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They Continued Regardless:
Discussing a Therapeutic Rape Culture with Jemma Tosh[1]

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Introduction: Situating Oneself

> *[E]scape the heterosexual and exogamous norm.*
> ~ Foucault, *Abnormal*.

Near the opening of *The Body and Consent in Psychology, Psychiatry, and Medicine* (2020), Jemma Tosh very openly explains where she is situated in relation to the subject matter she will go on to discuss. Rather than seeking to advance her academic brand status by positioning herself amongst the intelligentsia (by highlighting her ability to engage in rigourous "objective" research, pursue "the facts" no matter where they lead, publish with all the right imprints, teach at all the right institutions, and so on and so forth), Tosh proudly stands in the tradition of the "organic intellectual" (as per Gramsci) or the "critic as partisan" (as per Eagleton). Tosh is personally invested in this subject matter - she has been subjected to this way of mattering (as per Foucault with Karen Barad's discussion of meaning and matter in *Meeting the Universe Halfway*) - but along with those who are exploring ableism, madness, race, gender, sexuality, and class from liminal spaces (which are embraced rather than seen as environments to overcome or transcend), Tosh has embraced that which those invested in mainstream dynamics of power/knowledge have rejected and, by doing so, she offers a liberating way forward to those who refuse to be pathologised, disappeared, and abused, and who, instead, "take the power back" (as per Rage Against the Machine).

This, then, both challenges and invites the reader to situate themselves in a similar way in relation to the subject matter Tosh discusses. This is not a text that is simply to be read and then cited when it is convenient to do so (so that, for example, one can demonstrate one's breadth of knowledge - kind of like I did with all the name-dropping in the last paragraph!). It is also not a text that is to be read and considered, "interesting," before one moves on to something else. It is a text that challenges the reader to consider where they are located in relation to other bodies, in relation to power dynamics that influence consent, and in relation to rape culture that, all too often, masquerades as something

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[1] Originally published at www.danoudshoorn.com, republished with permission from the author.

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therapeutic. Therefore, before proceeding, I feel that it is important to explicitly situate myself in relation to what follows so that the reader can understand where I am coming from in my conversation with Jemma and so that the reader can also be encouraged to spend some time thinking about where they are situated as they think about these things.

I am a cishet White male of Christian and European descent. I colonize stolen land in territories that are occupied by the illegitimate Canadian state - and I am a citizen of that state. I am employed within the mental health field and have worked in the non-profit industrial complex for almost twenty years. I am also a male survivor of sexual violence and abuse that I experienced both as a child (within a Christian home) and as an adult (within environments that were supposed to be therapeutic). I am no longer a Christian, although I do find people like Jesus and Paul to be useful people to think with (especially if one wishes to undermine the foundations of some of the most violent institutions today). I also am not heavily invested in my performance of maleness or heterosexuality. To be honest, I fairly strongly identify with being agender (and have been heavily influenced by Judith Butler's approach to gender) but I continue to identify as male for a few reasons: first, I'm not entirely confident in the reasons that attract me to the agender identity (given all the violence connected with maleness, it may be a move I desire to make out of a desire to pursue personal purity - a motive that I find continually compromises activist [and other] circles); second, and related to the first, even if I identify as agender, I will still continue to pass as male, be identified as male, and enjoy all the privileges that come with being identified as male; and, third, strategically, I think it is more beneficial for me to continue to explicitly identify as male because, rather than fleeing maleness, I think maleness needs to be recreated and reimagined so that it can be made more tender-hearted, vulnerable, honest, and caring (and here bell hooks's book, *The Will to Change*, as well as Jennifer Siebel Newsom's documentary, *The Mask You Live In*, both come quickly to mind). Of course, the fact that I can think and make decisions in this way is a strong example of the privilege I enjoy as a cishet, White male. This, then, is where I am positioned when I read Tosh's book and think about it and try to understand what to do with it. In what follows, then, I will first offer a brief summary of the book and then move on to the interview I did with Tosh.

Containing Embodiment: Tosh's Genealogy

> *My body is a cage.*
> ~ The Arcade Fire

> *To create a culture of consent depends upon the dismantling of hierarchies based on a narrow and problematic conceptualization of 'normality' within psychology, psychiatry and medicine, so that when consent is articulated or resistance is evident, or when survivors say their therapists raped them, we believe them.*
> ~ Tosh, *The Body and Consent in Psychology, Psychiatry, and Medicine*, 104.

Tosh comes to her study of the body and consent in psychology, psychiatry, and medicine, informed both by the work of counter-historians like Michel Foucault and Peter

Conrad, but also as a person whose body is not so easily subsumed within the gender binary and the "oppositional sexism" it promotes (to borrow Julia Serano's term), which have been normalized and made hegemonic, and as a survivor of sexual violence that occurred within a supposedly therapeutic context. In her Introduction, she argues that the psy disciplines, as well as the biomedical model of health, have produced a particular human body that is taken as a norm. However, given the ways in which this body is constructed off of the model of middle- or upper-class, cishet, White men, this normative body is then deployed to other, racialise, colonise, disable, and pathologise bodies that are said to be abnormal. Especially influential in the construction of the "normal" body, is the notion that "bodies are simply a container in which people live" (5). As a result, any bodies that "do not fit into the theories of solid and universal objects or 'containers', those that look different, move differently, or function in unique and diverse ways" are not only "positioned as 'abnormal'" but must also be modified, retrained (or restrained), treated, and cured in order to fit within the norm (17). In the next five chapters, Tosh then offers a rather Foucauldian genealogy of the ways in which the psy disciplines and medicine engage in this project of containment which they claim is therapeutic but which Tosh demonstrates is nothing less than sexual violence, assault, and rape.

