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LGBT+ DIMENSION OF THERAPEUTIC VIOLENCE

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SUMMARY

This study explores therapeutic violence based on the concept of violence and explores the impact of various dimensions of therapeutic violence on LGBT+ clients. Because the concept of therapeutic violence is multidimensional, the topic is addressed in general terms, and the topic of therapeutic violence in the LGBT+ context is explored in detail. A review of studies in this area reveals There are no studies evaluating the effectiveness of psychological interventions in the context of therapeutic violence against LGBT+ individuals, nor are there any longitudinal follow-up studies of homosexual clients who have received specific counseling or therapy. Studies addressing the LGBT+ dimension of therapeutic violence and its effects on homosexual clients in Türkiye are also insufficient. Research in this direction will contribute to identifying the factors that contribute to therapeutic violence against homosexual clients, presenting existing results, and subsequently developing necessary preventative measures.

The key findings of this study are that therapists' attitudes, knowledge, and practices can both create and mitigate therapeutic violence, and they should be aware of the reality and stereotypes of the non-heterosexual world. Having sufficient knowledge in this area can lead to counselors exhibiting less prejudicial attitudes and making fewer heterosexual assumptions. Furthermore, therapists must be free of heteronormative biases. The therapeutic relationship, established with LGBT+ clients as well as with non-LGBT+ clients, is a crucial factor in preventing therapeutic violence. The extent to which the therapeutic process is clouded by therapists' assumptions and attitudes is a separate topic of discussion; therapists' implicit assumptions and attitudes about LGBT+ clients' actions and decisions can create conflict and potentially hinder therapeutic effectiveness. Therefore, therapists should remember that when claiming to understand LGBT+ clients, they must support this with a theoretical framework, not assumptions.

Keywords: *Therapeutic violence, LGBT+, conversion therapy, therapeutic relationship.*

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ABSTRACT

This study deals with therapeutic violence based on the concept of violence and investigates the effects of different dimensions of therapeutic violence on LGBT+ clients.
Since the concept of therapeutic violence is multidimensional, the subject was discussed in general terms and the issue of therapeutic violence in the context of LGBT+ was elaborated.
When the studies conducted in this field are examined, there are no studies evaluating the effectiveness of psychological interventions in the context of therapeutic violence against LGBT+ individuals, nor are there any longitudinal follow-up studies of homosexual clients who have received a specific counselling service or therapy. In Turkey, there are also insufficient studies addressing the LGBT+ dimension of therapeutic violence and its effects on homosexual clients. Research to be conducted in this direction will contribute to determining the forms of factors that create therapeutic violence in the context of homosexual clients, revealing the current results and then working on necessary measures.

The main findings of this study are that therapists' attitudes, knowledge and practices can both create and reduce therapeutic violence and that they should be aware of the reality and stereotypes of the non-heterosexual world. Counsellors' adequate knowledge in this area may lead to less prejudiced attitudes and less heterosexual assumptions. However, therapists need to be free from heteronormative prejudices. The therapeutic relationship with LGBT+ clients is as important a factor in preventing therapeutic violence as it is with non-LGBT+ clients.

How the therapeutic process is overshadowed by the therapists' assumptions and attitudes is a separate topic of discussion; the therapist's implicit assumptions and attitudes about the actions and decisions of LGBT+ clients have the potential to create conflict and hinder therapeutic effectiveness. Therefore, while the therapist claims to understand LGBT+ clients, he/she should remember that he/she should support this with a theoretical structure, not with his/her assumptions.

Keywords: *Therapeutic violence, LGBT+, Conversion therapy, Therapeutic relationship.*

Introduction

The phenomenon of therapeutic violence is a multidimensional and interdisciplinary concept. It begins with the therapeutic relationship between counselors (e.g., psychologists, clinical psychologists, psychological counselors, psychiatrists, social workers) and clients, and evolves when the therapist imposes his or her will on the client or when the client deviates from the goals of the collaboration. Dilemmas within the therapeutic process within the context of counseling constitute the fundamental elements underlying this evolution. Three key elements that trigger therapeutic violence in this process stand out: it involves a model of psychological manipulation, physical violence is not necessary to gain power over clients, and therapists use a wide variety of psychological tactics to maintain control (Daw, 2019). These elements of therapeutic violence can be seen not only in the context of counseling services but also in many disciplinary fields, such as health, law, and finance, with each discipline adapting its own form. Within this multidimensional framework, each discipline views therapeutic violence from its own perspective, but a common thread across all disciplines is their emphasis on collaboration and dialogue in preventing violence. Therefore, to avoid therapeutic violence, open and honest communication between client and therapist is essential, the client's rights, values, and wishes are respected, the appropriateness and effectiveness of treatments are determined, and the benefits, risks, and burdens of each option are considered, using evidence-based guidelines and criteria. Furthermore, the therapist's ability to loosen their grip on objective truth, avoid claiming objective truth in systemic studies, and remain open to alternative possibilities will be the most important factors in reducing the risk of therapeutic violence during the therapy process. (McNamee et al. 2020)

