to the people who suffer from being "unsuitable" of "unfit" to their environment and provide them tools of coping in their everyday life. The last one is

psychotherapy's role as a complementary to psychiatric treatment of the mentally ill. Next section locates these functions to the context of the research and show how they are constructed from therapist and client's perspective. We see, when looking at the data, these three functions correspond to three conceptions which can be classified as the one that takes therapy as a public intervention, the one that treat it as a place of support and the one that takes it, in contrasting yet complimentary sense to psychiatry, as a safe zone. As second and third functions draw closer in the context of the direct relationship between therapist and client, I prefer the term "Safe Zone of Support".

4.2. Therapy as a "Safe Zone of Support"

At the beginning of the study, I asked the sub question of how therapy was socially constructed and performed first by therapists. This part answers that questions and lays out position of the therapist with its relation to client. That also sets the scene for later analysis about reproduction of the sociality of young middle class men and women.

As mentioned, when one looks how psychotherapy is socially constructed and understood, there appeared three major conceptions. In the previous section, I asserted that the first function was turning the society back to its so-called normal state, in the face of a public crisis. Intervention of state to these events however brings itself a bigger picture than the direct relationship between therapist and the client and as it is the state that starts the process but not the client, sociality of the people who undergone therapy plays a lesser role. Furthermore, in order to understand the implications of this conception, one needs to focus on the cases like Soma accident or 1999 earthquake, which means this study, could not capture therapist's experience in the context of public crisis. In those cases, there exist an immediate need stemming from a very specific event in time and individuals that are subject to therapy are considered as part of a collective trauma. Furthermore,

the fact that the pain and suffering of the people who endure the trauma are acknowledged by a very large portion of the population, erasing them is a more legitimate concern and implications are wider in its scope than dealing with events that occur to s private client, which may seem more distant and less systematic to others.

Yet, in another but similar vein, therapist carry that conception of therapy as public intervention to social crisis and especially to social issues; while they desire their service to reach the masses. The wish to take more active role in intervening to social problems is echoed in therapist's accounts. Melda as a therapist who support the feminist cause and take active role in feminist organizations think that professional efforts of therapists can make an impact on the life of her clients reinforce their position as women. She says: "Nearly all of my clients are women. I wish I had the time to reach even more. We are living in a patriarchal society and I see that women who suffer from oppression really benefit from my service." Hence, the need to cure the pain was made public by connecting the resource to larger and deeper issues, like patriarchy, than the ones, which concern the client immediately.

The phrase "I wish I could reach more people" is repeated by all of the therapists and experts in the study approve and willingly take the role that support the victim in the problems they think society collectively faces. Melda, again, is not just wishfully sitting in her office and wait for someone else to take responsibility to intervene in the problems she described but offers, for a client or two in the week, her service voluntarily to the people who may not had the chance to pay for her service, via certain social aid programs.

While therapists desire therapy to be a free public good, they couple it with their wish of seeing the title "therapist" to be recognized officially by the state as a profession. Serra, who worked in film industry for a long time and left his career

after seeing a lot of people burn out and live one herself to become a psychotherapist, told: "If we had an official job definition, state would also easily appoint our therapist friends for the public good. There are a lot of them, newly graduated, waiting. But of course, if we had a welfare state !! " As she says this, Serra does not only refer to one-time events like disasters or accidents, but also she supports opening up any event that can be categorized as a social issue to the intervention of a therapeutic perspective.

Hence, therapists first establish the practice as a tool of intervention to the social, for the good of the public and in the name of social equality. They believe in the power of the profession to transform both the public and the client. Still, in their practice, most of their times passes with the clients who pay their price and they work in private clinics which brings us to therapy's second and third function.

Therapy, in its privately practiced form, works as a mechanism of support and empowerment to the benefit of the client. The expression "looking for support", is the best at describing the ethos and therapists' job, first and foremost, is providing support in the form of psychological insights. While it was conceived that to be able to establish a therapeutic relationship, experts have to believe in emancipatory power of their profession (Madsen, 2014; Rieff and Lasch-Quinn, 2006), the word my respondents use was the "restoration". While relativity of the pain and suffering is acknowledged (Kaminer, 1993; Cloud, 1998) as one respondent saying "The damage can be big or small, it certainly depends how clients feel it", therapist see their expertise as a means to the end of supporting and healing the client, that were regarded as weak and unfit, no matter the story of their pain.

Contrary to its popular conceptions in that case, which assumes constants threats to a vulnerable and sensible self (Furedi, 2004), they try to suggest and implement the idea that someone coming to therapy is, or potentially will be, strong enough to tackle challenges he/she previously considered unmanageable. As Berna told:

"People does not need to be weak to seek for support, they may just be hurt". It is, for therapists, rather strength for clients to think about seeking help and coming to clinic in the first place. Serra suggest that: "Therapy requires a certain amount of courage, because it still have connotations of weakness", a situation therapist want to revert.

The framework that takes support as the basis of the relationship, hence, consists of some assumptions. First one is: looking for support is normal/healthy/natural in the clinic while the client lives it as a weakness. Because of that it, hence, requires its own space, psychotherapy clinic in order to take client away from that environment.

When one considers the emphasis on "in the clinic", the framework of support also draw its boundaries of the field vis-a-vis psychiatric practice, which concerns itself with the cases that are considered "beyond the reach" of therapists. Experts refer, at this point, to "harsh" cases that involve harm or damage to client or to the people in his/her environment. As Berna suggested:

> The most difficult cases are the ones that pose danger to client… like self-harm or harm to the people around client. I came across only one case like this with a suicidal one. (When I asked what she did?) I had to direct the client to one of my psychiatrist friend and insisted in this suggestion. This was not the first time I recommended a medical doctor. Sometimes medicine can be complementary after all. But still, that was literally one of the hardest moments of my professional life.

Serra, who was the least experienced among the therapists, states the same thing in medical terms: " There is a difference between psychotic and neurotic patients. In neurosis, there is still something that holds together mental structure. Client is mentally stable, but lives in disturbance."

When there is a dangerous behavior or habit that can harm someone, the case ceases to be a matter of psychotherapy and becomes the subject of psychiatric treatment. In those cases, therapists expect psychiatrists to be ready, and the client may become a mental patient, turning from a neurotic person to a psychotic one.

The framework of support easily adopts the language of the control mechanisms at this point. Therapist describe these cases as the ones "serious damage can happen" or "client is totally out of control". Physicality of the damage and clients' inability to control and account for his/her self can still be explained by the scientific practice. As Serra says: " Psychotic cases has their place in psychology". Yet, therapeutic practice seems to limit itself to neurotic or alternatively "controllable" cases in which client sits, talk and listen. In most of the techniques, the conversation seems to be necessary. Hence, when the damage is to be understood as more difficult to heal, the therapeutic intervention can only come after some measures have been taken and meaningful conversation becomes possible in safety.

Therapeutic ethos in that sense is not aimed to prohibit or eliminate physical violence, but concerns itself only with harm's symbolic aspects in the bodily form of emotional pain. This is enforced by the state's position to fund psychiatric treatment and keep it as a part of the social security system. Therapists, whether they want it or not, are required to direct some clients to psychiatrist and in that situation, they always have a trusted psychiatrist friend available in order to avoid directing client to state hospitals where people are treated as mental patients and long-term therapeutic engagement is rare.

Therapy room, hence, is designed as a safe, violence free zone. It is a place, as Melde claim, that: "every emotion be it wrong or right, bad or good, are free to be expressed and experienced". They even specifically encourage clients to bring their most violent- and hence intimate- emotions to clinic. This, they assume, serve a double purpose. While these emotions find a channel to be expressed, something that was not achieved in the everyday, clients eventually see the ways to express them outside the clinic.

Therapeutic practice, in that sense, is imagined as a "sport de combat" although not in the collective sense Bourdieu use the term (2001). In the experts' stories, it

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works as a sandbag where clients can create imaginary threats or unpleasant situations that they then face, by affection and contemplation, in the privacy of the clinic. Serra, is a therapist who bases her practice on psychoanalytic school of thought and she claims:

> I don't make any suggestions to clients, but in case he/she wants one I asked them what would they say or do if they faced similar situations in their lives. Then, we discuss. What they feel and what they can do about it. In very specific cases, suggestions can be made. But it may not have the same effect when it does not come from clients' own thinking process.

All in all, while experts desire therapy to become a free public good available to a larger portion of population and some even offer very cheap prizes for a few hours a week to expand their support to the people who really need their service, they constitute clinic as mutually exclusive and complementary to psychiatric institution and they approve the role the state plays, to be the legitimate power to control and set the norms. As it was evidenced in the quotes, therapist do not hesitate consider their clients as "mentally ill" in the cases where a dangerous behavior may occur. By representing psychiatrist, in those cases, as the right hand in the battle against mental disorder and collapse, they are ensured to stay as the left- supporting and nourishing- hand in the everyday struggle of the client who live under the conditions make them weak, yet who, they assume, are internally strong.

4.3. Client's Construction of Therapy: Preferred Violence and Vulnerability within the Safe Zone: Assertive vs. Emotive Selves

When we look at the stories of clients, it possible to observe that they come to therapy, because while they are expected to represent their selves- their thoughts, beliefs, and especially their feelings - and develop a perspective, a narrative in which they are the productive force in their social surrounding, this environment both public and private, falls short in opening up the possibility of developing such narratives. Therapy, in their words "support", becomes necessary to empower one's self and assert it within the public in the desired form. Clients, prior to therapy, feel

unable to express a sense of selfhood/personhood, and assess their position. In Ahmet's story for instance, while confiscation of their house is an important breaking point, his inability to name his feeling was the main source of his anxiety as he says:

> At that time, I did not know to feel. All I could say was something was happening and I could not do anything about it. […] (Later on by referring to this and the verbal abuse he endured he says) Actually, not knowing what to do in such situations is what brought people to therapy.

For every one of client respondents, the most useful thing to do in difficult times is talking to people and making one's existence felt. Yet, the opportunities to do that in everyday life are not always abundant and potential clients need to make the extra effort to look for support and create a space for it. In their stories, while the process may not come as easy in the beginning, as the energy is safely accumulated in the therapy room, it finally leaks to everyday practice. As Su explains:

> At the beginning I was not talking about the clinic outside. Then, after the encouragement of the therapist, I started to talk about it starting from my close friend and expanding like wave to other people. Sometimes, even my therapist gave me exercises to be able to do that, in the case of seeing myself as beautiful for example. She assigned me to look at the mirror everyday. Then I started to see myself more beautiful among people as well.

In a similar manner, Yeşim, with whom I met and talked just after her therapy session, wanted to talk about how it did go. As she is someone who likes to talk and handle her problems by talking, she uses therapy as a part of this practice, a place in her words "that offers her insights like it is the case with the friends". Yet, she believes:

> The only difference is therapists' point of view is more critical and radical. I talk to my friends a lot and always share my feeling to them as well. But with them, you don't have to question much. […] Now I see that this questioning was something that I miss and wanted to realize, I may not even need to go the clinic.

Even when they are presented with the environments in which their selves could be heard and seen, like it was the case for feminist movement with one of the female clients, they still felt like part of their selves were not totally understood or felt. There lies the ambivalence, since all of the women in the study claimed in one way or another that they felt like they are not fully able to express themselves in their

relationship to men, either in romantic relationships or with a male authority figure, which meant that they did not see themselves in a position to posses enough discursive power to deal with oppressive mechanisms that surround them. The men or patriarchy as a whole became a figure of oppressor for clients in the study, because while they were expected to assent to a passive position- as they were fit within the dominant symbolic- (Bourdieu, 2001a) they nevertheless felt the need to express themselves and take an active part in the making of their personhood, which also signals to an expectation to perform an active, assertive self. In Feride's story, we see that therapy meant expressing both her anger against her rapist /constructing a resistive force against and being able to express her sexuality within the public sphere. Feride is a woman who had to work as her father left home after her mother was diagnosed with a heart disease. In that difficult breaking point she had to work and provide for her mother. After the rape she suffered during this period, she continued and gave herself to work. Feride states that focusing on work did not solve the problem, but created a temporary distraction. Although there were some people to share around her in the process, her main reason to go to a clinic was "breathing out the anger and anxiety that consumed her". While Feride had already friends encouraged her to do that and make something out of this anger, she said that this needed its own space and "does not just happen there" among friends.

