AN ABSTRACT OF THE THESIS OF

Vanessa A. Vanderzee for the degree of Master of Arts in Women, Gender, and Sexuality Studies presented on June 8, 2017.

Title: Accessing Health Care on the Asexual Spectrum: A Feminist Analysis of Patient-Practitioner Relationships and Compulsory Sexuality in Medical Discourse.

Abstract approved: ____

Mehra Shirazi

The LGBTQ population is widely recognized as an at-risk demographic—as a result of stigma, studies report sexual and gender minorities experience elevated risk for depression, suicide, anxiety, and substance abuse, as well as greater exposure to sexual, physical, and interpersonal violence (Logie 1244). Asexuality, a marginalized population traditionally excluded from the LGBTQ acronym, poses a unique set of challenges to existing health care policies and procedures. As neither queer nor asexual literature have adequately attended to such challenges, this study aims to address present limitations through two key inquiries: (1) How do ace individuals approach and navigate discussions about their health and wellness with health care providers? and (2) What is the relationship between asexual identity and the ways one accesses health care? To critically engage with the research questions, this thesis employs a discourse analysis of pre-existing public forum and blog posts collected from online asexual community spaces which include narratives that allude to the impact of the naturalization of sexuality, the medicalization of asexuality, and the conflation of libido with sexual attraction on access to health and wellness. Analysis of the collected data centers on the pathologization of queerness, existing wellness support networks, and perhaps most importantly, access to and comfortability with current health care models.

Key words: asexuality, online discourse, health care, medical discourse, compulsory sexuality

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Accessing Health Care on the Asexual Spectrum: A Feminist Analysis of Patient-Practitioner Relationships and Compulsory Sexuality in Medical Discourse

by
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A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Master of Arts

Presented June 8, 2017
Commencement June 2017

Master of Arts thesis of Vanessa A. Vanderzee presented on June 8, 2017

APPROVED:

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Vanessa A. Vanderzee, Author

ACKNOWLEDGEMENTS

This thesis was a community effort, and I would like to extend my gratitude to a great many people who made this work possible. First and foremost, thank you to the online asexual communities who helped me come to a better understanding of myself, who graciously provided contributions in the development of this research, and who affirmed this project when I needed it most. To my committee chair and mentor Dr. Mehra Shirazi, thank you for all of your thoughtful guidance and critical feedback—throughout this thesis project, and throughout my graduate school experience; Our conversations have been very important to me. Thank you to the members of my thesis committee, Dr. Janet Lee, Dr. Qwo-Li Driskill, and Dr. Elizabeth Gorman, for your investment in my progress as a graduate student, as an educator, and as a scholar. To my WGSS graduate cohort, I am so fortunate to have had such kind and generous individuals with whom I could share struggles and triumphs, food and hugs. Thank you to my friends, Dawn Carr and Andrés Lopez—two wise individuals who shared their invaluable knowledge on navigating graduate school and navigating life. Thank you to my dear friend and graduate school accountabilibuddy Emilee Hunt. Your energy and passion have been such an inspiration to me—and your words of validation and encouragement have fortified my own commitments and pursuits. Thank you to my mom, dad, sister, family, and friends for your unconditional love and support. Thank you especially to my partner Zach, who has listened compassionately to all of my complaining over the past two years of graduate school (and then some), and to my cat Echo, who has provided me with healing purrs and a reason to stay in bed just a little longer on some mornings. Thank you to everyone who has supported me in this journey—I am so very grateful.

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Chapter 1: Introduction

The LGBTQ population is widely recognized as an at-risk demographic: as a result of stigma, studies report sexual and gender minorities experience elevated risk for depression, suicide, anxiety, and substance abuse, as well as greater exposure to sexual, physical, and interpersonal violence (Logie 1244). As a result, a greater awareness of LGBTQ health disparities among health care professionals is necessary to provide comprehensive services to this population. This work, led for decades by queer of color communities, has only recently seen integration into the larger American healthcare system. The asexual (sometimes abbreviated as "ace") identity presently straddles the line between inclusion and exclusion in queer communities—in part because it is still very much contested whether the "A" in LGBTQQIA stands for asexual or allies. Because of this precarious standing, asexuality is often not considered in research centering on queer identities and health, nor in the slight amount of "LGBT-friendly" healthcare programming and training.

As a queer and ace-identifying scholar and activist, I find this erasure troubling at best, and violent at worst. Even for those who fit relatively comfortably within societal expectations, and thus enjoy a fair amount of privilege, health care can be an uncomfortable, if not hostile, environment. I have been fortunate to have not one, but two parents with backgrounds in health care, both trained in the U.S. Air Force—one as a medical laboratory technician and the other as a biomedical engineer. My parents' careers, as well as a succession of family illnesses during my early years, meant that I was raised in the midst of medical discourse, and at a young age grew quite familiar with critiques of the medical industrial complex. In addition, my own health issues have highlighted health care’s lack of approachability, particularly for those who live on the border of “normalcy.” My upbringing awarded me a base level of fluency in medical discourse, and instilled in me a rather hearty skepticism of health care systems. For countless individuals, the medical industrial complex is an omnipresent reality—particularly for those with chronic conditions like myself and, as this project demonstrates, for many others who identify on the asexual spectrum. Thus, given my location as a neurodivergent scholar and activist, I believe it is of vital importance to interrogate the particular intersection of (a)sexuality and health care. More precisely, the intent of this research is to better understand and describe current spaces of wellness support for online ace communities, to identify commonalities amongst asexual patients’ experiences “coming out” to their doctors, and to evaluate the impact of pathologization and erasure on willingness to seek out health services.

Researching asexuality has thus been a multi-purpose endeavor—to give greater visibility to asexuality, to potentially contribute something meaningful to asexual movement-building and, finally, to better understand myself. I was first introduced to asexuality as an identity in my early-twenties. Ignorant to the asexual spectrum, and with these medical discourses so central to my upbringing, I spent much of my young adult life self-diagnosing in an attempt to understand behaviors (or lack thereof) that I perceived to be abnormal. For a class project in my first year of graduate school, I distributed surveys to interested folks in the community, to confirm whether many of my own concerns might be indicative of larger issues, and what I might be failing to attend to due to the limits of my specific life experience. The survey was picked up by a fairly prominent member of the online ace community, and I received messages from many community members eager to contribute, and to see more of this ace-centered work being accomplished. This thesis is largely inspired by that early work done in collaboration with the Tumblr ace community.

Background and Research Questions

The Western model of healthcare normalizes sexuality in particular ways, thereby eliminating space for inclusive discussions of (a)sexual health. Additionally, Western society continues to perpetuate antiquated scientific knowledge regarding the link between hormones and heavily gendered personality traits, as well as sexualities (MacKenzie). Although it is clear that hormones play an integral part in the complex systems of the body, these discourses—rooted in settler colonial logics which prioritize sexism, homophobia, and racism—situate the hormonal body at the center of identity, and seek ways to facilitate the forced integration of individuals into mainstream sociocultural expectations (McRuer). The pathologization of “deviant” sexual practices and gender identities is nothing new, and it continues to repeat itself time and again. Hormones have been utilized as a way of “explaining” homosexuality and other non-normative sexualities, and marketed as a cure-all for transgender individuals, and discourse centering hormones is also prevalent in discrediting responses to the coming out narratives of asexual individuals, whose identities are often pathologized and diagnosed (Spade). The relationship between mental health and non-normative sexual and gender identities has also been fraught with pathologizing ideologies and discourse—counseling and therapy have often been complicit in attempting to diagnose such identities, depending upon the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Although the idea and identity of asexuality certainly is not a new phenomena—the establishment of hubs for ace community building is relatively new. The Asexual Visibility & Education Network (AVEN), a forum-driven online community created in 2001, now boasts over 100,000 members (Scutti). An orientation commonly defined by a lack of sexual attraction, asexuality is simultaneously considered by its members as a spectrum containing “people who experience little *or* no sexual attraction and/or self-identify with asexuality” (Cerankowski and Milks 17). This spectrum recognizes the fluidity and nuance of (a)sexuality and includes identities such as demisexual (in which one only experiences sexual attraction within already intimate relationships) and graysexual (in which one may experience sexual attraction rarely, in specific contexts, or experiences sexual attraction but has no desire to act upon it) (O’Brink). To recognize many (but not all) ace individuals’ need for relationships regardless of how their asexuality manifests, aesthetic, romantic, and sexual attraction have been sequestered and defined separately (i.e. hetero, homo, bi, pan, and aromantic) from sexual attraction (O’Brink).

Given the context outlined above, my central research question is two-fold:

- How do ace individuals approach and navigate discussions about their health and wellness with health care providers?

- What is the relationship between asexual identity and the ways one accesses health care?

In answering these research questions, I simultaneously aim to elucidate the ways in which medical discourse and public language and truths affect asexual individuals' access to and relationship with health and healthcare. To achieve this aim, I conduct a critical discourse analysis of pre-existing posts collected from online asexual community spaces, specifically focusing on those narratives that allude to the impact of the naturalization of sexuality, the medicalization of asexuality, and the conflation of libido with sexual attraction on access to health and wellness.

The research focuses on the following objectives:

- *Pathologization of queerness*. The first objective is to describe the salience of "the diagnosis" in ace "coming out" narratives in interacting with healthcare professionals. I interrogate the dominant Western cultural model of responding to queerness more generally, in order contextualize these particular asexual narratives.
- *Existing wellness support networks*. The second objective is to better understand and describe current spaces of support for ace communities, outlining their advantages and disadvantages. This objective additionally necessitates an overarching consideration of the politics of online knowledge-creation and movement-building, the influence of "mainstream" LGBTQ spaces and organizing, and the potential of future ace organizing/movement-building.

- *Access to and comfortability with current health care models*. The final objective is to evaluate the impact of the pathologization and erasure of asexuality on individual comfortability in seeking out care, based on discourse found among a representative sample of the online asexual community.

For my theoretical approach to this topic, I center Cooper and Przybylo's concept of "asexual resonances," a term which promotes a crossing of borders to imagine asexuality more complexly (303). In their article "Asexual Resonances: Tracing a Queerly Asexual Archive," the authors find and interpret "sources of asexual 'touch' between asexuality today and asexual resonances of other contexts, past and present" and thus establish a framework that allows me to conduct this project from a distinctly interdisciplinary vantage point (Cooper and Przybylo 303). Through this understanding of asexuality, Cooper and Przybylo build bridges between asexuality, feminism, and queer theory, and I seek to shift and expand this work by also foregrounding the work of scholars in Black Feminist Theory, Indigenous and Queer Indigenous Studies, as well as Disability Studies and Crip Theory. A significant aspect of this research project in particular is that, while not directly focused on the intersection of asexuality and race, I infuse the work of scholars and activists of color throughout to discuss the ways in which asexuality is already very white-centered. This is an important factor to consider when researching matters of health, as women of color in particular are one of the most vulnerable populations in regards to healthcare (Calabrese et al.). If asexuality continues on its current trajectory, without prioritizing intersectional conversations, it will only perpetuate discrimination against people of color in the medical industrial complex. Scholars and activists of color such as Malea Powell, Jacqueline Jones Royster, and Angela Hass—as well as many others upon which I will draw in this project—are already doing the kind of work I strive to accomplish here, they are simply working in other contexts, and for other communities. There is, therefore, much to learn from their perspectives and tactics.

