Healthy Sexuality in the Context of Asexuality

Introduction

Conversations around sexuality and sexual practices rarely feature discussions of asexuality. While mainstream conversations around sexuality have become increasingly inclusive, with LGBT+ orientations gaining more attention and serious consideration, the asexual orientation has stayed largely misunderstood and unaddressed. In my own conversations with others about my sexual orientation, I have personally found that I have had to explain what asexuality is to most people I interact with, including sexual activists, speakers presenting on sexuality and sexual orientation, and even a psychiatrist I had once met for an appointment. The legitimacy of my sexual orientation is regularly called into question.

The widespread erasure of asexuality impacts a significant proportion of our society. Little academic research has examined the prevalence of asexuality in people; however the most widely cited study comes from Anthony Bogaert, an associate professor at Brock University. He conducted a national probability sample in 2004, surveying 18,000 British residents about their sexual behaviors. The researcher found that 1% of the respondents indicated that they were asexual based on their response to the survey questions (Bogaert, 2004). If we took that 1% and applied it to the population of the United States, which currently stands at over 323.6 million people, we would be talking about over 3 million asexual people ("U.S. and World Population Clock").

Very few subsequent studies have been done to further examine the prevalence of asexuality in our society, and none have been as broad in scope and as direct in its examination
of asexuality as Bogaert’s. One study, conducted more recently in 2010, looks at the prevalence of asexuality in the United States based on responses to the 2002 National Survey of Family Growth from 12,571 Americans (Poston & Baumle, 2010). A major drawback to the study, however, is that the survey’s questions about the participant’s sexual interest fail to list the absence of sexual attraction as a possible response, ignoring a key facet of asexuality. One important aspect of Bogaert’s study comes from the design of the survey, which asked questions about people’s sexual behaviors and experience with sexual desire, rather than their personal identification with the asexual label.

Growing up, I knew that there was something different about my approach to interpersonal relationships. I rarely ever thought about sex, had never felt physically aroused by the sight of another person, and found the idea of sex repulsive even with my then-boyfriend, whom I cared dearly about. It was only when I happened to stumble across the term “asexual” on the internet, and then subsequently dove into any information I could find about the word, that I realized that there was a whole community of people with feelings similar to my own.

Prior to this discovery, I didn’t know that asexuality even existed, let alone that it could possibly be something that would resonate with me. A part of me felt incredibly relieved, to know that it wasn’t just me. For the first time, I owned a word that could accurately describe my feelings.

The other part of me felt devastated, mournful of what felt like the loss of a key aspect of my intrinsic humanity. I came from a reasonably liberal high school, where being gay or bisexual was mostly fine. We were free to feel attracted to whoever we wanted – the underlying assumption being that everyone was unquestionably attracted to someone. So when love is love
is not-so-secretly sex, what kind of cold monster is unmoved by the very thing that connects us all?

It took a long time for me to stop referring to myself as an “asexual monster.”

But there was, and still is, nothing wrong with me. Just as there is nothing wrong with any other young teenager who identifies as asexual, or thinks they might. Regardless of whether one chooses to engage in sexual activity, comprehensive sexual and relationship education matters as much for asexual people as it does for sexual people. Asexuality is still under-discussed and under-studied, and so this paper will define asexuality and then look at what healthy relationships and sexuality look like in the context of asexual people. This paper will then analyze asexuality and healthy sexual and relationship practices in within three institutions; film, psychology/therapy, and families.

What is Asexuality?

At its most basic, asexual people are defined in the current academic research around asexuality as “those who experience little or no sexual attraction, and/or who self-identify with asexuality” (Chasin, 2011). Asexuality itself, much like homosexuality or heterosexuality, is a sexual orientation. Last year, GLAAD, the LGBT+ media organization confirmed on its blog that the A in LGBTQIA stands for “Asexual, Agender, Aromantic” (2015).

While asexuals generally don’t experience sexual attraction, this does not necessarily exclude them from experiencing romantic attraction. The Asexual Visibility and Education Network (AVEN) is the world’s largest asexual community, dedicated to spreading information and awareness about asexuality. According to AVEN, there are asexual people who do not experience any desire for a romantic relationship; however there are also asexual people who do
have interest in romance. These asexuals can simultaneously identify as straight, bisexual, gay, lesbian, and so on. These markers are used to signify which gender or genders they experience romantic attraction toward. Romantic attraction is distinct from sexual attraction in that it describes a desire for an intimate, romantic connection with another person, rather than a sexual one (AVEN, 2012).