These stories show that while clients imagine and use clinic as a safe zone, they also define it vis-à-vis their former recognition and use of a safe place, like their relations with friends, within their sociality. Yet, as they like what they imagine as safe and stable to develop, expand and finally reach to the frontiers of what bothers them, they create a new space to achieve that goal. The word "support" become meaningful as a backing up to that domain, to become a safe zone in an environment that clients likes to talk and locate the emotions in a narrative as it is the main mechanism to exist public sphere and play the game, while the opportunities for this are not available. Gaye, for instance finds therapy valuable because she needed the confidence that therapy helped her to gain to be able to

both better express herself in the public but more importantly to get better in her expertise something his senior made her felt that would never happen. For Su, therapy meant being able to express her desires and put limits when necessary in her relationship to men. While Su, for long, thought that it was not going to be possible; her entourage in the university proved to opposite. Yet, she needed more than proof, had to put constant practice, to make it happen.

Men live a similar double burden on themselves, but in reverse. They come to therapy, mainly because they feel the need to get in touch with their emotive self, their passive and injured side. While coming to therapy may be a challenge to their strong outlook, they still do it since they need to reinvent themselves constantly within a certain lifestyle, getting in touch with emotions and connecting to one's soft side becomes a concern, and makes sense for this men who mostly work in white-collar positions or creative jobs.

Mehmet, for instance, goes to therapy "to make peace with his childhood" and to be better able to become intimate with his friends. As childhood is easier and more open to be coded with vulnerability, Mehmet have used a conception of vulnerable self, which became visible in the safe space of therapeutic engagement to his advantage to claim his male adulthood from a sensual perspective. Hence while it is possible to deliberately construct vulnerability in the clinic, it translates to client's sociality in the form of comfort with one's emotions, which makes it necessary to keep the therapeutic process private and under control.

Privacy of the clinic is, hence, a crucial factor in enabling men to better assert their emotive self. All of the male clients in the study accepted to give an interview because they wanted to share their stories, to socially bond by accepting their weak and passive sides. A woman figure in their social environment may also take part in the decision to go to a therapist. This figure, be it an aunt or a trusted neighbor,

provides male clients a relationship in which they can privately share their intimate selves. As Mehmet tells:

> My parents were doctors, they were too strict and our relationship was superficial, with no feelings. (When asked if there' anybody supportive) During my childhood, there was someone I called auntie. When I felt bad, got angry to my parents or just want to share something important, I was going to her. She is very old now and she could not deal with all my problems. Yet, she supported me for going to a therapist. When I think about it, therapy was something similar to that. The only difference is I was an adult (he means during his therapeutic engagement) and more aware of the situation.

For men, vulnerability lived in the therapy room is mostly associated with childhood; a neutral yet oppressed position within the gender order. With the discursive use of childhood, sentimentality becomes no longer taboo for men and even considered as a prerequisite for modern masculinity. The injured side within the men becomes expressible, not in front of everyone, but at least in the intimacy of therapy as they prefer it to be.

4.4 Factors Shaping the Process from Therapists' Perspective: Resources, Perseverance and Independence

This section answers the question of which dynamics are shaping the sociality of clients from therapist perspective before and during the therapy process. Therapeutic ethos as part of the popular culture has included an imagination of psyche as having an inside, which is open to be influenced by an outside, reflected in the concepts like vulnerability and resiliency (Furedi, 2004). Therapists similarly resort to these concepts when they recount how people come to therapy. Yet, as we have shown, these concepts' construction as strength rather than weakness makes the basis for therapeutic understanding and the partnership within the process that therapist expect to form.

When they were asked about the mechanisms that brought people to therapy clinic, two narratives appeared among experts. Therapists are first eager to assume that people possess an internal factor of resiliency, an ability to deal with emotional

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pain. Berna says: "At some point, as pain and damage accumulates within the psyche, resiliency brakes down and people feel the need to heal and come to therapy." The level of resiliency, in that narrative, varies from an individual to another and different people are imagined as reacting differently to similar events and stimuli. As a result, people who come therapy are the ones with lower levels of resiliency, while nevertheless they are still potentially holding it to a degree so that they can heal. Indeed, as with the case with "being mentally ready", higher levels of resiliency means also means that client may recover faster.

The second framework, on the other hand, relies on the concept of support networks around the individual. When people can't find the necessary support in their environment, in other words their support mechanisms start to fail, they become unable to cope situations that was formerly possible to handle and eventually, they come to therapy with the hope to find new resources to mentally and emotionally support themselves. Therapists' position hence is to be that resource, a last resort that client can come to when everything else fails.

In both narratives, the reasons that bring people to clinic are problems that accumulate over time and they are deeper than they first seem. But regarding the mechanisms in operation, therapists variably give weight to those two options. Therapists like Cemre who finds the second narrative more appealing attribute resiliency to individual factors like intelligence and cognitive capability. Cemre herself underlined that these treats are randomly distributed among population by taking my attention to how people from working class has also internal capabilities to develop resiliency. When I probed about what may the reason for this however, she stated that "people that are able to find a resource around them, such as an inspiring figure, they become more resilient". Concepts like resiliency in such cases work to fetishize a long social process, in which a lot social factors are at play, by the way of representing them in a single inherent characteristic trait that cannot be traced to the source of its own origin.

Yet, this also means that the support framework is still the more popular and therapists eventually conceive a client's story to come to therapy as a "fall from power", a temporal lack of resources. The first narrative, of resiliency and personal perseverance, works to hide it behind personality traits and individualize it in a fetishizing way consequently narrowing down the wider more systematic formations behind pain and suffering as was associated with popular therapeutic literature (Kaminer, 1993). Second and more popular narrative captures social dimension of client's pain by seeing him/her as already having a social power. Therapists, whether they adopt first or second perspective, picture a client that is vulnerable, in the sense that it is possible for anyone to be hurt, but someone also who express his/her will. This first requirement makes therapeutic relation possible within a context in which the pain becomes recognizable by client.

Still the client is someone who also uses resources available to him/her. When asked about the process, therapists tend to see therapy to be an intersection of their expertise and long-term effort of the client. Berna says: "First one has to be provided by the therapist and therapist only while second one is expected from both parties". While working on client's *self* provide the frame for the process; to do this, therapists expect from clients to already possess resources in the first place so that they can use these to cope with hardships they face. This can be understood from claims such as: "clients already have functional ways of coping and therapists' job is to fortify those while adding new ways to their repertoire". In therapists' understanding, hence, there has to be some material to work with in order for them to do their job in the sense when there exist nothing that keeps the client's psychic world together, it becomes pathologic. Those clients are considered even beyond the reach of the therapist. Only under this condition, then, therapists may use their expert tools to mobilize existing "healthy schemes" and change the unhealthy ones using these. As we have shown, this material can be a role model around the client, while things like hobbies or supporting communities are also

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considered in a positive light.

These resources and schemes of action are assumed to be there regardless of client's background and are named as "Functional ways of coping". Functionality, here, means that the things or people etc. that client take power from when dealing with a difficulty, are not totally incompatible with client's self, including his/her other needs and capabilities. Functionality refers, in that sense, accountability of clients' actions for his/her environment, and therapists believe it is the prime condition of "mental healthiness". It assumes that there are coping techniques legitimately recognized within the sociality, used here to refer not only to people but also beliefs worldviews and value systems, of the client.

In defining this log-term process, the school of psychotherapy that therapist is engaged with comes into play. In behavioral approaches, therapeutic relationship can be short and goal oriented. Yet, experts claim that a transformatory effect, in which client start to see, understand, express and hence make felt their feelings better and eventually "become their own therapist". When asked about their profession's representation and what it actually is, therapists claimed: "Yes, printed or visual media can be helpful, but nothing can give what a long-term, committed, face to face relationship can provide." Ayşe asserted: "There may also be expectation of magic wand. In applications of cogntiive behaviroral mehtod, it may be possible. For example, when someone comes with fear of airplane, it can be solve in like eight weeks. But even in such specific situations, it is difficult to solve everything in such a short time. Therapy is a process that lasts at least a year."

This requires clients to be ready for taking initiative in rather than leaving it all to therapist and it means that the process requires a lot of time and huge mental effort. Therapy, hence, was made into an invesment stemming from long-term training of the therapist, high prices of sessions, and the amount of time the therapist and the

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client spend together. Ayşe's claims are illustrative of the workload required in the process:

> A lot of people make their research before coming to clinic and there are even people who did some self-diagnoses. We may use such diagnosis in the beginning of the process to give start for sure. But as the therapy progresses, there always seem a deeper, bigger issue. [When I ask when this happened, she replies "always"].

Another important factor in order for therapy to work is the attitude of people around the client towards the process.

Therapists almost always prefer clients that come therapy with their own economic resources. This is because when someone other than the client pays therapy, the privacy of the process becomes violated. Hardest cases therapists face, in that sense, includes the cases where client's family- in general this means client's parents- is the main sponsor of the process. Psychotherapy clinics are private institutions and they are quite expensive for a person with average income, while psychiatry clinics are part of the public health system that state sponsors. Especially when parents themselves are part of the client's feeling of oppression, this becomes more problematic. Economic independence, then, is a criterion that assures trust and openness, which are necessary in the process.

Independence of the process, not in economic but also emotional terms, is something clients have to work to assure. Clients, hence, need to constantly isolate themselves within the process. This isolation is however, not something client can easily do, since if clients were isolated enough in the first place to assert the barriers for their isolation they would not need to assure it anyway. Hence, to assure the well being of the process, a certain distance has to be already at place. Berna explains this as follows:

> Sometimes families or close relatives try to intervene in the process. We are very strict about it and often remind client that this is not good for the working of process. Sometimes we even talk to these people directly to assure it. But you have to be careful. In the extreme cases, this may cause the process to end too soon.

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While they it is harder for them to have that independence, younger clients are still more favored by experts as they claim that younger the client, better and smoother goes the process. The criteria of openness to try out and juggle with new frameworks and alternative discourses in the clinic requires to be daring for novelties and nearly all of the experts agree on the idea that "younger people are more open to change". Both Cemre and Serra think that younger people come more often to therapy and they seem more motivated in the process and willpower, as other experts claim, is the most important thing that makes therapeutic relationship last. Considering the meaning of therapy for those clients, which I discuss in the next section, one can say that they are more willing to consider therapy as along term investment on themselves.

This makes young adults the perfect client of therapy, since this part of the population is as young as one can start to earn his/her money and be economically independent. Therapy's high cost and requirement for effort also makes it a long-term investment that will have an effect on the rest of client's life. Eventually, therapist's account also point out that younger generation, young women especially, makes up the most of their clientele.

The ideal, preferred client, hence, does not expect a magic wand and are open to both emotional and rational challenges that therapeutic practice may pose for them. This also requires for clients to not to come therapy with a certain diagnosis or let the diagnosis go with the process and focus her/his own story. Both being at the narcissistic end and to have too much self-pity makes therapy difficult. This means, however, eventually that coming to therapy should not be a moral burden on that person. Client has to share his/her sincere self, not what she/he wishes things to be, and hence in that sense, should not engage heavily in moral premises about therapy, either in a positive or negative light. Living under moral expectations of a parent or a partner for instance disrupts the process. A middle class sense of flexibility and openness (Lichterman, 1992) is expected. Berna says:

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We expect client to be open. Not in the moment he/she starts therapy of course. And from my experience I can say that as the time passes and we built trust, they do become more open. There are of course narcissistic clients who come to therapy only to prove their point. But those are not really many. Because you know, if someone has come to clinic, that means he/she want to change things.