Organization

In Chapter 2, I review existing literature to introduce the core concepts relevant to this study, map out the current status of healthcare in regards to LGBTQ+ policies and procedures, and expand upon the theoretical framework developed to address the topic of asexual health. At this time, asexuality is rarely found on medical forms, and is very typically excluded in the training of healthcare professionals in any and all fields. Therefore, opting to focus on asexuality in current healthcare policies and procedures would not provide enough perspective on matters of queer health. Because ace-identifying individuals do share some key characteristics with other marginalized identities, examining more general LGBTQ+ healthcare practices, and drawing parallels between ace and trans issues remains illuminating and valuable as a foundation for situating asexuality in relation to current structures (Utamsingh et al.). In addition, I survey previously published literature on asexuality more generally, as well as ace health specifically. This analysis provides context on the usefulness of existing data—for individual healthcare professionals, and for inclusion in health care programs and policies—and offers insight to the contribution of this thesis to the burgeoning field of

Asexuality Studies, as well as to other disciplines interested in asexualities and queer health.

In Chapter 3, I describe the methodology employed in this study, exploring the emergence of online and social media discourse analyses and the often-ignored wealth of information present in these spaces. I conduct a critical discourse analysis using narratives collected from three main online spaces: threads in the "Asexual" and "Asexuality" subreddits on Reddit, blog posts and reblogs on Tumblr, and forum discussions on the Asexual Visibility and Education Network (AVEN) website. This analysis allows me to glean overarching themes expressed by ace-identifying folks in regards to their attitudes toward and interactions with the medical industrial complex and healthcare professionals, while protecting their identity and their privacy. This section builds on the argument established in chapter three regarding the value of social media as a site for data collection, and the need for greater recognition of the knowledge being produced in these spaces.

Following a discussion of methodologies, Chapter 4 presents the findings gleaned from the collected data of this thesis research. In this chapter, I use the findings to identify overarching themes within asexual experiences with health care services, including "coming out" narratives, medical misconceptions of virginity, mistrust in patient-practitioner relationships, and asexuality as an intersectional identity.analysis of my study results. The chapter begins by introducing each online platform and its distinct qualities and examining larger commonalities in experience, and ends by narrowing the focus to specific intersectional issues. In Chapter 5, I return to my research questions to synthesize research findings and theory to discuss the themes of race, dis/ability, movement-building, and other central topics which emerged from the research. This includes a discussion of the white-centeredness of dominant ace discourses and activism and a look at the pertinent intersections of asexual health care experience with the experiences of other marginalized communities.

Finally, in Chapter 6 I conclude with a summary of the findings of all previous chapters and provide suggestions for ways this information could be used by healthcare professionals and their respective institutions to create a more inclusive environment for ace-identifying people, and by ace organizers seeking to expand and grow ace movement-building and activism. This section includes a brief acknowledgement of some of the limitations of this study and considers implications for future research.

Chapter 2: Literature Review

Introduction

Stigma, discrimination, and social exclusion are main contributors to LGBTQ health disparities globally. Though mainstream cultural attitudes toward LGBTQ orientations differ, these contributors, and the severity of their impact on LGBT health, are relatively consistent around the globe. In this chapter, I begin by conducting a brief survey of LGBTQ health care at large, then hone in on findings specific to my community. The survey of LGBTQ health policies and procedures is necessary when considering asexual health— the body of literature addressing asexual-competency in health care is small, and stigma, invisibility, and pathologization are experienced by both LGBTQ and ace communities. After addressing the existing body of relevant work, I build upon the theoretical framework introduced in the first chapter.

In the first section of this chapter, "Health Care: Programs and Policies," I compile relevant research findings on medical curricula, medical student attitudes towards LGBTQ patients, and LGBTQ-focused policies and procedures at health care institutions worldwide to gain a comprehensive understanding of the state of LGBTQ health care globally. I have intentionally centered studies from diverse locations, because the members of online asexual communities are also based in diverse locations and are communicating across borders. Thus, to understand queer and asexual health experiences, it is necessary to have a global awareness of the health disparities. Following this, I specifically explore the small body of literature covering asexual competency in health care. In the second section, "Disability and Neuro-atypicality," I draw on crip theory and disability studies literature to consider the intersections and tension between asexuality and disability, as well as neuroatypical traits. In the third section, "Asexuality Studies," I look back at foundational queer studies work that also holds value and relevancy for the burgeoning field of aseuxality studies, and introduce some of the key works in asexuality studies today. I conclude this chapter with a discussion of my theoretical framework, which considers the nature of archival curation, digital literacy, and responsibility online.

Health Care: Programs and Policies

LGBT (And Sometimes "Q") Competency in Medicine

LGBTQ health topics are consistently lacking in medical curricula on a global scale. This dearth is deeply concerning to say the least, given that LGBTQ individuals are widely recognized as an at-risk population in the areas of mental health, violence, and sexually transmitted disease. Khalili, Leung, and Diamant, in their article entitled "Finding the Perfect Doctor: Identifying Lesbian, Gay, Bisexual, and Transgender-Competent Physicians," share the findings of a survey conducted between June and December of 2012. This survey contacted all 138 allopathic medical schools in the U.S. and Puerto Rico, in order to "assess the existence of programs and policies to identify and train LGBT-competent medical physicians" (1115). Of the participating institutions, less than 9% had implemented procedures to assist patients in identifying LGBT-competent physicians, and even fewer had any policies in place—only 4% (Khalili et al. 1115). In addition, the majority of these institutions offered no LGBT-related training—only 16% percent of participating institutions had established comprehensive training in this area (Khalili et al. 1116). This study makes it clear that most newly educated health professionals are entering the field without a foundation of knowledge in LGBTQ health topics. Furthermore, as these new health professionals gain positions of power, they too fail to prioritize policies and procedures that could address the diverse needs of their LGBTQ constituents.

Alexandra Müller's findings from an analysis of University of Cape Town's medical curricula yielded similar results. Like Khalili et al., Müller mapped the university's curricula through an online survey. Müller notes that absolutely no education on LGBT health was conducted within the "allied health sciences" at the time of the survey in 2012 (4). There were no materials provided relating to "LGBT safer sex, mental health, substance use, chronic disease risks, and adolescent health," and stigma, discrimination, and social exclusion were never addressed in the curriculum (Müller 4–5). Müller's findings additionally reveal that curricula failed to teach students how to take a proper sexual history from LGBT patients (6). Müller argues that "[h]istory-taking and health prevention based on the heteronormative assumption that patients only have sex with people of the opposite sex risks not addressing the specific sexual risk behaviours of LGBT people," in addition to missing a crucial opportunity to provide educational resources to LGBT patients in regards to safe sex practices (6).

Insufficient LGBTQ-based health curricula—and thus ignorance and prejudice amongst practitioners—is not limited to any one field of medicine. The authors of "Dental Students' Regard for Patients from Often-Stigmatized Populations: Findings from an Indian Dental School" discuss Indian dental student attitudes towards LGBT orientations, in addition to "HIV-positive status, substance misuse, intellectual disability,

[and] acute mental illness" (210). I believe it is important to include studies such as this one, as they indicate practitioner attitudes outside of the vague "general practitioner" category. The authors claim discrimination and prejudice continue to plague the health care professions—despite a social justice emphasis in the code of professional ethics—and assert that "dentistry is no exception" (Madhan 210). Madhan et al.'s survey certainly proves this assertion: it was discovered that "students… had the least regard for LGBT individuals," rated only borderline positive in comparison to all other "stigmatized populations" included in the survey—which all received considerably positive scores (214). The authors state that the dental school environment has often proved inadequate "in its comfort with and support for LGBT individuals," citing a 1992 study that found dentists more likely to abstain from providing health care based on sexual orientation, compared with medical personnel (Madhan 211). In its concluding statements, the authors insist that an increase in adequate education, as well as greater experience with LGBT patients, could improve the environment significantly. The authors recognize that India's "conservative social milieu" contributes to prejudices in matters of sex and sexuality, but it is clear from the previous articles that these attitudes are common globally, and not only in countries with particularly conservative belief systems (Madhan 214).

Fiona Clark's article "Discrimination Against LGBT People Triggers Health Concerns" discusses discrimination and its impact on LGBT health from a legal perspective, in addition to examining sociocultural contributions. The piece focuses on HIV as an LGBT health disparity, and the legal barriers to treatment and prevention of the disease in many countries around the world. Threatened with 10+ year prison sentences (Kenya, Senegal), or in some cases the death penalty (Nigeria, Sudan, Iran, Saudi Arabia), LGBT individuals are often not receiving the care they need (Clark 500). Like many scholars contributing to efforts in LGBT health research, Clark stresses the gross lack of data and accurate estimates pertaining to the HIV-positive population, citing this as the core of the problem, an "epidemic we're missing because we don't know the true numbers" (502). From Cameroon to Kazakhstan, Russia to the U.S., this is a global health problem, and without a serious effort within the medical industrial complex to dismantle stigma around the LGBT population, development goals will fail to be met and more importantly, suffering will persist, and lives will be lost (Clark 502).

Nils Daulaire's "The Importance of LGBT Health on a Global Scale" provides a succinct overview of current health care barriers faced by individuals who identify as LGBT. The author echoes the message of other scholars when he suggests that it is virtually universal for this demographic to face barriers—though what these barriers look like will vary widely depending on religion, race, socioeconomic status, ability and so on. Daulaire recommends the World Health Organization (WHO) as the ideal location to begin the process of eliminating health disparities among LGBT populations through the broad implementation of common elements that could "promote access to health care and reduce stigma and discrimination" (Daulaire 8).

To promote this conversation, an agenda item on LGBT health was endorsed by the U.S. Department of Health and Human Services (HHS), Thailand, and Brazil (Kates). This item outlines "inequities experienced by LGBT persons in accessing health services" and suggests actions to address these inequities (WHO 3). Suggestions include removing transgender from the Mental and Behavioural Disorders chapter of the International Statistical Classification of Diseases and Related Health Matters, taking measures to ensure greater access to comprehensive services for men who have sex with men to address HIV transmission, and prompting global-level studies to increase understanding of LGBT-related disparities in health outcomes (Kates). However, consideration was deferred when the item was first introduced in May of 2013, faced by strong opposition from a number of countries in the Middle East and Africa. The topic was intended to be considered once more in January of 2014, but was once again rejected. Currently, it remains unclear when the agenda item will once again be reconsidered (kff.org). Though the WHO may theoretically be ideal for addressing LGBT health disparities, Daulaire's piece makes it clear that, for the time being, alternative, local-level solutions may be more effective.

The results of the studies explored in this subsection indicate that health care curricula, policy, and procedures that explicitly address the needs of LGBT (and sometimes "Q") patients are few and far between. The decision to decenter or altogether exclude the needs of such marginalized populations in health care not only fails to remedy the health disparities of diverse queer and trans populations, but also perpetuates these disparities. This dearth of even a *base level* of cultural competency makes the health care environment a toxic one—not just for queer and trans patients, but for everyone accessing (or attempting to access) health services.

Asexual Competency in Medicine

Although there are a number of barriers to establishing asexual-competent health care, there is arguably one overarching problem from which the rest of these barriers stem. Eunjung Kim's chapter of *Against Health: How Health Became the New Morality* entitled "How Much Sex is Healthy? The Pleasures of Asexuality" sets the stage for the primary tension between asexuality and health. Kim explains that

> Physicians, public health practitioners, and 'pro-sex' activists may agree that sexual drive is a natural, healthy, and essential aspect of the human. Health risks related to sexual activities are often highlighted by these individuals, but the idea that willingness and capability to have sex reflects and promotes a person's psychological and physiological health is widespread in Western contemporary culture. (157)

Because of this widespread understanding of "sexual activeness as healthiness," asexuality becomes an indicator of abnormality, and "reflective of poor health" (Kim 157). Despite the regulation of expressions of sexuality by society, widely documented by Foucault, compulsory sexuality nevertheless prevails (Kim 157) According to asexuality scholar Dr. Kristina Gupta, compulsory sexuality

> describe[s] the assumption that all people are sexual and… describe[s] the social norms and practices that both marginalize various forms of nonsexuality, such as a lack of sexual desire or behavior, and compel people to experience themselves as desiring subjects, take up sexual identities, and engage in sexual activity. (132)

Compulsory sexuality—and the alignment of sexual activity with well-being—therefore complicates the potential for asexual competency in medicine. Kim explains that "[t]he way we understand desire and the relationship between sex and health are rarely simple" and because of this complexity, it is a mistake to conflate asexuality with ill-health because "it obscures the diverse and ordinary aspects of asexual experience" (157, 159). Understanding the barriers that compulsory sexuality present in the health care context is critical to a thorough analysis of these systems, as well as to the future development of asexual-competent care.