Because therapeutic violence is a multidimensional and interdisciplinary concept, this study addresses the phenomenon of violence, examining its content within the context of psychological counseling services and revealing therapist- and client-related factors. Finally, the topic of therapeutic violence within the context of lesbian, gay, bisexual, transgender/transsexual individuals, and other sexual orientations [LGBT+] is elaborated. A review of studies in this area reveals no studies evaluating the effectiveness of psychological interventions related to therapeutic violence against LGBT+ individuals, nor are there any longitudinal follow-up studies of homosexual clients who have received specific counseling or therapy services.

1 LGBT refers to lesbian, gay, bisexual and transgender/transsexual individuals. However, it is recognized that these four letters do not necessarily include everyone whose sexuality is not heterosexual or whose gender identity is not based on the traditional gender binary. Therefore, the '+' symbol is used to include people whose identities do not fit within the typical binary concepts of male and female, or who choose to define themselves using other categories to define their gender identity or understanding of their sexuality.

While acronyms like LGBTQ, LGBTQ+, and 2SLGBTQ+ are used today, the word "LGBT+," which became synonymous with this movement and began to be used in the late 1980s, is an umbrella term used in the fight for gay rights. In this study, the acronym LGBT+ is used to preserve the meaning of the umbrella term.

No studies have been found. Therefore, this study themed *"LGBT+ Dimension of Therapeutic Violence"* will contribute to the literature.

1. Therapeutic Violence

The Turkish Language Association (2023) defines the concept of violence in its simplest form as the degree of extremity of an action, power, emotion, or behavior. The World Health Organization [WHO] defines it as threats or actions that cause or are likely to cause injury, death, psychological harm, developmental impairment, or deprivation to oneself, another, or a community as a result of the intentional use of force or physical force (Krug et al., 2002). However, this definition should be considered as a broader concept within the context of the client and therapist. Hick and Bien (2008) state that therapeutic violence occurs when the therapist imposes their own wishes or worldview on the client in any way during the session. Similarly, Karl Tomm states that relating to clients in a different way within therapeutic contexts, imposing our own values and beliefs on clients, whether intentionally or unintentionally, constitutes a form of therapeutic violence (Sanders, 2014). In the context of these statements, the action that occurs when counselors impose their will or worldview on the client in any way is defined as therapeutic violence (Malinen et al., 2013). More broadly, therapeutic violence involves the systematic and intentional use of words and non-physical actions to mentally and emotionally manipulate, hurt, undermine, or intimidate a client; distort, judge, or influence a client's thoughts and actions in their daily lives; take sides in a couple's dispute; attempt to resolve their own relationships and problems through their clients; publicly or privately pathologize them; violate their boundaries; use power and authority to persuade; create false ideas about the nature of reality or their inner world to ensure continued payment; minimize certain feelings or beliefs; diminish their quality of life; alter their sense of self; and harm their well-being (Hick and Bien 2008; Daw, 2019; Fisher, 2002; Set, 2022). As this broad definition suggests, therapeutic violence is multidimensional and interdisciplinary. Referring to the concept of the patient's quality of life decreasing as an object of this multidimensional process, the French Association for the Right to Die *with Dignity [L'association française pour le Droit de Mourir dans la Dignité]* states that "knowing how to die is part of knowing how to live."

(Rabelle, 2020), he says that trying to prolong a patient's life against their will, due to reasons such as a decrease in the patient's quality of life, an increase in chronic pain and reaching a level where they cannot cope with it, includes therapeutic violence.

In the United States, the State of Oregon enacted *a death with dignity law* in 1997, allowing terminally ill individuals to voluntarily self-administer a lethal dose of medication explicitly prescribed by a doctor . Furthermore, the European Medical Association and the WHO, at a joint meeting held in Rome in 1992, agreed that patients with incurable diseases should be treated with dignity.

They declared that they have the right to a dignified death (Bilgin, 2013). Objection to this right, namely euthanasia, has been defined by these institutions as therapeutic violence. While opposition to these two phenomena is defined as therapeutic violence, the extent to which concepts such as euthanasia and the law of death with dignity are compatible with ethical principles is a separate matter of debate.