While client is ready to take the responsibility, the process requires therapist to convince the client that he or she can enter a negotiation with him/her. When client and therapists do not meet in equal terms, like it is the case in the psychiatric gaze who assumes an active therapist and passive subject, building trust takes much longer and can even be unachievable. Consequently, in therapist's perspective, client should have both. First of all, they expect someone who will locate him/her self as equally effective and necessary for the process as therapist, someone who is the active subject of his/her experience; yet on the other hand someone who can recognize the necessity of the antithesis, like critical perspective, that therapist provides.

It is, hence, possible to state that in therapeutic relationship, therapist's technical knowledge is as valuable as the client's knowledge about the him/herself. As therapists state: "Best coping techniques are the ones coming from the client". While the mastery about one's own psyche do not translate to everyday wisdom- from therapist's point of view- it is not, nonetheless, something out of reach for the expert. Therapist, in that sense, has to "understand" client's position not as a hazardous disorder but rather as part of client's everyday life and struggle because otherwise it starts to resemble a psychiatric intervention. Melda believes that: "Sometimes clients need the therapist to direct her/him to a certain act. In that case, therapist' job is to not cooperate and remind the client that decision should belong to the client."

4.5. Role of Sociality in Therapeutic Process: Oppressors, Supporters and Gaining Self-Comfort

This section answers the question of what role sociality play in clients' decision to come to therapy, in the working of the process and reproduction of the sociality of the client. There seems to be two major actors, besides the therapist, to take into account when talking about client's sociality in this picture. First one is the oppressor, which comes to mind first in bringing client to clinic. The oppressor is someone, or something that bothers the client in his sociality with the supporter and creates a disturbance. Hence oppressor only makes sense when the client is thought together with the supporter, in the context through which client's feelings, of pain shame etc., is named as harmful and he or she feel it as a pressure and want it to end.

Then comes the outside supporter, which is generally found in client's immediate social surrounding like close friends or family. Here, of course the supporting character is considered as an outsider, because it is a figure client would rather to keep outside during the actual processing of the emotions that cause him/her to come to therapy in the first place. While supporters are formative of the client's sociality as they are the ones the client refers to when thinking about what client wants to achieve in the process, they nevertheless are left out to share the burden of client's pain. The word "figure" I used here, does not have to be taken literally as certain habits, items, cultural products etc. basically anything that make up the everyday surrounding of the client can become supportive in the process and are part of the sociality of the client.

The process of therapy, which happens to seem between therapist and client, then evolves around these figures that make up the sociality of the clients. I will show in that section that while clients' power and pain stem from a certain gendered, classed and culturally formed sociality, it forms the basis of the partnership

between therapist and client which keep the client in the process and help him/her to acquire affective and discursive tools to finally win over a moral authority and over the oppressor after the process, hence reproducing client's sociality.

I have talked about how naming and their feelings and make them visible was a main concern for clients in previous sections. To understand, however, the role of sociality one has to question how a feeling become a concern and a person become a client. This process tells us about both reproduction of client's sociality and the meaning of therapy within. As I talked with clients about the process, their stories revealed that they had practical gains within the process like "having confidence in public", "being able to express one's sexuality better" "expressing their emotion better and set boundaries in their personal relationship" etc. Prior to knocking the clinic's door, it is possible to recognize that all clients had a conception of standard for their lives and wanted to develop their life conditions as evident in the stories. Su for instance, desired to see herself beautiful and develop an ability to make it recognizable for others at the same time. While she recognized he idea that she can be beautiful long before the process, not only because it made sense in a culture of consumerism but also her surrounding in her new school resonated with that culture; she nonetheless was not convinced this was possible.

Although the client is constructed as weak, someone left alone in the journey to make something out of life, there also always seems a certain figure in the client's life that supports and approve therapy. In Ahmet's story, while he endured a lot of violence in both physical and verbal form from his peers and especially men, school kept him and his abusers in the same place and normalized what he was going through. He, eventually, started to see himself from the logic of the offender and accepted the position he was entitled. In Ahmet's words: "No one wants to look close to the people who is in that situation, and then you feel alone. You feel like this is the life you should be having. " Yet, as he was presented with some choices later in his life, like being able to choose to school or department he would

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like to go, Ahmet looked for places in which he can express himself better. He, then, found that place where open-minded people, especially women of his age. It became an option for him to consider going to therapy while he discovered and started to show his queer sexuality without fear within that social environment, the proximity of the women of her age; as he has choose a department that women prefer more, departments that are more verbally oriented, both in high school and university. After that, economic independence was the last step. Therapy, all in all, supported Ahmet in the place where he was comfortable but the oppression was still felt, the place he desired it but was not yet adapted. Similarly in Su's story, her story of moving to a big city alone and starting her university life there is the most important breaking point. While she says, "Most of my friends were supportive in the process", she means her friends from college, the place, which she thinks, granted her a relief after the turbulent family life. Gaye, similarly endured her depression with trusted friend of hers, who she believed rendered the process bearable. Her friend seems to play a key role even more than therapy in the sense that once her depression became bearable, Gaye felt already that something was about the change. After that point, her therapeutic sessions went smoothly. Lastly in Feride's story, we see that the feminist association she was in was very supportive of her therapy process, and in her struggle to become able to express and live her sexuality after she was raped. Friends, in this picture, are as supportive as they can be; yet as clients say they are not the solution to client's problem as Feride thinks: "You cannot just solve it there".

This shows that while friendship resembles a close and hence dyadic relationship for middle class clients, and they feel comfortable in that environment they still have the urge to go to therapy. This stems, as we have explained, from both unavailability of the chances to explain anger and disdain, for instance, within the public sphere and inability to accept the vulnerable self- especially in the childhood- within the private. As therapy offers a safe zone, clients, instead of developing these within the processes of the everyday, has to build upon them in

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clinic. During the process, while the supporters, like friends or relatives, are approving the process, and are the part of the sociality that makes the client think that there's something wrong in the first place; they nevertheless

Most of the clients are choosing their therapist with the help of their friends or basically anyone we might call a significant other. Approval and support of this people sometimes even come in the form of pressure itself like it is the case with Gaye whose mother wished her to "direct her grief to somewhere" which, in turn, also bothered Gaye herself. One of Gaye's close friends was the one who recognized she was depressed. Similarly, while Ahmet says "I thought this was the life I should be having (the time he was bullied)", he means that although he was aware that there's something wrong, he thought he had no power to change this. After finding a place he felt more comfortable, this idea has immediately changed.

The friends, in that sense, mediate the relationship of clients to their sociality. The urge to "be confident at work as a women", to "have a meaningful romantic life", to "feel better about one's mistakes and take lessons from them" are felt both within and with the help of friends. While clients feel "weak" and "injured" and they start to experience it as a social pressure. These concepts already makes sense to client as all of them claim that they always "internally" knew that was something wrong, this sense become to a willingness to move in their early to mid adulthood, along with an ability to make an impact- in therapist's word develop an autonomy- or to be able to isolate one's self within the many in an individualistic manner.

The next step in client's story is finding the economic means to go a clinic. While first the feeling and then second the willingness comes and the person is ready to be a client, there still is a necessary step she/he has to take and that is to find the economic resources. As therapist expect, the relationship between therapist and client has to be independent both in moral and economic terms. Client, hence, has to find his/her own economic means to start the process. That is also the reason, for

some clients in the study, that they did not start therapy earlier. It is not that this has not occurred to their mind, but the problem was the money. There are different economic sources that clients use in the process. First one is the money coming their family's wealth. Only one client in the study was living totally on the money coming from his family and as expected he was at the very end of the scale of "fulfillment". Therapy, for Mehmet, was all about good conversation and having an interest in one's self. This also tells us a lot about what may therapy mean for a certain group of upper class, but since there was only one person from that group in the study, any assertion may be exaggeration.

The second resource was the funds provided by their university. Since all of the client respondents attended university, psychological counseling services available in schools provided another means. While some clients started the process in school and continued outside; in the overall picture there were only few of them who completely attended therapy in their university. This brings us to last resource, which is the client's income. Most of client respondents used their income to pay for therapy. As they are in the beginning of their career however, this payment becomes a burden on their budget and that is the reason therapy is even more valuable for that part of the population. As İrem says, "Even if you don't believe in therapy, after paying that much money you start to believe!", Su similarly shares "I went to clinic every week without doubt. Not only because it felt good but also because it is a big investment. I had to make it work, because I paid a lot". While some of these people also need to borrow money from relatives and families to make therapy work, since mainly they live on their own incomes, they had to trust on their own income only.

The therapeutic process, as therapists also acknowledge, requires client and therapist to work together or at least form a basis for communication. It was shown that the language of therapeutic practice may be quite alien to people from the lower strata. In that case, lack of communication may harm the process or even

cause it to not launch in the first place. In a way, therapeutic practice necessitates clients to be familiar with some psychological concepts at least (Bernstein, 1964) for the process to start. Similarly, nearly all of the clients had certain degree of psychological literacy or a form of familiarity with the terms as they hear about some in the university. They all had apparently the basic skills to talk and share their thoughts in a certain fashion to the therapist. Su says, "In the process, I read a lot books on psychology and I even started to quote things from that books in the sessions." While this is expected for Su, who studied to be a teacher and had a certain interest in developmental psychology before, Gaye who has no interest in reading or hearing about psychology said she had no difficulties in her communication to the therapist. She says: "We understood each other as good as we do with other people."

Yet the first therapist is not always the right therapist and the process still require a fit between therapist and client. As therapist demand the client to have some resources, develop a sense of self and show perseverance, client in return posses the right to have some expectations. Since, therapist's technical knowledge is considered as equivalent to the client's knowledge about the self within the therapeutic process, those expectations are considered as natural. I have shown that "the fit" is an important part of the process from therapist's perspective since a certain degree of identification is necessary. Clients respond to this in a similar manner with expectations like Gaye's for instance. Gaye thinks that a good therapist for her has to read, or at least be familiar with, certain books, and must be critical about not only the client but also therapist's own practice itself. İrem, on the other hand, have chosen her therapist with different criteria and wanted him/her to have an entertaining personality. She says

> He is someone that looks just like you and me. You know normal, casual. I especially paid attention to avoid snob types who think because they had a certain medical degree they are too good and enlightened. […] But at some point I changed my mind about the guy. Through the end of the process, I came across to him in a concert to which I attended with my friends. He even knew one of them from university they graduated, which is interesting. When I saw him there trying to sneak to a cheap concert and thinking about all

the money he earns, I realized he was not the guy I thought. But the process was about to end anyway.

In the stories of "the fit", it is possible to see that the client and therapist not only share certain hobbies and worldviews, they even share friends, which shows how they are part of a certain common sociality.

Another point of fit stems from a middle class sense of self-development, along with critical and flexible thinking. Some clients, for instance, conceive the power of therapeutic techniques to keep emotions in balance and under control and show a certain critical standpoint towards psychology while also expecting the same from the therapist. Especially in Mehmet's story, which had the largest economic means among participants, this critical stance echoes again and again. While Can thinks therapy cannot adequately analyze his complex personality, he continued therapy because he enjoyed the conversation with therapist and the comments he made and as he said, "just wanted to see the guy and talk". He, however, also believes he now knows more about himself thanks to these conversations. Mehmet, who knocked the door of a number of therapist claimed, in a similar fashion to Mehmet that he did not want a therapist who gives cheesy self-development. Therapists also agree on the idea that client has to question the authority of the therapy to find his/her way as Serra says, "What we offer is not as effective as what they come up with".

The fit, however, does not have to stem from a certain shared middle class ideal of self-development and criticality. The fact that both therapist and clients see the need to find someone suitable for client's "personality" as natural form the basis of a shared understanding and is itself signal of a need for common sociality.

The idea of fit and necessity of communication also heavily relates to the oppressing factor and how it is understood. Serra says "Some clients want to change things immediately and there are therapists who does that. I am not just one of them." Here the school of psychotherapy the therapist works and the immediacy

of client's need has to coincide. I have shown that while therapists agree that not every problem go deep and sometimes easy solution may apply they, however, do not think a therapeutic process without effort is possible. I have also said that when we look at the client's perspective we also see that the resources, that therapists assume are there within the client's reach, available to client was what made the process start off at the first place. The actual process of therapy works in the exact same manner. While therapist claim not have the magic wand, client agrees that he/she is the one doing the job.

