Garrick Evan Weller

English 112

Professor Michele Marits

10 October 2022

The discourse of asexuality

The topic of asexuality is full of controversy including the one being discussed here: the lack of sexual desire is a disorder. “Asexuality is defined as a sexual orientation characterized variably as a lack of sexual attraction [sexual desire]” the A.P.A (American Psychological Association) defines Hypoactive Sexual Desire as “a low sexual desire accompanied by a marked distress or interpersonal differences.” Asexuals are known to encounter incidental or purposeful discrimination. Some who identify as asexual have had instances where necessary drugs and medications (antidepressants, antianxiety, and the like) were unprescribed due to asexuality or a misunderstanding of asexuality. The American Psychological Association should not consider Hypoactive Sexual Desire Disorder and its counterparts as a mental disorder, due to being a poorly defined version of asexuality and the damages, it could cause for “fixing” it.

Hypoactive Sexual Desire Disorder (H.S.D.D.) is a disorder defined in the Diagnostic and Statistical Manual of Mental Disorders (Diagnostic and Statistical Manual of mental disorders V) as a lack of sexual desire causing a “Marked Distress”, or “Interpersonal Difficulties”. With the definition of Hypoactive Sexual Desire Disorder overlapping significantly with the definition of asexuality they should not be described differently from each other. Those diagnosed with Hypoactive Sexual Desire Disorder are significantly more common to be women. Of those women, the higher quantity has been in a relationship for an extended period of time. Asexuals are also more common to be women, but are less likely to get into sexual relationships (or negotiate them differently) thus avoiding the diagnosis. Considering Hypoactive Sexual Desire Disorder is a disorder the patient must have a significant decrease in quality of life. How can an individual who does not desire sexual interaction have a reduced standard of living that is not based on societal pressure? An alternative way to ask this question is: “Why would you have a disorder because you don’t like to collect doorknobs?” Why does this have to be listed as a disorder because it is not what society expects?

An additional condition that may lead to the patient qualifying for a Hypoactive Sexual Desire Disorder diagnosis is “if the patient suffers from interpersonal difficulties” from a lower sexual desire. An understanding of the issue [Hypo-Sexual Desire Disorder] is a requirement for being able to “treat” the disorder. These interpersonal problems could just be relationship incompatibility, which happens to most demographics. These same definitions can be used to describe asexual persons. “Interpersonal difficulties” can be caused by Hypoactive Sexual Desire Disorder because of the sheer nature of the “disorder.” Issues revolving around the relevancy or frequency of sex are the biggest issue of Hypoactive Sexual Desire Disorder due to the lack of sexual desire. Relationship problems can be compounded by these issues creating the “interpersonal difficulties” condition required for Hypoactive Sexual Desire Disorder. Many of these issues are also encountered by asexual individuals. Their lack of desire for sexual activity thus leads to those “interpersonal difficulties. Sexual desire is difficult to define due to a misalignment of the definition. With a disorder based entirely on an abstract idea, it is an “issue” based entirely on theory and personal objections rather than neurological difficulties. According to the definition of Hypoactive Sexual Desire Disorder, a person cannot specifically self-identify as asexual. Identifying as asexual will exclude the diagnosis of Hypoactive Sexual Desire Disorder even though both find themselves with similar feelings. With asexuality not being mentioned in the desktop version of the Diagnostic and Statistical Manual of Mental Disorders, certain measures preventing the diagnosis are not available in the abridged version of the book. This makes a Hypoactive Sexual Desire Disorder diagnosis even more prevalent in a questionable manner, whether intentionally hostile or inadvertently discriminatory.

As the Diagnostic and Statistical Manual of Mental Disorders is a book of larger size, the abridged version is often the only copy of the Diagnostic and Statistical Manual of Mental Disorders on hand. This results in missing information not being accounted for in the diagnosis of Hypoactive Sexual Desire Disorder. This missing information may create the potential of a misdiagnosis of Hypoactive Sexual Desire Disorder, an asexual individual may wind up with other issues when this “disorder” becomes “medicated” and the medications do not work. An area of concern with Hypoactive Sexual Desire Disorder is that it is a disorder that can be diagnosed completely on another party’s experience with the patient. This diagnosis technique makes it not a disorder of the patient, but an issue with the third party. The treatments are also just as problematic as the standards of the third party who is stating there is a problem.

these third-party standards are held mostly due to a lack of awareness and education and may vanish completely with due time as resources become more discoverable, and ethics change. Treatments for Hypoactive Sexual Desire Disorder non-exhaustively include: psychotherapy. A subset of psychotherapy [conversion therapy; is used more commonly with those who are Asexual or Queer Hypoactive Sexual Desire Disorder than towards those who self-identify as gay, bisexual, or other identities,] These treatments, especially conversion therapy, can have powerful and long-lasting side effects for minimum [if any] benefit. Another option for treatments would be medication such as buspirone, Addyi (Flibanserin), testosterone, and others. These medications can cause adverse reactions including suicidal thoughts or actions, depression, anxiety, and other issues. Drugs such as Addyi can interact severely with 71 other known drugs such as anti-depressants and blood thinners, resulting in either more or less of one of the conflicting pharmaceuticals being absorbed into the bloodstream. These side effects include bleeding, new or worsening depression, anxiety, and many others. Are these treatments worth the cost based on a third-parties idea of what is right or wrong with someone else? Should it be the patients of ideas of how they are supposed to feel?