Ethical principles play a crucial role in preventing therapeutic violence, not only within the context of euthanasia but across all disciplines. Turkish Psychologists Association [TPD]
The General Code of Ethics for the Psychology (Counseling Services) profession was established at its 27th ordinary general assembly on April 18, 2004, and the regulations regarding these rules were finalized at its 35th ordinary general assembly on April 15, 2018. In its relevant regulation, the Turkish Public Prosecutor's Office (TPD) (2004) defines ethics as helping psychologists evaluate and plan their daily practices and laying the groundwork for the services they will offer to society. The Ministry of National Education (MEB) (2011) defines this concept as the articulation of all activities and goals, knowing what can and cannot be done, what is desirable and undesirable, and what can and cannot be achieved. Kuçuradi (2003) defined one of the different meanings attributed to the concept of ethics as determining the evaluations and actions of people within a specific group at a specific time in their relationships with each other. While definitions of ethical principles vary in the literature, their common point is that they encompass the norms and values that form the basis of the relationship between individuals and society. In the context of counseling, deviating from ethical values or failing to adhere to them constitutes a form of therapeutic violence. Harming due to incompetence, abusing the trust of the client, and sharing information obtained with third parties are also dimensions of therapeutic violence. When a therapist insists on an interpretation and calls the client resistant, this action constitutes an act of therapeutic violence. Choosing intuition over defense, imposing an agenda regarding the direction of a session, offering personal opinions, or offering advice are also common acts of therapeutic violence (Fisher, 2002).

Although the ethical guidelines of the American Psychological Association and the Turkish Psychological Association (TPA) contain references to sexual intercourse between therapists and clients, Saygÿlÿ (2021) reported the frequency of sexual intercourse between therapists and clients as 2.5% among female therapists and 9.6% among male therapists. This research was conducted in 1986, and the same team found these rates to be 5% and 17% in a 1995 study with mental health professionals. This situation, beyond a violation of ethical principles, constitutes a different dimension of therapeutic violence inflicted by the therapist on the client.

While events such as a therapist hugging a client due to sexual need, forcing them to talk about their sexual experiences, or intentionally looking at various parts of the client's body constitute indirect therapeutic violence, a therapist engaging in direct sexual intercourse with a client is a separate example of therapeutic violence that will cause clients to carry much more psychological burden and experience guilt (Akdoÿan and Ceyhan 2011). In the opposite scenario, a client hugging a therapist due to sexual need or intentionally looking at various parts of the therapist's body,

Attempting to touch the client is also an example of client-induced therapeutic violence. Furthermore, the client's refusal to perform tasks, intentional violation of or deviation from contract terms, failure to agree with the therapist on the goal (Set, 2022), and persistent behavior are other elements of client-induced therapeutic violence.

A departure from therapeutic respect—our inherent norms for viewing oneself and others in a certain way—is among the other reasons that can lead to therapeutic violence from the perspective of two poles—client and therapist. These reasons are also the underlying factors of therapeutic violence. The treatment process, which includes the therapeutic relationship, is based on the client's desire and trust, and the therapist's patience and dedication (Öztürk & Ayhan, 2021). During this relationship, factors such as the client's skepticism towards the therapist and lack of trust in the therapist manifest as overt (physical, verbal) or covert (mental) therapeutic violence.

1.1. Open Therapeutic Violence2

Overt therapeutic violence is the client's destructive verbal and physical behavior during the session, accompanied by defensive resistance. When the therapist reminds the client of situations such as refusing tasks, intentionally violating contract terms, etc., the client refuses to accept this and instead uses a threatening object.3
If the client positions the client at a point within the therapist's field of vision or unconsciously expects the therapist to approve of their defensive resistance, and this approval is not received, the client commits overt therapeutic violence against the therapist with verbal expressions of distrust, such as the therapist not understanding them, not accepting them, and judging them. In the same context, the therapist's continued attendance despite this attitude of the client, caring about the fee they will receive instead of ending the sessions, is an example of therapist-related therapeutic violence (Adshead et al., 2018; Blackman, 2012; Ballou, 1995; Daniels & Anadria, 2019; Dryden, 2013; Fisher et al., 2004; Özer, 2017; Öztürk & Ayhan, 2021; Sembera, 2017; Set, 2019; Meloy & Hoffmann, 2021; Wright et al., 2010).

1.2. Covert Therapeutic Violence

The client's mentally constructed actions that accompany resistance during the session turn into trust issues. The client's mental narratives about their therapist, such as "doubt about sincerity" and "the illusion of sharing their story with others," create a subconscious distrust, which then transforms into organized resistance, and during the session, this organized resistance transforms into therapeutic violence for the therapist (Adshead et al., 2018; Daniels & Anadria, 2019; Fisher et al.,

2 The concepts of overt and covert therapeutic violence are defined based on the theoretical foundations of the therapeutic alliance (Psychodynamic approach, Cognitive approach and Social Impact approach) and independently. In addition, Cambridge University's publications titled *The Role of Mentalization in the Management of Violence* (Adshead et al., 2018) and Oxford University's *Public Threats of Violence* (Meloy and Hoffmann, 2021) form the background of these concepts.

3 A firearm or a cutting, piercing, or bruising instrument

2004; Kugler et al., 2023; Öztürk and Ayhan, 2021; Sembera, 2017; Set, 2019; Meloy and Hoffmann, 2021, Wright et al., 2010).