In Chapter Two, Tosh looks at cases of non-consensual "normalising" treatments that have been applied to intersex children and youth, because intersex people were pathologised and associated with that which is deemed "monstrous" (21-25). In addition to non-consensual surgeries (which the UN called "torture and ill-treatment in health-care settings" in 2013 [21]), intersex children were also subjected to various other invasive, painful, and abusive treatments such as: vaginal dilation, genital stimulation and examination, being stimulated in front of a group of medical professionals and students, and having pictures and videos taken of their exposed genitals (30). According to the professionals engaged in these activities, all of these things are not so much "abusive" as they are "*necessary*" (27). When the people being treated claimed otherwise, John Money (a psychologist who greatly influenced the formation of this field of study) discredited those claims as false allegations because consent (as provided by parents or care providers with a signature on a contract) had been given and, in fact, health professionals were required to touch, expose, or otherwise (man)handle the genitals of children during treatment (30). Therefore, against those who prioritize the voices of survivors, Money feels free to disregard objections that arise (in his words) from "[t]he dogma of the new victimology industry" (see here). This notion of consent, and the impossibility of treatment being viewed as abuse, is foundational to the "therapeutic rape culture" that Tosh is exposing. Consequently, she argues for a very different perspective and writes:

> *[R]ape does not occur when an individual says 'no', resists, or cannot consent; it occurs when one person does not or cannot consent and another person continues regardless. The promotion of individualistic perspectives to consent and violence create dichotomies of accuser/abused that assume one is lying and the other is not, instead of viewing this disparity as evidence of a breakdown in the relational space between bodies and selves …*

> *The change needed, then, is not in 'giving' bodily autonomy but in others accepting and responding to the already voiced needs, experiences, and consent (or dissent) of intersex people (34).*

In Chapter Three, Tosh examines how the homo-antagonism that was present in conversion and behavior modification therapies that targeted and pathologized gay folx (especially in the 1950s and '60s), was redirected after changes were made to the DSM in the 1980s, and henceforth channeled into trans-antagonism and the pathologisation of people who are transgender, nonbinary, or gender nonconforming (37). Especially targeted are young people who have been labeled as boys who exhibit anything associated with femininity (37). Once again, John Money is influential here. He argued that boys could be trained to be stereotypically masculine and heterosexual, so long as their "lovemaps" were not "vandalised" by "a heterosexually phobic society" (38 [which, tangentially, is no contemporary society that I know of]). In order to produce these results, Money encouraged children (especially those between the ages of 3 and 5) to engage in explicitly sexualised forms of play, to re-enact scenes they were shown from pornographic movies, and to also sexualise other forms of play and exploration that they had previously experienced as non-sexual (38-40). Along the way, Money expressed frustration about how child pornography laws prevented him from photographing and filming kids engaging in this kind of "therapy" and he also argued that sexual relationships between adults and children were not always harmful (42-43). Of course, as this last point helps to illustrate and as Tosh makes clear, what this approach actually does is sexually abuse children and trivialise the traumatic impact that abuse has on survivors (41). What Money and other therapists were actually doing was exploiting a position of power in order to groom and then coerce children into obeying them (44-45; which, of course, is why sex between adults and children is *always* sexual assault—the power differential is too great to allow for free, informed consent). Note, then, how "the naturalization of heterosexuality in this discourse not only normalized sexual activity in childhood but also simultaneously silenced discourses of childhood sexual abuse" (49). Of course, as with the material discussed previously, a critical component of this approach is a refusal to centre the perspectives of children, a refusal to empower children, and a refusal to respect the subjectivity, embodied experiences, boundaries, and consent of children (51).

In Chapter Four, Tosh moves from children to women and examines how sexual stimulation and penetration have been used as treatments for women (especially "hysterics") up until the 1920s. In part, she observes, clinicians were able to argue that stimulating a person's genitals was a desexualised medical treatment, because "real sex" was said to involve penetration (i.e., penis-in-vagina sex) (54). However, the discourse of "healthy" or "normal" sexuality that develops after this, especially through the work of William Masters and Virginia Johnson (who pioneered the "four stage" model to sexual response), is one that is premised upon all parties experiencing orgasm during penetrative, penis-in-vagina sex - henceforth, "sexual dysfunction" is anything that interferes with this (54-55). Essentially, "Masters and Johnson promoted a therapy where women were encouraged to be sexually available and submissive to their husbands but not 'whores'" (58; or, as others have put it, to be "a lady in the streets but a freak in the