These are often not worth the slight adjustment to sexual desire because many of these drugs that interact with Addyi as an example can cause Hypoactive Sexual Desire Disorder without actually qualifying for a diagnosis. If we change the definition of sexual attraction to not include sexual desire, then Hypoactive Sexual Desire Disorder would only be encompassing the desire to actually have sex rather than lacking a key component for sexual attraction. Leaving the definition like this would still bring the question of whether this is in fact a disorder to the fore. As a disorder would need to lower the quality of life of those “inflicted” and a lower “libido” does not affect the quality of life much if at all. This only affects the partners of those with Hypoactive Sexual Desire Disorder through a lack of mutual perceived reciprocity in the relationship. Their relationships often would be negotiated differently by many asexuals having known they were asexual prior to the current terms of the relationship. Many who would negotiate their relationships differently may find that their relationships are incompatible or may find that their partners feel the same way and could find a closer bond through the negotiation. A strong relationship is not based on sex alone. If both parties genuinely care for one another, being able to understand the other party can make the relationship last. As humans get older, the ability and desire for sex fades away naturally anyway.

The Diagnostic and Statistical Manual of Mental Disorders V has also had arguments against maintaining the Hypoactive Sexual Desire Disorder/Female Sexual Arousal Interest Disorder diagnosis in the manual. some skepticism would lead to questions as to whether Hypoactive Sexual Desire Disorder would just be a simple symptom of regular sexual interest in the healthy population. Another “issue” that can or should be considered is that breastfeeding can significantly reduce sex drive [and therefore sexual desire] through the period that the mother is breastfeeding. After six months [the period of time that Hypoactive Sexual Desire Disorder takes to be eligible for a diagnosis] only one of three children in the United States is still nursing, with 17 percent still receiving breastmilk exclusively. With breastfeeding lowering the amount of estrogen, as well as introducing elevated levels of prolactin, both of these hormones can lower the sexual desire of a mother, thusly introducing the qualifications for a hypoactive sexual desire disorder diagnosis.

Finally, Hypoactive Sexual Desire Disorder is a “disorder” used against asexuality to try and force an asexual person into being “normal” or to reinforce the “need” for sexual desire. As sex has an extraordinarily strong embodiment in the modern-day culture, those who desire less of the “basic human need” for sex are commonly dismissed or pathologized. This feeds into Amatonormativity and “encouraging” the creation of the nuclear family through the pressure of society’s making. Hypoactive Sexual Desire Disorder is a manifestation of this behavior in the medical community. This behavior can have strong repercussions for those who do not have the knowledge and understanding of asexuality and can create more issues later on, due to the pathologizing of asexuality. This is a behavior inherent to the medical community as they are there to find “abnormalities” in individuals and treat them to follow the norm. A third party should not be able to label someone with a disorder, just because the person does not seem “normal”. Being asexual does not harm the patient or society. If the person is happy as they are, they should not have to conform to what others say they should want. Times change, and so do “normals”. A few years ago, you would be thrown in jail for years for walking into a bank with a mask. In the last couple of years mask became encouraged because of covid. In a few years or decades, Hypoactive Sexual Desire Disorder could be completely removed from the Diagnostic and Statistical Manual of mental disorders V just like Sexual Orientation Disorder was. In many aspects, there are not any differences between hypoactive sexual desire disorder and Sexual Orientation disorder.

Works Cited:

Bahrami\_Vazir, Ellahe, et al. “The Correlation between Sexual Dysfunction and Intimate Partner Violence in Young Women during Pregnancy.” *BMC International Health and Human Rights*, vol. 20, no. 1, 2020, https://doi.org/10.1186/s12914-020-00245-9.

Bradshaw, Julia, et al. “Asexuality vs. Sexual Interest/Arousal Disorder: Examining Group Differences in Initial Attention to Sexual Stimuli.” *PLOS ONE*, vol. 16, no. 12, 16 Dec. 2021, https://doi.org/10.1371/journal.pone.0261434.

Costello, Sara, and Kayla Kaszyca. “Sounds Fake but Okay Ep 44.” *Ep 44: Women's Viagra and Sexual Desire - Sounds Fake But Okay Podcast*, 29 July 2018, https://www.soundsfakepod.com/transcripts/womens-viagra-and-sexual-desire. Accessed 10 Oct. 2022.

This podcast was transcribed into a webpage which is what is cited here. The actual podcast for the multimedia portion of this assignment can be found on Spotify at the very least with the same name and episode number along with many other episodes of the podcast. This source provides a jumping-off point for the finding of many of the other sources. This means that I mostly didn’t use college resources, therefore, resulting in an interpretation of T.C.C.s copyright policy resulting in me holding the majority of the copyright with T.C.C.s stake in using this paper for academic purposes. Which I am perfectly fine with.

Decker, Julie Sondra. “Part Two: Asexual Experiences.” *The Invisible Orientation: An Introduction to Asexuality*, Skyhorse Publishing, New York, 2015, pp. 59–59.

“The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues.” *American Journal of Psychiatry*, vol. 138, no. 2, 1981, pp. 210–215., https://doi.org/10.1176/ajp.138.2.210.

Fallon, B. “‘Off-Label’ Drug Use in Sexual Medicine Treatment.” *International Journal of Impotence Research*, vol. 20, no. 2, 2007, pp. 127–134., https://doi.org/10.1038/sj.ijir.3901610.

Murray, F. “Asexuality Was Considered a Disorder?!” *Aceweek,Org*, Aceweek.org, 29 Oct. 2020, https://aceweek.org/stories/asexuality-in-the-dsm#:~:text=In%20many%20ways%2C%20this%20controversy%20around%20asexuality%20and,as%20an%20illness%20that%20needed%20to%20be%20%27cured%27.

Fallon, B. “‘Off-Label’ Drug Use in Sexual Medicine Treatment.” *International Journal of Impotence Research*, vol. 20, no. 2, 2007, pp. 127–134., https://doi.org/10.1038/sj.ijir.3901610.