While organized resistance is a factor—a cause—of therapeutic violence from the therapist's perspective, the underlying phenomenon of "resistance" is opposition to change and disruption of therapeutic work. Therefore, resistance is distinct from therapeutic violence and is characterized by factors such as the client's inability to complete tasks, noncompliance with treatment, irrational beliefs, opposition to change, a response to the threat posed by internal conflicts, and disagreement about therapy goals and needs.
The phenomenon of resistance, which carries a negative charge on the client, is said to contribute to the therapeutic relationship from a contemporary perspective (Tuna, 2016). However, in unplanned and unstrategic therapy, resistance emerges as a powerful weapon (Cummings & Sayama, 2013). This empowerment, in turn, is a source that fuels therapeutic violence.

2. LGBT+ Context

The term homosexuality first appears in Ulrichs's thought in 1869. While the third gender is defined as a male soul in a female body or a female soul in a male body, in Ulrichs's thought this formula was only used for individuals who would be called homosexual from 1869 onwards (Murat, 2012).
In the same years, it is also seen that homosexuality was defined as an illness and attempts were made to treat it. Between 1950 and 1970, homosexual individuals were forcibly hospitalized with electric shock, psychoanalysis, and a number of treatment methods in order to be cured (Matur, 2021). This treatment process became an indicator of therapeutic violence in the context of LGBT+ individuals. Although homosexuality was classified as paraphilia (such as pedophilia, excitonism, transvestic fetishism, zoophilia) and sexual deviation in the 1968 edition of the DSM-II, with the official decision of the APA in 1973, the category was removed from the paraphilia classification in the DSM-II and replaced by the category of sexual orientation disorder (Yüksel & Yetkin, 2013). Dr. Judd Marmor initiated studies in the early 1970s to remove homosexuality from the category of illness (Rosario, 2003), and more objective studies over the past 35 years have shown that homosexuality is unrelated to emotional or social problems (Tar & Güner, 2015). The decision to remove homosexuality from the category of illness was first made with the revision of the DSM-IV in 1973. The fact that experts who considered sexual orientation an illness before the removal of homosexuality from the category of illness with the DSM-IV were far removed from the understanding and tolerance shown to homosexual individuals in ancient times constitutes a separate issue of therapeutic violence that deserves discussion.

In the jargon of gay culture in Turkey, homosexuals who hide their sexual identity call themselves "hidden4." This expression is used by homosexuals

4 The "latent homosexuality" discussed here differs from Freud's definition of latent homosexuality or ego-dystonic homosexuality. In Turkish literature, latent homosexuals are individuals who, although they conceal their sexual orientation, do not hesitate to engage in same-sex sexual intercourse and are not visible.

There are many underlying reasons for this. Anti-gay attitudes include homophobia, heterosexism, anti-gay violence, and the moral condemnation of homosexuality (Drescher, 2004a). These attitudes, beyond being personal fears and beliefs, are explained in the context of cultural ideology (Herek, 2007; Meyer, 2003). This cultural ideology is the main reason behind the "closet" label. This prevents homosexual individuals from being themselves in their daily lives, and they consider themselves a second identity. With this second identity, homosexual individuals, although aware of their homosexual feelings, deny these feelings and may even attempt to change their sexual orientation, despite the likelihood of success (Shidlo et al., 2001).
Taking this process a step further, these individuals may begin to exhibit behaviors like "gay-bashers " or "gaybaiters ." A penile plethysmography study has shown that men with strong anti-gay beliefs actually have significant patterns of homosexual arousal (Adams et al., 1996). It's plausible that these strong anti-gay sentiments represent gay-bashers' attempts to control their perceptions of their sexual identity. In this process, these individuals who engage in hate speech develop a defense mechanism, such as "If I attack and belittle gay people, no one will think I'm gay," which in turn reinforces dissociative tendencies.

More severe forms of dissociation are common among married men who are aware of themselves as homosexuals but cannot allow themselves to be considered homosexual (Roughton, 2002). Some closeted gay people may exhibit a reflexive attitude during therapy, without revealing the gender of the person being discussed or delving into the details of their sexual life. This attitude points to the existence of a therapeutic violence that homosexual individuals unintentionally inflict on themselves. Concealing one's sexual orientation may be part of the support a homosexual individual might receive from a therapist when facing difficulties with their par This individual's fear of misunderstanding, presenting their partner as the opposite sex, and constructing their story accordingly, will be seen as *self-inflicted therapeutic* violence. This individual's concealment of their sexual orientation, their careful selection of every word during psychotherapy for fear of exposure, their prolonged silence during sessions for fear of making mistakes, their prolonging of the conversation unnecessarily, and their exposure of all factors of resistance will all constitute self-inflicted therapeutic violence, and the sessions will not serve their intended purpose. Furthermore, gay men feel the need to censor the information they give to their supposedly heterosexual therapists—especially about sexual matters—because they believe their experiences will not be fully understood (Mair, 2003).