sheets"). Instead of exploring why some women may not want to have sex with some men, or why some women may not (easily or ever) experience orgasm during penis-in-vagina sex, Masters and Johnson pathologised these women and required that they participate in certain sexual activities as treatment (58-59). Those who refused to do so were framed as rebellious ("non-compliant" is the buzzier word today) and if they claimed penis-in-vagina sex was too painful, Masters and Johnson would try to determine the validity of such "excuses" by using their fingers to penetrate the women (while their husbands watched) (60-61). Furthermore, given that the avoidance of penis-in-vagina sex, or difficulties having orgasms during penis-in-vagina sex, were classified as "dysfunctions" and given that sex itself was considered the cure for these dysfunctions, some therapists then saw themselves as those who were the experts best positioned to, quite literally, fuck their patients well (63 - although the language used is somewhat different). Again, however, taking the power differential into consideration, this is entirely unethical and, in fact, constitutes rape (64). Of course, the the*rapists* themselves are usually well aware of this and so, all too often, "[r]ationalizing the behavior functions like a mental loophole, where the individual can act in abusive ways and deflect accusations or as a defense against guilt or shame" (67).

Tosh then spends Chapter Five further developing her exposition of penetration as treatment and the pathologisation of sexual avoidance and pain. She notes two ways of thinking that have a long history within Occidental society. On the one hand, women who abstain from penis-in-vagina sex are pathologised as "frigid" but, on the other hand, "normal" (i.e., cishet, White women) are portrayed as lacking sexual desire unless it is forcefully "awakened" by a man who has "seduced" the woman (that this notion of normality is framed around cishet, White women is made clear when one recalls repeated portrayals of BIPOC women as "hypersexual") (71). In this context, the right to refuse sex is framed as a problem and invasive treatments are proposed as cures (72). Thus, when a woman's experience of pain prevents a penis from penetrating that woman's vagina, the *DSM-5* classifies this as a mental illness (i.e., "penetration disorder" which amalgamates and replaces the diagnoses of Dyspareunia and Vaginismus found in previous iterations of the DSM) (73-74). Hence, although other pain disorders exist within the psy and medical lexicons, this is the *only* pain disorder that is classified as a *sexual dysfunction* and even fear or distress related to penetration can then be diagnosed as a mental illness (73-74). This, then, works to make the woman's experience of pain less "real" or important than the woman being successfully penetrated by a man (73, 76). Consequently, in order to overcome this disorder, the DSM urges men to engage in continued penetration that overcomes "guarding reactions" despite the fact that "the individual in question is demonstrating a bodily reaction indicating that penetration is not wanted and is painful and/or distressing" (80). Women are then encouraged to engage in acts of dissociation that mirror those experienced by rape victims, and men are encouraged to ignore signs their partners give them in order to communicate that they do not want to have sex (80). Women, in other words, are to reconcile themselves with being raped and men are encouraged to embrace themselves as rapists. Other suggested treatments - from regular use of fingers or dilators that expand when inserted into the vagina, to electro-therapy, to intravaginal botox injections, to genital surgeries - are equally invasive, painful, and

potentially devastating (81). Refusing these treatments (treatments like being finger-banged daily by a man that you don't want to have sex with) can "be viewed as non-compliance with treatment or as a failure to complete treatment, rather than being viewed as non-consent to a sexual act" (82).

Finally, in Chapter Six, Tosh turns to the use of phallometrics ("the psychophysiological measurement of sexual arousal based on measurements of the penis" [86]) to how sexual violence, rape, and abuse have been deployed in so-called therapeutic interventions into male sexual arousal. Phallometrics are usually used in forced therapeutic interventions that take place within the criminal justice system - i.e., where men who have been charged or convicted of some kind of crime are then exposed to all kinds of sexual content - from vanilla porn, to rape porn, to what is essentially kiddie porn - while a "penile plethysmograph" is attached to their penis to determine if or when they get hard (and how hard? and for how long?) throughout the process. The process itself is regularly described as a form of "molestation" that is "humiliating, abusive, and forced" (87, 94). It is also frequently traumatic for those involved in administering the tests and so safety measures have been implemented to support them - although no attention is given to how this may traumatise those who are forced to participate (88, 94). However, as Tosh observes, not only are penile plethysmographs unreliable and easily gamed by those who are experienced with them (as with all lie detectors, which is why their results actually are not admissible in a court of law), but the very "construction of the penis as more trustworthy than [the word of] the person [being examined] is troubling" (89). As is now well-known, arousal or other bodily reactions we associate with sexual desire can occur for all kinds of reasons, and the test also fails to account for the fact that people can "fantasise about things they would never want to actually experience (89 - which reminds me of Joey Comeau's line about the sex we like to have versus the porn we like to watch). Here, the possibility that men might not actually want sex all the time, and the reality that arousal does not equal consent, are deliberately ignored in order to deny the "sensitivity and vulnerability of the penis" (along with its "contradictions and antagonisms") (95). This works to erase, deny, or invalidate any possibility of men being the victims of sexual violence - but, as Tosh observes, it is male survivors of sexual violence who should be the critical voices in this conversation. She goes on to note:

> As the experiences of male survivors of sexual abuse demonstrate, erections, ejaculations, and physical changes in the penis can occur for many reasons, beyond sexual arousal. This includes fear, anxiety, terror, and anger, or an erection can be independent of any emotional state … They can also co-occur with being 'psychologically paralysed' … or 'frozen', as the 'flight, flight, or freeze' reactions of the nervous system activate during trauma" (96).

