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YOU DON'T HAVE TO HAVE SEX: COUNSELLING FIELDS AND MANDATORY SEXUALITY

BY

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Dedication

For anyone who has learned to say no with a grin.

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Much gratitude to all those who have chosen to feed, teach, or listen to me.

Abstract

Asexuality, and by extension people's right to not have sex, is contentious ground. Psychology's conception of asexuality perpetuates a system of oppression called mandatory sexuality. Mandatory sexuality operates in white settler colonial nation-state interests by decreeing that normative sexual activity occurs frequently, in the context of marriage or marriage-like monogamous relationships, with the goal of decreasing undesirable populations while increasing economically productive settler populations. Mandatory sexuality is perpetuated in psychology via microaggressions, including clinicians presuming that clients want to and do have sex regularly, or with pathologizing assessments that call for investigation when people do not want to have sex. In the present study, three feminist, sex positive, and trauma informed therapy practitioners discussed mandatory sexuality in semi-structured online interviews. Mandatory sexuality is a colonially instituted form of violence that leads to interrupted relational development, interfering with clients' ability to have interdependent, grounded relationships with themselves and others.

Keywords: asexuality, mandatory sexuality, colonialism, trauma, counselling therapy, compulsory sexuality

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Chapter 1. Statement of the Problem

I don't think that having sex is a mandatory part of health, well-being, and overall good function, and I want to investigate why clinicians frequently seem to believe that it is. My thinking on this front has its origins in June of 2018. I was completing undergraduate courses at Athabasca University as prerequisites for applying to the Master of counselling program (for which I am now producing a thesis), and at the same time I began training in a trauma work modality called Somatic Experiencing. Somatic Experiencing (SE) is a theoretical orientation to psychotherapy that's been under development for the past 30 or 40 years; the person most associated with its nexus is Peter Levine but if you're familiar with books by adrienne maree brown, Pat Ogden, Maggie Kline, Alice Miller, or Dan Siegal among many others then many of the ideas in Somatic Experiencing might be familiar to you.

The basic principles behind somatic approaches to psychotherapy, including SE, go as follows. SE contends that traumatic events are 'stored' in the nervous system as incomplete responses to stressful life events. These biological patterns of stress response can be resolved by integrating non-verbal, physiological impulses into the therapeutic process. Further, creatures' bodies "know" how to discharge traumatic energy and can do so when fulsomely resourced, leading to overall change and health (Kuhfuß, Maldei, Hetmanek, & Baumann, 2021; Payne, Levine, & Crane-Godreau, 2015).

Because SE is a trauma work modality, training is organized around "types" of traumatic events. For example, there are units on car crashes, natural disasters, falls, and medical trauma. In the second portion of the training's Intermediate level, our training cohort reached the protocol for sexual violence (Levine, 1994, p. I2.7). To my horror, the very first bullet point encouraged practitioners to "bring back sexual feeling" (Levine, 1994, p. I2.7). I flooded with

frustration and resistance. I raced through hypothetical demands I could make of the trainers: How could this training presume that any survivor's response to sexual violence is a "loss" of sexual desire and function? According to what best practices is it appropriate for any given therapist without appropriate training to be working with sexual desire within the context of a therapeutic relationship? To what "normative" point might a therapist be "restoring" someone's desire? How is such a point determined? Do practitioners who take this instruction uncritically give their clients the opportunity to refuse such treatment? I wound up raising my hand in a cohort of 60 some peers as a junior practitioner, by this point in my first year of graduate work, and asking a few of these questions. I then simply asserted "you don't have to have sex" and left the training for the rest of the day.

As a queer person, as someone who has endured extensive sexual violence within intimate and familial relationships, and as a practicum student at a sexual assault centre, I am experientially and professionally familiar with the social forces that influence the development of human sexualities. Similarly, I am unfortunately extremely knowledgeable of the myriad ways sex and sexuality can be weaponized against others. This moment in the Somatic Experiencing training, though, catapulted me into a technicolour curiosity of how psychologists participate in mandating sexual activity for their clients, positing the experience of sexual desire and of having sex as mandatory, universal elements of healthy and functional living.

I appreciate that some clients draw a relationship between their survival of sexual violence and a decrease in their overall desire, sometimes referred to as "hyposexuality" in the literature, though such meaning-making does not occur in a vacuum of power relations. I believe psychologists can and should investigate our ethical obligations to clients who have experienced sexual violence such that we do not respond to them in ways that double down on the impetus for

sexual activity, but this is not where my analytical attention is focused. Rather, I am interested in psychology's role in constructing and reifying the idea that having sex is requisite to client health, and I aim to do so by both critically investigating the field's conceptualization of asexuality and investigating clinician perspectives on the concept of mandatory sexuality. I will be examining the phenomenon of mandatory sexuality not through literature that presupposes, however empathetically, that a lack of sexuality is largely derivative of trauma, but rather by beginning with the same assertion I made in my training: you don't have to have sex, and further, that clinical inquiry into why people don't want to have sex is a rhetorical move that bolsters the erroneous perspective that sex is mandatory.

Of course, inquiry into how and why lack of desire operates for clients is foundational to guiding our encounters with clients who present with "low" sexual inclination (American Psychiatric Association, 2013, pp. 434, 443). The presence of distress is key to how sexual interest disorders, arousal disorders, and desire disorders are diagnosed and treated in our field for example. However, treating a lack of sexual interest, arousal, or desire as a mental disorder does a disservice to a school of thought that contends that it is the very pathologization of these phenomena that causes distress in individuals, rather than not experiencing sexual interest, arousal, or desire in and of itself. A recent review of literature on asexuality by Brotto and Yule (2017) considered whether the phenomenon of asexuality, broadly defined in the academic research record as a lack of sexual attraction, ought to be considered a psychiatric condition, whether asexuality is more accurately understood as a paraphilia, or whether asexuality is more appropriately conceived of as a sexual dysfunction. Brotto and Yule's review concluded that asexuality is heterogeneous in nature, and that researchers might be advised to pursue a view of asexuality as a distinct sexuality in and of itself, one that might exist in the same organizational

category as "bisexual" or "lesbian": hence, the "A" in some iterations of the LGBTQ2SIA+ acronym.

Large-scale asexual organizing concurs wholeheartedly with this perspective. The Asexual Visibility and Education Network, for example, advocates for an understanding of asexuality as an iteration of "normal" human sexuality, asserting on its homepage that for asexual people, "asexuality is an intrinsic part of who we are, just like other sexual orientations" (AVEN, n.d.). Mainstream asexual organizing interfaces with the academic community through recent qualitative studies where asexuals have asserted the need to depathologize a lack of sexual desire: that is, not consider it a paraphilia, a sexual dysfunction, or a psychiatric condition at all (Cuthbert 2019, Dawson et al., 2018, Flanagan & Peters, 2020). However, "low" sexual desire is still enshrined in the Diagnostic and Statistical Manual of Mental Disorders as Male Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Interest / Arousal Disorder (SIAD) (American Psychiatric Association, 2013, pp. 434, 443). In 2013, following advocacy by asexual groups (Asexual Explorations, 2009) the diagnostic criteria for these disorders were restructured to allow diagnostic exemption for those whose low sexual desire is better explained "by one's self-identification as 'asexual'" (American Psychiatric Association, 2013, p. 434, 443). This was accepted as a win for some activists, who celebrated that they "are in this book because [they] are valid" ("Asexuality Archive", 2015). It's important to note here that the entries for HSDD and SIAD insist on the validity of the sex binary in making differential diagnoses between HSDD and SIAD, which is crucial to investigating mandatory sexuality and its relationship to cissupremacy in mandating colonially derived reproductively viable relationships amongst certain individuals. Much research notes that client gender and sexuality impacts their relationship to their own asexuality, because of the different ways that binary gender

expectations coach people's development of normative sexualities and the abuses hurled their way if they do not comply, which are dependent on peoples' perceived subject positions (Cuthbert, 2019). For example, a heterosexual cisgender white woman who is disinterested in sex might be termed "frigid," or a "bitch"; while heterosexual cisgender white men might be accused of being a "fag," (an insult that relies on perceiving homosexuality as negative). However, the relationship between mandatory sexuality and settler colonial cissupremacy has not been established in the field of psychology.

Outlining the changes to sexual dysfunction diagnostic criteria between the DSM-IV and DSM-5, IsHak and Tobia (2013) highlight that a diagnosis of HSDD and/or SIAD is contingent on a clinician's judgement of whether a person's low sexual arousal causes "significant distress." So too, they write, is diagnosis contingent on a "judgment of deficiency" (American Psychiatric Association, p. 440) made by clinicians: two discretionary requirements completely susceptible to perspectives regarding what is considered natural and human, and indeed, what—and who—is legible as suffering distress and why. The phenomenon of bias in assessing physical pain is documented in literature on medical practitioners. In a 2020 systematic mixed studies review Aronowitz and colleagues write that practitioners who hold beliefs (whether unconsciously or unrepentantly) about inherent racial differences are more likely to treat Black people seeking care as though we are more able of withstanding pain and as such treat Black patients presenting with pain with less rigorous protocols. Further, beliefs about the inherent criminality of Black patients can result in healthcare professionals believing that Black people lie about how much pain we are experiencing, or believing that Black patients require, or are deserving of, less attentive care than white people (Aronowitz et al. 2020). The authors report such phenomena as a "race-based pain sensitization myth" which they hypothesize healthcare providers internalize in

general (p. 43). In the field of psychology, such views can impact whether practitioners believe people when they say they're in distress—and whether such distress is "significant" or not. No practitioner operates in a vacuum of power relations when it comes to gender, race, class, or ability: no one is immune from the possibility of countertransference when it comes to accurately responding to and conceptualizing a person's pain.

"Low" sexual desire is enshrined in the DSM sans any definition of what might constitute "sufficient" sexual desire. The lack of definition entails a lack of precision in diagnostics, and means arousal disorders are subject to massive intangible goal posts dependent only on the practices of individual clinicians (Van Houdenhove et al., 2015). The impossibility of defining the norm (I certainly don't think it's possible or advisable to state with broad generalization how much sexual intercourse is the right amount of sexual intercourse) and the invisibilization of the norm is one example of the active construction of mandatory sexuality against which critical asexual theorizing pushes back in order to exist without psychiatric scrutiny. Qualitative research can and does address the fact that health industry professionals such as psychiatrists, doctors, and psychologists perpetuate harm against clients when uncritical of the impact of mandatory sexuality on asexuals' lives (Flanagan & Peters, 2020; Gupta, 2017b). However, this is often examined as an issue of individual clinicians, therapists, and clients, rather than a broader and more serious failure being perpetuated by health industries that do not question deeply the origins of distress.

I am curious to know how clinicians who operate with anti-oppressive, sex positive, and trauma informed lenses on practice conceive of these issues, and whether they are able to report on how mandatory sexuality has operated in their training. I intend to ask clinicians to speak to

where mandatory sexuality as a social force is present in their current practice, and if and/or how they've seen it deconstructed or pushed pack against.

Chapter 2. Literature Review

In order to understand psychology's relationship to mandatory sexuality, I first want to review the concepts of mandatory sexuality and asexuality through the lens of critical asexual theorizing, which incorporates perspectives from scholarly fields such as Black feminism, queer and gender studies, mad studies, crip studies, critical race theory, and anti-colonial thought broadly. I will then proceed to review field-specific work on asexuality, noting how psychology conceives of asexuality and asexuals, as well as what guidance is offered to clinicians who are interested in treating asexuals appropriately, whether through the DSM's distress lens or not.