In my research of asexual-identifying folks' interactions with and trepidations about the medical industrial complex, one of the more common concerns and complaints among online forum participants is in regards to therapy and counseling. Though there were of course mixed experiences, many posts described the ways in which therapists or counselors were simply ill-equipped to discuss asexuality with their asexual-identifying patient, or outright invalidated the identity via pathologization approaches. Stacey Anne Pinto's "ASEXUally: On Being an Ally to the Asexual Community" does something that is clearly needed—introduces basic information on asexuality as an identity and establishes a conversation about the differences between identity and disorder *specifically geared towards an audience involved in counseling* (given that it is published in the particular journal that it is).

Pinto brings greater visibility to key issues, recognizing that "[b]asic counseling principles suggest that it is easy to… break trust with… [and] inhibit the growth of a new or existing relationship with someone who identifies as asexual by making assumptions about their behavior or expression" (339). It is important for counselors and counseling scholars like Pinto to insist that "given the nature of asexuality, one can infer that asexual individuals are at a higher risk for intimate partner sexual or physical abuse" and ask necessary questions like, "whether more people would identify as asexual, or along the asexual continuum, if it was more commonly acknowledged as an acceptable, understood identity" (Pinto 340). Pinto's approach to this topic is compassionate and reaffirms that counselors should always "strive to be on the forefront of social justice and advocacy" (341). However, the author admits that a great deal of research has yet to be conducted, and Pinto's own case studies, included in this article, are limited—there are only two brief case studies which consider diverse aspects of sexuality and gender, but fail to acknowledge the interaction of race, class, language and more.

In their article "Mental health and interpersonal functioning in self-identified asexual men and women" Yule et al. suggest that, faced with social stigma akin to that faced by lesbian, gay, and bisexual individuals, asexual-identifying people likely "experience higher rates of psychiatric disturbance that have been observed among these non-heterosexual individuals" and as such are in need of, in a sense, a 'culturally competent' mental health services and support (137). The study focuses on "mental health correlates and interpersonal functioning," and the results of an analysis in these areas reveals that both asexual men and women are, perhaps unsurprisingly, more likely to report anxiety, depression, and psychoticism than their "non heterosexual counterparts" (Yule et al. 138, 144). In their limitations section, Yule et al. bring attention to the fact that "asexual participants have, in the past, felt compelled to curtail their responses to queries about psychiatric symptoms, in an attempt to downplay any potential relationship between [the two]" and thus the already significant findings of this study could potentially be "under-representative of the severity of mental health issues among asexual participants" (148).

The authors note further gaps in existing research when they articulate that "[p]revious research investigating asexuality and correlates of mental health is scant, and more direct comparisons, for example, to other sexual minorities, are warranted (Yule et al. 138). The researchers also recognize the noticeable lack of racial and ethnic diversity reflected in larger demographic surveys of the online asexual community, yet they make little to no effort to interrogate why this might be. In fact, Yule et al.'s study seems content to simply let these gaps continue, as their participant pool was limited to "Caucasian" asexual people. This was, apparently, "to avoid differences in ethnic groups obscuring any potential differences in mental health among sexual orientation groups" (Yule et al. 138). However, I find this approach disconcerting—multiply marginalized populations are further pushed to the margins in the name of seeking more "straightforward" outcomes. Like any identity, asexuality is not an island—it is shaped by and informs other aspects of an asexual individual's life. In the next section, I explore literature on disability and neuro-atypicality to further solidify this need for asexual research's commitments to center not on isolating aseuxality, but on interrogating its intersections.

Disability and Neuro-atypicality

Although implementing training and programs to cater to LGBTQ health is absolutely crucial, it is important to remember that to focus only on “fixing” gender and/or sexuality—by any meaning of the word—is ineffective. Madhan’s dentistry study suggests that marginalized sexuality is often regarded, to some extent, as “self-inflicted,” both by the general public and some providers (Madhan 214). In addition, LGBTQ individuals are often perceived through medical discourse to be “contaminated” with or “crippled” by their gender and/or sexuality. These perceptions have contributed to a complex, decades-long tension between LGBTQ individuals and individuals with disabilities, drawing a thick line between what are, in reality, heavily overlapping communities. This tension is also present between asexual individuals and individuals with disabilities—each community struggling to gain validation for their members’ diverse identities and experiences without contributing to the pathologization of the other community.

Alison Kafer’s *Feminist, Queer, Crip*, which imagines new futures for disability and disabled bodies, addresses this tension and calls for greater coalition-building efforts. Although *Feminist, Queer, Crip* is an incredibly rich and instrumental text in many ways, I am particularly moved by Kafer’s exploration of coalition building between crip/disability activists and other marginalized communities. Much of what she describes parallels ace (asexual spectrum) experiences—and not only parallels, but overlaps. Kafer begins the book with two very important statements about the health care industrial complex: first, that “medical framings of disability are embedded in economic realities and relations" and second, that "medical beliefs and practices are not immune to or separate from cultural practices and ideologies" (6). Kafer argues that what is sorely needed "are critical attempts to trace the ways in which compulsory able-bodiedness/ able-mindedness and compulsory heterosexuality intertwine in the service of normativity" (17).

In her concluding chapter, Kafer refers to Bernice Johnson Reagon and her description of "forming coalitions across difference [as] both necessary and terrifying" (151). I agree with this sentiment wholeheartedly, but I also think that between ace and disability/crip activists (and probably in other potential coalitions as well), the terror has multiple roots. One of these causes is the discomfort Reagon mentions of having our "founding assumptions" challenged, but there is also a fear of association—a fear of being labeled as the same as those with whom one is building coalitions, rather than having the choice to self-identify as such (151). For example, as a neurodivergent person who also feels a sense of belonging with the ace community, I am made to feel that by putting these two identities into conversation with one another, I run the risk of invalidating one or both of them. This pressure to keep certain identities separate is sometimes perpetuated by other aces, but more often by those outside marginalized communities who are attempting to enforce certain categories. In both cases, this stems from the fact that neurodivergent folks have too often been unjustly desexualized, while ace individuals have been thought of as "mentally ill," disabled, or "broken." Kafer argues that "a coalitional politics requires thinking disability, and disabled bodies, differently" (17). When willingly put in conversation with asexuality (a conversation which is currently on-going), both disability and asexuality have the potential to expand their parameters, their objectives, and their futures.

Rehabilitation—in medical and social contexts—is often considered an ideal solution for restoring both queer and differently abled people to a state of stability, defined by dominant cultural attitudes. Robert McRuer makes this connection in his book *Crip Theory: Cultural Signs of Queerness and Disability* when he discusses “[t]he twentieth century dream of rehabilitative return” (103). McRuer suggests that these dominant cultural attitudes are dependent upon both identity and rehabilitation—two concepts, he notes, “that are not always as far removed from each other as they might appear” (McRuer 109). Transgender individuals in particular are viewed in this way when hormonal and surgical treatments are considered “therapeutic and life saving” (MacKenzie 73). The end goal then, is to use the power of “rehabilitation” to “fix” “broken” individuals so that they may conform to socially acceptable gender and sexuality norms. This perpetuates ableism, and establishes the medicalization and policing of LGBTQ bodies.

McRuer explains the aforementioned dual effect on LGBT bodies in his metaphor of the “rehabilitative contract,” stipulating that, “in return for integration, no complaints will be made, no suggestions for how the world, and not the… body or mind, might be molded differently” (McRuer 112–113). The contract silences the “rehabilitated” individual by asking them to forfeit autonomy in exchange for societal acceptance. This contract is built upon an unspoken Western sex and gender code which defines “normal individuals” as those who “develop a gender identity, a gender role, a sexual preference, and a life based on the sex of their genitals" (MacKenzie 62). It is precisely this mentality that must be deconstructed and eradicated before any LGBTQ health curricula, training, procedures, or policies can have a legitimate chance at success—not simply bandaging damage caused by overarching societal stigma, or attempting to "fix" the "problem" of the LGBTQ population, but instead awarding such individuals dignified and quality care.

Eunjung Kim's interdisciplinary article, "Asexuality in Disability Narratives" is one of few pieces of scholarship to thoroughly examine disability and asexuality together in a way that directly challenges "the tendency to deny any connection out of fear that the stigma associated with one might attach to the other" (480). Kim thus reveals the thoroughly entwined relationship between sexuality and normality (480). In addition, Kim makes an important distinction between asexuality as an identity, and *imposed* asexuality, or desexualization, and suggests that rather than denying any possibility of overlap between asexuality and disability, recognizing such lived experiences can uncover the ways in which this desexualization also "intersects in specific contexts with features of certain other groups, including women, elderly people, transgender people, and ethnic minorities" (480–81).

Kim describes the ways in which "[c]laims for the sexual rights of desexualized minority groups mistakenly target asexuality," and therefore perpetuate a kind of universal assumption that sexual desire is a necessary aspect of empowerment (490). The author firmly and directly challenges "the assumption that being sexual is compulsory as a prerequisite for being normal," but also insists that asexuality must be respected as a form of sexual diversity, and a right that should be granted to both disabled and nondisabled people (Kim 485, 489).

Asexuality Studies: Queer Legacies and Asexual Foundations

Eve Kosofsky Sedgwick's *Epistemology of the Closet* is today considered a foundational text of queer theory. The central theme of the piece—an approach which rather than complicating binaries by building off of these dichotomous divides, simply deconstructs the contradictions of such binaries until their structures are crumbling—is also highly applicable to theorizing around asexuality. Sedgwick argues that much of Western culture revolves around the false binary of homosexuality/heterosexuality (1). Within the centering of this false binary is an assumption of sexual attraction as inevitable; Therefore, one must be sexually attracted to someone—so what does this mean for asexual individuals? By this definition it would seem they fall entirely outside this futile debate. At the same time, sexuality/asexuality becomes another false binary—like homosexuality and heterosexuality, sexuality and asexuality are not symmetrical opposites. It is for this reason that we see resistance in the ace community, to some extent, by presenting asexuality as a spectrum, and complicating attraction by separating the romantic and sexual.

Sedgwick notes that "the deadly elasticity of heterosexist presumption" means that queer people, with every encounter "find new walls springing up around them"—walls that erect new closets which necessitate the queer individual's 'coming out' time and again (68). This is something I see happening in the ace community, for similar but different reasons. In the case of asexuality, the individual must always be ‘coming out’ in resistance not only to heteronormativity, but sexual normativity. But whereas Sedgwick emphasizes the ‘coming out’ narrative as applying primarily to gender and sexuality—the “crossing of an axis of sexual desire by an axis of gender,” asexual individuals must often also come out romantically, particularly if they identify as something other than heteroromantic (i.e. pan/bi-romantic, aromantic, homoromantic, et.) (239). In Chapter 3 of *Epistemology of the Closet*, Sedgwick discusses David Halperin. Of particular interest to me was a quote from *One Hundred Years of Homosexuality* which states,

> That sexual object-choice might be wholly independent of such ‘secondary’ characteristics of masculinity or femininity never seems to have entered anyone’s head until Havelock Ellis wages a campaign to isolate object-choice from role-playing and Freud… clearly distinguished in the case of libido between the sexual ‘object’ and the sexual ‘aim.’ (Halperin 16)

I am interested in the power of isolation to which Halperin refers (an isolation of sexuality from masculinity/femininity), as isolation (of sexual attraction from romantic attraction, and attraction from libido) has recently become a powerful tool in destabilizing the assumption of sexuality within identity constructs. Sedgwick also claims that identification and desire are “closely linked in many or most relationships,” which she argues as a way of contradicting one of the differentiations between heterosexuality and homosexuality (159).

