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COMMENTARY

Considering Asexuality as a Sexual Orientation and Implications for Acquired Female Sexual Arousal/Interest Disorder

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In this piece, I comment briefly on the link between autism and asexuality mentioned by Brotto and Yule (2016), before exploring (1) considerations of asexuality as a sexual orientation, and (2) implications of Brotto and Yule's conclusions about sexual orientation regarding women's acquired low sexual desire.

Autism and Asexuality

As Brotto and Yule noted, there is evidence of increased prevalence of asexuality among autistic people (e.g., Gilmour, Schalomon, & Smith, 2012; Ingudomnukul, Baron-Cohen, Wheelwright, & Knickmeyer, 2007) and online asexual community rumblings of a possible correlation.[1] "Asexuality" is assessed in different ways. Ingudomnukul et al. found 17% of 54 autistic women reported a sexual preference for neither men nor women. Based on data generously shared by Dr. Melike Schalomon (MacEwan University) and collected by Laura Gilmour (now a Ph.D. student at the University of Alberta), 6.15% of 65 autistic participants (women and men) reported *both* no sexual interest for anyone during the past year *and* not identifying with any sexual orientation on a Kinsey-style range (as compared, respectively, with 1.24% of 341 control participants). However, in these studies and more generally too, there is evidence that people on the autism spectrum may collectively display more diversity of sexuality and/or sexual orientation than the general non-autistic population, i.e., less heterosexuality and more of everything else (e.g., Pecora, Mesibov, & Stokes, 2016). Assuming, for the sake of illustration a population prevalence of asexuality among autistic people at 6% (or 17%), a population prevalence of asexuality at 1% (i.e., Bogaert, 2004)[2] and population prevalence of autism at 14.6 per 1000 (i.e., Christensen et al., 2016), we would expect (all other factors being equal) the prevalence of autism among asexual people to be a whopping 8.76% (or 24.82%)—explained parsimoniously by the broad distribution of sexuality/sexual orientation among people on the autism spectrum, without having to posit any relationship between autism and asexuality specifically or any shared etiological factors. In practice, however, it remains to be seen what, if anything, that correlation means for particular autistic asexuals: asexuality and autism may and/or may not be phenomenologically related—and I say this as, among other things, an autistic asexual for whom those two aspects of my own experience are not intrinsically connected.

Asexuality and Sexual Orientation

There is a contradiction inherent in the project of determining scientifically whether asexuality should be classified as a sexual orientation, because, ultimately, that is not an empirical question: it is a political one. "Sexual orientation" is first and foremost a political category that exists for political reasons. It began emerging in freshly post-industrial Europe, in the context of turbulently shifting social mores and nostalgic backlash, which prompted the criminalization of same-sex sexual acts and the resistance against it (Robinson, 1976). Over subsequent decades, this political struggle radically transformed the theoretical landscape. As people strove to overturn criminalization and sought legal rights,

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[1] Brotto and Yule erroneously reversed the findings of Ingudomnukul et al., reporting that 17% of asexual women participants showed traits of autism, when, in fact, the finding was that 17% of autistic women participants were coded as asexual.

[2] I question these numbers—e.g., Bogaert's 1% is distinct from self-identified asexuality—but that is immaterial here.

same-sex inclinations shifted away from being conceptualized as some people's "deviance." Instead, they became part of (a possibly "deviant" manifestation of) an intrinsic characteristic of all (or most) people that comes in various flavors and which drives experiences of (sexual and romantic) attraction, behaviors, and relationships (Katz, 1996). Today, "sexual orientation" also pertains to how people interface with heteronormative institutions and homophobic violence, how people do significant relationships (and with whom), their community affiliations, and how legislation and state authority treat them for these things.

Any scientific criteria employed to determine "sexual orientation" category membership are operational definitions of scientific constructs, which are themselves based on popular understandings of broader sociopolitical and discursive constructs. Epistemologically, it is possible to assess scientifically whether asexuality fulfills particular operational definitions (as Brotto and Yule did) but the question will always remain of whether the operational definitions are appropriate (i.e., have construct validity—re: the scientific constructs or re: broader sociopolitical discursive ones), or need to be changed. Ultimately, researchers would be merely scientifically documenting a type of social history in progress (Gergen, 1973), namely whether asexuality would be a "sexual orientation" according to today's conceptualization of this social construct.