Another important aspect of asexuality is that while some asexuals are sex-repulsed or otherwise do not wish to engage in sexual activity, there are also asexual people who are willing to have sex. There are many reasons for why an asexual person may choose to have sex, such as occasional and circumstantial enjoyment. Another common reason is as a form of “compromise” for their sexual romantic partner (AVEN, 2012). In another study, Bogaert also found that there are asexual people who report masturbating despite identifying as asexual. He found that these asexuals disconnect this sexual behavior from their identity, desiring physical and sexual arousal without experiencing sexual attraction to other people or other things (Bogaert, 2012).

Distinct from asexuality is the concept of celibacy. While those who are celibate choose to refrain from sexual activity, asexuals don’t choose their lack of sexual attraction. Just as sexual people have no control over their sexual attraction toward others; asexuals have no control over their absence of sexual attraction.

**Defining Healthy Relationships and Healthy Sexuality**

Asexual people face a unique challenge due to what the “unquestioned presumption” of sexuality as the norm (Chasin, 2011). A widely held assumption in our society is that all people experience sexual attraction toward someone. While the object of our affections may differ, our
culture largely holds the idea that all people invariably and intrinsically desire sex. This notion largely allows asexuals to “pass” as sexual people.

Although passing affords a certain amount of safety and social acceptance, one significant issue is that because all people are assumed to be sexual, those who come out as asexual face skepticism and even outright disbelief from others. One recent study analyzed the coming out stories of 169 self-identified asexual individuals, finding that some of the common themes within the stories involved skepticism about their orientation from family and friends, lack of acceptance, and misunderstanding about asexuality (Robbins & Low, 2016).

In my own experience, almost every time that I have revealed my asexuality to someone, their response would be skeptical or even outright dismissive. I have received many questions about “how I could possibly know,” whether I am “sure that I am asexual or if I simply haven’t found the right person yet,” as well as confusion over the legitimacy of the asexual orientation as a whole. These types of responses have been incredibly hurtful for me, causing me to question the legitimacy of my own feelings and reinforcing in me the idea that I am broken and in need of fixing. If I could just find the “right person,” then I could be normal. My lack of sexual attraction, my disgust in sex would dissipate, and then I would be cured.

This study and my personal experiences highlight the importance of trust and belief in a healthy relationship. A healthy relationship involves one where partners trust that each person knows themselves the best and can most directly and accurately speak to their own feelings. Additionally, each partner also believes what the other partner says about their feelings and sexual orientation. In the case of an asexual person, this involves trusting that someone would know whether they themselves are asexual, and also believing them when they talk about what being asexual means to them.
This trust and belief is important, particularly given the widespread assumption that all people are sexual. Some asexuals do choose to pursue relationships with sexual people, making these aspects of a relationship critical for one’s emotional and mental wellbeing. My previous partner held this assumption about humanity’s inherently sexual nature, and so when I shied away from sexual activity and openly expressed my disinterest, he frequently responded by insinuating that if I really loved him, I would want to have sex with him. This sort of guilt tripping was incredibly emotionally damaging for me, and in multiple cases led me to acquiesce to activities I didn’t feel comfortable doing. A study surveying 64 asexual people about their history with romantic relationships found that many asexuals experienced pressure to have sex from their romantic partners. Additionally, many participants recalled having partners who would try to convince them or otherwise turn them into sexual people (Haefner, 2011). Healthy sexuality doesn’t include pressure to have undesired sex.

This sort of pressuring in relationships leads me to a point about healthy sexuality. Experiencing sexual attraction and/or having a desire for sex and sexual activities are entirely healthy feelings, and not experiencing sexual attraction, a desire for sex, or even a desire for romance are also entirely healthy feelings. While popular culture tends to send the message that all people are sexual, the numerous studies I have previously referenced, as well as the existence of AVEN, demonstrate that this is not the case. Asexuality is a sexual orientation, no better or worse than any other, and there is nothing wrong or unhealthy about being asexual. Asexuality doesn’t require a “cure.”