Sedgwick’s style (and in my opinion an excessive and unnecessary use of jargon) makes her work often difficult to dissect, and its context of having been written in the late

80s and still based in rather binary ways of thinking about gender, can make it difficult to draw parallels between the themes of *Epistemology of the Closet* and contemporary understandings of asexuality. However, there is much left to interrogate within this text, which has great potential to aid in a dismantling of the sexual/asexual binary, and indeed a more general questioning of the definition of sexuality and its perceived link(s) to identity.

"New Orientations: Asexuality and Its Implications for Theory and Practice," a foundational piece of contemporary Asexuality Studies literature, explores the ways in which asexuality might be considered theoretically feminist or queer and, conversely, how feminist and queer theory could be challenged by asexual logics. In particular to this latter point, the authors interrogate how asexuality as identity "potentially challenges feminist conceptions of sex and female sexuality," and suggest that asexuality, from a theoretical standpoint, is "especially conversant with radical feminism, pro-sex feminism, and the oppositional discourse that characterizes both (Cerankowski and Milks 655, 656). The two authors, as indicated in this foundational work, have since published an anthology of writings which today serve as a backbone for asexuality scholarship.

Cerankowski and Milks' piece is one of the first to articulate, from a feminist perspective, how "the presumption that all cases of disinterest in sex are pathological is what has contributed to the pejorative flavor of the word 'asexual'" and indeed one of the earliest works "to consider asexuality as it relates to identity, orientation, and the politics of an asexual movement" (653, 651). The authors imagine a "feminism that acknowledges asexual identity" as two-pronged (Cerankowski and Milks 657). The first prong is to utilize asexuality "to critique the liberatory rhetoric by which sex is still to a large extent framed within feminism," and the second "is to theorize modes of asexuality that are or can be feminist, likely beginning by extending the work of radical feminists" (Cerankowski and Milks 657). Although I do partake of this approach to some extent in my own theoretical foundation, discussed at the end of this chapter, I diverge from the suggestion to extend radical feminisms, perceiving this movement to be a typically white-dominated one. Thus, to link asexuality so directly to this particular movement would likely only serve to perpetuate whiteness in such spaces. Cerankowski and Milks emphasise that existing research on asexuality is certainly "open to criticism, revision, and expansion" and call for further analysis with "a more in-depth cross-disciplinary/interdisciplinary approach to the topic," which I endeavor to undertake in this thesis (654).

To conduct the type of analysis for which Cerankowski and Milks call, it is necessary to have an holistic understanding of asexuality's progression as an identity throughout recent history. Ela Przybylo's "Producing Facts: Empirical Asexuality and the Scientific Study of Sex," explores the body of scientific research on asexuality using a feminist lens. The article moves from the late 1970s to 1990s, a time Przybylo calls the "prehistory of asexuality," to the present day (226). Przybylo uses these findings to track the status of asexuality in research and the ways asexuality becomes "'discovered', mapped, and pursued by science" (224). This allows the author to posit asexuality as both "culturally and historically contingent" and increasingly normalized and de-radicalized (Przybylo 225). Przybylo suggests that earlier studies' "negligence towards asexuality reminds us that asexuality, like all sexualities, is not immutable and ever present in a self-same form" and perhaps more critically posits that the so-called "discovery" of asexuality "is not neutral, value-free, and apolitical" (229, 230). The author examines the ways in which the "territory claiming and boundary drawing… around asexuality is a form of sexual colonization" in that it falsely identifies "whole sexual realities" for groups of certain people (Przybylo 229). Przybylo's piece suggests that there is a high price to pay for the "legitimization and depathologization" so many desire (231). This cost, she explains, takes form as a "rehearsal of limiting and normative standards of gender, as well as a veritable binding of asexuality to the body" (Przybylo 231).

In "Crisis and Safety: The Asexual in Sexusociety," the author articulates how, despite the work of scholars like Foucault and Butler who have rather thoroughly exposed sexuality as one of many social constructs (and, I would add, the work of disability studies scholars and women of color scholars examining enforced desexualization), "sexual identity construction continues to be permeated by essentialist impulses" (Przybylo 445). Przybylo calls for a genuinely resistant and radical asexuality, and for asexuality to "repeat itself differently, plurally, and complexly" to achieve this aim (Przybylo 457). The author presents a "speculative and… provisional theory around the question of whether or not asexuality (as an identity category) may be considered genuinely transgressive" and ultimately calls for a reworking of "asexuality's reactive definition to reflect more accurately its subversive potentialities for plurality," calling for a more heightened awareness of the ways in which asexuality is always a product of culture (Przybylo 455, 457).

Notably, Przybylo articulates the “sexusociety” in which we currently live, and how the knee-jerk reaction to pathologize under-performers of sexuality, “or who do not repeat sexuality faithfully to ‘the norm’, is indicative of which repetitions are favoured by sexusociety” and reveals the ways in which sexusociety perpetuates a particular structure “that repeats along sexual lines” (449). Because asexuality “reveals the phantasm of the sexual project, unveiling the ‘natural’ to be an imitation,” the author suggests we are incorrectly lead to believe that asexuality is inherently radical in its challenge of commonly accepted logic, asexuality’s current reactive, binarized state, asexuality functions to anchor sexuality, not alter its logic” (Przybylo 451, 452).

Bishop’s “A Mystery Wrapped in an Enigma—Asexuality: A Virtual Discussion,” from a thematic issue of the journal *Psychology & Sexuality*, collates the responses of several Asexuality Studies scholars to a set group of questions—thus creating a “virtual discussion.” I find this approach intriguing—though it does not admit this, the collaborative effort to pose this piece as a virtual discussion seems to draw upon the structure of the kinds of online spaces where asexuality is most often talked about. Of particular interest to my own research are questions three and six, the former asking, “How can researchers disentangle asexuality from diagnostic entities such as ‘hypoactive sexual desire disorder?’” and the latter asking “What directions do you expect asexuality research to take over the next decade?” (Bishop 198).

In the conclusion of the piece, the article’s author highlights themes that emerged from this virtual conversation. One such theme that stood out to me both as a scholar, and as an individual who identifies with both ace and disability communities was Bishop’s suggestion that “presenting well-adjusted members of the asexual community through qualitative methods [in research], is needed to help pressure the developers of the DSM-V” to make distinctions between identity and disorder (205–6). This statement stands in stark contrast with Kim’s “Asexuality in Disability Narratives,” which argues against the “tendency to deny any connection out of fear that the stigma associated with one might attach to the other” (Kim 480).

Mark Carrigan’s “There’s More to Life than Sex? Difference and Commonality Within the Asexual Community” details the findings of his “mixed-methods qualitative study of self-identified asexuals utilizing semi-structured interviews and online questionnaires, as well as an analysis of asexual forums, websites and blogs” (465). Carrigan explains how both he and previous researchers, including Ela Przybylo, “suggest that qualitative methods can have an important role to play in supplementing previously purely quantitative approaches to the study of asexuality” (464). Carrigan calls for “[a] recognition and understanding of [asexual] diversity, as well as the commonalities which facilitate it” as a foundational aspect of asexuality research (464–5). The author cites the “curious” trait of asexual communities that are “simultaneously facilita[ing] the articulation of individual difference and the solidification of a communal identity” (470). Though Carrigan touches on this interesting dichotomy, like Bishop and other asexual scholars mentioned in this chapter, Carrigan’s approach is hardly intersectional. The author is focusing specifically on identity formation, but the gaps in his research are many when we consider the ways in which multiple identities intersect on both the individual and structural level. As scholars studying asexuality and its many forms, we should not only be asking how people come to identify as asexual, but also who these individuals are outside of this one identity factor, and what this could mean for accessibility to support and resources for a homogenous versus heterogenous community.

Ianna Hawkins Owen attends to exactly this intersectional shortcoming in her scholarly work—and provides a counter for Bishop's somewhat ableist argument—focusing specifically on the crossroads of asexuality and race. In an interview with *The Asexual Agenda*, Hawkins Owen describes a persistent challenge with online ace communities like AVEN, and their "collective readiness to pursue … what is 'just like everybody else'," or what is essentially identity politics. The scholar explains that while this may be an effective tactic with mainstream (read: white) media, "we have to consider whether this comes at the expense of other, more productive alliances" (Hawkins Owen). Unfortunately, much of Hawkins Owen's work is currently unpublished in the formal sense of the word, though she has presented her work at many conferences and lectures nationwide. She is active in online ace communities, and is one of too few scholars and ace community members discussing the racialization of asexuality. Hawkins Owen's work is critical to exposing the dearth in literature interrogating this intersection, and the lack of value awarded to online scholarship by the academy.

Although the author does have a chapter published in the aforementioned collected essays of *Asexualities*, it is the interview shared by *The Asexual Agenda* which has been particularly key in shaping this thesis project. In the interview, Hawkins Owen addresses tension present in online ace communities, where "[o]ften, white asexuals and those who do not identify themselves use [comment] threads to make statements that, 1) AVEN is a safe, diverse environment, 2) AVEN is a race neutral place and asexuals are color-blind, or 3) race is anachronistic, un-important or itself 'racist'." She critiques these problematic tendencies in online ace discourse, explaining that they "work to minimize the significance of race, to obscure 'white' as a race by claiming neutrality, and to dismiss user interests or lived/digital experiences." Because I strive to incorporate such intersectional considerations in my work, Hawkins Owen's critiques of online ace discourse are central to my own analysis of the discourse, as well as my own reflections on the limitations of this thesis.

The tensions between these numerous asexual scholars—Bishop and Kim, Carrigan and Hawkins Owen—are indicative of larger conversations taking place not just between scholars of asexuality, but also within and across various asexual communities. Asexual communities and research have not been impervious to identity politics, and this becomes increasingly evident when one begins to examine online discourses. Although asexual activists and community members online have made significant efforts to allow for fluidity of identity, there is nevertheless a very strong urge present to naturalize asexuality in particular ways, as a means to gaining visibility and acceptance from larger queer communities, and from society more generally. It is these kinds of identity politics that I seek to address using the theoretical framework described in the next section of this chapter.

An Ace Archivist's Theoretical Framework

It is clear from the aforementioned literature that implementing programs to improve perceptions and understanding of LGBTQ populations is a crucial first step in addressing health disparities in the LGBTQ community. It is also incredibly clear that far more data must be collected—and more accurate data, at that—and synthesized to effectively address these issues. Nearly every source I reference in this chapter mentions a severe dearth of comprehensive and relevant literature. However, research on LGBTQ health needs to implement theoretical frameworks that will truly benefit the LGBTQ population, and there seems to be a relative consensus among gender, sexuality, and public health scholars that this research framework must invoke intersectionality theory. Intersectionality theory is defined as "a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression… at the macro socialstructural level" (Bowleg 1267). Madhan et al. argue that an interdisciplinary approach in collaboration with other health care professionals is desirable as a means to motivate students to "recognize and disentangle the multiple layers of stigma" associated with LGBT identity and other marginalized groups (Madhan 215).

Madhan et al. are not the only scholars calling for an intersectional approach. Carmen Logie, in her piece, "The Case for the World Health Organization's Commission on the Social Determinants of Health to Address Sexual Orientation," recommends the Commision on the Social Determinants of Health (CSDH) implement an intersectional approach—not only taking sexuality into consideration, but examining the "interactions between identity categories" already included in the list, such as social position, education, occupation, income, gender, and ethnicity/race (1244). In addition, Lisa Bowleg's piece "The Problem With the Phrase Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health," outlines three core tenets of intersectionality theory that can most benefit public health: the perspective of social identities as multiple and intersecting, establishing these social identities as the "focal or starting point" for research and policy, and recognizing the ways in which the "micro level of individual experience" intersects with the "macro, social structural level" to produce disparate health outcomes (1267). Bowleg also points to the necessity of examining health of marginalized and complex populations in its own context, from its own vantage point, as opposed to in relation to the "norm" of the white middle-class (Bowleg 1268–9).