To assess whether asexuality qualified as a sexual orientation, Brotto and Yule drew on Seto's (2012) criteria, despite Seto's explicit recognition that "stability over time" would be inappropriate/invalid to characterize "sexual orientation" in women. While stability over time reflects the dominant narrative of men's sexual orientation experiences, it represents only one of many major narratives for women (e.g., Golden, 1987), and a meaningful number of women, in fact, do become lesbian or bisexual after a period of heterosexuality earlier in life (e.g., as reviewed by Butland, 2015). People draw different conclusions from the androcentrism of the construction of sexual orientation as inherently stable and lifelong: that some women may not have sexual orientations (e.g., Bailey, 2009) or that sexual orientation in women is fundamentally different from sexual orientation in men and may include change over time (e.g., Diamond, 2013).[3] However, defining sexual orientation as something necessarily inborn, lifelong, and static is fundamentally and phenomenologically at odds with the sociopolitical meaning of "sexual orientation," whether recognized explicitly or not.

This kind of definitional disconnect is particularly salient for asexuality. AVEN's often-cited "does not experience sexual attraction" asexuality definition was very explicitly a politically motivated, strategic choice, adopted to make "asexuality" inclusive, while also positioning it intelligibly within the discourse of contemporary neoliberal identity politics as a viable sexual orientation (e.g., as discussed by Hinderliter, 2013). Specifically, co-founders David Jay and paranoidgynandroid (n.d.) crafted AVEN's first FAQs in 2002 to emphasize the central importance of self-identification in determining asexuality.[4] AVEN's definition of asexuality was never intended to be applied as a rule to systematically categorize people as asexual versus not asexual. Continuing this tradition, today, many in-person asexual spectrum (i.e., "ace") communities specifically avoid giving any definition of asexuality (e.g., New York,[5] Austin,[6] Toronto,[7] etc.). Moreover, there have always been people within the asexual community who were "asexual" and/or under the not-yet-named "ace umbrella," while also experiencing sexual attraction, because people come to asexual and/or other ace identities from diverse experiences and for various reasons. As early as February 2003, AVEN's FAQs invited people who experience some sexual attraction to consider the label of asexuality for usefulness (paranoidgynandroid, n.d.), recognizing a diversity under the asexual spectrum umbrella that had not yet even been named. An "asexual" identity does not necessarily imply a lack of sexual attraction. This remains true even since 2011 when asexual spectrum communities have shifted more toward using "ace" instead of "asexual" as the umbrella term, at least for internal community purposes.[8] Brotto and Yule were not sufficiently mindful of this distinction in their analysis. For example, they cited messages posted on AVEN in 2005, to draw conclusions about masturbatory fantasies of people who "by definition, lack sexual attraction to others." However, the one quoted user, of three, I was able to reach was someone who identified as asexual (among other things) *and* experienced some sexual attraction to people.[9] This highlights epistemological limitations of analyzing decontextualized message-board data. Generally though, if researchers treat "absence of sexual attraction" (lifelong or otherwise) as interchangeable with "asexuality," then the "asexuality" they study is ontologically different from the "asexuality" of asexual-identified people.

Interestingly enough, Brotto and Yule neglected what, in my view, would present the most significant challenge right now to conceptualizing asexuality as a unique sexual orientation, namely the vast diversity of asexual spectrum identities, particularly along dimensions of romantic orientation and aromanticism. While "asexuality" was set up to be a sexual orientation, and there are

[3] This did not mean interpreting women's sexual orientation (stereotypically) to be shapelessly fluid or easy to change.

[4] Personal communication with David Jay, August 25, 2015.

[5] Personal communication with New York ace community organizer Bauer, September 13, 2016.

[6] Personal communication with Austin ace community organizer Sciatrix, September 13, 2016.

[7] This is stated explicitly in Ace Toronto's Mission Statement: https://acetoronto.wordpress.com/mission-statement/.

[8] David Jay proposed a repurposing of the semi-obscure slang "ace" to refer to the *entire asexual spectrum community,* for a San Francisco conference in June 2011 (because "asexual" was considered inadequate for this purpose by attendees) and that usage has since spread. (Personal communication with David Jay, March 26, 2016).