Mandatory Sexuality, Colonialism, and Eugenics

Mandatory sexuality can be understood as a contemporarily maintained colonial ideology rooted in eugenicist imperatives that should not be perpetuated (Campo-Arias & Herazo, 2018; Carter, 2008; Gupta, 2017a; Marks, 2017). The purported importance of sexual activity to individual and community fulfillment is rooted in individualist cultures where white supremacist settler nations require people to pursue relationships that are monogamous, heterosexual, and reproductively viable in order to sustain dominant society (Carter, 2008; Moreton-Robinson, 2015). In historian Sarah Carter's (2008) account of the ideology of monogamy in what is currently known as Western Canada, she shows that this religiously derived model of intimate relationship and family formation was not popular, dominant, or internalized as a goal for individuals until the late 19th century. Further, Carter's research demonstrates that the installation of this new ideology was intentional in its attempt to demolish previously extant definitions of relationship and family formation that existed amongst the Indigenous people who continue to live in these, their territories (p. 3) and to ensure the formation and proliferation of a new settler nation (p. 5). State and ideological processes that dictate the respectability and

appropriateness of people's intimate and sexual relationships have a powerful psychological effect on individuals deemed *un*respectable and *in*appropriate: these environments can indeed be justifiably distressing for individuals and communities who do not fit social norms.

Societal sanctioning of monogamous, heterosexual, and reproductively viable sexual relationships—or what is summarily described as mandatory sexuality—is contemporarily evident in areas where society is organized around these relationships and any individual's participation in a relationship of this form provides social security. Gupta, a feminist scholar of medicine, psychology, and health industries, conducted a series of in-depth interviews with asexuals published in 2017 inquiring into asexuals' perspectives on this topic. Her research notes that while not every asexual person nor community of asexuals is explicitly interested in undermining colonial ideologies of what she describes as compulsory sexuality, Western settler colonial nations award privileges specifically to people with certain forms of sexuality while actively marginalizing others (Gupta, 2017a). This power imbalance originates with how white supremacist settler nation states needed to transform Indigenous nations' interdependent relationships with land into the concept of private property and create relational structures that dictated how wealth accrued from property ownership would transfer between settler generations (Moreton-Robinson, 2015). Simultaneously, these relationally based economic partnerships and associated legal traditions needed to deny and erase extant kinship structures amongst Indigenous nations in what is currently known as North America (Carter, 2008; Moreton-Robinson, 2015).

Relationship law is based on the blueprint of a long term monogamous sexual relationship between two people. The Alberta Adult Interdependent Relationships Act (articulating new language for common-law relationships as of 2002) for example dictates that a person can only have one adult interdependent partner at a time; further, you cannot sign an

Adult Interdependent Partner Agreement with your adult interdependent partner while you are still married to someone else (Province of Alberta, 2002). Additionally, having sex, or "consummation," is a central question when immigration policies are attempting to determine whether two people are in a "genuine marriage" for the purposes of bestowing citizenship on people (Challborn & Harder 2019). Income tax law (ability to transfer income amounts to spouses in order to glean tax benefits), life and medical insurance policies (with regards to inheritance and beneficiary processes), and citizenship in the form of parental listings on birth certificates are all examples of how mandatory sexuality and its attendant relational forms structure people's lives. There are less barriers to navigation of institutional norms for those in long-term partnerships presumed to be sexual, and ideologies of mandatory sexuality would hold that securing such a partnership is a prerequisite for being a healthy self-fulfilled subject. Individuals without these partnerships and those whose partnerships end in divorce are often perceived as having somehow failed for this reason. This hierarchy of reward for those whose desires, subject positions, and relational patterns are congruent with state priorities detrimentally affects asexual individuals (Gupta, 2017b, p. 992). Social security afforded to those in sexual marriage and marriage like relationships ensures the continuation of settler state priorities through rewarding those in these relationships with easier wealth accrual and generations of settler populations being regenerated through procreation.

State processes that de-sexualize populations whose social and or biological reproduction is not advantageous to its own perpetuation are just as vital a component of the operationalization of mandatory sexuality. Desexualization here is comprised of two parts: one, the active sterilization of individuals and two, the construction of ideologies that cast people as undesirable, of being unworthy or incapable of sexual pleasure (and attendant romantic

commitment or devotion), *and* of being deserving of having sex weaponized against them in the form of sexual violence. These twinned projects are evident in research into the sterilization of Indigenous people who might otherwise have decided to gestate progeny, and disabled people; two populations explicitly targeted by eugenics movements throughout the 20th and 21st centuries and even more disproportionately earmarked if both Indigenous and disabled (Grekul et al. 2004 p. 375). Such coercive surgeries include tubal ligations, hysterectomies, oophorectomies, vasectomies, and orchiectomies. Forced and coerced sterilization fulfill the same state goal as ideologies of sexual violence when it comes to these populations: literature reviews estimate that the rates of lifetime sexual abuse for disabled people range from anywhere between 11 to 68% with lower estimates being reported by people whose perpetrators were their personal assistant service provider (Hughes et al. p. 315). Sexual violence against disabled people in Canada has historically been rationalized and excused in the criminal justice system through the repulsive logic that if people lack the intellectual faculties to consent to sexual contact, it follows that they can't *not* consent (Benedet and Grant, 2007). Similar logics are applied to Indigenous women in particular, where "discursive representations depicting Indigenous girls as uncivilized, promiscuous, and immoral" naturalize sexual violence (Scribe, 2018; WEA & NYSHN, 2016). Mandatory sexuality is a system of discipline that performs and facilitates violence against those whose reproduction is undesirable to settler states.

Asexuality and Additional Axes of Oppression

Asexual people who experience multiple intersecting oppressions along the axes of race and gender especially have identified mandatory sexuality as one of the forms of oppression by which they are targeted (Cuthbert, 2019; Foster et al., 2018; Hawkins Owen, 2018; Miles, 2019). Given that mandatory sexuality is a tool of colonial establishment and maintenance, it logically

follows that as an ideology it is paid special attention to by people whose genders and races are targeted by white supremacy and cis and heterosupremacy within a colonial paradigm. These populations note that suffering and distress experienced by asexual people related to their asexuality is as a result of the oppression they face via mandatory sexuality and other forms of marginalization, not as a result of an asexual identity or orientation itself.

For racialized asexuals for example, the imposition of white supremacy and its attendant attempts to subdue or eliminate socially constructed categories of people (e.g. by race) entails the twinning of racism and sexism to control behavior at individual, family, community, and global levels. These ideologies insist that "Black bodies are often viewed as untouchable, either promiscuous or unattractive; Asian bodies are often viewed as uniformly feminized and submissive; Brown bodies are often exoticized"; racialized people's asexuality exists in inextricable relation to these sexually objectifying ideas (Foster et al., 2018). Black women's' sexualities in particular often have external meanings thrust upon them, making it all the more deliberate and considered when Black asexual women assert asexuality as an intentional and fulsome identity and perspective: this can be done through resisting hypersexualization and/or the denial of sexual agency typified by the Mammy figure (Hawkins Owen, 2018; Miles, 2019, p. 165).

Similarly, the imposition of cis supremacy—the social dominance of cisgender identities that produces oppression of transgender people—entails that asexual transgender and agender people in particular be keenly intentional in their resistance to the purportedly biological imperative of mandatory sexuality (Mitchell & Hunnicutt, 2018). This intentionality must stand in opposition to perspectives on sexual development that are frequently derived from scientific research that impede justice for these communities and are grossly insufficient in accounting for

their existence (Cuthbert, 2019, p. 2). Indeed, gendered and racialized subjugation are embedded directly within the language of the DSM: the classification of sexual dysfunction is split into "male" and "female" conditions, ignoring evidence of the negligible veracity of gender and sex binaries (Phillips et al, 2019) and invisibilizing white supremacist culture as an unnamed authority with the power to determine what constitutes "deficient" sexual thoughts (American Psychiatric Association, 2013, pp. 434, 443). These prescriptions of normality and authority are so intentionally erased by their own processes that critical mention of gender and race is rarely present in research studies on asexuality, which frequently only include white, cisgender, and heterosexual participants. As a result, qualitative research with racialized and queer asexuals especially is generally the most attentive to the supremacist ideologies underpinning the existence of mandatory sexuality while other kinds of research often reproduce these binaries and hierarchies.

Cuthbert (2019), for example, provides a sociologically grounded account of the relationship between gender and asexuality arising from the observation that there are many transgender, agender, and gender nonconforming people who are asexual. This qualitative research focused on asexual participants of a broader project on asexuality, abstinence, and gender. The paper rightly points out, based on participant data derived from semi structured interviews and journal prompts, that research can play an important role in identifying the ideologies and discourses—or power dynamics—at play in the testimony participants provide. For Cuthbert, these power dynamics include racism, narrow and restrictive understandings of femininity and masculinity, and the organization of gender into binary opposites. When gender and sexuality are presumed to be possible to assign, always stable, and always in service of nation-building, mandatory sexuality targets those whose genders and sexualities are considered

aberrant to enforce sexuality through medicalization of low or absent sexual interest: a critical asexual lens can shed light on these harms.

Asexual Perspectives on Distress

The phenomenon of asexuals who experienced distress prior to adopting asexuality as an identity term and a lens of self-acceptance is accounted for in the research record. Sociologists Dawson et al., (2018) outline how some asexuals contend that their distress would have been minimized if broader acceptance of asexuality could transpire. For asexuals targeted by multiple systems of oppression, this narrative is all the more common, as these research participants are seen to be more skilled at coping with enduring prejudice and discrimination. This is true in Foster et al.'s 2018 qualitative exploration of the identity formation of asexual women of colour, derived from clinical psychology research, which provides narrative testimony from a number of asexuals who have struggled with negative stereotypes about their gender, race, and asexuality. These studies suggest that distress is an unsatisfactory and incomplete cornerstone for differentiating between asexuality as a healthy permutation of human sexuality, and sexual interest disorders, arousal disorders, or desire disorders.

Both of these studies also elucidate a common but problematic narrative about asexuals in research literature: that asexuals can and do heal themselves of distress by developing an identity of pride around their asexuality rather than focus on any harms that befall them in relation to their asexuality. While this might be the case, it evades the role helping professionals play in constructing and reifying this distress in the first place, and further individualizes distress as the responsibility of distressed individuals to cope with, rather than the responsibility of a distressing society to address and end at its root causes.

Perpetuation of Mandatory Sexuality in Healthcare Settings

Health and helping professionals can and do perpetuate mandatory sexuality and the oppression of asexual people (Flanagan & Peters, 2020; Gupta, 2017b). This is particularly salient in the way that mandatory sexuality is enshrined in medical and therapeutic practice (American Psychological Association 2013; Campo-Arias & Herazo, 2018; IsHak & Tobia, 2013). Questions I myself have been expected to ask of clients during their intake sessions in the Trauma Symptom Checklist, a 40-item assessment battery, such as asking clients how often they experience "low sex drive" or "sexual overactivity," hint at the existence of an elusive non-traumatized and normative sexuality that one could strive for (Elliott & Briere, 1992). Research on sexual desire has often attempted to quantify further differences between people who experience distress about relatively low or absent sexual desire (who would be considered to have HSDD or SIAD depending on binary sex assignment) and people who do not experience said distress (to whom a clinician utilizing DSM criteria might grant the validity of asexuality) (Antonsen et al., 2020).

One such example is Bellman Brown's (2020) neurological study of sexual cue cognitive processing in asexual individuals and heterosexual women with desire and or arousal difficulties. The Bellman Brown study investigated 42 asexuals and 25 heterosexual women with diagnoses of SIAD by asking them to complete a visual attention task, a task assessing their implicit assessments of sexual words, and a questionnaire that assesses people's explicit appraisals of sex. This study takes as a base assumption that visual processing of erotic stimuli is a prerequisite of sexual arousal, thus excluding from consideration blind people who experience sexual arousal and desire. This immediately destabilizes any ability to generalize the finding that heterosexual women with diagnoses of lifelong and acquired SIAD pay greater attention to

sexual cues, while asexual people pay less attention. The conclusion of Bellman Brown's work is that further medicalization of the already pathologized and contested distinction between asexuals and people with SIAD/HSDD might be helpful to health fields: neuropsychological assessment could assist in diagnosis, and "re-incentivizing" sexual cues could be a viable treatment route for women with SIAD. This amounts to the rationalization of psychiatrists and psychologists having a role in concocting people's sexualities and indoctrinating people *into* sexual desire: turning people into objects of scientific study with the instilling of sexual propaganda in a regression to psychiatry's historically harmful experimentations in conversion therapies (Flore, 2016).