Hence a partnership appears within the clinic against the threat of the oppressor factor on the basis of these shared understandings and both party's social backgrounds. The client is active in the process, and questioning of the process and search for the fit become the key. While the vulnerability of the client is kept within the borders of the clinic, the client is now ready to go back to outsider supporters and fight against what oppresses him/her. This is seen as the actual therapeutic process as all therapists agree that "first few month passes as a process of identification and agreement in which both parties know each other". The word clients use in that process is to "create a space for one's self". They think the real work is to translate the process that was practiced in the safe zone provided in the clinic outside. Hence, to provide the space and forcing the client to go there every week, since client pays lots of money, is the prime function of the clinic.

The last step, in the process, is gaining moral authority to narrate one's pain and emotions and finally celebration of this authority with the supporters. Clients, in the end of the process, become confortable with their supposedly weak or "unfit" selves in the form of self-confidence and ability express and deal with their pain. This is lived in the form of a moral authority, on understanding and dealing with pain, as most of the clients agree on the idea that the problems that they think were about themselves are about other people. Ahmet for instance believes that "If people who bullied me took therapy at an early age, I would not have to endure

their violence. I understood, after therapy, that they also need therapy, even more than I do." Gaye said after the process she understood that " I have learned not to take ideas coming from people like this too seriously" referring to his senior who insulted her in the first place.

CHAPTER 5

CONCLUSION

I started this thesis with the question "How does the sociality of young middle class men and women are reproduced within the safe zone provided by therapy?" and tried to expand the dyadic relationship between the client and therapist to reveal the social, which comes in not only as social pressure but also entered the picture in the sociality of therapist and client laying the basis of their partnership. To find the answer, I have used ethnographic methodology and gathered the data by talking the psychotherapists and people who were part of process as clients, and analyzed this data with a theoretical framework based on concepts of dyad, triad and sociality as sociologist Georg Simmel uses them, and was also inspired from social types he developed. The analysis comprises three main axes stemming from the sub questions. The first axis was the establishment and transformation of therapeutic field and therapists' position within. Then, I revealed how both parties socially construct the therapeutic engagement together. Lastly, I turned to the question of sociality to see dyadic partnership as a triadic relationship including other social types than therapist and client.

First and foremost, the data showed that while therapy became popular in the last 20 years, the earthquake of 1999 had a formative role in the process to render therapeutic intervention legitimate in the eyes of the public. While number of therapists and hence private clinics rose, the state fell short of adapting to the change and regulate therapeutic practice as a professional field, which leads to a heteronomy experienced in the form of ethical incapability, while therapist has to constantly define their practice and prove themselves against the people who take advantage of the increasing need for support.

Results of the analysis also showed that thee are three main functions of therapeutic practice in Turkey. Therapy, to being with, gained popularity as a means to cure the wounds that appear in times of social crisis within the country, like big accidents or natural disasters. Psychotherapists owe much of their reputation to the role they have taken after the aforementioned earthquake, which rendered healing the wounds of a public trauma a legitimate concern. Based on that reputation, therapy clinics started to work as a support mechanism for the people who are considered "weak" or "unfit" in the society. The practice became wide especially among young middle class population, who are willing to put the unease of being unfit to a narrative and recover from their situation. Therapy's function to support the weak and unfit also relates to its third principal role, which is to help psychiatric practice in its goal to control cases that are out of reach for psychotherapy, situations in which a meaningful conversation between therapist and client is not possible. In that case, use of psychiatric pills and techniques are encouraged to get in the terms with client in order to support him/her in a safe environment.

Thesis, then, focused on social construction of therapy by therapists and clients and showed that therapist often refers to therapy's principal role as a social intervention by referring to the social issues that they believe they possess the power to effect. Yet, in the private clinic, psychotherapy was constructed as a safe zone of support mechanism serving the individual purposes of clients based on separation between emotional and physical forms of harm and suffering. While psychotherapy dealt with the first one as a private institution, psychotic patients that heavily disrupt the social are controlled and regulated by the psychiatric institutions funded by the state. This distinction brings with it subject positions of, mental patient and client; while therapists constantly refer to them and distinguish cases that necessitate intervention and cases in which a safe zone can be constructed.

We have also seen that people become therapy clients – with a willingness to be active agents in expressing their selves and are ready to reconstruct their personhood accordingly- by looking at the accounts of people who undergone therapy. Gender positions already start to matter before people go to clinic and affect their reasons to come, the actual process of therapy and reconstruction of self that takes place after. Femininity is coded as passive and women need to reconstruct themselves as active agents and make their emotions visible. Women that applied to clinic did not want their emotions to be seen, by both themselves and others, as signs of their hysteria or defections that stem from their gender. Rather, they wanted their emotions to be expressed and become legitimate. Thus, in therapeutic process, women readily accept support while men need further encouragement since masculinity continues to be coded as though and men as independent- not in the need of emotional support. Yet, vulnerability of childhood as a gender-neutral category helps middle class young men to consider themselves as hurt and damaged and makes therapy a viable practice. Consequently, regardless of client's gender, heavy weight of emotions makes it necessary to create a safe zone in which the client can work without reflecting harm to people that support the client in their safe environment within sociality of the supporters.

Third axis, in the analysis, is the role of sociality in therapeutic relationship. While different gazes regarding mental patient and client also refers to different techniques in dealing with pain and suffering, the dyadic relationship between therapist and client is based on acknowledging a fit between the two through which a safe environment for free communication can be established and association of different ideas and practices becomes possible. From therapists' perspective, this requires for both parties to be involved and active in the relationship. Furthermore, client must be emotionally and mentally ready for the process in the sense that some resources to functionally deal with problems must already be available to him/ her. Economic independence and individuality also matter in the process. Client is expected to be the main source through which money for the therapy is

generated while involvement and intervention of other parties within the process cause disruption. Lastly, from therapists' perspective, therapy requires client to develop a certain critical gaze on herself and on people that surround her.

When one looks at the role of sociality in the therapeutic process of the client, there appear two important agents in this process, namely "oppressor" and "supporter". While "oppressor" refers to factors that make a person emotionally uncomfortable in his/her social surrounding; "supporter" is a character that makes people realize that their emotional disturbance can be problematized. These two social types make up client's sociality before, during and after therapy. It is possible to see that clients acknowledge their pain as an oppressor within the safe environment of supporters and aim to gain a social comfort to adapt to it. Since therapy as a technique has its roots in the modern, individualistic concepts of self-development, self-fulfillment etc., this resonates especially to young educated individuals and make sense within their sociality. This makes middle class men and women from that generation— who possess enough economic means to pay for therapy, are willing to commit an important amount of time and mental effort into process emotionally, and mentally ready for the idea of working on their self— suitable clients. Educated young middle classes consider themselves in an early part of life and desire to adapt better to their newly acquired social place in which they are positioned as white-collar workers with a certain economic and symbolic advantage. They are, hence, willing to make a big investment on therapeutic process, to the sense of self-development it provides and to practical gains of comfort and ability to express within whichever space they desire, public or private.

Young men and women from the middle class are also already competent at verbally communicating their emotions, putting their lives into a developmental narrative and make critical comments from that position while their social surrounding and cultural background is supportive of this processes. While prior to

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therapy, clients were socialized into environments that put on them social pressure, they would like to reconstruct themselves within a specific lifestyle— in which to gain confidence, to be able to express oneself in public, to be more comfortable at positions of power etc. matters. Yet, this only appears as a social pressure within a circle of supporters making the client realize that he or she can problematize the emotions associated with being weak and/or unfit. Hence, recognizing one's psychological weakness (or vulnerability) was made into a social strength within the process of therapy, based on the agreement to construct a third element as an oppressor, a threat to client's sociality within the supporting environment.

While the thesis also showed that therapy is a process of relief and the relief is based on a specific conceptualization of health, a state where client considers himself/herself as "normal" she or he can be. The self-development provided by therapy, then, does not really signal to development but rather to a self-repair, which assumes a strong structure in the first place and bases itself on it, rather than having transformative power. Yet, the effects are real in the sense that once the comfort is assured, clients start to talk on behalf of the uncomfortable, the oppressed, the people who does not have the means within their sociality to express their experiences as problematic in certain way or even sometimes on behalf of people who cannot make their problems legitimate and viable even though they express their pain with concern.

To sum up, client enters therapy already furnished with a certain feeling of safety, with a safe zone existing within their proximity, although it differs from the one provided by therapy. They also have monetary power and economic independence. Young clients from middle class backgrounds, in our case, can mediate their burdens, which become recognizable in that surrounding, thanks to the help of their achieved safety in that circle. Therapy process offers, to that part of population, the chance to adjust their unfit, weak position by furnishing them with symbolic means so that they can open up space to express and locate this unfit position, something

possible but not always automatically achievable within the social surrounding of the client.

Consequently, the thesis revealed the social dynamics that are at work in the interaction between therapist and young middle class clients, by the way of analyzing social construction of therapy by both sides, and the effect of client's sociality before, during and after the process. It helps one to see how therapists' agencies was performed from a certain position within the social sphere and what are the effects of gender and class as social factors on the private— dyadic— relationship between therapist and client. By the way doing this, it contributes to both psychological and sociological literatures on psychotherapy in which perspectives of these parties were not taken into account together, and shows how therapeutic relationship becomes social. While we see the effects of the age, class and gender at every step of therapeutic process, in clients' stories prior to therapy, the decision to come the actual performance of therapy and their self-reconstruction that took place after, I have also showed the ways in which the space created by the practice helps to reproduction of this sociality.

Furthermore, the study took actual experience of both therapists and clients into account, and hence added to the literature their subjective experiences and positions along with the factors that make their partnership possible and showed how power relations in the therapy room rely on certain social conditions. This also bridges an important gap in the sociologic literature about therapy.

The most important limitation of the study was that only four therapists were interviewed. I believe to understand the role of sociality in the therapy room, one could delve deeper in therapists' world and inquire more about their experiences. A sample comprising therapists who use different techniques and who worked with people from different parts of the social strata would provide further insights. Besides, experts who worked in aid campaigns developed by the state in the

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aftermath of events like 1999 earthquake or Soma accidents would give us more data about the function of therapy as an intervention to social crisis. Psychological practice's historical mission to modernize the country, although it was paid attention by a very little friction until the abovementioned big events, would also become a key factor in that case.

Accordingly, considering the data at hand, the study only focused on the middle class clients and did not attempt to reveal what therapy means for people from different social positions. Doing that requires a wider study on how working and upper classes in Turkey understand and perform therapeutic ethos, which compares those different positions. One can also take into account different media through which therapeutic is constructed, like television shows and self-help literature, to account for the differences in conceptions of therapeutic.

In this study, we have seen that the sociality becomes effective in every stage of therapeutic process from reasons that bring people to therapy to how the actual process is socially constructed. Since the reasons that bring people top therapy also affects this construction and the factors that are in play during the process while, in turn, those factors are formative of therapy; this created certain complications in distinguishing the sociality. To avoid this complication and reveal the social within the therapeutic process more clearly, one could also fix the reason to come to therapy. For instance if one only talks to people who start therapy because they become depressed after staying unemployed for a long time, role of the factors like age and gender can be seen in better light. Especially, looking at how the same problem is experienced by men and women would help one to see how sociality operates through gender.

While the study paid attention to include different gender positions, studying the use of therapeutic techniques for different age groups would also provide us the data to reveal historical dynamics of being a client or mental health user and show

what kind of social arrangements lie behind different attitudes to therapy that we are likely to observe across different generations. The rising interest of youth in therapy can also be linked to the social phenomenon of delayed adulthood that we came to observe recently in Turkey. Young individuals started to feel a lot more social pressure due to changing composition of labor market and resulting high employment rates which puts a social burden on the group. A further study focusing this would also tell us more about the sociality of younger generations and its relation to therapeutic ethos. Although research did not pay attention to these generational aspects and historical conditions, it nevertheless provided a general view of the mechanisms and formations effective in the reproduction of the sociality for young middle class men and women through therapeutic practice. This research, hence, showed that therapist-clients relationship is a socially embedded phenomenon.