Continuing the support of intersectional thinking, Labuski and Keo-Meier, in critiquing research on transgender issues in their article "The (Mis)Measure of Trans," suggest an approach to research that focuses on the intersections between trans identity and other social hierarchies. To achieve this type of methodology, my work in seeking to collect data on ace populations and develop health care solutions for this demographic must include my own voice as a scholar who identifies as a part of the communities I discuss, and can offer solutions based in first-hand knowledge and experience *in addition to* traditional academic research and analysis.

Given what I have described in this and previous sections, the question remains—what form and approach should research on asexual health take, exactly? It is my opinion that although applying an intersectional lens is certainly one piece of the necessary approach, it is not enough on its own to address the challenges faced by a diverse asexual population. After all, the medical industrial complex has been built from the ground up on a settler colonial narrative that depends upon a normal/abnormal binary as a means to police and/or disappear certain bodies. To address such a powerful and multifaceted tradition of oppression entwining a myriad of institutions (including academic ones), it is necessary for researchers exploring the topic of queer health to get creative. In my particular situation, as a feminist, queer, ace researcher focusing on the health needs of asexual individuals and communities, this theoretical creativity is critical because the existing theory upon which I can draw that explicitly addresses asexuality is sparse. My approach to theoretical creativity has been informed by both my personal and professional experiences: as a student, an instructor, a researcher, and—as I describe below—as an archivist.

Beginning my second year as a master's student in Women, Gender, and Sexuality Studies at Oregon State University, I was hired for a part-time position at the Oregon State University Queer Archives (OSQA). Since its founding in 2014, the archives have hired a student worker to assist in archival work, as well as act as liaison to the wider Oregon State community. Aside from being a graduate student with limited income and needing another job to support myself, I saw the archives position not only as an opportunity to take part in meaningful work, but also to consider my position as a scholar and activist within these queer histories. As a scholar doing research on asexuality, the concept of having a formal archive from which to derive inspiration and information is merely that—a concept.

There have been traces of asexuality in research for decades now—for example, Kinsey's "X" category in 1948 and 1953 reports documenting those who had experienced "no socio-sexual contacts or reactions"—but the main body of research would be considered recent by most standards. It was not until 2004 that asexuality research began on a more intention level, when Anthony Bogaert, a professor at Brock University, published "Asexuality: Prevalence and Associated Factors in a National Probability Sample." Online discourse around asexuality, the area upon which my own research focuses, is also a relatively small collection of posts and discussions, most of which follow the establishment of the Asexual Visibility and Education Network (AVEN) in 2001, first via the Myspace page of founder David Jay, and then on its own web platform.

I feel a great responsibility in both my scholarly and activist endeavours to contribute to the asexual archive—to contribute to present asexual organizing and movement-building, and to emphasize the value of this contemporary work as future history. With little archive to speak of, asexual scholars and activists must ground ourselves in a diverse array of histories, take responsibility for our present, and continually situate our minds and bodies in a way that allows us to imagine asexual futures. Though we certainly have allies supporting us in these endeavours, it should also be recognized that larger oppressive structures will not likely be eradicated overnight, and so we must accept that some of this work will have to be done within the system, and without much assistance. In other words, as June Jordan so beautifully articulated in her *Poem for South African Women*, “we are the ones we have been waiting for.”

My first major task as an archives worker was to process our most recent acquisition. The After 8 Records had recently been donated by a local community member and co-founder of After 8, an LGBT activist group which operated in Corvallis, Oregon in the 1990s. In undertaking this project, I could not have anticipated just how much I would learn in a situation where, for the first time, I was essentially being paid to research. Through this experience, I became entrenched in a process of exploration, organization, and introspection. The timing for this project was particularly poignant—as I began the task, Donald Trump had just taken his place in the White House. The experience of processing the After 8 Records gave me perspective on local legacies of queer activism and bolstered my own desire to participate as an activist in this volatile political climate. Thus, the theoretical framework for this thesis, has been in large part shaped by the discoveries and imaginings which arose from my work in the archives.

(Re)imagining the Archive

The primary work which has informed this archival theoretical framework—titled “Asexual Resonances Tracing a Queerly Asexual Archive,” and written by Danielle Cooper and Ela Przybylo—builds bridges between asexuality, feminism, and queer theory to question and expand “current definitions and possibilities of both asexuality and queerness” (298). In particular, this interdisciplinary exploration is executed via the central question of “why the exclusion [of asexuality from feminist and queer politics]?” which allows the authors to consider how asexuality challenges the “centrality of sex to feminist and queer politics" and come to a greater understanding of "what has been at stake in the neglect of asexual articulations and perspectives by queer theory and the feminist movement" (298). However, the authors make it very clear that they are not arguing an expansion or revision of queerness, but instead a sort of comprehensive reimagining or reworking of queerness from asexual perspectives (298).

Cooper and Przybylo divide current asexual archives into two "interconnected and mutually informing" bodies—the "truth archive," comprised of scientific literature, and the "vernacular archive," compiled by web pages, blogs, new coverage, as well as non-scientific literature (299–301). Through this division, the authors articulate the many ways in which asexuality is articulated as unchanging, a non-choice, as a means to visibility and acceptance, but is therefore made un-queer by theses ideologies. The article presents an approach to theorizing about asexuality that articulates an assemblage of "personal asexual archives" to encourage an interrogation of "public and personal disinterest in asexuality [that] leads to broader questions" outside of standard identity strategies (311). The authors acknowledge that the broad understandings of asexuality—or "asexual resonances"—engaged with in this article are "not attuned to the intersections of asexuality with disability, heterosexuality, race, spirituality, nationalism, and age or to asexuality in non-Western, premodern, or nonsecular contexts" and ask how "an analysis of asexuality transnationally would engage with and radically disrupt the queerly asexual methodology" they themselves introduce (311). I also wish to interrogate here how these concepts of the archive may still be falling short of a radical reimagining.

As someone who has been formally educated in the U.S., for much of my life it has been a natural tendency to value certain forms of participation, knowledge, and documentation. According to postmodern theorists (and evident in my own experiences), the U.S., as well as the West more generally, is a logocentric society—one which puts a strong emphasis on traditions of formal speech and writing in expressing external realities. Queer and other alternative archives in the U.S. have begun to resist this kind of ideology, but it nevertheless persists—sometimes in subtler ways. For example, in “Cultivating Land-Based Literacies and Rhetorics,” Gabriela Ríos explains that, even if these alternative spaces are more frequently turning to other forms of knowledge-creation, there nevertheless exists a common practice which “reduces extradiscursive phenomena to text” and “sustains a ‘textual fetishization’ that turns non-discursive objects into text (Ríos 66). For those us of indoctrinated into a Western system of knowing, it is easy to fall into this kind of mislead and harmful “translating” of archival materials. In prioritizing alternative ways of knowing in archival work—both literal and metaphorical—we instead must draw on a “paradigm that can account for the transfer of meaning without reducing the body to a text or a performance into a narrative” (Ríos 67).

Even as someone who has tried to resist dominant and persisting Western ideologies in my work, Ríos’ cautionary remark was somewhat of a wake-up call, and I hope to pass along the message to other asexual scholars and archivists, so that we may come to a better understanding of the ways in which we might continue and expand upon reimaginings of the “archive” accomplished by queer archives and oral history projects, but more holistically by women of color scholars and activists like Ríos. In addition to using an archival theoretical framework informed by women of color critiques, the methodology employed for this research—discussed in the next chapter—also strives to resist a settler colonial definition of the archive.

(Re)embodying the Archivist

In the process of reimagining the archive—and situating the library in social justice contexts—it follows that we must then reimagine the role of the archivist and the archivist-researcher, and ask who is called to embody this role. Although not all archives exist within libraries, the Oregon State Queer Archives do happen to be nestled under the Special Collections & Archives Research Center (SCARC), located at the university's Valley Library. Regardless of their physical location or relationship however, archivists and librarians share a number of key roles and responsibilities. For both positions, part of our "power lies in our ability to select and organize resources that support research and scholarship" (Pagowsky and Wallace 197). Librarians and archivists are "uniquely equipped and empowered to define and redefine systems of knowledge that convey 'truths' about what we know about the world" and thus, it can be argued that we have a particular responsibility to harness this information literacy for social justice (Pagowsky and Wallace 197).

Librarians themselves, authors Nicole Pagowsky and Niamh Wallace argue for precisely this kind of social responsibility in their article "Black Lives Matter! Shedding Library Neutrality Rhetoric for Social Justice." Like many feminist scholars bringing so-called "objectivity" into question, Pagowsky and Wallace warn against constructing the library as a “neutral” space, and urge librarians to recognize the ways in which institutional racism and white privilege make neutrality impossible to achieve or maintain, a “false construct” (198). Instead, the authors suggest that librarians ask “how our collections, organizational schemes, interfaces, instructional practices, and learning objects impact our communities” to make way for an intentional “[p]ositioning the library as anti-racist, anti-sexist, and anti-oppression” as a practice which allows librarians to “stay at the heart of the community” (Pagowsky and Wallace 198, 196). It is therefore critical for those of us engaging in this work, including those who archive in online communities, to be honest and intentional in our discourse, and our use of literacy. To return for a moment to Ianna Hawkins Owen’s interview with *The Asexual Agenda*, “by acknowledging the violence involved in race dialogue (or gender dialogue or sexuality dialogue or ability dialogue, for that matter) we are more honestly situated to grapple with the very real consequences of entering into dialogue/posting/what-have-you.”

What Pagowsky and Wallace are calling for—a commitment to social justice on behalf of academic librarians—can be further contextualized using Indigenous understandings of both time and responsibility. For example, in doing the kind of social justice work these librarians suggest, Cherokee author and community organizer Zainab Amadahy’s concept of a “relationship framework” is useful because it stresses webs of connectivity rather than isolated neutrality (Briarpatchmagazine.com). This kind of relational framework allows us to “see our roles and responsibilities to each other as inherent to enjoying our life experiences” and through this to “challenge a dehumanizing social organization that perpetuates our isolation… and normalizes a lack of responsibility" (Walia 51).

To fully comprehend this kind of responsibility and connection—and to reimagine both the archive and our place in it—entails a different understanding of time than the one commonly utilized in Western society and culture. In his foreward to *Two-Spirit Acts: Queer Indigenous Performances*, Native playwright, novelist and songwriter Tomson Highway notes that "the superstructure of pantheism," the structure upon which many Indigenous belief systems are built, "is a circle… a yonic design" (xvi). Within this design, there is that which is animate and that which is inanimate. The animate, those with souls, "sit on the circle of the living" and when they die, they "get 'translated' onto a concentric circle, the circle of the non-living" (xv). In this understanding of time, when we die, we essentially "go nowhere" and our energies are instead relocated to a slightly different location on the circle (Tomson muskratmagazine.com). The concept of life as circular in this way drastically alters the way time is constructed and perceived. History becomes volatile, the future even more so. Conceptualizing time as a complex, multidimensional web gives us the ability to understand ourselves not just as descendents and comrades, but as ancestors, and to accept the responsibility that comes with this role.