Some research on asexuality, rather than focus its lens on asexual people or on the phenomenon of not experiencing sexual desire, takes as its subject the psychiatric nosology of sexuality generally. Such is the case with Campo-Arias and Herazo's 2018 review of changes in the DSM-5, which is specifically a critical analysis of how sexual dysfunctions, gender dysphoria, and paraphilic disorders are outlined in the newest iteration of the Manual. The authors point out that classification of behavior generally leads to the transformation of a neutral concept into an ideological reality with material consequences (p. 58). The trajectory of classifications leading to theories and hypotheses, which leads to the social domination of those who diverge from an arbitrarily enshrined normality, is one that applies to asexuality and asexuals (p. 58). Medicalization has transformed the completely morally neutral experience of not experiencing sexual desire into grounds on which people can be cast as wrong, bad, in need of amendment, and ultimately deserving of discrimination within intimate relationships and at the hands of the state.

The assumptions guiding "diagnosis" of asexuality are harmful, and interpersonal interactions between asexuals and clinicians who come from these ideological perspectives are harmful too. Gupta's 2017 qualitative research on prejudice faced by the asexual community in healthcare settings provides a number of first-hand accounts of how the medicalization of not experiencing sexual desire and mandatory sexuality plays out in healthcare settings (Gupta, 2017b). The primary area of inquiry in this study is trying to determine with greater sensitivity when sexual disinterest is simply a way of existing and when it is a condition that requires some form of therapeutic intervention. This is because, as Gupta (2017b) points out, scholars have not investigated how testimony and advocacy from contemporary asexual movements might alter therapeutic practice for asexuals and allosexuals—individuals who do experience sexual desire and attraction—alike.

Asexuals interviewed by Gupta for the purposes of this research discuss the following healthcare related scenarios as distressing: the mere existence of diagnostic categories and treatment protocols; the fact that when seeking psychological services to cope with unwanted pressure from a partner to have sex, professionals often side with the partner and try to coax the patient or client into having sex they do not want; and the proliferation of pharmaceutical companies who artificially create and profit from medicalized and marketable sexual "deficiencies" in people. All this is in addition to the fact that it is rare to find health professionals who grasp that some asexual people do sometimes want to have sex, and this does not negate their identity as asexuals (Hille et al., 2020).

Asexual individuals are aware and wary of meeting these scenarios in doctors' offices and therapists' offices alike. This wariness is well-founded, and results in up to half of asexuals not disclosing their asexual identities or discussing sexuality-related topics with their care

providers according to research done by social workers and psychologists who administered a digital survey about asexuals' experience with mental and physical health care providers (Flanagan & Peters, 2020). In this study, participants who did disclose their asexuality to a mental health or medical care provider stated that negative responses to these disclosures included practitioners refusing the reality of their identity by "dismissing, not believing, [or] even mocking [asexuality], or assuming that [asexuality] was something that would change in the future" (p. 1636). Further, Flanagan and Peters report that between 25 and 50% of participants experienced being diagnosed with a mental, physical, or sexual disorder due to a clinician's perception of the participant's asexuality, and a majority of these participants feel that the diagnosis was irrelevant and inappropriate for them to receive (p. 1640).

The encounters described in research examining asexuals' experiences in healthcare settings is evidence of the way oppression in the form of mandatory sexuality operates. To meet beliefs and treatment like this in healthcare settings, from authority figures who are meant to provide assistance, can have doubly damaging psychological effects on anyone who simply does not want to have sex, for any reason. Concern about enduring these attitudes from providers can prevent asexual people from accessing competent medical and mental health attention, which amounts to a systemic barrier to healthcare for asexuals.

Mandatory Sexuality, Asexuality, and Clinical Competence

Medical and therapeutic fields could divest from mandatory sexuality as a tenet that guides practice. For distress to be the defining clinical feature of HSDD and/or SIAD, which is diagnosable by clinicians, but for those same clinicians to be part of creating a distressing environment for asexual people and anyone who does not experience sexual desire or interest, is a self-fulfilling prophesy. Furthermore, clinical diagnosis can impact the therapeutic relationship

within the context of counselling psychology, as it can influence a client's self-perception and a counselor's perception of the client including creating a therapeutic plan. Research literature on the negative impacts of healthcare on asexual people has several main recommendations for clinicians. First, it is recommended that clinicians be educated about the existence of asexuality and be able to demonstrate this literacy to clients in case asexuality is not an identification they've explored; second, be aware of the varying and fluid relationships asexuals can form to the idea of wanting to increase their own desire without negating their identity as asexual. Third, clinicians should treat contentious differences in relative amounts of sexual desire in a relationship as a relationship issue rather than an issue of one "deficient" partner; and finally, that clinicians should be self-reflexive about any biases they have in favour of sexual activity generally (Antonsen et al., 2020; Flanagan & Peters, 2020; Gupta, 2017b).

While these may be viable stop-gap measures for any clinicians who happen to come across this research in their quest to simply not harm potential clients or patients, it does not go far enough in addressing and ending mandatory sexuality. The insistence that having sex is a compulsory part of experiencing wellness and fulfillment is an iteration of eugenicist and white supremacist mandates installed by colonialism. Given this reality, and the reality that most graduate level training programs insist that social justice is a value contemporary counselors must operate from, I am interested in discussing mandatory sexuality with current clinicians.

Particularly in the realm of attempting to operate from a socially just perspective, critical asexual theorizing, sometimes known as prude discourse, calls for "liberation from gendered / sexualized labour, racial fetishization & white supremacist rape culture, capitalist survival as structured around nuclear family & capitalist pillaging of sexuality as a whole" (for real, 2020). Prude perspectives recognize that the impetus to have sex informs the rationalization of rape,

homophobia in the form of heterosexual supremacy, the rupturing and invalidation of kinship networks that do not revolve around nuclear families, and a host of other injustices.

While Brotto and Yule (2017) contend that asexuality ought to be considered a sexuality unto itself alongside other sexualities articulated within LGBQ+ acronyms, I think it would also be advisable for justice-oriented practitioners to move to a conceptualization of asexuality as a viable way to intentionally resist the idea that people have to have sex. I do not accept the notion that asexuality as a sexuality is immutable nor intrinsic: such arguments pave the way for attempts at achieving legitimacy forged by scarcity in the form of competition ("should they or shouldn't they be included in queer communities?") and genetic testing ("we need funding to see if there are biomarkers for asexuality like there are for homosexuality in cisgender gay men!"). What I'm mulling over instead are my own ethical and relational responsibilities to any potential client regardless of how much sexual desire they may experience and my responsibilities to a field that purports to value nonmalfiesance and justice. How are my professional peers with these values confronting mandatory sexuality? How are they avoiding the reification of individual productivity or "normalcy" and an ability to function within dominant society as the ultimate goal of therapeutic intervention? Is it possible to divest from being complicit in creating the very distress leveraged against asexuals in the name of social control via clinical diagnoses? Are contemporary practitioners addressing distress from a perspective that disavows mandatory sexuality and allows for the possibility of asexuality as morally neutral, and as a way of being that refuses certain forms of eugenicist colonial control? While these larger questions guide this research project generally, the specific questions I intend to ask participants are in Appendix A. The objective of my work overall is to establish working definitions of mandatory sexuality

amongst feminist, sex positive, and trauma informed therapy practitioners and to understand the varied ways such practitioners confront the concept of mandatory sexuality in their work.

Chapter 3. Methodology

I intend to approach these research questions through an interpretive phenomenological investigation of current practitioners' experiences with the concept of mandatory sexuality in their training and practice. While many studies have investigated asexuals' experiences of mandatory sexuality in encounters with helping professions (Flanagan & Peters, 2020; Gupta 2017a; Hille et al. 2020; Mitchell and Hunnicutt 2018; and Van Houdenhove et al. 2015), none have investigated clinicians taking responsibility for disavowing this system of oppression within their practice. Shifting the directionality of this research is an attempt at intervening in the power dynamic of academic fields' incessant othering of research subjects, an attempt at returning said objectifying gaze, and avoiding research fatigue amongst asexual people (Ashley, 2020).

Phenomenology is a form of study where the focus of an investigation is someone's consciousness (either the self or another's) as it is experienced by that person (Smith, 2018). Interpretive Phenomenological Analysis (IPA) is a qualitative research method used within the field of psychology to do phenomenology, or in other words, to deeply investigate the nature of experience (Smith, 2018). In Edward Noon's article questioning whether IPA is an appropriate methodology for doing educational research, the author indicated that the goal of IPA is to "understand lived experiences and explore how individuals make sense of their personal and social worlds" (2018, p.1). In interpretive phenomenological research, researchers ask about participants' thoughts, feelings, memories, and ideas generally (Willig, 2019). Here, I will explore both the history of phenomenology and its various approaches, narrowing in on interpretive modes; outline researcher responsibilities and preparatory steps researchers must undertake when performing such investigations in psychology; and undertake a review of the concepts of methodology and rigor within these research methods. To ensure a balanced

overview, I will briefly note some limitations of phenomenological approaches and how its drawbacks can be accounted for or mitigated in ethical research practices. I will then proceed to outline the logic for using this method for this research.

History of Phenomenology

While most academic sources claim the origins of phenomenology as a practice originate with early 20th century philosophers such as Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, and Jean-Paul Sartre (Käufer & Chemero, 2021; Laverty 2003; Rapport 2005; Smith, 2018), phenomenology is not a uniquely—or even originally—white or western thought process, as demonstrated in a review of literature on phenomenology. Dr. Roxanne Struthers, an Anishinaabeg Doctor of Public Health Nursing and researcher from Miskwaagamiiwi-zaaga'igan, wrote that the oral ontologies so central to Indigenous worldviews in occupied North America are a "type of narrative communication and understanding" that are "the cornerstone of phenomenological research" (La Valleur, 2001; Star Tribune, 2005; Struthers & Peden-McAlpine, 2005). Arab and Black feminists have observed that theorizing one's own body and somatic existence as a site of resistance—notably exemplified by Sojourner Truth in 1851—is a phenomenological strategy employed by racialized women in particular (Lennon, 2019; Ryman & Al-Saji, 2013). Finally, Chinese scholar Kwok-Ying Lau has demonstrated the way that both Husserl and Heidegger "reductively categorized non-Western forms of thought as essentially unphilosophical and non-conceptual forms of expression" despite drawing heavily on Zen Buddhism and Chinese and East Asian Daoism in their work (Nelson, 2017).

Recent examples of phenomenological research in psychology and related fields such as nursing and education include: an investigation of Pakistani women psychologists and their experiences of discrimination while pursuing professionalization and career establishment in

Pakistan (Anjum et al., 2019); an exploration of students studying at disadvantaged universities in South Africa and how public health mandated school closures initiated by COVID-19 responses impacted their learning and health (Makgahlela et al., 2021); a study of nursing students and their perspectives on what constitutes effective instructors within Iranian clinical education environments (Yekefallah et al., 2021); and an inquiry into nursing faculty members' experiences incorporating simulations into how they teach in both the Caribbean and the Midwestern United States (Hernandez-Acevedo, 2021). All these studies used interpretive phenomenological methods such as in-depth semi-structured interviews, focus groups, surveys or questionnaires, and thematic analysis. These recent examples of phenomenological investigation are of interest to me in the present moment due to their examination of systemic challenges in the form of institutional processes, academic disenfranchisement, and social oppression, demonstrating the critical ethics of rigorous phenomenological analysis and the origins of phenomenology as a method of resistant praxis. These are major elements of my investigation into psychology's perpetuation of mandatory sexuality as a form of discrimination. I am specifically interested in hermeneutics as a mode of phenomenological analysis due to the fact that I already have personal background and experience with this topic. My perspective that I already am in the world of mandatory sexuality and that I understand it in some small way due to this immersion renders difficult the idea of attempting to simply outline the phenomenon, which is an important distinction between interpretive and descriptive phenomenologies (Rapport 2005).