[9] Personal communications with AVEN user Shivers, June 26, 2005; October 6, 2016.

important political and practical reasons for conceptualizing it as such (i.e., in contrast with a disorder, a paraphilia or a personality quirk), reality is a little more complex. The question of whether asexuality is a sexual orientation does not necessarily furnish (just) a yes/no answer. In some sense, asexuality functions as a meta-category positioned in opposition to non-aceness; in some sense, it functions as a unique sexual orientation category in opposition to other sexual orientations; and, in some sense, it does both simultaneously, and/or neither. Sexual orientation is a sociopolitical category and whether and how asexuality qualifies will depend on sociopolitical context. For example, an asexual lesbian should not be interpreted as only partly or liminally asexual and only partly or liminally lesbian: she[10] can *be* fully and legitimately both simultaneously, without contradiction—even if she (or they or xe) has come to this identity or any part of it after/through a process of change. Whether one aspect of her (or their or xyr) identity precedes the other in terms of her (or their or xyr) sexual orientation, or alternatively whether both function together in either cooperation or combination, will likely depend on the individual. Moreover, accepting this does not require reifying romantic orientation as a whole separate orientation posited as another inherent characteristic of all (or most) persons that functions independently of "sexual" orientation. Asexual spectrum identities are intelligible without fracturing "sexual orientation" in this way, but they might require a shift in perspective—letting go of "sexual orientations" as mutually exclusive domains on a landscape where everyone has one location. This process may require "sexual orientation" itself to be clarified or rebuilt. What this means politically is still taking shape for *when/how* asexuality will function properly as a sexual orientation—and I say this as, among other things, a queer aromantic asexual who experiences homophobia, and whose answers to the sexual orientation question are context dependent.

Asexuality and Disorders of Sexual Desire/Interest

There are far-reaching consequences to accepting what Brotto and Yule proposed in their consideration of asexuality as a sexual orientation, namely that sexual orientation for asexual people might show similar kinds of variation over time as sexual orientation in women (either because ace communities include significantly more women than men, or for other reasons). Specifically, asexuality *can* be a valid sexual orientation that people (possibly especially women) come to later in life, after a period of not necessarily being asexual (and perhaps a change of sexual desire), and that it deserves appropriate recognition as such. However, this conflicts with the makeup of the DSM-5 diagnostic criteria and accompanying text for sexual disorders in ways that Brotto and Yule did not explore. Notably, the DSM includes a potential exclusion for people with a (pre-existing) asexual identity from the diagnoses of *lifelong* Female Sexual Arousal/Interest Disorder (FSAID) and for Male Hypoactive Sexual Desire Disorder (MHSDD), acquired *or* lifelong (American Psychiatric Association, 2013).

Depending on the clinician, this would not necessarily help *any* asexual who, *before* coming to (or considering) an asexual identity, were to experience distress about low sexual desire—even if it is lifelong—and seek treatment aimed at changing their desire. However, some asexuals do just that before coming to accept their asexuality and crossing the line between asexuality and Hypoactive Sexual Desire Disorder (HSDD) in the DSM-IV (or MHSDD or FSAID in the DSM-5) (Gupta, 2015). The new framing of FSAID in the DSM-5 was supposed to be about structuring the diagnostic criteria for women in a way that centers the experiences of women (i.e., a main justification for splitting the DSM-IV criteria of HSDD into two gendered disorders; Graham, 2016), though some have argued this attempt failed to escape heterosexist discourses of women's "inherent passivity" and "lower (than men's) sexual interest" (Spurgas, 2016). In any event, it is interesting that for women—who encompass a notable proportion of people whose sexual orientations change over time—asexuality is considered a viable sexual orientation alternative to a sexual disorder only if it is "lifelong," but that for men—who encompass mostly people whose sexual orientations are lifelong—asexuality is considered a viable sexual orientation alternative to a sexual disorder even if it is "acquired."

Building an androcentric definition of sexual orientation into the fabric of FSAID (but not to MHSDD) disproportionately sets up asexual women who come to asexuality later in life for pathologization, and disproportionately pushes women who experience a decrease in sexual desire into a pathologizing framework that might not be appropriate—instead of considering whether an asexual/ace identity might be useful for these people. Already, therapists advocating the importance of asexuality-affirming clinical practice outright insist that "individuals cannot 'acquire' asexuality" (Steelman & Hertlein, 2016, p. 87), while arguing that asexuality is clearly distinct from "acquired FSAID." Moreover, asexuals/aces commonly describe having their asexuality (or grayasexuality) generally pathologized by medical practitioners (not necessarily via the DSM) and/or being "convinced" into therapy seeking a cause and/or "treatment" for their asexuality with service providers who oblige (e.g., Gupta, 2016), albeit without necessarily recognizing this as a type of "reparative therapy."