5. A person who participates in the denigration of gay culture. Individuals who attempt to conceal their own homosexual tendencies and desires by speaking negatively about gay people or by engaging in physical violence against them (Clay, 1996).

6 In the context of social media, heterosexual male celebrities post content that appeals to gay men in an attempt to attract their attention and admiration. These posts generate interest and curiosity among gay men, thus earning the celebrity more followers and likes (Mynextadventure, 2019).

7 By measuring physiological responses to visual stimuli by attaching electrodes to the penis It is an attempt to define sexual arousal scientifically (ORAM, 2010).

Sedgwick (1990) characterizes Closetedness as a performance initiated by the speech act of silence, calling it not a specific silence, but a silence that acquires particularity through agreements and initiations in relation to the discourse that surrounds and constitutes it differently. Hiding from oneself is tied to dissociative defenses, while opening up to oneself holds the possibility of psychological integration.

An implicit value of psychotherapy is that integration is more psychologically meaningful than separation (Drescher, 2004b).

A queer-aware man or woman may eventually accept their sexual orientation; however, due to concerns such as loss of status, harassment, stigma, and humiliation, they may regret their decision and return to their previous practices of concealment. In LGBT+ literature, this condition, known as *"Closed"* (returning to the closet), is used to describe a person who is not heterosexual but hides this fact from others. A person seeking psychological support during the process of returning to the closet may also experience "sexual conversion" therapy. Conversion therapy, also known as *"conversion therapy,"* recognizes the sexual orientation of homosexual individuals as an illness and aims to transform them into heterosexual individuals through intervention. This method is another dimension of therapeutic violence.

The biggest example of therapeutic violence that can be experienced by homosexual clients is when a therapist who approves of conversion therapy is insincere with a homosexual client, delivers messages in a distorted manner, makes decisions on behalf of the client, violates ethical values, and imposes his own thoughts instead of responding to the client's needs and situation (Set, 2022).
In addition, a family that knows their child's sexual orientation directs their child to this therapy, expects him to turn into a *"normal"* individual after this therapy, and instills this expectation in their homosexual child, is another dimension of therapeutic violence seen within the family.

A 2015 study by the National LGBTI Health Alliance (9) revealed the extent of family-based therapeutic violence against gay youth. In this study, parents or biological relatives

8 In the past, the word 'closet' meant 'bedroom,' meaning that a person's sexuality was not shown beyond the bedroom. In the 1960s, the metaphor 'skeleton in the closet,' meaning to keep a secret due to taboos or social stigmas, was also used to refer to a gender identity or sexuality that a person might not want to disclose.
Therefore, revealing one's LGBTQ+ identity, which one had previously hidden or kept secret, meant letting a skeleton come out of the closet (Scott, 2018).

9 National LGBTI Health Alliance: These experiences of "therapeutic violence" often occur depending on the family context and living conditions of young people.
reported:

- Involuntary and forced medical interventions applied to intersex youth.
- Trying to forcefully change the sexuality and gender identity of young people under the name of conversion therapy.
- Refusal or denial of medical interventions requested by trans youth delay.

'Conversion therapy', typically conducted by mental health professionals and religious leaders in faith-based communities, has been documented as initiating or permitting it, and has been defined as collaborative therapeutic violence implemented by parents and health professionals through joint decisions made in direct opposition *to the wishes* of the young person (Reynolds, 2015). The involvement of family or biological relatives in the therapeutic violence experienced within the context of the client and the counselor *(defined as mental health professionals and health personnel in this research)* further compounds the magnitude of therapeutic violence in the context of these young people. Research by Michael King and colleagues found that from the 1950s to the early 1980s, an unknown number of LGB people (primarily men) in Britain, the United States and Australia underwent psychoanalytic and psychiatric 'treatments' to become heterosexual, with these treatments having negative effects on their sense of identity, self-esteem and mental health (King et al., 2007).

Internalized anti-gay attitudes are often rigid and disdain compromise or relativism. Exploring internalized moral absolutes and the identifications from which they arise requires therapeutic tact (Drescher, 2004a). Lack of this tact, or reluctance to do so, can lead to therapeutic violence. Furthermore, while an LGBT+-oriented field has developed in mental health services over the past 20-30 years, certain areas requiring attention and understanding remain to be addressed. These include: therapists' expertise and sensitivity in these matters; the therapist's sexual orientation and its relevance to the therapeutic process and outcome; and the specific mental health sensitivities and needs of LGBT+ individuals (King et al., 2007). This lack of therapist-based knowledge and understanding is also a potential source of therapeutic violence.