Situating Interpretive Phenomenological Analysis

Phenomenology as an investigative process and way of knowing was formalized into a qualitative philosophy and enshrined in white western European academic tradition in the 1800s

and 1900s (Knaack, 1984). Hermeneutic phenomenology in particular has its origins in the interpretation of religious texts (Rapport 2005), and holds that any interaction between a being and that being's environment elicits some form of interpretation; further, it is not possible to distinguish any being's interpretation from that being's contextual development (Laverty 2003). Hatch (2002), in a book on hermeneutic research in education settings, writes that this form of research is particularly interested in historically contextualized experiences and how these experiences impact individuals. As Noon (2018) explains, interpretive phenomenology is not simply about any given phenomenon in question: it is vital to appropriately and thoroughly locate each participant in their physical, social, and ontological environments and take those contexts into consideration. Careful accounting for environments can allow a researcher to observe and disclose having found patterns in experience.

Integrating the philosophy of phenomenology with functional and replicable interpretive applied models for use in qualitative research is a frequently commented upon task. The study in question will not be replicable due to my decision to focus on producing an account of specifically situated knowledge around sex positive, feminist, and trauma informed therapists practicing in Alberta at a particular moment in time. Pietkiewicz and Smith (2014) remarked in a practical guide to using interpretive phenomenology in qualitative research that the method consists of three components: hermeneutics (which are the researcher's interpretations delineated from and laid over any participant's interpretations), phenomenology (where the researcher endeavors to specify what makes the phenomenon in question unique from other phenomena), and idiography (or each individual's specific experience and meaning-making). Given my desire to approach this research hermeneutically, I have a number of obligations in order to render clear

when I report on a respondent's language and when I report on my own interiority that has been elicited by the participant's verbal and embodied language (Rapport 2005).

Researcher Responsibilities in Phenomenological Work

Researcher ethics are critical to hermeneutic phenomenological success. Such work does not pretend that a researcher is capable of objectivity, and so researcher responsibilities are numerous, varied, and detailed (Kacprzak, 2017; Willig, 2019). With hermeneutic interviews for example, which will be conducted for the present research, researchers must establish conversational interview environments that include sufficient room for participants to be able to turn their inherent knowledge of a subject into the disclosure or reporting on that subject (van Manen 1990). This entails researchers ensuring that interruptions are minimal, and questions are flexible and responsive to each participant; interviewers must focus more on listening actively to participants rather than treating them as data banks to unlock (van Manen 1990). Quiet on a researcher's part is essential to eliciting disclosures that are multi-dimensional enough to interpret (Vandermause and Fleming 2011).

A researcher's role requires careful attention to the process of interpretation to accurately portray participants' interpretations of their own experiences. Noon (2018) described the researcher as inherently being an interpreter, which requires a "double hermeneutic stance": researchers are interpreting *and* reporting on *participants*' interpretation and reporting (p.1). The importance of interpretation is echoed by Pietkiewicz and Smith (2014) whose work has instructed that researchers must shift seamlessly between "emic (outsider view) and etic (insider/psychological perspective) lenses" (p. 11). The researcher simultaneously must try to deeply understand a phenomenon through the participants' experience while also maintaining the emotional and psychological distance required to effectively analyze and interpret data collected

through interpretive methods. This requires a researcher to have a firm grasp of their own relationship to a phenomenon prior to engaging with interviewees about the topic. To interpret and to record these interpretations involves close reading of the "texts" produced (the transcriptions of interviews themselves), attentiveness to commonalities and differences between respondent narratives, and a capacity to make hypotheses and draw connections within and between interviews (Vandermause and Fleming 2011).

Another major researcher responsibility is reflexivity (Goldspink & Engward, 2019). Kacprzak (2017) presented a set of criteria to evaluate IPA papers and to provide high-quality future research; she noted that researcher reflexivity and transparency are often lacking in interpretive phenomenological papers, despite their centrality for effective use of the method. For van Manen, (1990) reflexivity can be ensured if a six step method is followed, and the centrality of researcher reflexivity is evident in the rhetorical composition of the steps. Addressed to researchers directly, van Manen recommends firstly orienting towards a phenomenon in which we are deeply interested; secondly, probing the experience through the lens of how we experience it directly as opposed to simply how we think about it; thirdly, grasping the central elements that make up the phenomenon; fourthly, ensuring that writing and rewriting compose a central role in outlining the phenomenon in question; fifthly, ensuring a clear and stable personal grasp of the phenomenon; and sixthly ensuring a balanced research project by maintaining clarity around both the parts of the phenomenon and the whole of the phenomenon (1990). Paying attention to and rendering legible our own perspectives and choices, how they came to be, and why we permit ourselves to make them in research is vital as researchers (Goldspink & Engward, 2019). Careful and clear self-reflexivity that is written into interpretive studies can increase transparency.

Methodology and Rigor in Phenomenological Research

Clear and rigorous methodologies within qualitative research are not only important for the quality of the research itself, but also as part of a duty of care towards the participants who entrust the researcher with personal and vulnerable experiences. A central concern in phenomenological research in general is developing a trusting and ethical relationship with participants such that they are willing to engage in self-report in a rich enough fashion that researchers can fulsomely report on the phenomenon in question (Churchill, 2018). This entails intentional sampling, and transparency with participants such that they can make informed and consenting decisions regarding their participation (Churchill, 2018). One key difference that must be outlined to participants is whether the research they are participating in is simply descriptive or whether it will be interpretive, as in hermeneutics. Willig (2019) notes that descriptive phenomenologists "are concerned with getting as close as possible to the actual experience by describing its quality and texture in detail" while interpretive phenomenologists "aspire to make sense of the experience and to give it wider meaning" (p. 798). Because a hermeneutic phenomenological approach is at play in the current study, I will discuss the phenomenon of mandatory sexuality with participants during the informed consent portion of finding interviewees; as such, they will have time to think about their experiences with mandatory sexuality more deeply (Vandermause and Fleming 2011).

For hermeneutic studies, relatively homogenous samples are important such that the experience of the phenomenon shared by participants can be more accurately understood and reported on (Noon, 2018). If participants were not discussing the same phenomenon or were discussing the same phenomenon but from radically different social locations, it might be more difficult to draw observations about commonalities or patterns in their utterances during the

interpretive phase of the research. The number of participants is especially important, due to the large volume of data received from each individual participant in IPA; having that much data multiplied by an excess of participants entails a lack of ability to do each participant's contributions justice, and interferes with a scholar's ability to effectively identify and report on patterns.

One way of beginning to sort through an appropriate amount of data includes finding key repeated words using either word cloud generators online or in programs such as NVivo. Word clouds generate an image of all the words in a particular data set, and enlarge the words that are repeated the most often: by using such visualization tools researchers can glean key terms to search for within interviews in order to have an entry point into finding patterns in data. I intend to use word frequency analytics and word clouds to create nodes in NVivo, such that I can highlight text and drag said text from within each interview into any given node to derive statistics from my close reading of interviews. I also intend to review syntax, diction, themes, and rhetoric broadly within interviews. These variables, such as the presence of active and passive voice in participant disclosures, can be rich sources of interpretation.

Errors in research that impact rigor frequently include erroneous sampling methods, research questions that don't account for participant perspectives and location, and lack of researcher transparency (Kacprzak, 2017). Appropriate collection techniques according to Noon (2018) include anything that elicits "thick" descriptions. For hermeneutical work, a method that allows for interplay between researcher and interviewee worlds is necessary, as such engagement is fundamental to a researcher's ability to interpret results (Vandermause and Fleming 2011). Crucially, writeups must include transparent and reflexive process notes about how research was undertaken because the environments within which the researcher operates are just as important

as the environments for participants. Researchers must be able and willing to interpret our own developing relationship to phenomena in order to demonstrate how we might interpret a participant's. Moreover, participants' words must be included when possible (Kacprzak, 2017; Pietkiewicz & Smith, 2014). Finally, the research question is key to successful IPA, as research questions can be incompatible with IPA if they fail to foreground participants' lived experience as the central concept under investigation (Kacprzak, 2017).

Issues in Phenomenology

Phenomenology is not a research practice without criticism or pitfalls. Noon (2018) states three primary speedbumps encountered by IPA researchers in particular. First, language barriers can render data collection tricky; second, managing both participants' individualities and the need to find common themes can feel like diametrically opposed projects; and third, the need to have few participants can interfere with researchers' ability to draw generalizable findings. Ultimately, as Kacprzak (2017) noted, one of the most major issues with phenomenological work, which includes IPA, is the fact that many of the guidelines in place to effectively coach researchers through processes are subjective and not universally agreed upon, because IPA is still a relatively young method as articulated within white and western academic traditions. To address and counteract some of these weaknesses in IPA, a researcher can lean even more heavily on transparency and documentation, being sure to disclose the specific guidelines for IPA being followed and the limitations of the study itself in terms of sampling and other methodology issues. Incorporating a literature review component can ground the research in specific theories and practices being used for a particular study; since IPA is still a relatively new approach, engaging directly with the research record within a study would also contribute positively to the growth of the field.

Like many philosophical traditions, phenomenology's location in the academic canon is attributed to white western European scholarship. However, restricting phenomenology to this limited history erases millennia-old Indigenous oral tradition across what is only currently known as North America; the somatic theorizing of African and Black abolitionist women through the history of the trans-Atlantic slave trade; and multiple dynasties of East and South Asian intellectual tradition (Lennon, 2019; Nelson, 2017; Struthers & Peden-McAlpine, 2005). Interpretive Phenomenological Analysis, psychology's take on qualitative phenomenological investigation, has its origins in participant-centered activities in health research in the latter half of the 20th century (Noon, 2018). IPA has been effectively used as a modern take on long-standing phenomenological practices to understand, interpret, and communicate psychological and sociological patterns in the experiences of historically and contemporarily marginalized people by genuinely paying thoughtful attention to our testimony.

Researcher responsibilities in IPA include ensuring that appropriate methods are selected for their ability to draw out rich participant data; forging ethical, consensual, and trusting relationships with participants and participant communities; engaging in reflexivity and transparency such that research is both replicable and the researcher's own positionality is accounted for; and making clear where and how we arrive at interpretive conclusions (Goldspink & Engward, 2019; Kacprzak, 2017; Rapport 2005). Specific methods vital to IPA's practice are semi-structured interviews, focus groups, surveys or questionnaires, and thematic analysis (Alase, 2017; Noon, 2018; Pietkiewicz & Smith, 2014; Vandermause & Fleming 2011). Researchers using IPA are expected to provide interpretations of data beyond parroting the content of participants' contributions. The process of undertaking interpretation is one where reflexivity and transparency are key, lest researchers inappropriately impose authority over their

participants' perspectives and interiorities or inadvertently engage in practices that are not in fact congruent with IPA methods: the inclusion of a first-person voice in writing results can assist in delineating the reporting of participant data with the interpretation of the data (Kacprzak, 2017). While there are documented guidelines for the practical application of IPA, it has some limitations; IPA studies must account for these shortcomings with thorough documentation of all processes utilized and citations for where those guidelines originate.

Ultimately, Interpretive Phenomenological Analysis is a qualitative research methodology whose strengths include the ability to elicit, outline, and analyze individual people's experiences *within* and meaning making *about* their own environments. The valuing of these perspectives is especially important for researchers interested in undertaking investigation of how systems of oppression and institutional barriers impact those they target. Given this method's value in analyzing systemic issues from the perspective of those directly impacted, employing this method in my thesis work is sound.

Phenomenology in the Current Research Context

To examine the perpetuation of mandatory sexuality in the counselling field, I discussed the phenomenon with a small group of sex-positive, feminist, trauma informed clinicians. I interviewed three clinicians; all part of a specific geographically precise community of practice oriented around Edmonton, Alberta, Canada. Clinicians are practitioners with graduate level training in either counselling psychology, clinical psychology, or social work who are explicitly sex-positive, feminist, and trauma informed by virtue of their stated praxis and their worksite (feminist counselling centres such as sexual assault centres, reproductive rights focused agencies, etc.). I welcomed practitioners of any race, any age, any gender, any ability, and any socioeconomic class. Clinicians are currently located in Alberta in order to streamline the

number of professional registration bodies represented amongst participants and ease interview processes by limiting the number of time zones represented. I recruited through word of mouth as the previously described demographic already represents a community of practice of sorts to me.