Ultimately, the shape of the DSM-5 criteria seems tailored toward maintaining a claim of definitional legitimacy and clinical authority over as many women as possible, most notably including those whom clinicians are most hopeful about being able to "treat," by strategically forfeiting claims on men's asexuality and women's lifelong asexuality. After all, the bulk of people diagnosed with the DSM-IV criteria of HSDD were (heterosexual)

[10] While lesbians are women (including some who are trans women) or women-aligned people, some are also non-binary. Not all lesbians use "she" pronouns. There are a variety of other possible pronouns, including "they" and "xe" (though their usage is not specific to lesbians—non-binary or otherwise).

women whose (men) partners wanted more sex from them (Cacchioni, 2007), and psychiatric powers recognized years ago that there was little or nothing they could do to change lifelong low sexual desire (e.g., Montgomery, 2008). However, clinicians should not assume that increasing sexual desire is either the *only* or *best* indicated therapeutic avenue for easing distress about low sexual desire, even if it is possible: claiming a positive asexual/ace identity and/or coming to happily live a life with little or no sex(ual interest) are equally valid therapeutic approaches, which some women may prefer. Unfortunately, the composition of FSAID all but eclipses that possibility.

The asexuality exclusion criterion (where it applies) does not resolve the tension between asexuality and psychiatric authority. In particular, the asexuality of asexual women who come to their asexuality after a period of something else (with a change of sexual desire) can be subsumed under the DSM-5 diagnosis of FSAID to the extent that these women can be made to feel bad about being asexual in a social context that is inhospitable to asexuality, and which affirms partners' entitlement to sexually access their bodies. Moreover, as Spurgas (2016) argued, the new DSM-5 criteria implicitly encompass partner distress, insofar as they pertain to a client's lack of receptive desire, which can lead to distressing relationship conflict between the client and a partner who wants more sex. The border between territories claimed by psychiatric institutions and those granted unchallenged to ace communities is grounded, for women, on the (erroneously) presumed inborn and unchanging nature of asexuality as a sexual orientation. This promotes the sexual-centric conditional of compulsory sexuality that I have discussed elsewhere (Chasin, 2013), namely that if someone can be made "normally sexual" or non-ace they *should* be made "normally sexual" or non-ace, and that asexuality (or aceness) should only be accepted otherwise—that asexuality (or aceness) is inherently inferior to non-aceness. This bears similarity to the heteronormative injustice of predicating sexual orientation legitimacy on immutability, presuming heterosexuality to be superior (e.g., Diamond & Rosky, 2016).

Generally, the boundaries are not only "fuzzy" between asexuality and lifelong HSDD, as Brotto and Yule suggest, but fuzzy generally between asexuality and disorders of low sexual desire at least for women, even if the criteria for FSAID would imply otherwise. Ultimately, despite all the scientific considerations, whether asexuality "counts" as a sexual orientation, and what conceptual territory if any it is expected to cede to psychiatric institutions, are political questions. As personal and political stakeholders are currently still working to influence their outcomes, the answers themselves are in progress.

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bailey, J. M. (2009). What is sexual orientation and do women have one? In D. A. Hope (Ed.), *Contemporary perspectives on lesbian, gay, and bisexual identities* (pp. 43–63). New York: Springer.

Bogaert, A. F. (2004). Asexuality: Prevalence and associated factors in a national probability sample. *Journal of Sex Research, 41*, 279–287. doi:10.1080/00224490409552235.

Brotto, L. A., & Yule, M. (2016). Asexuality: Sexual orientation, paraphilia, sexual dysfunction, or none of the above? *Archives of Sexual Behavior*. doi:10.1007/s10508-016-0802-7.

Butland, K. A. (2015). The complexities of female sexuality: Narratives of women who have experienced both heterosexual and same-sex marriages. (Unpublished doctoral dissertation). Walden University.