Both therapists and clients need to be aware of dominant discourses and stereotypes within the LGBT+ world; if they fail to do so, the potential for collusion and shared assumptions can limit the depth and benefit of therapy (King et al., 207). Therefore, therapists must recognize that gay clients' struggles to define themselves are an important therapeutic focus and are not typically a struggle for those claiming a heterosexual identity (Drescher, 2004b). In this process, they can minimize the potential for therapeutic violence.

Factors associated with unhelpful therapy experiences for gay and lesbian clients in the context of therapeutic violence include viewing homosexuality as a disorder, attributing all concerns to sexual orientation, lacking knowledge and awareness about the potential consequences of coming out, using a heterosexual frame of reference for same-sex relationships, and expressing derogatory beliefs about homosexuality (Israel et al., 2008).

Research has shown that the therapeutic relationship is a crucial variable that characterizes both helpful and unhelpful situations and their outcomes (Israel et al., 2008). Factors that prevent therapeutic violence in the context of homosexual clients and therapists include therapists' respect for clients (Bachelor, 1995), the client's partnership with the therapist in achieving their goals (Set, 2022), and clients' acceptance of the therapist's role in the relationship

It is possible to see expressions such as evaluations of the client's understanding, openness and supportive attitude (Price and Jones, 1998), encouragement of clients to express their needs and feelings as independent individuals (Safran and Muran 2000), warmth and sincerity of the therapist (Israel et al., 2008), and clients' perception of their therapists as caring and skilled (Hersoug et al., 2001).

The therapeutic relationship process can be significantly influenced by factors stemming from the therapist's and client's human nature —*cultural values, general well-being, values, religion, and moral attitudes* . Therefore, it's clear that homosexual clients will be more affected by this process.

Conclusion

Therapeutic violence is not a one-sided process; it can be described as a bipolar violence originating from the client and the therapist. While therapeutic collaboration and dialogue are important in preventing this violence, it is important to recognize that this is a difficult task for both parties. Therefore, to avoid therapeutic violence, it is crucial to have open and honest communication between the client and therapist, respect the client's rights, values, and wishes, use evidence-based guidelines and criteria to determine the appropriateness and effectiveness of treatments, and consider the benefits, risks, and burdens of each option. Furthermore, the therapist's loosening of their grip on objective "truth," their reluctance to claim objective truth in systemic studies, and their openness to alternative possibilities will all reduce the risk of therapeutic violence during the therapy process.

While an LGBT+-focused field has developed in counseling services in recent years, this is proving insufficient. In particular, counseling therapists' lack of expertise and sensitivity to these issues, their stereotypes, the specific mental health sensitivities and needs of LGBT+ individuals, and counseling providers' lack of knowledge and understanding are among the driving forces behind therapeutic violence. Furthermore, the endorsement of conversion therapy, a distinct aspect of therapeutic violence, by a counseling therapist constitutes a separate case of therapeutic violence. A lack of knowledge and understanding of conversion therapy and counseling providers has been found to negatively impact the sense of identity, self-esteem, and mental health of gay individuals.

The key findings of these studies are that therapists should be aware of the reality and stereotypes of the non-heterosexual world, where their attitudes, knowledge, and practices can both create and mitigate therapeutic violence. Having sufficient knowledge in this area can lead counselors to exhibit less prejudicial attitudes and make fewer heterosexual assumptions. Furthermore, therapists must be free of heteronormative biases. To prevent therapeutic violence, the therapeutic relationship is an important aspect of therapy with LGBT+ clients, just as it is with non-LGBT+ clients. Clients should feel safe and respected in the therapeutic environment. Therapists should ensure that clients are aware of their own potential for therapeutic violence.

Therapists should create a supportive environment by respecting their boundaries. The extent to which the therapeutic process is clouded by therapists' assumptions and attitudes is a separate topic of discussion; the therapist's implicit assumptions and attitudes about LGBT+ clients' actions and decisions can create conflict and potentially hinder therapeutic effectiveness (Cowan & Presbury, 2000). Therefore, therapists should remember that when claiming to understand LGBT+ clients, they must support this with a theoretical framework, not assumptions.

During this research period, there were no studies evaluating the effectiveness of psychological interventions in the context of therapeutic violence against LGBT+ individuals, nor were there any longitudinal follow-up studies of gay clients who had received specific counseling or therapy. Studies addressing the LGBT+ dimension of therapeutic violence and its effects on gay clients in Türkiye are also insufficient.

Research to be conducted in this direction will contribute to determining the factors that create therapeutic violence in the context of homosexual clients, presenting the current results, and subsequently working on the necessary precautions.