I conducted interviews using my personal, password-protected computer and the Google Meets video meeting program; I used the Chrome extension Otter.ai to produce a transcript of these meetings for analysis. Otter.ai saves transcripts to cloud storage and the company uses AWS services for its data storage in the AWS region West, United States. Video meetings are congruent with COVID-19 related protocols recommending digital rather than in person meetings whenever possible for participant and researcher safety. I asked participants to join interviews from a private and confidential physical location. When I exported the transcripts to local files on my computer, I did not include speaker names, only timestamps: this ensured participant anonymity. Once transcripts were local files on my computer (Microsoft Word documents), I uploaded them to NVivo for textual analysis in the form of identifying themes within and between participant interviews. The supervisors of this project spot checked transcripts of interviews to ensure interviews are conducted effectively. After each interview concludes, I engaged in personal reflection writing, as keeping a study diary is recommended for those engaged in hermeneutical research (Rapport 2005). Following participants' completion of the interview, I provided each with a $50 honorarium. The funding for said honorarium came from the AU Access to Research Tools Award.

Two weeks after interviews, I provided participants with a written transcript of their interview and extracted quotes; from this point participants had two weeks to provide feedback and withdraw any of their testimony. Although it is common, in writing results of the interviews,

to assign pseudonyms to interviewees, I did not make use of them: nor did I use any pronouns, including the oft-used singular gender neutral pronoun "they" in order to control for reader gender bias.

Chapter 4. Results

The results of the interviews will first be presented as a narrative where I describe the process of conducting interviews and my impressions of their proceedings. Following this narrative, I will be presenting the content of the interviews descriptively, drawing out themes and ideas and providing extensive direct quotes from interviewees that illustrate the phenomena at hand.

I conducted interviews with three current therapeutic practitioners in order to glean their understanding of psychology's role in constructing and reifying the idea that having sex is requisite to client health, an indicator of that health, and an encouraged activity to undertake in the name of wellness. I conducted interviews using Google Meets, an online video meeting platform, and all my participants spoke to me from their private soundproof home offices in late May and early June of 2022. I too was located in my private soundproof home office. I asked questions about participants' own definitions of mandatory sexuality and inquired as to where and how they began being indoctrinated with the phenomenon's messaging. I also asked how they began to develop a critical consciousness about the topic, asking specifically about their professionalization as therapists and if or how their training contributed to their learning processes. I also asked participants to theorize as to why mandatory sexuality continues to exist, and asked interviewees to locate themselves subject-position wise in order to draw out how their lived experience with regards to gender, age, race, class, sexuality, and other demographic forms contributed to their testimony.

I formulated questions in a manner that I myself would have appreciated or enjoyed receiving, and in all but one case these universally elicited thick responses from participants: the

outlier is my question to participants about their own social location. I asked the question in the following manner at the very onset of the interview:

> Are there any subject positions with regards to gender, race, sexuality, ability, class, religion, etc that you'd like to share and have associated with your answers that you think impact your understanding of what we're going to talk about today?

I know how I would answer this question: I would speak to being a lightskinned Black person largely perceived as a woman and how it informed my early exotification and sexualization by adults and my queerness in terms of how my own varying decisions about how to demonstrate that queerness to a broader audience impacts the nature of the sexual violence I receive in public. I would also speak to my position as a queer Black person trying to become pregnant and how navigating healthcare services in this lifestage—particularly around gamete provision and medical fertility assessment and interventions—has been radically different than seeking medical care for reproductive organ related pain.

Depending on how much space an interviewer offered me, I might also have mentioned the nature of my Judaism and how it mediates my relation to discourse on religious freedom and the availability of abortion services. Finally, I may have come to how my neurodivergence is not a source of de-sexualization in the form of ideologies that deem me unworthy of sexual attention. Rather, my overall embodiment as a thin and largely physically able person in addition to all subject positions mentioned above has deemed me de-sexualizable by naturalizing and excusing the sexual violence perpetrated unto me by others from my childhood onwards. All these subject positions have informed how smooth my life path is in response to how proximate I am to complying with my assigned role within a settler colonial state that operationalizes mandatory sexuality to persist. The experiences I outline above inform my own perspective on mandatory

sexuality insofar as I am a person who has been targeted by its goals; this lives experience in addition to my own academic research position me as someone who would benefit from the ideology's destruction and this is true for all of the clients I've had in my young career thus far. This context is important in terms of both my contemporary location, which impacts how I am approaching my research, and in terms of my error in establishing the interview environment.

Participant statements such as "I didn't anticipate that one" (P1); clarifications requested of me including "[w]hat do you mean by that… in terms of my own positionality?" (P3); and reflections about how the format of the question was different than how demographic information is typically gleaned in research (one participant self-reflexively joked "what boxes do I check if there aren't any to check?!" (P1)) all indicate that this question, whether in form or in content, was novel or unexpected. Generally, demographic questions such as this one are asked at the onset of research. However, due to the fact that most researchers are interested in coding their data sets quantitatively with respect to subject positions, the question is usually offered to participants in a highly standardized manner, with lists of options to choose from. By rendering my demographics question 1) voluntary and 2) open ended, where participants had to actively name their own subject positions rather than passively choose from a menu of options, I broke many contraventions of surveying. Such a rhetorical move impacted the quality of data I received.

The remaining questions elicited detailed participant testimony and theorizing distillable into 1) general observations and working definitions of mandatory sexuality 2) hypotheses about mandatory sexuality as a phenomenon and 3) best practices for working with clients. Participants communicated these elements in the first person, demonstrating attention to the fact that their statements derive from their specific selves and unique key contexts such as independently

undertaken learning and ongoing professionalization environments. Further, participants nearly ubiquitously spoke in simple present or present indefinite tense, indicating that mandatory sexuality as a phenomenon for these practitioners is indeed happening currently and also happening regularly and constantly.

Participant Observations and Working Definitions

Participants easily and unanimously offered definitions of mandatory sexuality. In our sessions, interviewees provided these definitions by way of both broad descriptions of mandatory sexuality's ideology and concrete examples of its effects. For example, Participant 1 noted that mandatory sexuality's symptoms include "...social expectations we have that certain kinds of sex are legitimate and are therefore a requirement" which entails the individual categorization of beings insofar as "anyone who doesn't engage in that very narrow idea of sex is somehow deviating from the norm… or… at extremes may be labelled as dysfunctional in some way" (P1). Participant 3, too, named symptoms of mandatory sexuality, including the fact that "You are policed—so if you were a woman, and—[if] others identified you and labelled you as that, then you had to act in a specific way… not necessarily around sexual preference only, but also what was your duty… [a]s a cisgender woman, you are expected to have sex with a man for reproductive purposes" (P3). Another manifestation named by Participant 2 is the experience of adolescent peer relationships, which frequently revolve around "questions of losing your virginity and… how far have you gone and what have you done" which expose an undercurrent of "these assumptions that any interaction with a human will lead to something sexual" (P2).

Participants themselves observed and drew causal lines from mandatory sexuality as an ideology on hierarchical par with heterosupremacy and cis supremacy to the symptoms named above. P1 noted for example a sense that mandatory sexuality is related to "heterosexism, where

there's only certain kinds of sex that are referred to when we talk about sexuality in… medical models." P3, in naming the active and intentional construction of cis womanhood alongside the duty of reproduction, connected individual coaxing of people's sexual duties with the ideological systems of cis supremacy, which rationalizes coercively assigning people a sex and gender at birth, and heterosupremacy, which dictates that sex between heterosexual cisgender people for the purpose of reproduction is the sole, or at the very least preferred, mode for people to be sexual. P2, meanwhile, demonstrated that queer sexualities are not exempt from mandatory sexuality's clutches, referring in an explicitly all-gender and all-body manner to the fact that the phenomenon entails "[A] very deeply socialized experience of being in the world [where] if you exist in a body, that body should want to… fuck. And if it doesn't… you're broken. And that if… you can't make yourself want to fuck… then your brain is also broken." Mandatory sexuality is a force that impacts LGBTQ+ individuals in myriad ways, and while mainstream advocacy frequently focuses on gay marriage rights as a way of trying to overcome this shame, such focus is ultimately insufficient. Scholars such as Dean Spade (2005, 2013) have long insisted that simply because presumably sexual marriage or marriage-like relationships can legally occur between people who are not heterosexual, it does not represent a radical reorganization of how mandatory sexuality operates.

Participants spoke of the relationship between intertwined realities when it comes to mandatory sexuality: it is both a social force that is naturalized (i.e., spoken about in terms of what is "natural" and "unnatural") and simultaneously a social force that is dynamically, energetically, and intentionally coached into people from a young age. On multiple occasions, interviewees discussed the threat of social ostracization inherent in adolescent conversations about "what was legitimate… and these unhealthy obsessions with… virginity and… numbers of

partners and what was okay and what wasn't okay" (P1) or how "in terms of sexuality," authority figures such as religious leaders, familial elders, and educators were clear about "what is accepted and what's not accepted" (P3). P3 outlines the outcomes for those steeped in mandatory sexuality, whether broadly deemed unnatural or not:

> It's about… having power over people's bodies, and having control over people's bodies and what… they are supposed to do and what they are not supposed to do. [This creates] a disconnect that we talk so much about in embodied practices of not being in touch with your body and with your needs. I think mandatory sexuality disconnects you from yourself… and when you're not connected to yourself, there is more opportunity for people to force you to do things, or make you do things that you maybe don't actually want to do, but you're not aware that that's not what you want, and you're placed in a very vulnerable position because of that.

P3's analysis of how mandatory sexuality creates vulnerable subjects demonstrates how mandatory sexuality is itself a form of sexual violence. The World Health Organization defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (World Health Organization, 2021). While most definitions of sexual violence focus on specific interpersonal interactions between individual people, it's worthwhile to note that a system of ideology that renders it difficult or impossible to say no to sex creates the conditions for individuals to coerce others. These conditions, in turn, entail sexual assault's capacity to be used as a tool of colonial dispossession and genocide—by divorcing people from themselves, from one another, and from land and paving the way for the state to continually

thieve and profit from stolen territory. The idea that mandatory sexuality is, as such, an important state tool is continually referred to by all participants in a variety of ways.

As defined by P2, mandatory sexuality silos the possibility of pleasure into an exclusively sexual realm, creating a world where if you want pleasure, you must have sex: this interviewee asserted "I do deeply believe in pleasure education alongside sex education. I think if you want pleasure, you deserve it." However, P2 continues, "pleasure isn't only sexual" and it's a false imposition of mandatory sexuality to believe that it is (P2). Mandatory sexuality, as explained by P3 and P2, divorces people from their own sense of yes and no when it comes to sexual activity of any kind—for fear of being cast out, for fear of being "abnormal," for fear of never experiencing pleasure or any kind—attempting to coerce people into narrow genders, sexualities, activities, and life possibilities that they otherwise might be sovereign to explore infinitely and inhabit fulsomely. Anyone of any gender and any sexuality experiences this coercive pressure and can respond in myriad ways, including with attempts at attaining or aspiring to some vision of "normal" monogamous sexual activity as described above.

P2 and P3's commentary elucidates how, as with all forms of violence, mandatory sexuality interferes with kinship formation broadly including kinship with self and others. P1's commentary about peer relationships in adolescence is an important piece of this puzzle: this interviewee recollected that, due to "being encouraged to disregard my own sense of what was right for myself, and my own sense of consent" it became easy to "[engage] in a lot of things that didn't feel very good" in terms of relational ethics such as "ghost[ing] people and do[ing] things that I would not want." P1 further reflected "I wouldn't want to show up that way in the world at this point. And I didn't want to show it that way then, but I didn't know how else to." As an ideological underpinning of sexual violence, mandatory sexuality for these three participants

sows seeds of mistrust and disconnection, paving the way for hierarchized power relationships that must benefit someone or some group. Otherwise, as a social force, it would likely not be continually invested in nor socially sanctioned at all.