Cacchioni, T. (2007). Heterosexuality and the 'labour of love': A contribution to recent debates on female sexual dysfunction. *Sexualities, 10*, 299–320. doi:10.1177/1363460707078320.

Chasin, C. D. (2013). Reconsidering asexuality and its radical potential. *Feminist Studies, 39*, 405–426.

Christensen, D. L., Baio, J., Van Naarden Braun, K., Bilder, D., Charles, J., Constantino, J. N., et al. (2016). Prevalence and characteristics of autism spectrum disorder among children aged 8 years—Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2012. *Surveillance Summaries, 65*(SS-3), 1–23. doi:10.15585/mmwr.ss6503a1.

Diamond, L. M. (2013). Concepts of female sexual orientation. In C. J. Patterson & A. R. D'Augelli (Eds.), *Handbook of psychology and sexual orientation* (pp. 3–17). New York: Oxford University Press.

Diamond, L. M., & Rosky, C. J. (2016). Scrutinizing immutability: Research on sexual orientation and U.S. legal advocacy for sexual minorities. *Journal of Sex Research, 53*, 363–391. doi:10.1080/00224499.2016.1139665.

Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology, 26*, 309–320. doi:10.1037/h0034436.

Gilmour, L., Schalomon, P. M., & Smith, V. (2012). Sexuality in a community based sample of adults with autism spectrum disorders. *Research in Autism Spectrum Disorders, 6*, 313–318. doi:10.1016/j.rasd.2011.06.003.

Golden, C. (1987). Diversity and variability in women's sexual identities. In Boston Lesbian Psychologies Collective (Ed.), *Lesbian psychologies* (pp. 19–54). Chicago: University of Illinois Press.

Graham, C. A. (2016). Reconceptualising women's sexual desire and arousal in DSM-5. *Psychology & Sexuality, 7*, 34–47. doi:10.1080/19419899.2015.1024469.

Gupta, K. (2015). What does asexuality teach us about sexual disinterest? Recommendations for health professionals based on a qualitative study with asexually identified people. *Journal of Sex and Marital Therapy*. doi:10.1080/0092623X.2015.1113593.

Gupta, K. (2016). "And now I'm just different, but there's nothing actually wrong with me": Asexual marginalization and resistance. *Journal of Homosexuality*. doi:10.1080/00918369.2016.1236590.

Hinderliter, A. (2013). How is asexuality different from hypoactive sexual desire disorder? *Psychology & Sexuality, 4*, 167–178. doi:10.1080/19419899.2013.774165.

Ingudomnukul, E., Baron-Cohen, S., Wheelwright, S., & Knickmeyer, R. (2007). Elevated rates of testosterone-related disorders in women with autism spectrum conditions. *Hormones and Behavior, 51*, 597–604. doi:10.1016/j.yhbeh.2007.02.001.

Katz, J. N. (1996). *The invention of heterosexuality*. New York: Penguin Books.

Montgomery, K. (2008). Sexual desire disorders. *Psychiatry, 5*, 50–55.

paranoidgynandroid. (n.d.). "Questions Asked by Asexual and Questioning People" on the official website of the Asexuality Visibility & Education Network. https://web.archive.org/web/20030225191733/http://www.asexuality.org/bigfaq.htm. Accessed 28 Sept 2016.

Pecora, L. A., Mesibov, G. B., & Stokes, M. A. (2016). Sexuality in high-functioning autism: A systematic review and meta-analysis. *Journal of Autism and Developmental Disorders*. doi:10.1007/s10803-016-2892-4.

Robinson, P. (1976). *The modernization of sex: Havelock Ellis, Alfred Kinsey, William Masters and Virginia Johnson*. New York: Harper & Row Publishers.

Seto, M. C. (2012). Is pedophilia a sexual orientation? *Archives of Sexual Behavior, 41*, 231–236. doi:10.1007/s10508-011-9882-6.

Spurgas, A. K. (2016). Low desire, trauma and femininity in the *DSM-5*: A case for sequelae. *Psychology of Sexuality, 7*, 48–67. doi:10.1080/19419899.2015.1024471.

Steelman, S. M., & Hertlein, K. M. (2016). Underexplored identities: Attending to asexuality in therapeutic contexts. *Journal of Family Psychotherapy, 27*, 85–98. doi:10.1080/08975353.2016.1169014.