This prompts Tosh to ask: "How do researchers know, then, that a physical reaction to a rape stimulus is not a result of experiencing these emotions instead?" (96). Once again, prioritising the voices of those who have survived this kind of violence is critical for, what becomes clear is that rape is not "the result of a faulty or inherently violent penis with a mind of its own" (98).

Having completed this genealogical survey, Tosh then summarises the cycle of pathologisation, victimization, and normalization that she believes is definitive of a therapeutic rape culture that abuses those who are labeled as "mentally ill," "deviant," or "abnormal" (101-102). First, those positioned as abnormal (over against the constructed bougie, cishet, able-bodied White male norm) are pathologised and marked as needing treatment, curing, or repairing. Once pathologised in this way, these "abnormals" are then positioned as fair game for any number of harmful interventions which are described as normal, professional, medical, and therapeutic but which, in actual fact, result in people being "touched, stimulated, penetrated, and sexualised" (101). In order to have these violent practices accepted, those who are subjected to them, but who resist, object, or fail to comply, are then silenced, discredited and repathologised. Resistance, refusal, dissent, outrage - all of these things are taken as evidence of further dysfunction, mental illness, and abnormality and so the cycle continues again. Ultimately, then, Tosh concludes that a true culture of consent requires us to tear down hierarchies of power and conceptualisations of normality that interfere with us being able to hear and meaningfully respond to what survivors say they want, what they say they don't want, and what they say happened to them (104).

The Interview

[DO] Jemma, what a wonderful book you have written - thank you so much for engaging in what must have been an extremely difficult task (as a male survivor of sexual violence and as a friend of many other survivors, reading it and writing *about* it is challenging - actually spending as much time as you must have spent dealing with your sources, dwelling on these themes, engaging them from your own location and in light of your own experiences as a survivor, and writing all this down, well, that must have taken a huge toll on you). I am very grateful for your work and for your willingness to do this interview with me - I lift my hands to you.

While I was reading through your genealogy, I found myself thinking about the appalling devices that were created in the 19th century to try and prevent teens from masturbating (or to try and prevent nocturnal arousal or orgasms from occurring) and I found myself thinking that, more than therapy, what you describe sounds like medieval torture. I did notice that a number of your main sources (Money, Masters, and Johnson - you can't make these names up!) come from the mid-twentieth century and extend until about the 1990s. Are these techniques, methods, and perspectives still influential today or have things changed? If so, how much and in what way? While a therapeutic rape culture appears to have dominated the psy and medical fields in the twentieth-century, how are things looking in the 21st century?

[JT] Thank you Dan, I am glad that you found it a good read!

Writing this book was extremely difficult, definitely the most challenging writing task of my career so far. Part of that difficulty was having to read through so much violent and distressing content, and the other part was being constantly reminded of my own

experiences. What I found even more arduous though, was that I was overwhelmed by the amount of possible examples I could have included. The scope of the issue was astounding. When I decided to write a book about abuse in psychology, and psychology ***as*** abuse, I was familiar with many examples from my own work already. Yet, finding so much more and having to make that difficult editing decision of what abuse to include was very tough. The reason being, that one way we can manage facing such horrific descriptions of violence, or torture to use your word (as many do and I consider it a valid descriptor), is to think (or perhaps hope) that it is rare. Being confronted with so many examples, over such a long period of time, makes it almost impossible to dismiss or minimize.

Yes, a lot of my examples are historical. I do that for a number of reasons, one being that I think an issue or concept can look very different once it is situated in its historical context, and the other is that again it becomes harder for those who might dismiss this as 'new' or 'unusual' to see that it is actually a longstanding issue that has existed since the beginning of psychology (and before).

In the book I trace these kinds of practices from historical examples such as 17th century works on intersex individuals, conversion therapies with gay men in the 1950s, to sex therapy techniques devised in the 1970s. This is again to show the scope of the issue, but it is also a tracing of the influence and interrelationships of these concepts, as Money's work influenced Masters and Johnsons, and Masters and Johnsons' work influences approaches used today. For example, the chapter on 'penetration disorder' discusses a diagnosis that was introduced (or 'rebranded') in 2010 and made official in the *Diagnostic and Statistical Manual of Mental Disorders* [DSM] in 2013. The treatment approaches described (such as being penetrated by objects either by a professional or under the supervision of one) is a current practice that is ongoing, despite the long and problematic history of the penetration of cisgender women in 'therapy' as either treatment for 'hysteria' or as a part of sex therapy. Similarly, the treatment of gay men has a controversial and harmful history. Yet, conversion therapies (i.e. those that attempt to 'make' gay individuals straight) are still occurring in the present day, albeit with public and professional condemnation in many cases. Moreover, the phallometrics critiqued in the penultimate chapter (i.e. the measurement of arousal in the penis) are currently used on cisgender men in clinical and forensic settings. The situation is the same for intersex and transgender people. The treatments discussed with regard to the very problematic concept of 'gender normalization' for intersex people, and the focus of some therapies on gender conformity for trans people, are increasingly challenged as harmful but they continue. Therefore, many practices analysed in the book have a long and complex history, and some can look slightly different today or are described differently, but they are also ongoing in a variety of contexts.