Participant Hypotheses

Stemming from participant observations and general working definitions come two valuable hypotheses interviewees made about the nature of mandatory sexuality as it relates to therapeutic environments and white supremacist settler colonial nation states more broadly. Namely, interviewees suggest that professional environments that permit a vacuum of information about sex mean that clinicians are compelled to call on their own highly subjective experiences to fill in their own—likely uncritical—presuppositions about the role of sex in society and in clients' lives. Additionally all participants agreed that for mandatory sexuality as an ideology to continue to exist, it must serve an important state purpose, the nature of which participants talked about at length.

Interviewees asserted that therapists are liable for perpetuating mandatory sexuality alongside numerous other healthcare professionals. In both workplaces and training environments interviewees reported receiving a simultaneous narrative of the ubiquity and automaticity of sexual activity combined with sex and sexuality never being spoken about in any analytical detail. The presence of sex and sexuality as a rarely-critically-analyzed yet broadly presumed natural force is related to the previously mentioned naturalization process observed by P1 and P3 in particular. The invisibilization of mandatory sexuality as a system that forcibly attempts to form individual and social futures constitutes both another naturalization (turning sex into a force as constant and inescapable as gravity) and also an obfuscation of the power clinicians have to project ideas of normalcy and deviancy onto clients. P2 reflected that amongst

very progressive sex positive people,

> the line is, you can have as much sex or as little sex as you want. There [is] always this underlying assumption that even if you just have a little bit of sex you will still have some sex. Everyone will have sex. In all of the training I've done and all of the workshops, everything. There's always this assumption that there will be sex. We just have to figure out the right combination of things to get you to the place where there will be sex… It [is] always "how do we get people back to sex?"

This resulted in ostensibly progressive training atmospheres where "asexual people were constantly an addendum. Like, 'oh, yeah, and asexual people exist.' [The training was always focused on] how to how to have sex, how to do it better, how to have more of it, how to do it consensually, bla bla bla, sex toys, etcetera" (P2). This recollection of P2's demonstrates a quintessential example of how asexuals can be harmed in clinical environments and also an example of how mandatory sexuality enables a culture where "yes" to sex is focused on to the detriment of the robust and prorelational capacity to say "no" to sex: congruent with the reality that such an environment is conducive to state power's need to weaponize sex. P1's experiences with a workplace's assessment tools follow suit, pathologizing "no." While no single therapist "would endorse [this] viewpoint" at this workplace, "there was a baseline assumption built into a lot of the framework…that if someone wasn't having sex, it was because of their trauma history and therefore, it was a problem that could be resolved." Materially, despite staff discomfort, this workplace's measures of progress such as the TSC-40 (administered to clients due to the demands of funding models), actively construct and reinforce mandatory sexuality as an ideology in the same way as the educational environment described by P2 (Briere & Runtz, 1989). Therapists' workplaces and training environments permit a dearth of knowledge about the

"why" of sex and sexuality—doubling down on mandatory sexuality in the process by reinforcing the norm.

Interviewees all had their own experiences of being subjected to mandatory sexuality at another clinician's hands, which further reinforced their certainty that such exchanges were possible for clients in their own—or any other therapists'—offices. P3 recollected:

> I was just having memories as well about a couple of appointments I had recently where the first question I was asked was about birth control when it wasn't related at all. I thought, "why are you asking me this? This is not something that I brought up. This is not something that I named as a concern, or why I came here! What is happening here!?" The ideas around mandatory sexuality are always pushed. The doctor sees me, they look at "female" on my ID, okay, then that means that you are of reproductive age. So that means that you're going to reproduce — just an assumption — and it's like, what if I don't like having sex? What if I don't have sex with my partner? What if I don't have the kind of sex that could get me pregnant regardless of the kind of partner who I have?

Similarly, P1 reflected that

> mandatory sexuality has also shown up for me in the context of doctors and naturopaths, and in my own therapy… as a patient of the medical system and as a client in therapy. Yeah, actually, it's showing up a lot. In therapy and then probably a decent amount with my medical doctor and then a small amount with my naturopath. But it's shown up in pretty much all places that I've accessed services, even if it's not immediately relevant to what I'm talking about.

These interactions, termed microaggressions, are ones to which interviewees do not take kindly.

> Whether facing down mandatory sexuality as clients themselves or as clinicians,

participants had differing coping and resistance methods. These included private processing, such as P3, who said "... you just find one or two people that get it and then you just debrief about it later. Or do your own research or just, in class, write it down and then think about 'who can I talk to about this'... but it has to be kind of on your own. I think this is part of my own personal coping strategies, that I wouldn't bring it up." Alternatively, participants either created their own independent career opportunities that included elements of advocating for systemic change (P1) or direct resistance through initiating conversations and reframes in the contemporary moment where a microaggression was occurring (P3). P3 recalled: "I honestly cannot remember conversations about sex in relationships and having those conversations with clients unless I brought it up."

The development of the critical consciousness necessary to mount resistance to mandatory sexuality using any of these strategies represents the field downloading responsibility for conducting itself ethically onto individual clinicians. This is particularly true for the three participants interviewed for this research, whose political educations are in part derivative of experiencing marginalization on the basis of some combination of gender, sexuality, race, and ability. While one participant in particular noted that an alternative model of engaging with the concept of sex was provided via family of origin, where there "was a bit of a critical take on mandatory sexuality at times" (P1), individual therapists' family of origin and subject positions are not a viable means for ensuring members of the field operate without malfeasance on mandatory sexuality's front. The dearth of appropriate learning environments for clinicians constitutes a form of mandatory sexuality in and of itself, and leaves the possibility of projecting harmful ideologies of mandatory sexuality onto clients to too much chance.

Interviewees confidently asserted the idea that given mandatory sexuality continues to

exist, it must serve some important state purpose. P3's comments about power and control, above, exemplify this fact, and so too do P1's:

> I think that when something is entrenched in our discourses, it's because it benefits someone, right? And, and if you asked me who it benefits, I could come up with a bunch of ideas, but… [mandatory sexuality] upholds power dynamics, because it states 'okay, the people who are engaging in sex that fits within this description of mandatory sexuality are therefore normal and okay, and we don't need to look at those people; we therefore need to focus on all these other people who are doing something that deviates from this arbitrary norm.' And that obscures a lot of issues, right? Because, you know, in my experience, a lot of folks who maybe would meet what is deemed 'normal' in quotes through mandatory sexuality are also people who are perpetrating some amount of harm [via sexual violence], and I like to acknowledge that as a bias on my part, but that is something that does come up. I think that it also intersects with a lot of other discourses we have around like things like procreation and things like validity of relationships and that also cascades into this capitalist mentality how we are valued based on what we can produce and how sometimes that also means our value is based on whether or not we can produce progeny and how fucked up that is.

P2 expanded on mandatory sexuality's relationship to capitalism, recalling an infographic on social media created by an Indigenous educator the participant could not specifically remember:

> [From the graphic, I learned that] a British naturalist came over [to what is currently known to settlers as Canada] during colonization times and learned about all these herbal abortifacients [from Indigenous people]. Upon the naturalist's return, the person passed

> on the research to British authorities and all the materials were banned in Europe, because they needed to have enough kids to pay taxes and fill the workforce. And [giving birth] was viewed as a woman's requirement and a patriotic duty to expand the population. And so I think [mandatory sexuality] is a holdover… of colonialism and of a weird nationalism. The logic of 'we need a good tax base.' And, I think it translates—so even though birth control is widely available and rampant [there is] this ancient birthright socialization 'sex is a thing people do.' It is generations old. I think it's almost an intergenerational trauma. And as with most things, you know, we can trace it back to capitalism and colonialism.

P1, P2, and P3's comments in amalgam render clear the fact that creating vulnerable subjects, ensuring an ever-growing population of vulnerable subjects from whom to extract wealth in the form of labor, and obfuscating the processes that do so are vital components of maintaining state power. P1's assertion that many of the people who might be perceived to be engaging in "normative" sex are those who could be perpetuating harm is an important reminder that having shifting goal posts about what constitutes appropriate sex serves those who leverage sexual violence against others. Telling those who endure and try to disclose sexual violence in interpersonal relationships that their experiences were "just sex" is a frequent dismissal tactic of rape culture.

Further, while P2's comments about the widespread availability of birth control are true, it is also true that politically conservative ideology ceaselessly targets reproductive sovereignty. This is true of the increasing scrutiny of queer and trans youth evident in Alberta's Bill 8, of the June 2022 overturn of Roe v. Wade in the United States, and of the subsequent banning of vital medications because of their capacity to induce abortion or result in the birth of disabled people.

These medications in fact, are referred to in the literature on occasion as teratogens: the word originates from the Greek word for monster, teratos. What is monstrous, or unnatural, to the state are disabled people who are not able to toil ceaselessly to produce wealth; trans people who interfere with the alleged stability and immutability of the sex binary; and people who could ostensibly not perpetuate a white, wealth accruing nuclear family form—whether because of racially-informed lineages and traditions of more nuanced kinship formation, queerness, or both. Mandatory sexuality targets these groups quietly and effectively, permitting sexual violence to be leveraged against some to traumatize and prevent more widespread trusting and coalition building social relationships, and allowing perpetrators to believe their actions are "just sex."

Participant Recommendations

Interviewees, due to their status as therapists exceptionally willing to explore the nature of mandatory sexuality with their clients, had both insights about client presentations and recommendations for addressing these presentations. The three participants all had narratives of clients feeling shame and doubt about their sexual activities, wondering if they are "having enough" or if they are having "the right kinds." These clients present with the kind of distress about sex that is a diagnostic criterion for the arousal disorders discussed in Chapter 1. P2 noted that for those systemically denied sexual worth, where mandatory sexuality has interfered with the sexual relationship one can have with themself and others, sex is available as a means of proving one's own worth to themselves and others, to mixed results. In the context of fatness and desirability, P2 reported:

> And I think particularly for fat folks, there's that added layer of 'my worth is determined by my desirability' in a, in a world where you know, fatness is publicly not seen as desirable. Maybe the world is getting 5%, 2% , 1.5% better? Maybe? I'm not convinced.

> But I noticed that this notion of desirability and worth came in and that I think mandatory sexuality has a deep tie to worth and to the way we are socialized to see ourselves as worthy. I can absolutely see that… And I think I see it often in clients, you know, a huge part of the work that I do with people is around worth. I think a lot of counselling in general is really around self-worth and helping people discover their worth. But I think a lot of the work that I've been doing, and that I did over the pandemic around sexuality was also around loneliness, worth, and connection, because we are social animals. That idea that sex can be part of connection—but it's not the only part of it. I worked with a lot of people who were starting to realize that their sexual relationships were stand-ins for connection, but that they actually weren't. And this was the piece of the pandemic I think that was interesting for people who were pursuing sort of solo poly or like casual sex or those kinds of relationships. They were recognizing, like, the ways that sex had become a stand-in and coming to the realization that, 'Holy fuck, I don't have any friends.' Or like, 'I hate my family.' And so, sex was this easy way to sort of to get a bit of connection, but then when the pandemic hit and sex wasn't as accessible, it [facilitated] the recognition that another piece of mandatory sexuality is [how it can stunt] connection.

P2 reports on a microcosm of how mandatory sexuality can interfere with kinship formation in all its forms. Mandatory sexuality denies certain people their worth through the desexualization processes outlined in Chapter 2, interferes with their capacity to know themselves, and posits the rational resistance option as ensuring their capacity to engage in "lots" of sex, which then limits people's options for rich and nuanced connection to self and others.

Crucially, this is not a perspective that can or should be forced upon clients. Even when clients entered session with explicit anxieties or opportunities for growth that might be resolved

by an analytical and embodied sense of the damage mandatory sexuality has wrought on their path, participants universally recommended only brief analytical work with clients, preferring instead curiosity and introducing the concept of not needing to have sex as a gentle invitation as therapeutic strategies. This recommendation exists in stark contrast to literature on clients who present with "distress" about their sexual activities, which is largely concerned with how best to label them at best and pathologize them at worst. P1 shares the urgent need to recognize when mandatory sexuality's harm is showing up in the therapeutic relationship:

> I can think of countless clients who have had really terrible experiences with counselors who've reinforced mandatory sexuality. I have a client who was told by a therapist that she had to engage in sex in order to successfully maintain a relationship when she said that she doesn't want to have sex. And when I say one client actually can think of like probably four or five who've been told something like that. And I've been told similar things like that. In the context of therapy, too. So it doesn't seem like it's a one off, right. Like, it seems like it's really this undercurrent, and unless you're intentionally acting against it, it's very easy to get swept into it.