SOURCE

Adams, H. E., Wright Jr, L. W. ve Lohr, B. A. (1996). Is homophobiaassociated with homosexual arousal? *Abnormal Psychology,* 105(3), 440-445. https://doi.org/10.1037//0021-843x.105.3.440

Adshead, G., Moore, E., Humphrey, M., Wilson, C. ve Tapp, J. (2013). The role of mentalising in the management of violence. *Advances in Psychiatric Treatment,* 19(1), 67-76. https://doi.org/10.1192/apt.bp.110.008243

Akdoÿan, R. and Ceyhan, E. (2011). Human Factors in the Therapeutic Relationship. *Current Approaches in Psychiatry,* 3(1), 117 - 141.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology,* 42(2), 323-337. https://doi.org/10.1037/0022-0167.42.3.323

Ballou, M. (1995). *Psychological Interventions.* (1. Basÿm). ABC-CLIO.

Bilgin, NG (2013). Euthanasia: definition and history. *Lokman Hekim Journal,* 3(2), 25-31.

Blackman, J. S. (2012). *The Therapist's Answer Book.* (1. Basÿm). Routledge.

Clay, G. (1996). *Gay Bashers* . Menstuff: http://www.menstuff.org/issues/byissue/gaybashers.html

Cowan, E. ve Peterbury, J.H. (2000). Meeting client resistance and reactance with reverence. *Journal of Counseling and Development,,* 78(4), 411-429. https://doi.org/doi:10.1002/j.1556-6676.20 00.tb01924.x

Cummings, N. ve Sayama, M. (2013). *Focused Psychotherapy: A Casebook Of Brief Intermittent Psychotherapy Throughout The Life Cycle.* Taylor and Francis.

Daniels, J. K. ve Anadria, D. (2019). Experiencing and Witnessing Patient Violence-an Occupational Risk for Outpatient Therapists? *Psychiatric Quarterly, 90,* 533–541. https://doi.org/doi.org/10.1007/s11126-019-09648-x

Daw, J. (2019, Aÿustos 30). *Psychological Violence* . Safe lives: https://safelives.org.uk/SafeLives-research-psychological-abuse

Drescher, J. (2004a). *Psychoanalytic Therapy and the Gay Man.* (e-kitap). Taylor and Francis.

Drescher, J. (2004b, Ekim). *The Closet: Psychological Issues of Being In and Coming Out.* Psychiatric Times:https://www.psychiatrictimes.com/view/closet-psychological-issues-being-and-coming- out

Dryden, W. (2013). *Rationality and Pluralism: The selected works of Windy Dryden.* Taylor and Francis. https://www.routledge.com/Rationality-and-Pluralism-The-selected-works-of-Windy-Dryden/ Dryden/p/book/9780415813778

Fisher, J. E., Hayes, S. C. ve O'Donohue, W. T. (2004). *Cognitive Behavior Therapy: Applying Empirically Supported Techniques in Your Practice.* Wiley.

Fisher, R. (2002). *Experiential Psychotherapy with Couples: A Guide for the Creative.* Zeig Tucker & Theisen Publishers. https://books.google.nl/books/about/Experiential_ Psychotherapy_with_ Couples.html?id=YNw6V7R2LTkC&redir_esc=y

Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. Journal of. *Journal of Social Issues,* 63(4), 905-925. https://doi.org/10.1111/j.1540-4560.2007.00544.x

Hersoug, A. G., Høglend, P., Monsen, J. T. ve Havik, O. E. (2001). Qualityof working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Practice ve Research,* 10(4), 205–216.

Hick, S. F., Bien, T. (2008). *Mindfulness and the Therapeutic Relationship.* (1.Basÿm) Guilford Press.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M. ve Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Research and Practice,* 39(3), 361–368. https://doi.org/10.1037/0735-7028.39.3.361

King, M., Semlyen, J., Killaspy, H., Nazareth, I. ve Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* BACP.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B. ve Lozano, R. (2022). *World report on violence and health.* World Health Organization: https://iris.who.int/bitstream/handle/ 10665/42495/9241545615_eng.pdf?sequence=1

Kuçuradi, ÿ. (2003). Ethics and ethics. *Turkey Engineering News,* 423(1), 7-9.

Kugler, B., Clark, A., Gurner, J., Collins, J., McCollum, S. M. ve Schnapp, J. (t. y.). *What does a therapist do if their client doesn't trust them?* https://quora.com/What-does-a-therapist-do-if-their-client-doesnt-trust-them

Mair, D. (2003). Gay men's experiences of therapy. *Counselling and Psychotherapy Research,* 3(1), 33-41. https://doi.org/10.1080/14733140312331384608

Malinen, T., Cooper, S.J., ve Thomas, F. N. (2013). *Masters of Narrative and Collaborative Therapies.* (1. Baskÿ). Taylor & Francis

Matur, M. (2021, February). *Is homosexuality an illness? The history and present of homosexuality.* Molatik: https://www.milliyet.com.tr/molatik/iliskiler/escinsellik-hastalik-midir-escinselligin-tarihcesi-ve-bugunu-88869

McNamee, S., Gergen, M. M., Camargo-Borges, C., ve Rasera, E. F. (2020). *The Sage Handbook of Social Constructionist Practice.* SAGE Publications Inc.