Asexual Representation in Television
Openly asexual characters are largely absent from television shows, and those who are asexual are often shown to be lying about it, experiencing some sort of pathological or medical illness, or otherwise shown as in need of fixing. When addressing asexuality or asexual behavior at all, mainstream television regularly presents asexuals as unhealthy and poor romantic partners; the only way to truly be happy is for them to become sexual.

In the ninth episode of the eighth season of *House M.D.*, titled “Better Half,” a married couple asserts that they are asexual. The eponymous Dr. House doesn’t believe in their asexuality, and over the course of the episode searches for some medical cause. He ultimately discovers that the husband has a tumor in his pituitary gland, which has been blocking his libido and causing him erectile dysfunction. When another doctor reveals this information to the asexual couple, the wife confesses that she has been faking her asexuality all along for the sake of her husband (Lingenfelter, 2012).

Stories like this episode reinforce the idea that all people are sexual, and if they are not, then it must be due to some medical problem that must be fixed. Dr. House clearly doesn’t believe in their asexuality, and the doctor who does is ultimately proven incorrect. Not only that, but while one partner has a tumor, the other was simply lying, subtly implying that anyone claiming to be asexual probably isn’t.

*House M.D.* is not the only show to address asexuality in a problematic manner. *The Big Bang Theory’s* Sheldon Cooper regularly demonstrates a complete lack of interest in sex, intimate activities, or the physical bodies of others. His girlfriend Amy makes it very clear that she wishes to have sex with him, while his friends consistently deride him for being disinterested in sex and physical intimacy. In the fourteenth episode of the sixth season, “The Cooper/Kripke Inversion” Sheldon’s roommates Penny and Leonard interrogate him about his reasons for not
yet having sex with Amy, who he has been in a relationship with since the previous season. They both ask “what are you doing?” and “what is the problem?” – the implication being that he is wrong for not acquiescing to Amy’s sexual desires, and that there is something wrong with him if he doesn’t want to have sex (Lorre et al., 2013).

While Sheldon’s character is never specifically stated to be asexual, the way that his friends and girlfriend respond to his lack of sexual interest reinforces the idea that asexual behavior is problematic, even selfish. His friends search for root causes to his disinterest, and the show makes it clear that Sheldon is being difficult and unfair to his girlfriend for his refusal to have sex. When Sheldon finally decides to have sex with Amy as a means of showing her how important she is to him, this decision and the sexual consummation of their relationship is presented as a major achievement (Molaro et al., 2015). The show depicts Sheldon as finally overcoming his deficits in order to successfully be a good partner to Amy.

In both cases, the characters who demonstrate asexual behavior are depicted as having something wrong with them, and their happy ending involves fixing whatever is blocking their ability to have sex. Disinterest in sex isn’t presented as a viable option, and the characters do not consider the possibility that it could be healthy and acceptable to have no desire for sex and physical intimacy. In television programs directed towards teenagers, sexual maturation, engaging in kisses and sexual activities, marks the transition from adolescence into adulthood (Berridge, 2011). Television presents people as fully realized, whole adults once they become sexually active. Television’s reinforcement of this sexual norm and of the idea that those who dislike sex are damaged can have harmful effects on asexual people’s understanding of themselves.
In order to better demonstrate healthy sexuality in television, I believe that one way is to increase the representation of asexual people on the screen. People feel pride, inspiration, and comfort when seeing members of their sexual orientation represented in media, which helps them to come to self-realizations about their sexuality and feel more comfortable coming out (Gomillion & Giuliano, 2011). When more sexual orientations are seen on television, this normalizes those sexualities and allows for increased self-acceptance in people who identify with those orientations.

Also important is to have an increased tolerance for a diversity of sexual experiences in television. Even for characters that don’t identify as asexual, such as Sheldon, television can work toward demonstrating healthy sexuality by portraying Sheldon’s feelings and approach toward sex as perfectly normal and acceptable. Sheldon himself doesn’t have an issue with his disinterest in sex, and yet the show and the characters within the show insist that he needs to eventually get over it and have sex. If we can see more television shows breaking away from the assumption of inherent sexual interest in all people, this would be a significant step towards normalizing asexuality and asexual behavior.