Aurora Levins Morales' work can help us begin to understand the significance of our ancestral responsibilities—to consider how librarians and archivists can use the tools of information literacy to heal. In "The Historian as Curandera," from her book *Medicine Stories*, Levins Morales expands upon the kind of critique of neutrality that Pagowski and Wallace employ when she states that "failing to take sides when someone is being hurt is immoral" (Levins Morales 37). Furthermore, Levins Morales points out that "[a]ll of us use some process of selection" in telling stories and as such, storytelling is not a neutral practice (Levins Morales 25). Due to a centuries-long practice of invading the "historical identities of the subjugated" and emphasizing "an imperial version of our lives," Levins Morales articulates that the role or responsibility of a "socially committed historian" is to "use history… to restore to the dehistoricized a sense of identity and possibility" (24). Although Levins Morales speaks of this responsibility specifically in regard to historians, I believe she also suggests that this responsibility extends to other positions of power. Whether we are theorists, historians, archivists, or librarians Levins Morales' call to employ "medicinal" histories should not be ignored (Levins Morales 24).

Aurora Levins Morales claims that we are all storytellers and so must each strive to become historians as curanderas or healers—I have suggested that this responsibility clearly applies to librarians and archivists as well. And so, to extend this concept of responsibility in archival work even further, I posit that we must consider the ways in which we are *all* archivists, whether or not we are perceived—or perceive ourselves—to have significant power. With this mindset, and given the significant lifespan of information and contributions online, those who participate in online activism and discourse assume the responsibility of maintaining a heightened level of spatial and temporal awareness. What this looks like will vary, but for me, this kind of digital archival work as curanderismo is twofold. First, I commit to being intentional about who and what I give my support to online (through liking, sharing, and other modes of online interaction). Second, I recognize the immense power of words and the potential for these words to gain near-eternal physicality in online spaces. I commit to taking special care with what I set free online, and to updating such work when I have outgrown it. Archival work as curanderismo is no small feat, but I believe it is a practice accessible to all who wish to take on the responsibility.

As I have discussed in this section, Pagowsky and Wallace suggest an envisioning of information literacy "as a holistic practice rather than a more singular focus on skills," and that this can be accomplished by centering women of color, their communities, and their commitments (199). As a researcher engaging with online archives, I have centered women of color theorizing to develop a theoretical framework which positions archival processes in the context of healing and responsibility. This theoretical framework uses theory as a form of coalition building, and enables me to center the voices of scholars from diverse backgrounds in Black Feminism, Indigenous and Queer Indigenous Studies, as well as Disability Studies and Crip Theory, to both enhance understandings of ace identities among academics and health care providers, but also to complicate understandings of these identities within ace communities.

This theoretical framework is applied to situate the research questions within a much larger cultural and historical context when considering how ace individuals approach and navigate discussions about their health and what the relationship between asexual identity and the ways one accesses health care looks like. In addition to addressing these questions, this theoretical approach grants me the ability to ask: How can asexual activism and community building learn from previous mistakes of dominant LGBT and queer movements to make asexual communities authentically inclusive and self-aware? What can we as ace individuals do to avoid continuing harmful settler colonial approaches that have damaged Native communities for centuries, and erased the lives of queer Indigenous and Two-Spirit people? In what ways can we intentionally decolonize sexuality in organizing and community building that seeks recognition of asexuality in current systems like that of the health care system? If we can implement critiques of settler colonialism and actively decolonize constructions of gender and sexuality, the ace community can not only learn from the harmful white-centering of dominant LGBTQ movements, but also strengthen some of the arguments against the naturalization of sexuality that the ace community has already been making—in a way that intentionally avoids reifying oppressive structures.

Digital Literacy: Rooting Online Ace Activism in Women of Color Stories

One of the ways in which we resist logocentric approaches to the archive lies in literacy. In Jacqueline Jones Royster's text, *Traces of a Stream: Literacy and Social Change Among African American Women*, the author explains that by exploring literacy in regards to African American women, she is "in effect extending a call to readers for other ways of reading… for a shift in paradigms in research and in scholarship, or for other ways of analyzing and composing" (12). Throughout the text, Royster solidifies the ways in which African American women have historically and continue to master and reimagine literacy as a channel to identify and solve problems, to expertly articulate their views and sociopolitical commentary, to "get critical jobs done," and to inspire others to assume the mantle of change (240). I use the concept of "literacy" (in a loose sense) to build upon Jacqueline Jones Royster's framework—examining how the cultural contexts which have shaped both African American and Indigenous women's literature now shape their online media presence, and what we can learn from their varied approaches.

Royster defines literacy as "a sociocognitive ability… to gain access to information and to use this information variously to articulate lives and experiences and also to identify, think through, refine, and solve problems" (45). Of course, on a more basic level, literacy is defined only as the ability to read and write, but this is only one of many definitions Royster examines, and based upon her own provided definition, it is clear she tends to lean more heavily on literacy as a specific competency or knowledge. Royster's definition is open, making it applicable to a great deal more than the traditional writings of African American women upon which she chooses to focus. Thus, Royster sets up a framework full of possibility for digital literacy in asexual communities, and the asexual activism it may produce.

Royster's breakdown of the characteristics of the essay, the format traditionally and historically prefered by many of African American women writers since the 19th century, is invaluable. The author identifies the following constant characteristics of the essay:

1. The writer is self-authorized.
2. The "I" perspective is foregrounded.
3. Knowledge and understanding are grounded in experience.
4. There is a sense of a mind at work.
5. The thinking is exploratory, unfinished, open-ended.
6. The writer recognizes a listening audience and expects response.

> 7. The writer invites skepticism and thereby situates the text as going quite appropriately against the grain of current practice.
> 8. The text is situated in time and place and is thereby responsive to its context—the material realities of time, place, and the person/writer
> 9. The writer's knowledge, experience, and insight can intersect in variable ways
> 10. The form itself is protean [ever-changing, versatile, adaptable] and lends itself easily to an incorporation of a full range of expressive and organizational devices. (23)

Each and every one of these characteristics, I argue, is shared with multiple forms of online authorship, but with social media genres in particular. However, I recognize the concept of literacy, and the essay specifically, has been used both as a tool for and a weapon against African American women, and marginalized communities more generally. This also applies heavily to online genres, which serve as breeding grounds not only for social justice, but also for violence and hate.

Angela Haas' chapter entitled "Toward a Decolonial Digital and Visual American Indian Rhetorics Pedagogy" describes the ways in which the "hegemonic homogenous fiction" of a monolithic Indigenous identity is being interrupted by American Indians and allies who are "engaging in digital and visual storytelling" by drawing upon oral and visual traditions (205). Haas argues that by "writing themselves into digital and visual spaces and histories," American Indians challenge colonial rhetorics and create a space in which we can "make, remake, and unmake the world" (205). Drawing upon Royster's foundation and viewing countless examples of African American women spearheading countless contemporary social movements (perhaps #BlackLivesMatter most noticeably), it becomes clear that this digital world-making is also being supported by other communities of color.

Just as colonial logics have "placed literacy in a privileged position and orality in a deficit position," so too does this logic discount the language of social media (Royster 44). In a digital realm where "funky punctuation substitutes for conversational cues" to convey the kind of emotion traditionally transmitted through speech, those writers who come from traditions of oral storytelling are therefore more likely to be literate in digital languages (Puschak). Royster touches on this many times throughout *Traces of a Stream*, noting that "in African American communities, classical rhetoric has been most vibrantly internalized in community practices through oratory, such as preaching," and illustrates that Alice Walker's essays demonstrate that this "is indeed a well-internalized organizational building block" (30). If Royster argues that oral traditions have undoubtedly influenced the overall 'look and feel' of African American women's writing, it stands to reason that these influences continue to have effect, not just upon the traditional or academic written word, but upon a myriad of online genres.

In her article entitled "Rhetorics of Survivance: How American Indians Use Writing," Malea Powell essentially makes the claim that the master's *rhetorical* tools will never dismantle the master's house when she says "the language in which this struggle is named… is itself a trap, an integral part of the rhetoric of empire" and calls for a new language that "allows us to imagine respectful and reciprocal relationships (41). The complex rhetorical approach of "survivance" detailed by Powell, and the creativity of both African American and Indigenous rhetorics more generally are so valuable to online social justice work and writing (Vizenor, Powell). Conversely, online platforms provide a key space in which to "undo what Jacqueline Jones Royster and Jean C. Williams call 'primacy'—the status given to 'official' (that is: dominant) viewpoints" (Powell 41). These scholars suggest that because Western viewpoints are rooted in colonial logics, literacy informed by these logics is not enough for social justice work, and in fact may be working in opposition to it.

Let us return to Gabriela Ríos for a moment, and her concept of the repertoire of embodied practices and performances. Ríos is adamant in insisting that "[t]he relationship between the archive and the repertoire is not inherently binary," a perspective which lends itself well to thinking about digital activism as both archive and repertoire. Ríos calls scholars to "think beyond our disciplinary norms to account for the repertoire of embodied meaning-making practices that… is vital to creating and sustaining social change" (Ríos 68). As a response to Ríos' call to action, in this section and the next, I discuss the ways in which digital activism (and the digital literacy that informs it) has become an embodied practice and performance for many activists of color, and ultimately consider how this repertoire could be further centralized in other segments of online activism—namely that of asexual communities.

Although research on digital activism has examined both its "networked and connective character" and engaged in debates "about the question of organization and leadership" in such movements, media and communications scholar Guobin Yang points out that this previous study of digital activism has neglected to examine the narrative form of agency (13). This particular focus is key in understanding the ways in which movements like #BlackLivesMatter have been informed by legacies of women of color activism—as I have outlined in the previous section and as Yang says “like works of literature, social movements have narrative forms” (Yang 14). Yang argues that “[i]n contrast to ‘traditional’ forms of digital activism” like online petitions, “hashtag activism has a distinctly narrative character” (14). Thus, it stands to reason that activist genealogies rooted in practices of storytelling—like Indigenous and African American ones, for example—are better positioned for success in digital activism.

Digital activism assumes a narrative form when “comments and retweets consist of numerous personal stories and appear in temporal order” thus making *narrative agency* central to hashtag activism specifically (Yang 14). Yang defines narrative agency in hashtag activism “as the capacity to create stories on social media by using hashtags in a way that is collective and recognized by the public” (14). Like the beaded wampum belt used by the Eastern Woodlands tribes of the Indigenous people of North America which serves as “a living rhetoric that communicates a mutual relationship between two or more parties,” these digital “[n]arrative forms have agency because they ‘invite’ audiences, readers or listeners to participate in the co-production of stories” (Haas 80, Yang 14). In the case of #BlackLivesMatter and other hashtag activist movements, the addition of the hashtag sign to a word or phrase harnesses hypertextual practice to make searching, linking, and interacting with one another easier (Yang 14).

Royster—as well as Powell, Hass and the rest of the scholars featured in this section—provide a fruitful foundation from which we can build our social media tactics in asexual activist communities—perhaps now more crucial than ever, with a Twitter-ing U.S. President who has arguably mastered a particular narrative agency in his Twitter literacy. Just as #BlackLivesMatter and other women of color-led digital activism has revealed the potential of online spaces for social justice, so does Donald Trump exemplifies that narrative "agency can be malign, divisive, and destructive," as well as "protean, ambiguous, [and] open to reversal" (Campbell 7, 1). Although there is much positive change to be accomplished through digital activism, we must also be intentional in these practices, as "the openness of the narrative form makes it susceptible to perversion" (Yang 14).

Conclusion

In this chapter, I have explored relevant literature, including works on the current status of LGBTQ health policies and procedures and asexual-competency in health care; articles considering the intersections of disability, neuro-atypicality, and asexuality; and general scholarly work on asexuality and the queer scholarship which has preceded it. In addition, I have outlined my theoretical framework—an archive-oriented strategy which allows me to approach this research in an intersectional manner, considering the emergent topics of this research within a larger context of systemic marginalization and resistance. In the next chapter, I continue the discussion of feminist research informed by women of color critiques, and outline my methodological framework—Critical Discourse Analysis.