[DO] As I was reflecting on your book, especially in light of Foucault's work and what Peter Conrad has written about the medicalization of deviance, I kept returning to the central role that constructions of "the normal" or "normality" play in disciplinary environments that posture as therapeutic and caring. Obviously, having some kind of

commonly agreed upon norm is central to violent interventions like those which you describe. Creating a binary between that which is normal/good/healthy/whole and that which is abnormal/bad/sick/broken is what justifies forceful interventions that restore the abnormal to normality, the bad to goodness, the sick to health, and the broken to wholeness. However, as I was reading through your book, I kept asking myself, "but ***why*** does the notion of normality appeal so much to so many people?" If, as Steve Biko has asserted, "the most potent weapon in the hands of the oppressor is the mind of the oppressed," what is it about the notion of normality that makes it such a useful tool for infiltrating the minds of the oppressed? Furthermore, given discussions that occurred last year in relation to "homonormativity" and Queer radicalism (I'm thinking not only of TERFs here but also about the conversation that took place between Black Lives Matter! and Pride in Toronto), how do we go about checking ourselves to ensure that we have not drifted into being enforcers of the norms precisely at the places where we thinking we are pushing back against oppressive forces?

[JT] I'm probably oversimplifying my thoughts here, but for me the allure of normality is that it can seem ***easier****. The world is literally structured and designed with the normal in 'mind'. As a result, the barriers that those on the outside of that narrow concept face and overcome, do not exist for those categorized as (or assumed to be) 'normal'. Whether it is the ease of moving through immigration processes and procedures as if whiteness, education, affluence, and English language were VIP passes to an exclusive venue**, to the cisgender men who get rewarded for their leadership skills while femme folks get labeled as a 'bitch' for the same behaviour. For those who can walk right into a medical institution and access medication or surgeries they need because they have the financial means to do so, and have not been pathologized so that their very request for medicine or medical support becomes questioned (such as trans folks and the barriers to gender affirmative care). Those who exist outside of that 'normal' category are at more risk of abusive interventions, abuse in general, and the emotional toll of frequent (if not near constant) microaggressions. The pain that comes from years or decades of trauma for simply being who you are and living in a world that says there is something wrong with you, or that you shouldn't exist at all, accumulates. It is a pain that I can empathize with anyone who would be seduced by the thought of 'normality' to make existing (seem) safer and more bearable – but the struggle of trying to ascertain an impossible (constructed) 'ideal' has its own cost.

This is evident for example by those who stay in the closet for safety, or try to pass as neurotypical, because being categorized as 'abnormal' is a risk – and it can be exhausting. But this is where those who are different are damned if they do and damned if they don't: being yourself in a world that says you shouldn't exist opens up the risk of violence, discrimination, oppression, and the physical and emotional impacts that all of those bring. On the other hand, living in the closet, not by choice but because the world we live in has created a toxic and hostile environment for people who are different, means living behind a mask which is also exhausting with its own physical and emotional impacts (nor does it make you immune from the oppression, discrimination, or violence). Which is why my work focuses on the context, on changing the environment in which we live and why we

define people in these ways, because for anyone outside of that narrow idea of 'normality' there is a suffering that often stands in the way of the kinds of care, support, and healing that is needed.

The other aspect, for me, is visibility and representation. That idea of 'normality' is promoted across media and throughout all institutions, whether it is the government, the church, or education. For example, I was born during The Troubles in Northern Ireland. As a queer and nonbinary youth in this context, I had no visibility of queer or gender nonconforming people. The only context in which I heard about, or saw, non-straight relationships was in their condemnation as 'abominations' and a 'punishment from God'. It wasn't described as something a person is, but as something that was done to them, a punishment or a sin. With no internet and living in a sparse rural farmland, and a 'sex education' that would make any sexuality researcher weep, how could a non-straight existence be seen in any way as desirable? With such negative and hostile representations of queerness, how could 'normality' seem anything but appealing? Who would choose to be an 'abomination', an 'outcast', judged as deserving an eternity suffering in hell? So too do we see parallel descriptions in psychology and psychiatry, of framing people as 'bad', 'abnormal', 'sick', and 'perverse'. The attempted neutrality and objectivity of the profession does not eliminate the negativity and stigma that becomes associated with diagnoses that are positioned in opposition to 'normality', thus the same outcome prevails – being told that there is something wrong with who you are. In that context, 'normality' can seem like the better alternative. It's not, of course. The better alternative is to dismantle the concept entirely.