REFERENCES

Adkins, L., & Skeggs, B. (2005). *Feminism After Bourdieu*. Oxford: Blackwell Publishing.

Ahad, B. (2015) *Confessions* in T. Aubry & T. Travis (Eds.). *Rethinking therapeutic culture*. (University of Chicago Press. Chicago & London., 2015) 86-95.

Aubry, T., & Travis, T. (2015). *Rethinking Therapeutic Culture*. Chicago & London: University of Chicago Press.

Bauman, Z. (2009). *Postmodern Ethics*. Oxford: Blackwell.

Becker, D. (2005). *The Myth of Empowerment: Women and the Therapeutic Culture in America*. New York: NYU Press.

Bender, C. (2015). *Spirit* in T. Aubry & T. Travis (Eds.). *Rethinking   therapeutic culture*. (University of Chicago Press. Chicago & London., 2015) 46-58.

Bernstein, B. (1964). Social Class, Speech Systems and Psycho-Therapy. *The British Journal of Sociology*, *15*(1), 54.

Blum, L. M., & Stracuzzi, N. F. (2004). Gender in the Prozac Nation: Popular Discourse and Productive Femininity. *Gender & Society*, *18*(3), 269–286.

Bookman, S (2014) Brands and urban life: Specialty coffee, consumers, and the co-creation of urban café sociality. *Space and Culture* 17(1): 85–99.

Bourdieu, P. (1987). What makes a social class? On the theoretical and practical existence of groups. *Berkeley Journal of Sociology*, *32*, 1–17.

Bourdieu, P. (2001a). *Masculine domination*. Stanford University Press.

Bourdieu, P. (2001b). *Outline of a theory of practice*. Cambridge: Cambridge University Press.

Brown, W. (1995). *States of Injury*. Princeton, N.J: Princeton University Press.

Casey, M. A. (2002). Authority, crisis, and the individual. *Society*, *39*(2), 78–82.

Chesler, P. (2005). *Women and Madness: Revised and Updated* (Revised, Updated edition). New York, N.Y: St. Martin's Griffin.

Chodorow, N. J. (1991). *Feminism and Psychoanalytic Theory* (Revised ed. edition). New Haven London: Yale University Press.

Chriss, J. J. (1999). *Counseling and the Therapeutic State* (1 edition). New York: Aldine Transaction.

Cloud, D. L. (1998). *Control and consolation in American culture and politics: rhetoric of therapy*. London & Thousand Oaks, California: Sage Publicaitons.

Cobb, J., & Sennett, R. (1993). *The Hidden Injuries of Class* (Reprint edition). New York: W. W. Norton & Company.

Colvin, C. J. (2018). *Traumatic Storytelling and Memory in Post-Apartheid South Africa: Performing Signs of Injury* (1st ed.). London: Routledge.

Cresswell, J, Baerveldt, C (2011) Bakhtin's realism and embodiment: Towards a revision of the dialogical self. *Culture and Psychology* 17(2): 263–277.

Crossley, M. L., & Crossley, N. (2001). "Patient" voices, social movements and the habitus; how psychiatric survivors "speak out." *Social Science & Medicine*, *52*(10), 1477–1489.

Crossley, N. (2006). *Contesting psychiatry social movements in mental health*. London: Routledge.

Dineen, T. (1998). *Manufacturing Victims: What the Psychology Industry Is Doing to People* (1552070328 edition). Montreal: Robert Davies Pub.

Donzelot, J. (1980). *The Policing of Families*. New York: Random House Inc.

Duncan, W.L. (2017), *Dinámicas Ocultas*: Culture and Psy-Sociality in Mexican Family Constellations Therapy. Ethos, 45: 489-513.

Ehrenberg, A. (2016). *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age* (1 edition). McGill-Queen's University Press.

Elder, Jr. Glen H.; Johnson, M.K.; Crosnoe, R., (2003). "The Emergence and Development of Life Course Theory" in *Handbook of the Life Course* ed. by Jeylan T. Mortimer and Michael J. Shanahan (New York: Kluwer Academic/Plenum Publishers, 2003): pp. 3-19.

Elliott, A. (2016). *Subject to ourselves: social theory, psychoanalysis and postmodernity*.

Emirbayer, M., & Mische, A. (1998). What is agency? *American Journal of Sociology*, *103*(4), 962–1023.

Faludi, S. (2006). *Backlash: The Undeclared War Against American Women* (Anniversary edition). New York: Broadway Books.

Foucault, M., & Dreyfus, H. (2008). *Mental Illness and Psychology* (2nd edition). Berkeley, Calif.; London: University of California Press.

Freud, S. (2015). *A General Introduction to Psychoanalysis* (G. S. Hall, Trans.). Dodo Collections.

Furedi, F. (2004). *[(Therapy Culture : Cultivating Vulnerability in an Uncertain Age)]*. Taylor & Francis Ltd.

Gabriel, J. (2015) "Damage" in Aubry, T., & Travis, T. (eds.). *Rethinking Therapeutic Culture*. (University of Chicago Press. Chicago & London., 2015) pp:24-33.

Geçtan, E. (2016). *İnsan Olmak*. İstanbul: Metis Yayıncılık.

Giddens, A. (1992). *The Transformation of Intimacy: Sexuality, Love, and Eroticism in Modern Societies* (1st edition). Stanford, Calif: Stanford University Press.

Grodin, D. (1991). The interpreting audience: The therapeutics of self-help book reading. *Critical Studies in Mass Communication*, *8*(4), 404–420.

Gross, M. L. (c1978.). *The psychological society : a critical analysis of psychiatry, psychotherapy, psychoanalysis and the psychological revolution /* (1st ed.). New York : Random House.

Heidegger, M. (2008). *Being and Time* , translated by McQuire,J and Robinson, E. , New York: Harper Perennial Modern Classic.

Illouz, E. (1997). *Consuming the Romantic Utopia: Love and the Cultural Contradictions of Capitalism* (First edition). Berkeley: University of California Press.

Illouz, E. (2008). *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help* (First edition). Berkeley: University of California Press.

Kaminer, W. (1993). *I'm Dysfunctional, You're Dysfunctional: The Recovery Movement and Other Self-Help* (First Printing edition). New York: Vintage.

Kitzinger, C. (1996) Therapy and How it Undermines the Practice of Radical Feminism',in Bell, D., & Klein, R., (eds.) . *Radically Speaking*. North Melbourne, (Vic: Spinifex Press. 1996) pp. 921-101

Knorr Cetina, K (1997) Sociality with objects: Social relations in postsocial knowledge societies. *Theory, Culture and Society* 14(4): 1–30.

Lasch, C. (1984). *The minimal self: psychic survival in troubled times*. New York; London: Norton.

Lasch, C. (1991). *The Culture of Narcissism: American Life in an Age of Diminishing Expectations* (Revised edition). New York: W. W. Norton & Company.

La sociologie est un sport de combat. (n.d.).

Lerner, J., & Zbenovich, C. (2013). Adapting the Therapeutic Discourse to Post-Soviet Media Culture: The Case of *Modnyi Prigovor*. *Slavic Review*, *72*(4), 828–849.

Levinas, E. (1993). *Freedom and command.* In: Lingis, A (ed.) *Collected Philosophical Papers.* London: Kluwer Academic Publishers, pp. 15–23.

Levinas, E. (2007) *Totality and Infinity: An Essay on Exteriority*, trans. Lingis, A. Pittsburgh, PA: Duquesne University Press

Lichterman, P. (1992). Self-help reading as a thin culture. *Media, Culture & Society*, *14*(3), 421–447.

Lowney, K. S. (1999). *Baring Our Souls: TV Talk Shows and the Religion of Recovery* (1 edition). New York: Aldine Transaction.

Madriz, M. (2000). 'Focus Groups in Feminist Research', in N. K. Denzin and Y. S. Lincoln (eds), *Handbook of Qualitative Research*. 2nd edn. Thousand Oaks, CA: Sage.

Madsen, O. J. (2014). *The Therapeutic Turn: How Psychology Altered Western Culture*.

Mandziuk, R. (2001). Confessional discourse and modern desires: power and please in True Story magazine. *Critical Studies in Media Communication*, *18*(2), 174–193.

Mattley, C. (2006). 'Aural Sex: The Politics and Moral Dilemmas of Studying the Social Construction of Fantasy', in D. Hobbs and R. Wright (eds), *The Sage Handbook of Fieldwork*. London: Sage.

Matza, T. (2012). "Good individualism"? Psychology, ethics, and neoliberalism in postsocialist Russia. *American Ethnologist*, *39*(4), 804–818.

Maynes, M. J., Pierce, J. L., & Laslett, B. (2008). *Telling Stories: The Use of Personal Narratives in the Social Sciences and History*. Cornell University Press.

McLeod, J., & Wright, K. (2009). The Talking Cure in Everyday Life: Gender, Generations and Friendship. *Sociology*, *43*(1), 122–139.

Mead, G. H., Joas, H., & Huebner, D. R. (2015). *Mind, Self, and Society: The Definitive Edition* (First Edition, Enlarged edition; C. W. Morris, Ed.). Chicago ; London: University of Chicago

Mendes, G. (2015) "Race" in Aubry, T., & Travis, T. (eds.). *Rethinking Therapeutic Culture*. (University of Chicago Press. Chicago & London., 2015) pp:59-71

Mercan, B. A. (2018). Çağdaş Sınıf Sosyolojisinde Psikososyal Çözümleme. *Alternatif Politika*, 2018, 10 (2): 271-297 .

Mills, C. W., & Jacoby, R. (2002). *White Collar: The American Middle Classes* (50th anniversary edition). New York, N.Y: Oxford University Press.

Moskowitz, E. S. (2008). *In Therapy We Trust: America's Obsession with Self-Fulfillment*. Baltimore, Md.: Johns Hopkins University Press.

Plummer, K. (2009). "A preface, On Narrative Pluralism" in *The Story of Sexual Identity: Narrative Perspectives on the Gay and Lesbian Life Course* (Oxford, New York: Oxford University Press, 2009): pp. vii–xiv

Polsky, A. J. (1993). *The Rise of the Therapeutic State*. Princeton, NJ u.a.: Princeton University Press.

Reay, D. (1998). Rethinking Social Class: Qualitative Perspectives on Class and Gender. *Sociology*, *32*(2), 259–275.

Reay, D. (2008). Psychosocial Aspects of White Middle-Class Identities: Desiring and Defending against the Class and Ethnic `Other' in Urban Multi-Ethnic Schooling. *Sociology*, *42*(6).

Rieff, P., & Lasch-Quinn, E. (2006). *The Triumph of the Therapeutic: Uses of Faith after Freud* (1 edition). Wilmington, Delaware: Intercollegiate Studies Institute.

Rose, N. S. (2005). *Governing the soul the shaping of the private self*. London: Free Association Books.

Rose, T. (2004). *Longing to Tell: Black Women Talk about Sexuality and Intimacy* (1st Edition edition). New York: Picador.

Salmenniemi, S. (2017). "We can"t live without beliefs': Self and society in therapeutic engagements. *The Sociological Review*, *65*(4), 611–627.

Satel, S. S., & Sommers, C. (2006). *One Nation Under Therapy: How the Helping Culture Is Eroding Self-Reliance* (First edition). New York: St. Martin's Griffin.

Satter, B. (2015). *The Left* in Aubry, T., & Travis, T. (eds.). *Rethinking Therapeutic Culture*. (University of Chicago Press. Chicago & London., 2015) pp: 119-131.

Saunders, R., & Aghaie, K. S. (2005). Introduction: Mourning and memory. *Comparative Studies of South Asia, Africa and the Middle East*, *25*(1), 16-29.

Sayer, R. A. (2005). *The moral significance of class*. Cambridge University Press.

Sayer, R. A. (2011). *Why things matter to people: social science, values and ethical life*. Cambridge University Press.