Ministry of Education. (2011). *Professional Ethics.* (1st Edition). Ministry of Education Publications.

Meloy, R., Hoffmann, J. (2021). Explicit Threats of Violence. L. J. Warren, R. Z. Basocak, T. Bobera, S. J. Chamberlain, P. E. Mullen, ve T. E. McEwan (Edl.), *International Handbook of Threat Assessment* (ss. 22-44.). Oxford University Press.

Meyer, I. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin,* 129(5), 674-697. https://doi.org/10.1037/0033-2909.129.5.674

Murat, L. (2012). *The Law of Gender: Cultural History of the Third Gender.* (1st Edition). Dost Bookstore.

Mynextadventure. (2019, Temmuz 31). *Urbandictionary.* Gaybaiter: https://www.urbandictionary.com/define.php?term=Gaybaiter

ORAM-– Organization for Asylum, Refugee and Migration. (2010, December). *Scientific and Legal Analysis of Plethysmography in Asylum and Refugee Status Procedures.* https://www.refworld.org/cgi-bin/texis/vtx/rwmain/opendocpdf.pdf?reldoc=y&docid=524c0d774

Ozer, I. O. (2017). A Bump in the Therapeutic Journey: RESISTANCE. *Inonu University Journal of Education,* 18(3), 217-228. https://doi.org/10.17679/inuefd.295994

Öztürk, E., & Ayhan, H. (2021). Basic Principles and Basic Components of Psychotherapy. *Artuklu Journal of Human and Social Sciences,* 1(6), 136-158. https://doi.org/10.46628/itbhssj.908609

Price, P. B. ve Jones, E. E. (1998). Examining the alliance using the Psychotherapy Process Q-Set. *Psychotherapy: Theory, Research, Practice, Training,* 35(3), 392–404. https://doi.org/10.1037/h0087654

Rabelle, B. (2020, Haziran). *End of life: The Association for the Right to Die with Dignity makes a stop in Dieppe and Caen.* https://france3-regions.francetvinfo.fr/normandie/Seine-Maritime/Dieppe/End-of-Life-Association-Right-to-Die-with-Dignity

Reynolds, R. (2015, Temmuz). *Examination of children affected by family and domestic violence.* https://humanrights.gov.au/sites/default/files/49.%20National%20LGBTI%20Health%20Alliance.pdf

Sembera, R. (2017). *Metapsychology for Contemporary Psychoanalysis.* (e-kitap). Taylor and Francis.

Rosario, A. V. (2003). An interview with Judd Marmor, MD. *Journal of Gay & Lesbian Psychotherapy,* 7(4), 23-34. https://doi.org/10.1300/J236v07n04_03

Roughton, R. E. (2002). Being gay and becoming a psychoanalyst: across three generations. *Journal of Gay and Lesbian Psychotherapy,* 6(1), 31-43. https://doi.org/10.1300/J236v06n01_04

Safran, J. D. ve Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology,* 56(2), 233-243.

Sanders, C. J. (2014). *Narrative poetics of resistance: Towards an aesthetics of engagement.* (e-book). Tilburg University.

Saygÿlÿ, ÿ. (2021). Who made the apples rot? *Psikeart,74,* 27.

Scott, D. T. (2018). 'Coming out of the closet' – examining a metaphor. *Annals of the International Communication Association,* 42(3), 145-154. https://doi.org/10.1080/ 23808985.2018.1474374

Sedgwick, E. K. (1990). *Epistemology of the Closet.* (1. Basÿm). University of California Press.

Set, Z. (2022, April 5). *Putting values into action in helping relationships/ The first value is empathy.* Arel Uzem.: https://uzem.arel.edu.tr/mod/adobeconnect/view.php?id=884537

Shidlo, A., Drescher, J. ve Schroeder, M. (2001). *Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives.* Haworth Medical Press.

Tar, Y. and Güner, U. (2015). *Hate Speech Towards LGBTIs in the Media.* (1st Edition). Details Printing house.

TDK. (2023). *Violence.* Turkish Language Association Vocabulary: https://sozluk.gov.tr

TPD. (2004, April 19). *Turkish Psychologists Association Ethics Regulation.* Turkish Psychologists Association: https://psikolog.org.tr/belgeler/etik-yonetmeligi-qbf8w.pdf

Tuna, E. (2016). Understanding and Working with Resistance in Psychotherapy. *AYNA Journal of Clinical Psychology,* 3(3), 10-25. https://doi.org/10.31682/ ayna.470691

Wright, J. H., Sudak, D., Turkington, D. ve Thase, M. E. (2010). *High-yield Cognitive-behavior Therapy for Brief Sessions.* American Psychiatric Publishing Inc.

Yüksel, ÿ., Yetkin N. (Edl.). (2013). *Information File-10 Homosexuality.* (pp. 36). CETAD.

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