Again, this may be an oversimplification, but personally and professionally, I've found that in defending against normalisation, or checking myself and making sure that I'm not recreating the kind of oppression that I am trying to challenge or dismantle, has been to listen. The first time I got involved in activism, I organised a protest against homophobia in psychology. What most people don't know, is that when organising this event, I was threatened with a counter protest. Having focused on the homophobia regarding the issue, but neglecting to consider its impact on trans people, I had unintentionally caused distress. My immediate reaction was to listen. I contacted the potential organisers of this counter protest and listened to what they had to say, educated myself on the issue, made active changes to my actions and event, and made space for them in the leadership, organising, and decision-making of the event. Because at the end of the day, you don't know what you don't know. The first person to confront me on this issue quickly became a friend. This is one example of many, and it is one where I used my training in psychology for social change, community, and healing. Learning how to listen, validate, and emotionally support those who are involved in challenging their own oppression is an area where those skills can be used to subvert the very kinds of psychology that contribute to that oppression.

Other times, it's about listening to conflict. Again, growing up in Northern Ireland with so many visible examples of violence, I learned the importance of history and context, the hard work of collaborating in a context of division, and the crucial relationship between

colonialism and violence (and who gets to decide what gets defined as violence). Also, one of the first examples of cross-community building in Northern Ireland that I remember, was the organisation of events that brought together youth from different/ polarised communities. It was about getting to know each other outside of the conflict context, recognising that maybe what you had heard about a group wasn't accurate, and that your own lived experiences of engaging with that community could be more powerful than the harmful rhetoric that resulted from centuries of colonial violence and religious conflict. I'm often surprised how often I hear hate speech from those who have no direct contact with the very people they supposedly despise. How can you possibly know what a community is like if you've only ever watched from the periphery, met them in a context of conflict and violence, or listened to the opinions of others who have a reason to promote division?

In contrast, some of the most informative experiences I have had has been listening to those I disagree with, simply so that I can learn what ***not*** to do.

*Not necessarily easy, but not made more difficult by existing outside of a narrowly constructed concept of 'normality'.

**Not that immigration is ever easy, and it's important to counter the harmful rhetoric of 'they let anyone in'. In my personal experience, the numerous stages and comprehensive checks during the immigration process were not only more complicated than completing my PhD, it was far more stressful. It's just that my skin colour, race, education level, and language didn't make those processes more difficult.

[DO] I was especially struck by the various times when you highlighted the ways in which resistance to abuse is pathologised by those who have the authority to influence the dominant narrative. I was reminded of how, in 1851, Samuel Cartwright coined the term Drapetomania, which described a mental illness that afflicted slaves and prompted them to try and run away to freedom (various cures for this mental illness included increased whippings and cutting the toes off of slaves who received this diagnosis). However, it seems only a small step from Drapetomania to Oppositional Defiant Disorder, to non-compliance or resistance to the so-called treatments you describe - what we seem to find are those who refuse to perform "the sick role" (as per Talcott Parsons) in ways in which they are supposed to perform that role. Consequently, just as in the cycle you describe, the punishments meted out to those who resist (under whatever label) are normalised and valourised, those targeted by the punishments are repathologised, and the cycle continues. Psychology has a very long history of targeting, disciplining, and punishing, those whom the parties most invested in profiting from the trajectory of the status quo label as deviant, ill, or problematic. And yet, here you are, a chartered psychologist, and the Director of Psygentra, an organization that specialises in the psychology of gender and trauma. Can you speak more about how you have found your way through this discipline and why you choose to continue to root yourself within it? Perhaps you could also give advice to others who are looking to use the psy disciplines for more life-giving and life-affirming ends?

[JT] My journey through psychology has certainly been an interesting one. The first stage in training is meant to be a broad overview, but because it is so broad, it really only covers the majority or mainstream approaches. Critical perspectives (such as critical psychology or mad studies, for example) or whatever might be included under the heading of 'diversity' (e.g. courses on LGBT+ psychology, feminist psychology, decolonizing psychology and so on) can be rare. It requires a great resistance, personally, emotionally, or mentally, to absorb the information you are given when it can be so harmful – information that is needed to be known and repeated back to the institution to pass. For example, as I have stated before, I was born during The Troubles in Northern Ireland. This included regularly seeing military and violence in my day to day life, whether it was tanks driving through towns, soldiers checking under cars for bombs, or doing 'bomb drills' in my primary school outside of Belfast (like fire drills, except that we didn't walk, we *ran*). After moving to England to complete my studies, I remember vividly a Professor of 'Cross Cultural Psychology' stating in a class that the Irish were an 'unpopular race' because 'they keep bombing people'. I remember my friends looking at me in horror at such a thoughtless and loaded comment, but as a student who needed a positive outcome from that very Professor to pass the course and become a psychologist in the long run, I stayed silent but distressed. It wasn't a context where criticism or feedback was easy. I still remember telling one of my supervisors that I was planning on doing a PhD in critical psychology due to my interest in analysing the profession, such as its problematic approach to sexual violence. Her response was, "That sounds a bit negative, why don't we call it *reflective* psychology instead?" With the status and hierarchies within psychology, there can be a reluctance to admit that as a profession we have made mistakes, we have caused harm, and we need to change.