Scanzoni, J. H. (2000). *Designing families: the search for self and community in the information age*. Thousand Oaks, Calif.: Pine Forge Press.

Sennett, R. (2003). *Fall of Public Man*. London: Penguin New Ed. Edition.

Showalter, E. (1998). *Hystories: Hysterical Epidemics and Modern Culture* (Main Market edition). Cambridge: Picador.

Simmel, G. (1965). *The Sociology of Georg Simmel*, ed. by K. H. Wolff, New York: The Free Press.

Simmel, G. (1971). *On Individuality and Social Forms*, ed. By D. N. Levine, Chicago: The University of Chicago Press. pp.6-35.

Simonds, W. (1992). *Women and Self-Help Culture: Reading Between the Lines* (First Edition edition). New Brunswick, N.J: Rutgers University Press.

Skeggs, B. (2004). *Class, Self, Culture*. London: Psychology Press.

Skeggs, B. (2010). The Value of Relationships: Affective Scenes and Emotional Performances. *Feminist Legal Studies*, *18*(1), 29–51.

Skeggs, B. (2011). Imagining personhood differently: Person value and autonomist working-class value practices. *The Sociological Review*, *59*(3), 496–513.

Skeggs, B. (2012). *Formations of class and gender: becoming respectable*. London: SAGE.

Skeggs, B., & Loveday, V. (2012). Struggles for value: value practices, injustice, judgment, affect and the idea of class: Struggles for value. *The British Journal of Sociology*, *63*(3), 472–490.

Soyubol, K. (2018). Turkey Psychoanalyzed, Psychoanalysis Turkified: The Case of İzzettin Şadan. *Comparative Studies of South Asia, Africa and the Middle East,* 1 May 2018; 38 (1): 57–72.

Staub, M. (2015). "Radical" in Aubry, T., & Travis, T. (eds.). *Rethinking Therapeutic Culture*. (University of Chicago Press. Chicago & London., 2015) pp: 96-107.

Swan, E. (2008). "You make me feel like a woman": Therapeutic cultures and the contagion of femininity. *Gender, Work & Organization*, *15*(1), 88–107.

Türk Psikologlar Derneği websitesi url: http://www.psikolog.org.tr/tr/

Van Maanen, J., and Kolb, D. (1985). 'The Professional Apprentice: Observations on Fieldwork Roles in Two Organizational Settings', *Research in the Sociology of Organizations*, 4: 1–33.

Weeks, J. (1997). *Invented Moralities* (First Edition edition). New York: Columbia University Press.

Whalen, S. (1996). *Therapeutic Constitutions of Shop-Floor Speech*. Paper presented at the 1996 convention of the Speech Communication Association, San Diego, CA, Nov. *World Memory - Personal Trajectories in Global Time | J. Bennett | Palgrave Macmillan*. (n.d.).

Wittel, A. (2001). Toward a Network Sociality. *Theory, Culture & Society*, *18*(6), 51–76.

Wright, K. (2008). Theorizing therapeutic culture: Past influences, future directions. *Journal of Sociology*, *44*(4), 321–336.

Wright, K. (2009). Engendering a therapeutic ethos: Modernity, masculinity & nervousness. *Journal of Historical Sociology*, *22*(1), 84–107.

APPENDICES

A. HUMAN SUBJECTS ETHICS COMMITTEE APPROVAL

Sayı: 28620816 / 183

12 Haziran 2019

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)
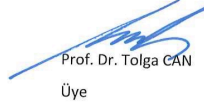
İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Doç.Dr. Fatma Umut BEŞPINAR

Danışmanlığını yaptığınız **Yiğit AKÇİN'ın "Türkiye'de Terapi Kültürü: Danışan-Terapist İlişkisinde Sosyal Sınıf ve Cinsiyet Boyutlarının Analizi"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **173-ODTÜ-2019** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof. Dr. Tülin GENÇÖZ

Başkan

Prof. Dr. Tolga CAN
Üye

Doç.Dr. Pınar KAYGAN
Üye

Dr. Öğr. Üyesi Ali Emre TURGUT
Üye

Dr. Öğr. Üyesi Şerife SEVİNÇ
Üye

Dr. Öğr. Üyesi Müge GÜNDÜZ
Üye

Dr. Öğr. Üyesi Süreyya Özcan KABASAKAL
Üye

B. TÜRKÇE ÖZET/ TURKISH SUMMARY

Son dönemde etrafımda konuştuğum pek çok genç insan ya bir psikoterapi sürecinden geçmiş olduklarını ya da bir terapi kliniğine gitmeye devam ettiklerini söylediklerinde bu konuyu sosyolojik bir gözle araştırmaya karar verdim. Terapiyle ilgili kendi kişisel deneyimim de bu konuyu, özellikle de terapist-danışan ilişkisinin *sosyalliğini* araştırmaya motive etti.

Bu tezin amacı benim gibi orta sınıftan birçok genç insanın içlerinde yaşadığı ve öznel biçimde tecrübe ediyor gibi göründüğü acı, şiddet, korku ve kaygı gibi duyguların terapi kültürü diyebileceğimiz bir etos içerisinden yorumlanışının toplumsal ve ilişkisel işleyişini ortaya koymaktır. Bir diğer ifadeyle özellikle orta ve üst orta sınıflardan pek çok genç kadın ve erkeğin bir şeyleri dert edinecek kadar yoğun duygular yaşayıp bunlarla mücadele edememesiyle başlayan, fakat yine de bunları bir çerçeve dahilinde formüle ederek terapinin sağladığı güvenli alanda ortaya dökmeleriyle devam eden sürecin nasıl toplumsal ilişkiler üzerine kurulu olduğunu anlamak bu tezin temel hedefidir.

Buna mukabil bu tez, terapinin sağladığı güvenli alanda orta sınıf kadın ve erkeklerin içinde bulundukları *sosyalliğin* nasıl yeniden üretildiği sorusunu da cevaplamayı amaçlamaktadır. Bu çerçevede dört soru öne çıkmaktadır. Öncelikle araştırma terapistlerin terapi ilişkisini nasıl sosyal olarak inşa ettikleri, terapistlerin danışanın etrafındaki hangi faktörleri bu süreçte önemli gördüğünü, ikinci kısımda ise danışan tarafına geçerek, genç orta sınıf kadın ve erkeklerin bu süreci nasıl sosyal olarak inşa ettiğini, son olarak tez danışanların *sosyalliğinin* terapi ilişkisindeki rolüne odaklanarak özel bir alanda kurulan bu ikili (dyadic) ilişkideki üçlü (triadic) yapıyı ve buradan hareketle terapi odasına dahil olan toplumsalı açığa çıkarmayı amaçlamaktadır.

Bu sorulara yönelik olarak terapinin nasıl bir çerçeveden yorumlandığı ve yorumlanabileceğine dair bir art alan çalışması yapıldığında, terapi kültürü tanımının batıda popüler hale gelen terapi uygulamalarının bireyselcilik ve tüketimcilik çerçevesinde kavramamıza yaradığı ve onu geniş kitleler tarafından harekete geçirilen bir eylem ve tahayyül çerçeveleri bütünü olarak algıladığı ortaya çıkmaktadır. Buna karşın, terapinin en yaygın uygulama alanlarından olan terapist ve danışan arasındaki birebir ilişkiye dayalı psikoterapi pratiğinin ne tarz toplumsal etkenlerle şekillendiği bu literatür tarafından sıkça göz ardı edilmiş bir konudur. Sosyalleşme (sociation) kavramını kullanarak sosyal tipler geliştirmiş ve ikili (dyadic) ilişkilere daha geniş bir çerçeveden bakarak toplumsalı anlamak için triad kavramını kullanan Georg Simmel'in teorik çerçevesi danışan ile terapist arasındaki özel ilişkiye odaklanarak bu ilişkinin toplumsallığını açığa çıkarmayı amaçlayan tezin ana referans noktasını oluşturmaktadır. Simmel'in sosyalleşme anlayışı (1971), Levinas (1993), Heidegger (2008) ve Bauman (2009) gibi çağdaş düşünürlerin işaret ettiği ilişkisel "sosyallik" (sociality) kavramıyla uyumlu olarak insanları çevrelerini etkiledikleri ve ondan etkilendikleri ve günlük etkileşimde sürekli olarak gerçekleşen bir sosyalleşme süreci içerisinde var oldukları haliyle algılanmaktadır.

Literatürdeki tanımlarla uyuşmakla birlikte, bu tezde *sosyallik* kavramının belirli bir sosyolojik anlamı öne çıkmaktadır. *Sosyallik*, burada, sosyal tipleri ve onlara dair toplumsal eylemleri üreten bir gerçekliğe işaret etmektedir. Bu anlayışa göre, toplumsal bir fragmana çok yakından bakıldığında birey ön plana çıkarken odağı büyütmek toplumsal olanı öne çıkarmakta ve *sosyalliğin* araştırma nesnesi olması bir ölçek tanımlaması yapmayı gerektirmektedir. Bu nedenle, bu tezde etkileşim ve *sosyallik*, sadece bir ikili ilişki (dyad) içerisindeki tarafları değil, toplumsalın oluştuğu geniş gruplar ve toplulukları da kapsayan bir ölçeğe gönderme yapmaktadır. Sonuçta, toplumsalın ortaya çıkışını gösteren en küçük grup, en az üç unsur içermelidir ve bu nedenle triad olarak adlandırılır. Üçüncü taraf, bu resimde, ikili arasındaki ilişkiye yeni bir yön ekleyerek bir ortaklaşma sağlanmasını

mümkün kılmaktadır. Böylelikle dyad içerisindeki iki unsuru aşan bir resim açığa çıkmaktadır (Simmel, 1965).

Ayrıca, tez, sosyoloji literatürü içerisinde terapi uygulamalarını araştırma nesnesi olarak ele alan çalışmaları serimlemektedir. Terapinin, sadece psikoloji ve psikiyatriye dayalı bir tıbbi uygulama olarak değil de sosyolojik bir nesne olarak kavramsallaştırılması, terapiye eleştirel bakan bir literatürle birlikte ortaya çıkmıştır. Öncelikle terapi, bir dünya görüşü olarak kabul edilirken (Rieff, 1966; Madsen, 2014), insanların iç dünyalarını ve sosyal gerçekliği anlamak ve açıklamak için benimsenen kapsamlı ve tutarlı bir dizi varsayım bütünü olarak nitelendirilmektedir. 1950'li ve 60'lı yıllarda eleştirmenler, uzman terapistlerin terapiyi öncelikle Freud ve çağdaşlarından ilham alarak özgürleştirici ve bilimsel bir pratik olarak inşa ettiklerini ve psikanalize büyük bir güven duyduklarını, ve hatta bunun bir hayat tarzını da beraberinde getirdiğini ileri sürmektedir (Rieff, 1966; Madsen, 2014).

Buna göre, Freud'dan ilham alan terapistler, toplumun bireylerin hedonistik arzularına kurallar ve sınırlar koyduğunu ve insan ruhunun doğal olarak benmerkezci olduğunu varsaymaktadır. İlk eleştirmenler terapötik dünya görüşünde toplum düzeni zarar görmedikçe insan özgürleşmesi sağlanamayacağı için bu görüşün toplumsal uyumu tehdit ettiğini düşümektedir (Rieff, 1966). Bu dönemde terapi literatürü buna yeni bir boyut ekleyerek, öncelikle "dünya görüşü" kavramını "kültür" ile ikame ederken analizler terapiye eleştirel konumdan yaklaşmaya devam etmiştir. Terapi deneyimi de, popüler kültürde, özellikle de Amerikan kültüründe ayrı bir yeri olan bir dizi temel inanç, duygu ve pratiği imlemeye başlamıştır. (Ehrenberg, 2016). Esas olarak terapistlerin failliğiyle oluşan bir dünya görüşü olmaktan ziyade, toplumsal süreçlerde üretilen ve tüketilen bir kültürel meta olarak ele alınan terapi, 1960'larda o kadar yaygın hale gelmiştir ki, televizyon şovları ve popüler dergiler gibi yeni yükselen medyanın içerisinde kişisel danışmanlık sayfalarının ortaya çıkmış ve travma hikayelerinin bu

çerçevede buralarda yer almıştır. Bunun sonrasında terapi etos'unun varsaydığı savunmasız fakat rasyonel benlik kavramının doğum, ölüm veya ebeveynlik gibi gündelik dertleri açıklamakta yaygın kullanılan bir çerçeve haline geldiği de görülmektedir (Furedi, 2004). Bu aynı zamanda terapinin analizinde erken bir kırılma anlamına gelmektedir. Bundan böyle terapinin klinikle sınırlı kalmadığı kabul edilirken, danışan ve terapist arasındaki yüz yüze ilişki de analizin ana konusu olmaktan uzaklaşmıştır. Aksine, insanların kavrayışlarına ve duygusal durumlarına dayanan daha geniş bir inanç ve uygulamalar seti analizin merkezine geçerken ortaya çıkan bu olguyu tanımlamak için "psikoloji toplumu" (Gross, 1978), "terapi kültürü" (Furedi, 2004; Imber, 2004) gibi kavramlar kullanılmaya başlanmıştır.