The consequence P1 outlines of "getting swept into it" is crucial to understand, as it relates to therapists' capacity to enact mandatory sexuality unto their clients and indeed perpetuate the ideology of mandatory sexuality generally. P2 demonstrated how transformative genuine questioning with a lack of presumption in mind can be, sharing anecdotes of intakes:

> [Couples might say] "Well, we haven't been intimate in a while." And I'll say, "well, what does that mean? What is intimacy? Like you haven't held hands? You haven't what? You haven't shared feelings? Tell me what intimacy means!" And they're like, "well… sex" and I [say], "Okay, well, what sex?" and they're just baffled. They'll say, "well, like,

> you know, sex." And I say, "okay, so what is that? When does sex begin?" Because sex meaning penis and vagina is what you're taught. And they say "Yeah, that sex." And I just say, "okay, well, what about all the other stuff before? Doesn't count?" To which they'll reply, "Well, that's foreplay" or whatever. There's these really deeply held beliefs about, what even is sex? And I think queer people have a better, more expansive definition of what sex is when asked those questions, but I think there is still a lot of socializing around what queer sex is, and a lot of people come in with their own assumptions about what queer sex looks like. Or individual clients come in and say "Oh, I can't have an orgasm" and I'll say "well are you having fun?" And they''ll say, "well, what does that matter?" And I'll say "well, there's a lot of things that happen between when sex begins and an orgasm, do you like those things? Are they cool with you? Or do you simply want 20 seconds, you come, you're done?" Or I'll say, I did an intake yesterday with a couple and I asked "Are you in a monogamous relationship?" And they were like, "oh, no, we're not." And said, okay, "how do you identify sexuality-wise" and said "oh, no one's ever asked us that. We've been to four different couples' therapists and nobody has ever asked us those questions."

This questioning, while grounded in a sense of the system of mandatory sexuality within which a couple or individual might operate, is demonstrative of person centered therapy modalities being utilized by participants; these therapies are able to address a wide variety of client histories and needs; have generous assumptions about human nature; and use non-judgmental theories of change. Rather than pathologize or dismiss clients ("no, there's definitely a normal amount of sex people should have and even if you don't have someone to have sex with you should definitely try masturbating," "yes, the way you have sex is fine") these exchanges

build rapport and understanding between therapist and client and permit the therapist to comprehensively center the client's worldview in sessions for caring examination.

Being permitted to choose—being provided the opportunity to answer novel questions—is a precursor to building the capacity to truly say "yes" and "no" to all kinds of activities: precisely what mandatory sexuality denies so many. P3 recalled: "I know I have asked a few times, 'what if you don't like sex?' And for a lot of people it really contradicts everything that we're taught because of the assumption [that sexual activity is universal], and so people do feel very surprised [to be asked]." In Stacey Haines' The Politics of Trauma, she writes that "traumatic experiences and oppressive social conditions cause us to move into a series of automatic, holistic, and incredibly creative means of first surviving then adapting to the harm, ruptured connection with ourselves and others, and betrayal" (95). Further she continues that these responses of "fight, flight, freeze, appease, and dissociate are protective and adaptive responses that come with the package of being human… when these defenses 'generalize', they become a foundational embodiment from which we are functioning. These survival reactions can then create suffering and breakdowns, mistrust and disconnection" (Haines 96). Lighting paths for people to find their way back to themselves is a way of instilling the very bodily autonomy intentionally stripped by the state in the name of selling solutions to dissatisfaction and a lack of kinship and helping those who use sexual violence against others evade responsibility.

Closing Remarks

The sex positive, trauma informed, feminist practitioners with whom I discussed mandatory sexuality had rich ideas about its nature. From casual observations to hypotheses to ideas about how the profession could divest from its role in perpetuating the phenomenon, interviewees felt a high degree of responsibility to ensure they were not reifying the idea that

there is such a thing as “normal” sex and sexuality or indeed that sex is requisite at all. These therapists strongly believe in a future where it’s possible to divest from creating distress in clients, and find no moral neutrality in the field’s propensity for avoiding discussions of sex in clients’ lives: one interviewee remarked that “it's almost like the profession is scared to even talk about sex.” The fact that this group of three has been required to cultivate a robust set of ethics independently and intentionally in order to respect peoples’ dignity around sex is an example of how the field of counselling downloads responsibility for appropriate conduct onto individual clinicians without oversight. Despite this lack of guidance, these practitioners unanimously connected mandatory sexuality to colonially instituted forms of violence with the radically consequential outcome of interfering with relational development of all kinds, between ourselves and others.

Chapter 5. Conclusion

Asexuality, and by extension people's right to simply not have sex, is contentious ground. In July of 2022, medical students on Twitter shared screenshots of a question from PassMedicine, a training question bank for burgeoning doctors written by practicing physicians, that reads as follows:

> You are the F2 in psychiatry. You are reading the notes of a 28-year-old man who is described as 'preferring to be alone, has never been in a relationship and doesn't want one, and identifies as asexual.' Which of the following personality disorders is this man most likely to have?
>
> a) Borderline
> b) Dependent
> c) Paranoid
> d) Schizoid
> e) Schizotypal

The correct answer, according to PassMedicine, is D *(PassMed Question,* 2022). In this example, we see mandatory sexuality in action: the sense that asexuality in our clients or patients is a sign of something gravely wrong; the notion that having sex is a key measure of overall wellness and function; and the willingness of a society to tie not having sex to other frequently pathologized positions. With no other medical or social context provided in the question stem, medical students are expected to pair a description and naming of asexuality with schizoid personality disorder. Here, mandatory sexuality is leveraged along with ableism and patriarchy to cast a man with a potential personality disorder as aberrant (how could a man not want to fuck, after all?), but someone's relationship to desire can be weaponized against them for a variety of

reasons and in a variety of contexts all to hierarchical, state power motivated ends. Should we want to avoid such curiosity, suspicion, or mistreatment, we must have sex. This conclusion will present a brief summary of the results of this research, inclusive of both literature on the subject and clinician interview findings. I will then proceed to outline limitations of this research; implications for practice, policy, training of counselors; and potential directions for future research.

The field of psychological counselling constructs mandatory sexuality through a variety of processes. The first is research on asexuality, where inquiry and assessments into why people don't want to have sex is a rhetorical move that bolsters the erroneous perspective that sex is mandatory. By using distress as a metric to determine whether clients require intervention into their relative levels of desire, the field effectively constructs mandatory sexuality as a problem only if individual clients are able to disclose or self-report their own suffering. However, pathologizing such suffering assists in creating the very conditions that sow distress. The second is training programs that permit a vacuum of information about sex, an observation brought forth by interviewees. The last major process wherein mandatory sexuality is constructed, and indeed reified, by the field permitting professionals to practice without competence in this area and without an awareness of their knowledge dearth.

These three main paths result in a number of impacts for clients, most of which are reflected in the literature. For asexual, allosexual, LGBQ+, and heterosexual people alike, mandatory sexuality based microaggressions can permeate their experiences with counsellors and therapists. These include, specifically, unchecked presumptions about frequency of spontaneous sexual feelings for clients, the nature of sexual relationships clients might have, the kind of sex they have or want to have, and how they do or do not feel about their sexual activities

and desire. Mandatory sexuality as a system of ideology is necessary for the eugenics and genocides required for the establishment and maintenance of white settler colonial capitalist nation states. An environment where the tacit expectation is for people to have sex is an environment where sex is more easily weaponized for the purpose of nation building. For clients—and indeed clinicians—who have subject positions targeted by white supremacy, hetero supremacy, cis supremacy, ableism, and other such systems of oppression, attunement to mandatory sexuality is sharp. The interviewees were all clear that in both their experiences as counselling professionals and their experiences as people who access human services and medical care, they see oppression resulting from mandatory sexuality as arising not because of people's subject positions but as a result of the ideological systems of hierarchy in place that construct and maintain these subject positions.

In their interviews, participants provided general observations and working definitions of mandatory sexuality; hypotheses about mandatory sexuality as a phenomenon; and best practices for working with clients. Interviewees provided definitions in two forms: broad descriptions of mandatory sexuality's ideology and concrete examples of its manifestations. Descriptions touched most frequently on the concept of broad social expectations, sometimes spoken about explicitly and sometimes simply passively internalized. The group of three also converged on two hypotheses. First, that professional environments that permit a vacuum of information about sex mean that clinicians fill in their own presuppositions about the role of sex in society and in clients' lives. Second, that mandatory sexuality fulfills an important state purpose and power structure given its ongoing existence. Importantly, the notion that sex is a taboo subject serves a vital purpose in terms of maintaining hierarchized power relationships as well, because it is difficult to analyze and resist a force that it is considered inappropriate to discuss. Finally,

interviewees agreed that when topics related to mandatory sexuality arise in the therapeutic relationship, approaching clients in a person-centered, sex-neutral manner is an advisable approach. This involves garnering an understanding the client's perspective in order to collaboratively discuss the provenance of their feelings and ideas about sex, including how they do and do not serve the client. Crucially, this process must involve defining terms and explicitly stating that sex is not a mandatory element of human existence. This latter statement, when spoken by interviewees with clients, is sometimes the first time a client has heard such a notion. If sex were ubiquitously natural to people, the onslaught of messages encouraging people to be sexual would not be necessary. Altogether, the therapists interviewed here agree that mandatory sexuality overall has an anti-relational and anti-social impact. In creating shame-laden, under-informed, and narrowly defined subjects, mandatory sexuality renders it difficult or impossible to say no to sex. This fosters the conditions for sexual assault to be employed in the name of colonial dispossession and genocide, and also sows dispossession from one's self and a dearth of positive social relations: the purported solution, then, can only be purchased.

Pointing out that clinicians can perpetuate mandatory sexuality related ills unto clients is not a novel research finding. Qualitative research can and does address the fact that health industry professionals such as psychiatrists, doctors, and psychologists perpetuate harm against clients when uncritical of the impact of mandatory sexuality on asexuals' lives (Flanagan & Peters, 2020; Gupta, 2017b). Similarly, the research record is clear that clinicians should be self-reflexive about any biases they have in favour of sexual activity generally (Antonsen et al., 2020; Flanagan & Peters, 2020; Gupta, 2017b).

Where the current study's findings diverge from extant research in psychology is on the relationship between mandatory sexuality and settler colonial ideologies, and, moreover,

psychology's role in establishing and maintaining the former. Confirming participants' comments about mandatory sexuality, heterosupremacy, cissupremacy, and family formation, legal scholar Dean Spade writes "civil marriage is a tool of social control used by governments to regulate sexuality and family formation by establishing a favored form and rewarding it" (Spade & Willse 2013). These authors made an identical argument in 2005, writing that the "focus… on marriage rights… fails to meaningfully oppose state regulation of sexuality, gender, and family structure" because "marriage [is] a technology of power that organizes all parts of a population in terms of access to resources necessary for survival" (Spade & Willse, 2005, pp. 311-312). Mandating sexual activity is a crucial part of marriage's role in society. As such, even if it is not possible to comply with state priorities for cisgender or heterosexual norms, it is possible for LGBTQ+ people to aspire to some vision of "normal" monogamous sexual activity and/or frequency as a way of approximating a centered way of being through respectability politics. While legal theorists have pointed out how the law reinforces sex and marriage as vital and violent state processes, psychology has not reckoned with the same. The current research represents a small initial step towards doing so.