A lot of that early training was, in a word, traumatic. Torture might be another appropriate word. Whether it was being 'taught' that bisexuality was 'a phase in adolescence that people grow out of' and that 'transsexuality' was a 'brain disease', the amount of harmful (and/or hateful) content that you can be exposed to and have to 'learn' to be accepted, to pass, to continue in psychology, can be extremely difficult. My coping strategy was to find spaces where I could access support as I made it through this problematic context (one that I did not have the energy or position to challenge at that time). These tended to be feminist and queer spaces. Over time it included qualitative and critical psychology ones too, but these aren't always accessible to everyone, nor are they immune to harmful discourses, such as the transphobia in some feminist and mad studies spaces for example. I ended up carving my own path. Due to my own experiences of chronic and complex sexual trauma that started in childhood, I have always wanted to heal from my abuse, and help others so that they didn't have to live with the kind of physical and emotional pain that I have. I wanted to understand why rape happened, how we could stop it, and how to heal from it. I chose psychology and I focused on feminist and social psychology to answer those questions. But I did not go the typical route, because I found it unhelpful at best, and harmful at worst. Whether it was psychologists victim-blaming survivors, or just not believing them because of a 'diagnosis', I walked away from what was on offer to me in clinical and forensic psychology. I enjoyed my training in counselling psychology but

was disappointed at the lack of content on sexual abuse and sexual trauma. That's why I ended up pursuing a pure research PhD on sexual violence that I designed. I worked almost full-time in the UK National Health Service whilst self-funding my full-time PhD. The workload was immense, but it was the only way for me to get the answers to the questions I had been asking since I was a child.

Having achieved my PhD I started teaching and doing research in universities, but became equally disillusioned with the current context of academia. I spent more time justifying my existence than on my work, or consoling students who were going through the same harmful content that I did. The emotional impact of working alongside colleagues whose main focus of work is that you shouldn't exist or that there is something wrong with you (for being queer, nonbinary, or all the ways that you can exist outside of that 'norm' produced and promoted by psychology), creates a context where abuse can occur too – much like it can in therapeutic contexts as outlined in my book. Rather than spend my energy trying to exist in a system that is structured to exclude me or continue to survive the abuse I experienced in work contexts, I chose to create my own space – Psygentra. My journey continues, however, as I devise ways of working outside of those spaces and how my company can thrive where it exists in a larger context that is structured to exclude work like mine, done by people like me.

(For more: I've recently described my experience of becoming a psychologist in a forthcoming book chapter – '*Sexual abuse and surviving with(in) psychology.*')

[DO] Consent - how it is attained, manipulated, or ignored, what it is and is not, who all are involved in expressing and respect it - is a major theme in this book. It is also a topic that I personally wish more people were discussing and trying to understand. Why? Because the therapeutic rape culture you describe is but one aspect of a much more comprehensive, all-encompassing rape culture. I wonder if you could spend some time commenting on the relationship between the therapeutic rape culture you describe and this broader rape culture and if you could then also describe some steps we might take to achieve an equally comprehensive, all-encompassing "culture of consent" (and, for those who may be new to this topic, perhaps there are some other resources or links you could suggest to help people better understand and pursue consent)?

[JT] I also wish that more people were thinking about and talking about consent, and in more contexts than it usually is. In the context of therapy and research, there can be a 'norm' of signing a document. It's a contractual version of consent that is deeply problematic and has been critiqued by feminists fairly extensively. Unfortunately this kind of consent can be assumed in other areas of life too, such as sexually. For example, in some coercive contexts, people can assume that a single utterance of 'yes'* (as one possible indication of assent), is a binding contract and all subsequent evidence of resistance is irrelevant. This kind of 'consent' (or perhaps a pseudoconsent) allows for sexual abusers to categorize the coercion and violence as 'consensual'.

Reframing consent as fluid and context specific is an important and necessary part of building a culture of consent and dismantling rape culture – and it applies to everything, not just sex. That means that it can change at any time and is multifaceted. In other words, I might consent to one type of sexual activity but not another. In a culture of consent it cannot be assumed that because someone has indicated an interest or desire for sexual activity that all possible activities are on the table. Similarly, just because someone has consented to a sexual activity before does not mean that they will again. Assumptions are antithetical to a culture of consent and communication is key. The same goes for therapy. I may consent to therapy – but that does not mean that I consent to all possible forms of therapy. I may agree to participate in person-centred or solution-focused, for example, but not reparative therapy. I may consent to address feeling depressed, but not sexual trauma (even though they may be related). Too many health professionals assume that the signing of the document at the beginning of a therapeutic relationship is consent to any possible (or potentially relevant) intervention, and any possible areas of trauma and healing. The authoritative context of psychology and the power structures within it, can make some therapists believe that it is their (sole) decision what interventions to use, and sometimes, what issues need to be addressed.