Konuyu teorik açıdan ele almada bu ilk çabalardan sonra, terapinin insanları kendi sosyal çevreleriyle uyumlu bir hale gelmeye teşvik ettiği fikri makul görülmeye başlanmışken terapi etosuna bu temelde yeni eleştiriler getirilmiştir. Bu eleştirel yaklaşımlara göre, öncelikle terapi, 20. yüzyılın tüketimci ve bireyci popüler kültürü içinde ideolojik bir araç olarak anlaşılmaktadır. Bu dönemde terapötik ethos ile doğrudan ilgili olmayan, ancak bu kültürel eğilimleri eleştiren Sennett'inki gibi (2003) bazı analizler dahi terapi kültürüne referans verme ihtiyacı duymaktadır. 1990'lı yıllarda ise Lerner ve Zbenovich (2013), Matza (2012), Rose (1998) ve Salmenniemi (2017) gibi bazı araştırmacılar Foucault'nun çalışmalarından ilhamla yaygın psikoterapi uygulamalarının ve terapi kültürünün, psikiyatrik paradigmanın yerini "sağlık tüketicisi" çerçevesine bırakmasından sonra ortaya çıktığını göstererek bunun tüketimci bir toplumsal durum içerisinde nasıl yeni faillikler ürettiğini göstermiştir. Buna göre eskiden "akıl hastalığı" çerçevesinden tanımlanan, örneğin depresyon, insanların özdeşleşip kendine mal edebileceği bir "ruhsal durum" haline gelmiştir.

Tez bu noktada sosyoloji literatürü içerisinden danışanların *sosyalliğini* etkileyen faktörlere, özellikle de sınıf ve toplumsal cinsiyet ilişkilerine odaklanmaktadır.

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Sosyo-ekonomik statü söz konusu olduğunda anılması gereken farklı araştırmalar olmakla birlikte toparlayıcı olanlardan biri, Lichterman'ın (1992) orta sınıfların kişisel gelişim kitaplarını nasıl karmaşık bir hikayeleme geliştirerek yorumladığını ve bu literatürü "karakter özelliklerine dayalı bir benliği" toplumsalın içine yerleştirmek için kullandığını gösteren çalışmasıdır. Bu yorumlarda orta sınıfa ait "esnek davranma" ve "kendini geliştirme" kültürü açıkça görülmektedir. Benzer şekilde, Lasch ve Foucault'nun argümanlarını takiben Donzelot, (1979) ataerkilliğin gücünün azaldığı dönemde psikolojik bilginin aileyi fethetmesinin sınıflar arasında statüye dayalı bir hiyerarşi ve ayrım yarattığını, sonuç olarak da orta sınıfı desteklemek için bir araç olarak çalıştığını iddia etmiştir. Buna göre ancak orta sınıflar kendi kültürel eğilimleriyle uyumlu olarak terapiye ne zaman ve nerede başlayabileceklerine karar verecek güce sahiptir.

Tez, sınıfsal ayrımlara dayalı toplumsal ilişkiler düzlemiyle terapi uygulamalarının kesişimine dikkatimizi çektikten sonra tartışmanın en üretken hattına, terapinin toplumsal cinsiyet ile ilişkisine odaklanmaktadır. Terapi ile feminist hareketin kesişim ve ayrışma noktaları birçok feminist akademisyen tarafından üzerine çalışmış bir meseledir. Öncelikle araştırmacılar beyaz orta sınıf kadınların sürüklediği ikinci dalga feminizm ile terapi uygulamaları arasında kadını kamusal alanda güçlendirmeye dayalı bir ittifak kurulabildiğini göstermektedir (Becker, 2005).

Ancak feministler bu ortaklık kurulduktan sonra Freudcu yaklaşımı, zamanın eril idealleri olan bağımsızlık, özerklik vb. kavramların üzerine kurulu olması nedeniyle eleştirirken (Chodorow, 1989), psikolojik bilginin iktidar ilişkilerinde oynadığı rol konuşulmaya başlanır (Becker, 2005). Terapinin mevcut sosyal eşitsizlikleri onaylayan özelliklerini kadınları yönetmeyi ve kontrol etmeyi amaçlayan araçlar yorumlayan feministler terapinin duyguları ve kadınların iç dünyalarını öne çıkararak kamusal meseleleri kişiselleştirdiğini göstermektedir (Kitzinger, 1996). Bu dönemde güçlü bir kurum olarak bilim ve tıp psikiyatri

uygulamaları ve akıl hastalığı kategorisini kullanmaya devam ederek kadının durumunu patolojik bir çerçeveden yorumlaya devam etmektedir (Chesler, 2005; Showalter, 1998). Psikoloji ve psikiyatri pratiğinde "histerik kadın" imgesiyle birlikte kadınların dezavantajlı konumları ve buna bağlı mutsuzluklarını psikiyatrik tanı ve psikotik ilaçlar yoluyla ölçme ve düzeltme çabası da feminist hareketlerin eleştirdiği ve gündeme getirdiği bir konudur (Blum ve Stracuzzi, 2004).

Sonuçta, terapi ile feminizmin arasındaki ilk ittifak yerini bir tartışmaya bırakırken bu resme terapi kültürün her zaman sınıflı bir konumdan sosyal olarak kurulduğu gerçeğini eklersek, bazı insanlar terapiyi popüler kültürün bir parçası olarak deneyimlediği, bazılarının ise uzmanlarla uzun vadeli güven ilişkisi kurarak terapiyi psiko-sosyal bir araca dönüştürdüğü bir durum ortaya çıkmaktadır. Bu kısa literatür taramasından sonra kullanılan metodolojinin ortaya konmakta ve veriler analiz edilmektedir.

Çalışmanın temel çıkış noktasının terapi süreci içerisindeki toplumsal ilişkiler ağını haritalamak olduğu dikkate alındığında katılımcıların, yani terapist ve danışanların, deneyimleri, sözleri, sesleri ve yaşamlarını duymak için etnografik metodoloji en uygun veri toplama yöntemi olarak ortaya çıkmaktadır. Bu tezde araştırmacı iki ayrı grup için iki görüşme sorusu seti oluşturarak dört kadın terapist ve terapi sürecinden geçmiş beşi kadın dördü erkek toplamda dokuz danışanla görüşmüştür. Veri toplama sürecinde kullanılan mülakat soruları ODTÜ Sosyal Bilimler Enstitüsü Etik Kurulu tarafından onaylanmış ve sürecin tamamlanması 5 ay sürmüştür. Uzman katılımcıları araştırmacının içinde bulunduğu çevreye yakınlıklarını bağlı olarak seçilirken halihazırda terapi görmüş ya da görmeye devam eden ve terapinin yaşamları üzerinde önemli bir etkisi olduğunu iddia eden kişiler arasından seçilen danışan katılımcılara kartopu örnekleme yoluyla ulaşılmıştır. Araştırmacının kendi terapötik geçmişi görüşmecilere ulaşmada kolaylaştırıcı bir işlev görürken, hem terapistlerin kendilerine başvuran danışanların orta sınıflığına vurgu yapması hem de katılımcıların genelinin

araştırmacıya benzer yaşam koşullarına sahip olması, büyük kentlerde yaşayan orta sınıftan geçlerin deneyimini tezin odak noktası kılmaktadır. Bu nedenle, giriş bölümünde belirtildiği gibi bu çalışma, işçi sınıfı ve üst sınıflarından oluşan geniş bir grubun terapi deneyimlerini kapsamamaktadır. Son olarak, diğer birçok etnografik çalışmada olduğu gibi görüşmelerde ve sahada toplanan veriler kısmen teorik çerçeveden hareketle kısmen de verinin içerisinden çıkan kategorilerle kodlanarak nitel bir analize tabi tutulmuştur.

Buna bağlı olarak bu tez "Genç orta sınıf erkeklerin ve kadınların *sosyalliği* terapist-danışan ilişkisinin sağladığı "güvenli alan" içerisinde nasıl yeniden üretilmektedir?" ana sorusundan yola çıkarak danışan ile terapist arasındaki ikili ilişkiyi genişletmeyi ve bu özel alan içerisinde toplumsal ilişkilerin bir parçası olarak çıkan *sosyalliği* anlamayı amaçlamıştır. Öncelikle bulgular terapi olgusunun profesyonel bir meslek alanı olarak son 20 yılda, özellikle 1999 depreminin terapinin topluma müdahale etmesini halk nezdinde meşru kılmasıyla birlikte, popüler hale geldiğini ve bu tarz toplumsal kriz durumlarında biçimlendirici bir role sahip olduğunu göstermiştir. Terapistlerin ve dolayısıyla özel kliniklerin sayıları buna bağlı olarak hızla yükselirken bu durum profesyonel psikoterapi alanında, devlet kurumlarının bu değişimi yönlendirme ve terapiyi bir meslek alanı olarak düzenlemekten geri durması ve özel girişimlere yer açmasıyla, etik ihlaller ve mesleki sınırların muğlaklığına bağlı bir heteronomi olarak tecrübe edilmektedir. Terapistler, bunun sonucunda, mesleklerinin sürekli olarak tanımlamak ve artan danışan sayısından kişisel fayda sağlayanlara karşı kendilerini kanıtlamak zorunda kalmaktadır.

Bununla beraber, terapi etosunun toplumsal olarak nasıl inşa edildiğine baktığımızda, Türkiye'de terapi uygulamalarının üç temel işlevi olduğunu görülmektedir. İlk olarak terapi, yukarıda bahsedilen örnekteki gibi büyük kazalar veya afet gibi toplumsal kriz zamanlarında ortaya çıkan yaraları iyileştirmenin bir aracı olarak konumlanmıştır. İkinci olarak bu role biçilen sosyal itibara da

dayanarak, toplumda ruhsal durumu nedeniyle dışarıda kalmış ve duygusal olarak zayıf görülen insanlar için bir destek mekanizması olarak çalışmaktadır. Bu mekanizma özellikle toplumsal konumlarının duygusal yükünü bir anlatı içerisine yerleştirip kanalize ederek kendini hem kamusal hem de özel alanda rahat hissetmek isteyen orta sınıf gençler arasında popülerlik kazanmıştır. Terapinin zayıf ve uygun olmayanı destekleme işlevi, psikoterapide ulaşılamayan vakaları, terapist ve danışan arasında anlamlı bir konuşmanın mümkün olmadığı durumları kontrol etme hedefiyle beraber psikiyatri pratiğine yardımcı olma noktasındaki, üçüncü, ana rolüne referansla tanımlanmaktadır. Şiddet içermesi muhtemel psikiyatrik durumlarda hapların ve farklı tekniklerin kullanımına, ve bu süreçte de terapi kliniği psikiyatrik müdahaleyi güvenli bir ortamdan destekleyerek danışanla anlaşmanın yolunu açan bir işlev üstlenir.