Interviewees outlined how they saw mandatory sexuality as tied to settler colonial ideologies because it attempts to naturalize sexual activities based on their likelihood to produce progeny: sexual intercourse without barrier methods on a frequent basis between cisgender and heterosexual people in marriage or marriage-like relationships under this ideological system is what is perceived as normal, or preferred. The field of counselling then, has a role in perpetuating these naturalization attempts, when it takes up the gauntlet of declaring sexual activity universally beneficial; directing academic and clinical inquiry into how and why people *don't* have or want to have sex; and profiting from the capitalist pillaging of sexuality as a whole

by touting "solutions" to perceived deficits in people's relationship to sex. The field's efforts, though frequently grounded in well-meaning attempts at sex positivity, can have the inadvertent effect of rationalizing rape, bolstering homophobia and transphobia, rupturing and invalidating kinship networks that do not revolve around nuclear families, interrupting people's relationships with themselves and their own embodied sense of consent, and a host of other injustices.

There are limitations to the current research. The list of participants, at three, is small; and despite their respective distinct clinical designations they are all relatively early in their careers and are drawn from a small population of practitioners who refer to themselves as feminist, trauma informed, and sex positive in a discrete geographic area. Because this population is one I am a member of, there is a degree of political familiarity between myself and the participants, opening up the possibility that this was more a self-reflective research study than an investigative one. Further, while the interviewed practitioners have been clear on what they think about the topic and in their descriptions of how they enact this practice, it is outside the scope of this study to compare such statements with their practice when they are with clients. This study is theoretical, and stands to inform future studies that can measure counselling practices, strategies, and or techniques.

In a larger future research project, for example, one might be able to observe or be provided with session recordings where counselors and clients are doing explicit therapeutic work on how mandatory sexuality is showing up in a client's life. Client perspectives on hearing that they don't have to have sex could be solicited. It might also be possible to interview clinicians who are expressly invested in perpetuating mandatory sexuality through coaching people into particular forms of sexual activity and desire. Were such data possible to acquire, it could inform more tangible guidelines on best practices and also develop a metric for how to

measure clinical competency when working with mandatory sexuality. However, I would strongly caution the field against adopting an approach to teaching competency predicated on a diversity of clinicians or inclusion of anti-mandatory sexuality literature into training programs. Such efforts disproportionately place the burden of teaching onto extant marginalized therapists; do nothing to decenter the power relations that cast psychology as a source of knowledge with the capacity to determine what is and is not normal; and erroneously position the field as possible to divorce from the project of state building and maintenance. Rather, mandatory sexuality might be used as a historically and politically grounded case study to illustrate how the field has reified and continues to reify hierarchies of power installed to meter out life chances based on the priorities of capitalist nation states.

The current study is likely to be of interest to those working in gender-based violence prevention, anti sexual violence work, and couples counselling fields. However, as illustrated by participant disclosure, the potential to harm clients through uncritical assessment based on ideas inculcated through mandatory sexuality is not limited to these areas. As such, it would not be responsible to limit finding applicability to them. Virtually all human serving and paramedical fields have some degree of an internalized sense that sexual activity is a viable metric of wellness. Policy and assessment tools could be amended such that a client's engagement with the concept of sex is an open ended or qualitative investigation initiated solely at that person's direct request; the concept of pleasure and joy could be lifted from the jaws of a sexual imperative; reproductive justice could be foregrounded for any being of any gender and any body.

What does such a reconfiguration of therapeutic goals and priorities look like in practice? Prior to my retraining as a therapist, I was predominantly engaged in the field of adult education about anti-oppression. My workshops gave participants the opportunity to learn about the

hierarchies of life instituted by colonialism, analyze case studies of material environments intentionally instituted to categorize and ease certain ways of life over others, and reflect on their precise social location in both being harmed by and benefitting from such systems. At the end of these sessions, there was always one common question asked: what can I do? I always struggled to answer this question; it's impossible for me to grasp a person's entire being in such brief pedagogical encounters to make tailored recommendations for their comportment. Similarly, an imagined reader of this thesis might at this point also be asking as a counsellor, "How can I address mandatory sexuality with my clients?" While there are no formal practice guidelines or established protocols on this topic that I am aware of, we can draw from best practices and socio-political frameworks to explore how this might present in client sessions with individuals or couples.

We may feel that our role as a therapist is simply to resolve a presenting concern; for example, a couple may communicate to a counsellor that their goal for undertaking couples therapy is to "have more sex". However, through the perspective of understanding mandatory sexuality, I personally cannot imagine conceiving of such a couple without forging them in an image that reifies systems of power and control around what is "normal" or "standard" and what is not. I also cannot imagine making recommendations for therapists that did not presume a specific audience of practitioners in need of recommendations whose identities similarly align with and reify such ideologies of "normalcy." Who we imagine in the therapist's chair and who we imagine in a client's chair make a difference with regards to who lands safely in both.

Rather, what I am comfortable and confident in stating is that each and every person has arrived at their present moment having internalized some notion of mandatory sexuality. Perhaps those internalized messages are about what "real" sex is and is not; the impetus for penetrative

sexual activity; how frequently "sex" ought to occur between people and who those people should be to each other; or whether desire is a ubiquitous and innate human force or not. One of the forms of power we hold in our field is the disproportionate capacity, in our therapeutic relationships, to form and shape reality for our clients. If we aspire to be client-centered practitioners, or practitioners who wield our power and authority with careful ethics, then we are called to understand our own realities and how we project them onto our clients, making these ways of being available for our clients' uptake.

To illustrate this concept, I recall an occasion in my early 20s when I presented in the office of a psychologist who had stated expertise in sexual trauma. I disclosed feeling dissatisfied in my then-domestic and sexual partnership, and grieving how much my own relationship to my desire was shifting within it. "What if," this person offered, "you simply keep having sex until it feels better again?" Rhetorically, this is a reasonable question for me to have been asked: it is an open-ended inquiry and it invited me to imagine a possibility that perhaps I had not considered. However, for me in my early 20s only having seen one therapist previously for school-related stress, the message I internalized was that I *could* keep having sex until it felt better, and that there was a *likelihood* that if I kept having sex it would eventually feel better. I left feeling nauseous, because the reality of the relationship I was discussing with the psychologist that day is that I had been quietly groomed for months into accepting routine assaults; it took me an additional year to realize and another year and a half on top of that to leave. I never saw the psychologist again.

What would my session, and indeed my life had been, if, instead, this person had asked me what sex meant to me, in terms of both a mechanical definition and in terms of my meaning-making around its presence or absence in my then-relationship? If this person had asked me, "do

you think you could tell me a little bit about how your desire felt to you previously?" Had this person had said to me: "you don't have to have sex"? If we want a world where people do not have to have sex, do we not owe it to our clients to speak the words "you don't have to have sex," in order to conjure such a world into being?

Radically reorganizing the conceptualization and epistemology of sex's role in peoples' lives is not a task solely for the anti-violence or couples counselling field. Ultimately whether or not people have sex and what kinds of relationships they have sex within should not be grounds for accessing medical care or the material distribution of wealth; and it should not be a counselling professional's place to reinforce the idea that life chances being ruled by sex is reasonable. Ending mandatory sexuality is the task of anyone with an interest in fundamentally upending systems of control in the name of sovereignty for those whose land and selves are being stolen in the interests of merely a few, and I hope there are counselling professionals amongst that group.

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Appendix A: Interview Questions

1. What do the words "mandatory sexuality" mean to you?
2. Where, non-institutionally, have you encountered learning about any concept related to mandatory sexuality?
3. Where, institutionally, have you encountered learning about any concept related to mandatory sexuality?
4. Wellness discourses often insist that people have to be having sex in order to be healthy, agential, and well-adjusted members of society. How has this impacted you personally?
5. Where have you encountered colleagues or training materials that perpetuate mandatory sexuality?
6. How did you navigate those situations?
7. Do you notice a consideration of mandatory sexuality operating differently with clients of different subject positions?
8. How might you navigate a client who presents with distress stemming from their self-reported lack or dearth of sexual desire and states that their goal is to feel sexual more frequently?
9. How do you combat mandatory sexuality or any related concepts in your practice?

Appendix B: Informed Consent Documents

INFORMATION LETTER

Study Title	*Research Investigator*
You Don't Have to Have Sex: Mandatory Sexuality and Counselling	Rebecca Lieb (she/none) Masters Student Graduate Centre for Applied Psychology Athabasca University rblakey1@athabascau.ca

Background and Purpose

Wellness discourses often insist that people have to be having sex in order to be healthy, agential, and well-adjusted members of society. I am writing to invite you to participate in a research project on the role counselling fields have in perpetuating this concept of mandatory sexuality. This project is a masters level thesis I am completing as part of the degree requirements of a Masters in counselling Psychology at Athabasca University. If you are amenable to participating, I would like to interview you about your experiences as a feminist, sex positive, and trauma informed therapy practitioner with the concept of mandatory sexuality.

The following objectives guide my research:

1. Establishing a working definition of mandatory sexuality amongst feminist, sex positive, and trauma informed therapy practitioners
2. Understanding the varied ways such practitioners confront the concept of mandatory sexuality in their work

The results of this research project will be written into my Masters thesis. Your identity and participation in this research study is confidential; I will anonymize your testimonies.

Study Procedures

This study involves interviews with a small number of current therapy practitioners. The intention of these interviews is to understand practitioners' experiences of mandatory sexuality. As a participant in this study, I would like to ask you questions about this topic in an interview that would take approximately one (1) hour. The interview questions will be semi-structured, meaning I will have prepared open-ended questions and I will ask additional follow-up questions to gain a more in-depth understanding. The meeting would take place online using the platform Google Meets; you could attend the meeting from a confidential location of your choosing with an internet connection sufficient for conducting video meetings.

Benefits

This research is founded on the principle that those who hold interpersonal and systemic power and authority ought to reflect critically on our role in perpetuating systems of oppression. Participating in this research may give participants new lenses of reflection on their professional practice. This interview may also provide the opportunity to foster a sense of community amongst practitioners who approach therapeutic relationships with similar political ethics of care.

There will be a one-time honorarium paid to participants of $50 for each interview.

Risk, Confidentiality & Anonymity

Reflecting on systems of oppression can be an emotionally draining experience; there are no known further risks associated with study participation. I will anonymize your comments and any publications resulting from this work will not name you nor any defining characteristics of your person. I will quote you only with your permission. Identifying information will be kept in a master list, which lists identifying markers and pseudonyms, so that participant professional designations and contexts can be taken into account during analysis. The master list will be kept on a password protected document on a password protected computer. The interview will be transcribed using otter.ai software and stored remotely on a cloud server; my account with this software is password protected. I am required to retain interview data for 5 years after the completion of the study. After the required 5 years have elapsed, I will destroy electronic files and shred any hard copy materials.

Voluntary Participation

You do not have to participate in this interview and there will be no negative consequences if you withdraw. If you consent to the interview, you can pass on any questions you'd like, and you can also stop the interview at any point. The interview will happen only once. You will have the chance to clarify any statements and/or to have sections deleted at a later date (see Post-Interview Consent Form below). Should you wish to withdraw any of your comments from the study after the interview has taken place, you may send this request by email within four weeks of your participation to Rebecca Lieb at rblakey1@athabascau.ca.

Further Information

The Athabasca University Research Ethics Board has reviewed this research study design to ensure it complies with ethical guidelines. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Officer at 1-800-788-9041. If you have further questions, comments, or would like more information in order to help you make a decision about participating, please feel empowered to contact me. I am very happy to share questions ahead of time if that will help you make a decision or otherwise prepare for potential participation. Thank you very much for your consideration.

PRE-INTERVIEW CONSENT FORM

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

_____	_____	_____
Participant Name	Participant Signature	Date
_____	_____	_____
Researcher Name	Researcher Signature	Date

Mailing Address

Please provide your mailing address in full such that a $50 honorarium cheque can be mailed to you upon completion of the interview.

_____
_____
_____
_____
_____

Appendix C: Ethics Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **24778**

Principal Investigator:
Mx. Rebecca Lieb, Graduate Student
Faculty of Health Disciplines\Master of Counselling

Supervisor:
Dr. Jeff Chang (Co-Supervisor)
Dr. Alexa DeGagne (Co-Supervisor)

Project Title:
You Don't Have To Have Sex: Counselling Fields and Mandatory Sexuality

Effective Date: May 12, 2022 **Expiry Date**: May 11, 2023

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: May 12, 2022**

Paul Jerry, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board
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