Using expertise in this way can be beneficial, but only if consent is addressed. That is, you can plan what kind of interventions and topics you think would be effective or helpful, but this needs to be discussed with the individual at the very least. Better still, having this discussion with a critical awareness of the context that therapy occurs within (the power inequalities of psychology, pathologisation, oppression, stigma and so on) and recognizing that someone who attends therapy may not feel able to challenge, question, or disagree with their therapist – even if they want to. It requires a giving up of control and providing a context where people can say yes as well as no. There are currently a lot of negative constructions around individuals who say no to a particular kind of treatment or intervention, such as either framing them as 'noncompliant' or their refusal as part of a 'condition'. This is instead of listening to the concerns or perspective of the individual and finding a way forward that they are more comfortable with. One is framed as an expert delivering a service, the latter a co-construction of a therapeutic relationship.

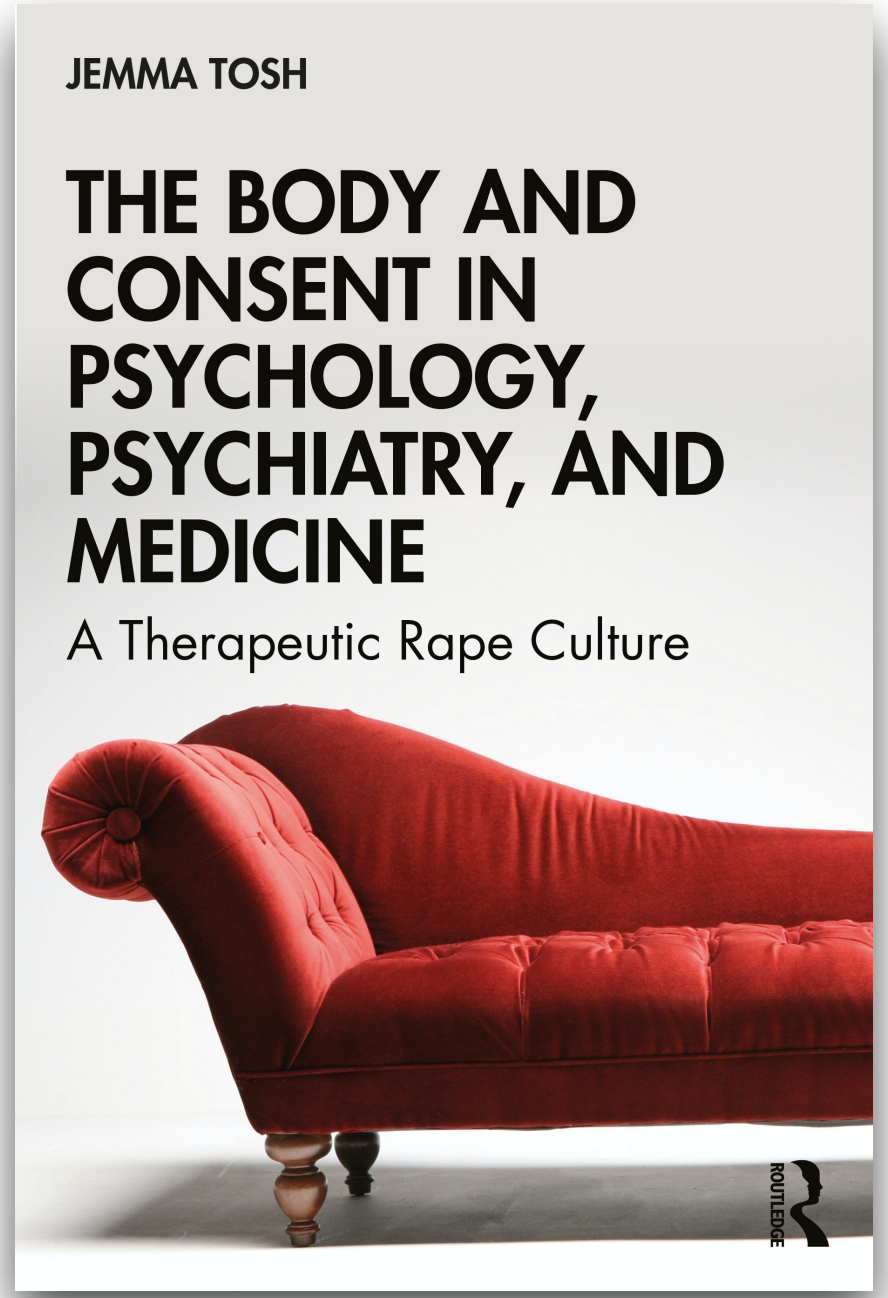
Here are some places to start if you are interested in learning more about consent and creating a culture of consent:

https://thebodyisnotanapology.com/magazine/creating-a-culture-of-consent/

https://www.psychologytoday.com/us/blog/the-wide-wide-world-psychology/201702/what-the-bdsm-community-can-teach-kinky-world

https://www.unwomen.org/en/news/stories/2019/11/feature-consent-no-blurred-lines

*It is also important to note that there are many ways to consent or resist sexual activity that are not verbal, in addition to the sexual consent and communication of non-verbal people.



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