Chapter 3: Research Methodology

Introduction

The overarching objective of this research is to better understand the varied approaches taken by medical professionals in their interactions with ace-identifying people, and what impact these approaches have on the overall health of this population. Furthermore, this research seeks to analyze the ways in which ace-identifying individuals and their online communities discuss health and wellness *amongst themselves*, and what this discourse indicates about the rhetoric(s) which dominate online asexual spaces. The ultimate purpose of this project is to provide tangible examples to medical professionals of how their approach and/or language may be (intentionally or unintentionally) damaging to their ace-identifying patients. To achieve this purpose, the research must be useful to organizers and activists seeking not only greater visibility for ace-identifying individuals, but also seeking growth within ace community-building and movement-building strategies.

In this chapter, I begin with a brief history of my research methodology to provide context and outline its structure to rationalize its application for this particular process. Following this, I detail how the research has been inspired and shaped by online ace community members, and describe the virtual worlds in which these community members discuss, develop imagine, and provide support. I then present my sampling and selection criteria, the analytical techniques or methods used to derive meaning from the collected data, and some of the challenges that accompany online research. The chapter ends by considering my positionality not only as a researcher, but also as a member and beneficiary of online ace communities.

Discourse Analysis Approach

To address the research objectives of this project, I have employed Critical Discourse Analysis (CDA) as my methodological approach. I have tailored Critical Discourse Analysis to analyze the specific relationships involved in this research project, the conversations that happen within the myriad contexts of these relationships, and the dynamics of power and privilege present in these conversations. Critical Discourse Analysis was born from "critical linguistics" and was most notably developed by scholars Norman Fairclough and Ruth Wodak (Fowler and Kress 185). Critical linguistics was, in part, created in response to the shortcomings of sociolinguistics, which at the time gave little thought to matters of social hierarchy or power, and generally considered discourse as neutral, "designed merely to elicit information" (Fowler and Kress 186). Through the introduction of this new analytic framework, a greater awareness was fostered, centered on the idea that "linguistic meaning is inseparable from ideology, and both depend on social structure" thus revealing the potential for linguistic analysis to act as "a powerful tool for the study of ideological processes which mediate relationships of power and control" (Fowler and Kress 186).

Part of the value in Fairclough's early outlines for CDA is that they are fairly straightforward and broad enough to be widely applied:

> As Fairclough perceives CDA, discourse analysis aims to systematically explore opaque relationships of causality and determination between (a) discursive

> practice, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power; and to explore how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony. (Lisay 3)

Using Fairclough's model of CDA, I analyzed the collected online discourse in a multi-tiered fashion. Fairclough describes CDA as "the analysis of relationships between three dimensions or facets of [a communicative event]" (57). These three facets are defined as *text*, *discourse practice*, and *sociocultural practice*. Through the first tier (text) I examined posts for the surface-level information—namely, what the original poster (OP) or commenter has articulated about their interactions with others in a health or health care context. These narratives were compiled—along with any responding posts which also articulate personal health and health care experiences—to identify commonalities (themes) across multiple posts on multiple platforms. These themes included the relationship between asexuality, mental health, and disability; pathologization of asexuality not only via hormone discourse but also discourse around clinical depression; and an inconsistent understanding within asexual communities of what exactly the impact is of other identities intersecting with asexuality.

In employing the second tier (discourse practice) I looked for what is more deeply rooted and less apparent—the systems of power and oppression at play. This process entailed identifying the systems of power and privilege present in (1) the patient-practitioner discourse, and (2) the OP-commenter discourse. It is important to note that I observed the OP-commenter relationship and discourse firsthand, while I can only know the patient-practitioner discourse as it is described by the OP or commenter sharing the story. In the third tier (sociocultural practice) I considered what the specific language and phrasing utilized in these posts indicated about the larger dynamics and assumptions within online asexual communities, and the ways in which these communities organize for social change. While the second tier enables me to identify sub-themes, and more thoroughly consider the micro, the third tier makes outward connections, and allows for a macro perspective to be introduced.

In addition to applying CDA in this research project, I also strive to make my methodological approach a feminist one. Although it addresses sociocultural structures and the power dynamics present within and between these structures, CDA is not automatically a feminist methodology. In fact, since the late 1980s, many feminists have "opposed the idea of there being distinctive methods or methodologies" (Doucet and Mauthner 40). However, Doucet and Mauthner point out that, "over the past decade, a large body of scholarship has laid out some key underlying principles that are central to much feminist research" (40). These principles include (1) methodological innovation which challenges traditional (i.e. Western) ways of collecting and analyzing data, (2) making broader social change and social justice central to the research, (3) recognizing and attending to power imbalances between researcher and participant, and (4) practicing self reflexivity (Doucet and Mauthner 40–41).

As a researcher committed to feminist praxis, I have attempted to draw on each of these four key principles in my application of CDA through my choice and application of methods. First, by focusing this project in online discourses specifically, I seek to challenge methodological practice within the academy which too often dismisses social media as a valid site for data collection. This practice of methodological innovation also includes prioritizing personal narratives and other forms of storytelling, and centering the voices of women of color. Second, I center broader social justice issues by considering the health consequences of asexuality intersecting with other marginalized identities. The third and fourth principles, which are generally intertwined, are addressed in the following section, where I reflect on my positions of power and privilege both as a researcher, and as an individual.

Positionality

I have been an active user on Tumblr since March of 2011, on Reddit since January of 2015, and on AVEN since February of 2016, but I have participated in online communities of all kinds—America Online, LiveJournal, MySpace, YouTube and more—from a very young age. As someone who has grown up with one foot in these virtual worlds, I consider myself to be a "netizen" fairly well-versed in the dynamics of these online spaces. Admittedly, asexuality, and considering myself to be a member of the asexual community, are relatively new concepts to me. Like many ace-identifying folks, I was introduced to asexuality after the age range when one typically considers and questions their sexual orientation. Thus, I now consider myself a member of the ace community, but I do not have a considerably long history in this regard.

I have had many privileges in life—my racial identity, class, and access to education have inevitably had an influence on the ways in which I have conducted, analyzed, and now present this research. I have, like anyone, also had my fair share of challenges—particularly in regards to health, both mentally and physically. These experiences have instilled in me a commitment to challenging the medical industrial complex, and to work for a system of health and wellness services that is accessible and recognizes the dignity of all patients. I believe in centering the voices of the most marginalized in our society, and within our communities. The voices of women of color and queer and trans people of color, as well as their silences, tell stories of both oppression and resilience; I believe that to achieve social justice in healthcare, it is critical to prioritize these stories.

In this particular project, I am drawing solely on existing online discourse, rather than utilizing a survey where I can ask direct and tailored questions. One of the benefits to this approach is that discourse will not have been impacted by my biases as a researcher, or by potentially leading questions—although my interpretation and analysis of these will undoubtedly be influenced by my own positionality. This approach to data collection additionally means that I am less likely to know a significant amount about the identity of the OP or respondents in the comment threads aside from their asexuality. I also recognize that only certain kinds of people can access internet regularly to participate in these kinds of online discourses, and I am only identifying and analyzing discourse in English. According to ITU, the United Nations specialized agency for information and communication technologies (ICTs), as of the end of 2016, 3.9 billion people, or 53% of the world's population was not using internet (ITU 2). In addition, internet "penetration rates" are higher for men than for women in all regions of the world

(ITU 3). ITU defines "penetration rate" in this context as the "number of of [sic] women/men that use the Internet, as a percentage of the respective total female/male population" (ITU 3).

These statistics provide important context for understanding who exactly makes up the "community" or "communities" I describe in the next section of this chapter. The discourses occurring online—in this case within online asexual community spaces—are being participated in by a minority of the population, which is going to have a significant impact on the content and therefore on my analysis. Therefore, in addition to stating my own positionality in regards to this research, it is also critical to note these characteristics about the community/communities being discussed.

Community Collaboration

As stated previously, much of this research project was designed in response to public calls for a greater understanding of asexual health, as well as my own conversations with other ace-identifying people. My early investigations into this topic were heavily informed and directed by ace community members on Tumblr because, prior to beginning this research project, I reached out to members of my community to ensure my own priorities and hypothesis were aligned with theirs. I became fully engrossed in the topic of asexual health when a noted ace community member and activist who is widely followed on Tumblr and other social media platforms reblogged a post I made on my own Tumblr for a class project. The Tumblr post ultimately received over 100 notes (likes and reblogs), and I was contacted by more than 20 ace-identifying Tumblr users who shared their thoughts, experiences, and social activist priorities with me. The support for my research was overwhelming, and I hope the work I have done on this project will in turn benefit those who have supported me.

Without social media, this research project simply would not have been possible. Because the visibility of asexuality is extremely low in comparison to other sexualities, and because formal queer spaces have been inconsistent in welcoming ace-identifying people, nearly all of the community-building that has occurred for these populations thus far has taken place online. This is beneficial to my research because there is already a comprehensive and well-documented archive of discourse taking place within ace communities. Furthermore, when we consider the larger picture of this platform, "[s]ocial media is a discursive system where social issues are enacted through textual discourse… where social practices develop [and] linguistic techniques can be employed to analyse such data" (Lisay 1). Understanding social media in this way, and recognizing these key traits, it becomes clear that social media is an ideal site for data collection and analysis that uses CDA.

Although social media is constantly being developed and adapted by young people around the world, and thus has taken on many progressive characteristics and causes, it continues to perpetuate many of the social dynamics and inequalities present in our larger societies. CDA, when applied to critical online discourse such as that occurring in ace communities, "bring[s] to light the exhibited behavioral patterns that reflect [a] population's stance on an issue" (Lisay 1). Furthermore, it reveals the systems of power and privilege at play both within this population, as well as in the larger context of interaction with healthcare professionals.

Website Selection

According to “a continually updated average of each [social media] website's Alexa Global Traffic Rank, and U.S. Traffic Rank from both Compete and Quantcast,” the top ten social media platforms are, from highest rank to lowest: Facebook, YouTube, Twitter, LinkedIn, Pinterest, Google+, Tumblr, Instagram, and Reddit (ebizmba.com). Facebook, as a platform where many share a more complete picture of their identity with friends and family, was determined to not possess a significant concentration of ace-related discourse. Additionally, much of this discourse is password protected, making it private information not suited to this study. Because of their overall design, both YouTube and Twitter are also lacking a hub or concentrated area of ace-related discourse and were not suitable for the purposes of this study. LinkedIn is primarily used for business-related networking, and both Pinterest and Instagram revolve around visuals, rather than text. Thus, these social media platforms were also not suited to the kind of discourse analysis I sought to perform.

After these exclusions, only Reddit and Tumblr remained from this top ten list as suitable for the approach this research sought to undertake. Reddit is a social news and media aggregate founded in 2005 which in 2015 alone saw 725.85 million comments made by 8.7 million total authors made on Reddit’s 88,700 active forum groupings called subreddits (redditblog.com). The site has an estimated unique monthly visitors count of 85 million (ebizmba.com). Reddit has six separate subreddits that focus specifically on asexuality-related issues—r/Asexual (5,238 subscribers), r/Asexuality (12,784 subscribers), r/AceTeens (335 subscribers), r/AsexualMen (438 subscribers), r/Aromantic

(1,424 subscribers), and r/Demisexuality (3,019 subscribers). In the interest of maintaining focus and clarity, only the two largest subreddits, r/Asexual and r/Asexuality, were used in collecting data for this research project.

Founded in 2007 and today boasting over 330 million unique blogs in 17 different languages, Tumblr is typically described as a "microblogging" and social networking website (tumblr.com/about). The site has an estimated unique monthly visitors count of 110 million (ebizmba.com). Tumblr's structure is vastly different from forum sites like Reddit. It is design-oriented and centers on personalized individual blogs where users interact with one another through liking, sharing, and adding comments to others' posts. It is therefore much more difficult to discern how many asexuality-focused blogs exist or how many Tumblr users are interacting with these asexuality-based blogs. However, my research has revealed that there are, at minimum, at least 50 Tumblr blogs dedicated to asexuality-related issues in a wide variety of areas—from BDSM to K-pop, fashion to fanfiction.