Pathologizing Asexuality in Psychology and Therapy

Common not just to television, but also in psychology and therapeutic treatment is the idea that asexuality and disinterest in sex are symptoms of a disorder that must be cured. I was searching for a psychiatrist two years ago for treatment for my depression. During my first visit with one doctor, she began with asking me basic questions from a form, eventually reaching one about my sexual orientation. When I answered that I am asexual, she looked up and jokingly asked if I meant that I wasn’t getting any at the moment. After I told her that I was serious and
proceeded to explain what asexuality is, she abruptly stopped filling out the rest of her questionnaire and insisted that I have my thyroid checked, and start on antidepressants in order to increase my libido. I did not see her again, although when I told her later that I had decided to pursue different doctors, she insisted that she could help me and once again urged me to let her prescribe medication to fix my lack of a sex drive.

The idea that asexuality is rooted in something pathological is quite common. The Diagnostic and Statistical Manual, used by clinicians for the diagnosis of mental illness and disorders, includes Hypoactive Sexual Desire Disorder (HSDD) as a type of disorder. HSDD is characterized as the deficiency or absence of sexual fantasy and desire for sexual activity, coupled with marked distress and/or interpersonal difficulty (DSM-IV). HSDD has been split into female sexual interest/arousal disorder and male hypoactive sexual desire disorder for the DSM-5, and while the presence of interpersonal difficulty has been removed as an indicator of the disorder, the pathologizing of those who lack interest in sex remains (IsHak and Tobia, 2013).

Similar to the way that homosexuality was classified as a mental disorder up until 1987 (Burton, 2015), the most current edition of the DSM still includes a disorder for behavior that can describe asexuals. The field of mental health also maintains the assumption that all people are inherently sexual.

There has been some debate in the academic research over whether asexuality is distinct from HSDD, and in what ways. One recent study compared those who score above the cutoff for asexuality identification (AIS>40) with those who have been diagnosed with HSDD, finding that women in the AIS>40 and HSDD groups both had significantly lower sexual desire than those in the control and subclinical HSDD groups. Those in the AIS>40 group were less likely to experience sex-related distress, and the best predictors of whether a participant would be in the
AIS>40 group or the HSDD group included relationship status, sexual desire, sex-related distress, and alexithymia (Brotto et al., 2015).

One aspect the researchers touched upon as an indication that asexuality and HSDD are distinct is in the differences in subjective distress. However, given the current climate around what is and isn’t acceptable sexual behavior, using one’s sex-related distress doesn’t clearly indicate whether the distress is due to a personally perceived problem, or if it is due to our current society’s consistent messages telling us that normal people desire sex. Other research has further examined the difference between asexuality and HSDD, finding that the distinction can be dependent on how one conceptualizes normal behavior (Flore, 2014).

Whether HSDD and the disorders it eventually branched off into are legitimate is beyond the scope of this paper. However, research has shown the distinction between asexuality and HSDD to be quite muddy, and the widespread pathologizing of asexuality in the field of mental health can be quite unhealthy. The field of mental health sends the message that low sexual desire is a problem that must be fixed, in this case through therapy and other forms of psychiatric treatment. This erasure of asexuality as a legitimate orientation, as observed in the case of HSDD and my not-uncommon experience with a previous psychiatrist, is harmful, especially from a professional whose role is to attend to one’s emotional needs.

My experience with that doctor also demonstrated another unhealthy approach to one’s asexual orientation. This doctor didn’t believe me when I explained my sexual orientation, ignoring my acceptance of my asexuality as being a valid part of who I am. Instead, her response conveyed that she believed she knew me better than I did, and dismissed my self-concept. Under my definition of a healthy relationship with an asexual person, one’s identity is not a topic of debate, and it is important for people to be trusted to know themselves.
I propose that increased knowledge and understanding of asexuality as a legitimate sexual orientation for those working in the field of mental health would ultimately help asexuals build healthier relationships with their sexuality. Increased acceptance and trust that asexuals know themselves and their bodies would help to improve the field of mental health’s treatment of asexual people. A study that interviewed bisexual people about their experience with mental health professionals found that many of them reported having negative experiences with their therapist. These negative experiences included cases where the therapist was expressing judgment, dismissing and/or pathologizing bisexuality, and asking intrusive/excessive questions. Some participants noted that their therapist focused on their bisexuality, despite their sexual orientation being entirely unrelated to the problem they originally came in for, which is similar to my own experience (Eady et al., 2011).