Çalışma terapistler ve danışanlar tarafından terapinin sosyal olarak nasıl inşa edildiği üzerine odaklanmaktadır. Terapi kliniği bu ikili ilişki çerçevesinde danışanların bireysel amaçlarına hizmet eden güvenli bir destek mekanizması olarak inşa edilmiştir. Buna göre danışanın konuşarak ifade edebildiği sorun ve acılar özel bir kurum olarak terapiye havale edilirken, danışanın çevresine ya da kendisine zarar vermesi ihtimali olan psikotik vakalar devlet tarafından finanse edilen psikiyatri kurumları tarafından kontrol edilmektedir. Bu ayrım beraberinde akıl hastası ve danışan ikiliğini getirmekte; terapistler bu ayrımı biyolojik müdahale gerektiren vakalar ile güvenli bir bölgenin inşa edilebileceği sosyal uyumsuzlukları ayırt etmekte kullanmaktadır.

Aynı zamanda bu tez insanların duygularını ifade ederek kamusal alanda etkin bir fail olma istekliliği taşıdıkları ve kişiliklerini buna göre yeniden yapılandırmaya hazır oldukları ölçüde göre danışan olabileceklerini göstermiştir. Bu durumlarda toplumsal cinsiyet pozisyonları, terapi öncesi sırası ve sonrasında kişilerin acılarını sorunlaştırma biçimlerini, ve yeniden kimlik inşa süreçlerindeki dinamikleri etkilemektedir. Buna göre kadınlık pasif olarak kodlanırken ve onlardan kamusal

alanda, örneğin sıklıkla iş yerinde, kendilerini aktif failler olarak yeniden yapılandırmaları ve duygularını görünür hale getirmeleri beklenmektedir. Terapi deneyimi kadınlar duygularının hem kendileri hem de başkaları tarafından histeri belirtileri veya kadınlıklarından kaynaklanan kusurlar olarak görülmemesine, varoluşlarının bir parçası olarak yaklaşılmamasına neden olabilmektedir. Ayrıca kadınlar kendi "zayıflıklarını" ele alma ve mücadele etmekte, bunula birlikte yardımı kabul etmekte erkeklere oranla daha az cesaretlendirmeye ihtiyaç duymaktadır. Buna bağlı olarak terapistler danışanlarının yüzde seksini kadınların oluşturduğunu ifade etmektedir. Erkekler ise duygusal kimliklerini, terapist-danışan ilişkisinin sağladığı güvenli alan içerisinde, kamusal alanda gösterdikleri "desteğe ihtiyaç duymayan" "bağımsız" erkeklik performansları yerine cinsiyetsiz olarak görülen çocukluk ve buna bağlı olarak savunmasızlığı koyarak yeniden inşa etmektedir.

Analizde üçüncü eksen, terapi ilişkisinde *sosyalliğin* rolü ile ilgilidir. Akıl hastalığı ve danışan olma ile ilgili farklı bakışlar aynı zamanda acı çekme ve bunun giderilmesi ile ilgili farklı tekniklere atıfta bulunurken, terapist ve danışan arasındaki ikili ilişki, rahat ve özgür bir iletişim için güvenli ortamın kurulabileceği ve ikisi arasındaki bir uyumun yakalanabileceği fikrine dayanır. Terapistlerin bakış açısından bu, her iki tarafın da ilişkiye dahil olmasını ve süreçte aktif olmasını gerektirir. Dahası, danışanın kendisini kliniğe getiren problemlerle işlevsel olarak başa çıkması için bazı kaynakların hali hazırda mevcut olması ve danışanın terapinin gerektirdiği zihinsel ve duygusal zorluklara hazır olması gereklidir. Terapistlere göre bu süreçte ekonomik bağımsızlık ve bireysellik önem kazanırken danışanın, sürece müdahil olmak isteyebilecek kişileri klinikte olan bitenden uzak tutabilmesi ve terapiye ödenen paranın ana kaynağı olması beklenir. Son olarak, terapistlerin bakış açısıyla terapi, danışanın kendisi ve onu çevreleyen insanlar üzerinde belirli bir eleştirel bakış geliştirmesini gerektirir.

Danışanın *sosyalliğinin* rolüne bakıldığında, danışanın sosyal ilişki ağı içerisinde

sorunların tanımlandığı ortaya çıkmakta ve hatta terapinin gerekliliğinin kimi zaman bu ağ içerisinde kararlaştırıldığı görülmektedir. Terapiye gelmeden önceki *sosyallik* , baskılayıcı ve destekleyici olmak üzere, iki faktörün olduğu bir üçlü grup içerisinde şekillenmektedir. Bu resimde kişiyi duygusal olarak rahatsız eden unsurlar "baskılayıcı", kişinin bu unsurları fark ederek sorun haline getirmesinde rol oynayan kişi ya da unsurlara da "destekleyici" adı verilmiştir. Hem terapi süreci öncesinde hem de sonrasında bu iki unsurun danışanın sosyalliğini ve terapi sürecini belirleyen bir rol oynadığı görülmekte, danışan ile terapist baskılayıcı unsurun bir tanımını yaparken bir ortaklık kurmaktadır. Aynı zamanda danışanın dışarıdaki destekleyicilerinin de bu süreçte, bir referans noktası oluşturması ve terapi öncesi ve sırasında bir destek kaynağı işlevi görebilmesi açısından önemli olduğu görülmektedir.

Terapinin sağladığı "güvenli alan" halihazırda klinik dışında var olan psikolojik destek kaynaklarını yaygınlaştırarak "kendini geliştirmek", "hayatını yaşayabilmek", "daha rahat olmak" isteyen genç ve eğitimli orta sınıf için anlamlı hale gelmektedir. Terapiye yatırım yapmak için yeterli ekonomik araçlara sahip olup kendilerini hayatlarının erken bir döneminde gören orta sınıf erkek ve kadınlar, bu şekilde duygusal ve zihinsel olarak kendileri üzerine çalışmak için önemli miktarda zaman ve zihinsel çaba göstermeye istekli hale gelmekte ve belirli bir ekonomik ve sembolik avantajı olan beyaz yakalılar olarak konumlandırıldıkları sosyal yerlerine daha iyi uyum sağlamalarıyla sonuçlanacak bir süreç olarak terapiyi kurgulamaktadırlar. Ayrıca, duygularını sözel olarak iletme ve yaşamlarını kronolojik bir anlatıya koyma ve ilerleme, iyileşme eğilimiyle sosyal çevreleri ve kültürel geçmişleri bu süreçleri desteklemektedir.

Bununla birlikte, destekçilerin olduğu sosyal pozisyonları içerisinde, danışanın zayıf veya uyumsuz olmakla ilişkili duygularını fark edip harekete geçmeye yönlendiren bir, gizli, toplumsal baskı da ortaya çıkar. Böylece terapi kişinin psikolojik zayıflığını tanımasıyla beraber, *sosyalliği* çerçevesinde kendisine tehdit

oluşturan üçüncü bir unsuru terapistle beraber tanımlayarak onunla ittifak oluşturmasına dayanan bir süreç haline gelmektedir.

Tez, buradan hareketle, terapinin danışanın *sosyalliğine* uyum sağlaması üzerine kurulduğunu ve buradan gelen rahatlamanın belirli bir toplumsal karşılığı olduğunu göstermektedir. Bu anlamda terapi tarafından sağlanan "kişisel gelişim", dönüştürücü güce sahip olmaktan ziyade bir kendi kendini onarım sürecidir. Ancak yine güvenli alandaki konfor dışarı taşındığında danışanın kendini rahatsız eden şeyleri ifade edip bunlarla terapi yöntemiyle mücadele etmeyenler hakkında konuşmaya başlamasında görülebileceği gibi etkileri gerçektir.

Özetlemek gerekirse, danışanlar arkadaşlarıyla olan ilişkilerinde olduğu gibi, yakınlarında bulunan güvenlikli bir alandan kaynaklanan bir güvenlik hissi ile donatılmış şekilde terapiye başlar ve ekonomik bağımsızlığa sahiptirler. Orta sınıftan genç danışanlar kendi *sosyallikleri* içerisinden doğan güvenlik hissi sayesinde, yine bu çevrede tanınabilir hale gelen acılarını ve duygusal yüklerini terapi içerisinde oluşturdukları tercihli zayıflıklarına kanalize ederler. Terapi süreci, bu gruba, kendi çevrelerinde tanıyabildikleri ancak tam olarak müdahale edemedikleri, zayıflık olarak tanımlanmış özelliklerini dönüştürebilecekleri ve yeniden tanımlamayabilecekleri alanı sunmaktadır.

Sonuç olarak, bu çalışma terapistler ve genç orta sınıf danışanlar arasındaki etkileşimde, her iki tarafın da süreci nasıl toplumsal bir konumdan inşa ve pratik ettiğini analiz ederek ve terapi öncesinde, sırasında ve sonrasında danışanın *sosyalliğinin* hangi toplumsal dinamikler çerçevesinde oluştuğunu ve yeniden üretildiğini göstermektedir. Bunu yaparken toplumsal faktörler olarak cinsiyet ve sınıfın terapist ile danışan arasındaki ilişki üzerindeki etkileri bu araştırma vesilesiyle görünür hale gelmektedir.

İki tarafın da bakış açılarının dikkate alan araştırmaların az sayıda olduğu da düşünülürse, bu çalışma terapist ile danışan arasındaki ilişkinin toplumsallığını gösteren sosyolojik bir araştırma olarak terapi üzerine sosyolojik literatüre katkıda bulunmaktadır. Ayrıca, çalışma hem terapistlerin hem de danışanların öznel deneyimlerini ve konumlarını, iki arasındaki ortaklığı mümkün kılan faktörlerle birlikte göstererek ve terapi odasındaki güç ilişkilerinin belirli sosyal koşullara nasıl bağlı olduğunu açığa çıkararak sosyolojik literatürde terapi ile ilgili bir boşluğu doldurmaktadır. Son olarak bu çalışma yakın dönemde artan şekilde terapi kliğine giden genç orta sınıf kadın ve erkekliklerin toplumsal koşullarını ve bunun terapiyle olan ilişkisini yeniden üretim ve *sosyallik* çerçevesinden ele alarak toplumsal cinsiyet ve sınıf ayrımlarının duygulanımsal boyutuyla ilgilenen araştırmacılar için de zihin açıcı analizler içermektedir.

Bu çalışmada, sosyalliğin, insanları terapiye getiren nedenlerden başlayarak sürecin sosyal olarak nasıl inşa edildiğine kadar terapinin her aşamasını etkilediği gösterilmiştir. İnsanların terapiye geliş nedenleri hem bu sosyal inşada hem de süreçte etkili olan faktörlerin etkisiyle belirlenmiş olduğundan farklı sebeplerden terapiye gelmiş insanlarla konuşulması araştırmaya farklı boyutların yansımasına neden olmuştur. Aynı nedenle terapi sürecine başlamış bir grubun, örneğin uzun süre işsiz kaldığı için depresyona girerek tedaviye gelmiş kişilerin, seçilmesiyle yapılacak bir çalışma terapi içerisinde toplumsal mekanizmaların daha iyi görülmesini sağlayacaktır.

Ayrıca çalışmada sadece belirli bir yaş grubundan insanlarla görüşüldüğü için farklı yaş gruplardan danışanların süreci deneyimleme biçimlerine yer verilememiştir. Farklı jenerasyonlardan danışanlarla görüşülerek yapılan karşılaştırmalı bir çalışma hem terapinin popülerleştiği tarihsel sürecin anlaşılmasını hem de terapiyi insanların yaşam seyirleri içerisinde daha geniş bir çerçeveye yerleştirerek yaş faktörünün etkilerinin belirgin olarak görülmesini kolaylaştıracaktır.

Bununla birlikte yakın dönemde gençlerin yetişkinlik deneyimlerini erteleyerek iş hayatına yaşamlarının daha ileri bir döneminde girdikleri düşünüldüğünde bu toplumsal olguyu dikkate alarak yapılacak bir çalışma orta sınıftan gençlerin *sosyalliklerinin* hangi toplumsal koşullarda oluştuğunu ve yeniden üretildiğini daha iyi anlamayı mümkün kılabilecektir.

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