However, those who reported having a positive experience described cases where the mental health provider sought out additional information about the participant’s sexual orientation, asked open-ended questions, and expressed positive or neutral reactions to the participant’s self-disclosures (Eady et al., 2011). I propose that one way to improve mental health services for asexual people is to encourage mental health professionals to trust what their patient tells them and to be open to learning from their patient. Trust and lack of judgment from health practitioners would improve mental health services for asexuals and help to destigmatize asexuality.

**Familial Responses to Asexuality**

The final institution I will discuss in this paper are families. For asexuals that choose to come out to their families, they regularly experience dismissiveness or outright denial. Negative
parental reactions to their children coming out as gay or lesbian have been found to elicit concerns about what other parents and friends will think about them, concerns about losing the chance of having grandchildren, as well as concerns over having to answer questions about their children’s sexuality from other people (Baiocco et al., 2015). When family members respond negatively to their children revealing that they are gay, their concerns often deal with the implications of being gay and what that means for both their child and themselves.

Interestingly, asexual people experience a unique phenomenon in that when they come out to family members, the implications of being asexual aren’t often considered because the asexual person isn’t typically believed to really be asexual in the first place. A study published in the Archives of Sexual Behavior found that denial of one’s asexual orientation manifested in multiple ways (Macneela & Murphy, 2015). One way was through re-interpretation; participants recalled their parents insisting that their claiming to be asexual was merely a cover for being gay or transgender instead. Rather than taking the confession as legitimate on its own, coming out as asexual was perceived as a way to hide some other sexual orientation instead. Another response was angry disbelief. A participant described their family being “angry that [they] ‘lie’ to them,” holding the belief that a person can’t possibly be asexual and thus must be fabricating their sexual orientation. Still other parents entirely dismiss their child’s coming out entirely, forgetting that their child is asexual each time they are told (Macneela & Murphy, 2015).

Other responses to asexuals coming out to their parents resulted in assumptions about being sexually repressed; with parents asserting that they simply need to have sex and that would solve their problems. Still other parents would assert that love simply impossible without sex. Some parents even openly asserted that asexuality is impossible, and that their child would have
to see a psychiatrist (Haefner, 2011). In each of these responses, family members demonstrate both a lack of belief in their asexual relative, and distrust in their assessment of themselves.

Both the result and fear of denial as a response causes asexuals to be less likely to reveal their sexual orientation to family members, leading to significant amounts of social and emotional isolation (Macneela & Murphy, 2015). Families are the first institution people are introduced to, being born into them, and thus they have a strong impact on one’s beliefs around their sexuality. However; families are still subject to the same misinformation that people in the world are, and the pressure to achieve acceptance from family members, close personal relatives, can have significant impact on one’s self-acceptance toward their sexual orientation.

Within the context of a family, it is difficult to encourage some sort of change in behavior due to the personal nature of one’s relationship to their parents and siblings. It is unlikely that anyone could force their parent or sibling to believe what they say about themselves. However, I think that building towards a healthy sexuality involves teaching children to know that their feelings are valid, and that it is just as acceptable to want to have sex as it is to not want to have sex. Failure to accept one’s sexual orientation can lead to a child feeling guilt and rejection, and potentially internalizing social stigmas (Baiocco et al., 2015). Greater tolerance and acceptance of non-heterosexual orientations within families would help people to develop healthier conceptions of their own sexuality.

**Conclusion**

Asexual people face a number of significant and unique challenges due to being a part of a routinely erased and misunderstood sexual orientation. Many institutions in society reinforce the harmful notion that all humans are inherently sexual, which can significantly affect an
asexual person’s knowledge of and acceptance of themselves. This paper has looked at the myriad ways asexual people are harmed by the lack of information surrounding asexuality, and ultimately I find the solution to involve increased awareness and representation of asexual people. This sexual orientation is still relatively unknown, but ideally some of the courses of action addressed in this paper will help to change that. Sex-positive discourse is important, and I hope that in the future discussions of sexuality will seek to normalize lack of sexual interest as much it does the desire for sexual activity.
References