In addition to data collection taking place via Tumblr (tumblr.com), and Reddit (reddit.com), the Asexual Visibility and Education Network, otherwise known as AVEN was also identified as a viable platform. Founded in 2001, AVEN claims to host "the world's largest online asexual community as well as a large archive of resources on asexuality," and is the oldest of the sites used in this research project ("Home" asexuality.org). The centerpiece of AVEN is their web forum, which "provides a safe space for asexual and questioning people and their partners, friends and families to discuss their experiences" ("About AVEN" asexuality.org). In addition to English, AVEN has website branches and forums in Chinese, Czech, Dutch, Finnish, French, German, Hebrew, Italian, Japanese, Norwegian, Polish, Portuguese, Russian, Spanish, Swedish, and Turkish. Unfortunately, statistics on AVEN's forum membership are few and far between. A semi-official count in 2012 found that there were approximately 35,000 members, while a more recent statistic posted by one of AVEN's own members put the number of users at 119,000 in 2014. Regardless of the exact count, AVEN is widely considered to be the foundational block of the online asexual community, and remains central to this day.

Though the website selection process was very specific, the "participant" selection was intentionally kept fairly broad. This study centers around the voices of online community members who identify anywhere on the asexual spectrum. The population upon which this study focuses has had no other restrictions—all ages (18 and above), gender identities, ethnic groups have been considered. Online members of AVEN, and those posting to the asexuality-focused communities on Tumblr and Reddit, were assumed to identify somewhere on this spectrum unless otherwise stated. If relevant postings also happened to contain other demographic information (i.e. the member's location, nationality, and various other identities), this was also recorded, though this additional information was not always disclosed. To achieve comprehensive data collection, and because I am limited in knowing the true and complex identities of many online contributors, the data also includes several online posts made by self-identified partners, friends, and allies of ace-identifying individuals, though these make up a negligible percentages of the data.

Procedures

When this research was originally developed, it was unclear whether or not Institutional Review Board (IRB) approval would be needed to proceed. I submitted my application to IRB in late September of 2016, and after meeting with IRB members, it was determined in early October that the research did not involve human subjects, and was therefore exempt. This determination came about when it was decided that the password protected forums on AVEN would not be necessary to collect sufficient data. All posts on Tumblr and Reddit are available to the public, and are therefore not considered private according to IRB standards—it is from these sources that direct quotes or identities may be collected to include in the final publication with permission from the contributor/author/activist. Only some forums on AVEN require a login to access, and it is these posts that may be considered private by their OPs and commenters and must therefore be protected. None of the OPs of these private forums were contacted, and research data from AVEN was only acquired without a login, which automatically censored out any private content.

Although the study was exempt from IRB review, I took measures to respect the contributions of community members, per feminist research principles. Any online research is accompanied by a number of unique challenges in regards to ethics and informed consent. For example, the use of direct quotes taken from the public sources used for this project could make any blog and forum contributors vulnerable to online harassment. Regardless of pseudonyms used in the thesis, these quotes could be run through a Google search to locate the quote and identify its speaker. At the same time, it struck me that paraphrasing the quotes could have the unintended effect of withdrawing credit from the online community members who authored them. To mediate these challenges in conducting the research project, I ultimately decided to include usernames and direct quotes in my findings to respect the intellectual property of these contributors, and ensure credit was given to these extremely valuable contributions. It was determined that the benefits outweighed the potential risks involved in including these details, and that this approach more directly recognized and grappled with my subjectivity as a researcher.

As previously discussed, in conducting this research, I have used an explicitly qualitative approach to collect data, synthesizing observation with a critical discourse analysis on existing online blog and forum posts. According to Teun A. Van Dijk, critical discourse analysis “primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context” (352). The researcher conducting a critical discourse analysis thus takes an “explicit position” in their work “to understand, expose, and ultimately resist social inequality” (Van Dijk 325). The “explicit position” of myself as a researcher lends itself well to maximum variation sampling, a strategy which

> aims at capturing and describing the central themes or principal outcomes that cut across a great deal of participant or program variation. For small samples a great deal of heterogeneity can be a problem because individual cases are so different from each other. The maximum variation sampling strategy turns that apparent weakness into a strength by applying the following logic: Any common

> patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program. (Patton 172)

The basic principle behind this kind of sampling is to gain greater insight into a phenomenon, examine the phenomenon from all angles, identify common themes across the sample, and perhaps most importantly, to resist erasure of other marginalized identities which intersect with asexuality (i.e. race, class, dis/ability, etc.).

Although no comprehensive demographic data has been collected from the asexual population as a whole, AVEN's census data indicates that their own asexual population is hardly diverse. The preliminary findings of the 2014 AVEN census (the most recent census accessible to the general population) revealed that 85.9% of census participants were citizens of white-majority nations (i.e. Australia, Canada, Germany, U.S., U.K.), and 77.3% of census participants identified their race as white (Kame Ginoza et al. 5). These numbers are highly indicative of a larger dynamic of race, nationality, and language impacting representation and dominant voices in online ace communities. Therefore, as a researcher I see it as necessary to employ methods such as maximum variation sampling so that the research may push back against relatively apathetic attitudes towards this lack of diversity.

Identifying the Discourse

The search terms utilized to locate and identify topical posts can be divided into three distinct but overlapping categories:

- Various titles for medical practitioners (i.e. “doctor,” “physician,” “gynecologist,” “psychiatrist,” “psychologist,” “therapist,” and “counselor”)
- Types of healthcare services (i.e. “therapy,” “counseling,” “mental health,” “hormone treatment,” “women’s health,” and “gynecology”)
- General and broadly-used vocabulary (i.e. “hormones,” “health,” “healthcare,” “health care,” “medical,” and “medication”)

These search terms were developed based on the language used in and priorities gleaned from previous discussion and collaboration with online community members. Terms or concepts which appeared with the greatest frequency in these early discussions were deemed to be most effective in locating further documented discourse on the topic of this research project.

After identifying posts containing these keywords, I then narrowed my selection to those contributions that discussed either direct interactions with health care and health professionals, or described interactions with friends, family, and other relations that pathologized asexuality or otherwise suggested that a medical intervention was needed. I excluded posts from asexual or questioning forum or blog contributors asking for medical advice from online community members. The number of posts in this category is significant, and so an analysis of these specific interactions has potential to be explored in future research. However, some of the rhetoric and identity politics present in the latter posts, as well as present in the former, are addressed in my discussion section when considering what these online discussions suggest for the present and future of movement-building for asexual communities.

Conclusion

In this chapter, I have provided a brief history and structure of CDA to justify its application as a methodology for this research project. Due to the nature of analyzing pre-existing discourse, and the support from ace communities prior to this research project, the data collection process has been fairly simple and straightforward. As stated previously, there already exists a substantial asexual archive on Tumblr, Reddit, and AVEN; This research seeks to tap into the archive, to value the stories told in such online spaces, and to consider the systems of power and oppression present within. In the next section, I describe the themes and sub-themes which emerged from the collected data and its subsequent analysis, using the principles of an explicitly feminist application of CDA.

Chapter 4: Findings

Introduction

In this chapter, I present the research findings and analyze the collected data to address the research questions: (1) How do ace individuals approach and navigate discussions about their health with friends, family, and health professionals? and (2) What is the relationship between asexual identity and the ways one accesses health care? This chapter is divided into five sections; The first section provides a survey of the data collected from each platform (AVEN, Tumblr, and Reddit), reviews key facets of the data collection process, and explains the process of coding used as a foundation for the analysis. Each platform is then divided into a subsection, where I spend time describing each platform and its community separately, highlighting the key differences between the experiences, discourses, and online cultures of each platform. By providing the general impressions from each platform, my intention is to avoid essentializing the experiences of asexual-identifying people and their communities, as well as to provide a rich context for each platform's discussion.

The four sections which follow the overview each represent one of four themes that emerged across all three platforms. These sections seek to unify the varied experiences of asexual-identifying individuals with health care and medical practitioners contributing to a myriad of online discussions. The themes are as follows: (1) "coming out" in the health care context, (2) medical and cultural understandings of virginity and their relation to asexuality, (3) patient-practitioner relationships of mistrust, and (4) asexuality's intersections with other marginalized identities.

Data collection and analysis was completed using maximum variation sampling. To “maximize the diversity relevant to the research question[s],” a small number of cases have been selected to understand how various phenomena are “seen and understood among different people, in different settings and at different times” (Cohen D). The larger themes described below emerged from significant commonalities among experiences and their accompanying discourses. In the final theme, I center specific narratives which, rather than representing an overarching experience, instead highlight the diverse experiences of asexual-identifying individuals—many of whom also expressed being multiply marginalized. These narratives resist a whitewashing and “mainstreaming” of asexuality, and are indicative of key intersections of asexual identity and experience. It is this final section that critical sub-themes emerge, setting the tone for the discussion chapter that follows.

Overview of Findings

Table 1: Coded Statements from AVEN, Tumblr, and Reddit Combined

Type	Percentage
Neutral	15%
Negative (General)	50%
Negative (Pathologizing)	13%
Negative (Corrective)	5%
Positive	17%

Using the search terms outlined in the previous chapter, relevant data was collected across the three platforms of Tumblr, Reddit and AVEN. This data included:

- 29 unique posts to the two asexual-focused sub-Reddits /r/asexual and /r/asexuality, each containing a thread of responses ranging in number from two to 37 comments—the median number of comments for this sample was 15.
- 18 original Tumblr posts, almost all of which belonged to unique Tumblr users. Tumblr's microblog design is unique—centering a main feed consisting of singular posts from individual blogs. This design meant that I did not have a thread of direct text responses to include. Instead, I took into consideration how many "notes" each of these posts received, as this documents the number of times other Tumblr users interacted with this post, including the number of "likes" and reblogs (which sometimes include a comment added by the user reblogging the OP). These notes ranged from six to 4,802, with a median number of 85 notes. In addition, any reblogs that contained comments were included in the data.
- 8 unique AVEN forum posts, each containing a thread of responses ranging in number from 4 to 72, with an overall average of 20 responses. It is likely this grouping was smaller due to the password protection of most of AVEN's forums. This small group nevertheless provided important insight into asexual health more generally, as well as the specific online culture of AVEN's community.

Thus, across all three platforms, over 600 unique comments were documented (via screenshots) and considered for this analysis. Comments discussing health and wellness topics but not describing interactions with medical practitioners were ultimately discarded, though this content has much potential for future research. After going through all of the collected data, I identified 146 statements describing interactions with medical professionals.

The purpose of this study was not to collect demographic data—however, some relevant trends nevertheless emerged during data collection. Although contributors did not always note their age, the ages listed ranged from 15 to 30 years old. This aligns with the most recent census data from AVEN, which found the median age of census respondents to be 21 years old, with a mean age of 22.45 years old (Kame Ginoza et al. 2). In the discourse collected for this thesis, contributors almost never directly mentioned their race or nationality in their forum or blog post; When it was mentioned—or listed in their profile—these demographics also aligned with the race and citizenship data collected by AVEN in the 2014 census (i.e. most were from white-majority countries like the U.S., U.K., and Australia). The majority of contributors identified as asexual, while a much smaller number identified as either demisexual or grey-asexual. Additionally, when gender was discussed or listed by contributors, the majority identified as women, with a smaller number identifying either as men, or as transgender or nonbinary.

To organize the data, and extract overarching themes, interactions described by OPs (original posters) and commenters were coded as neutral, negative, or positive. Positive and negative posts were coded as such based on their explicit use of positive or negative language. Positive posts included emotive expressions of happiness, pleasure, contentedness, and excitement (i.e. “I really like my doctor”). Negative posts included expressions of dismay, frustration, irritation, shock, pain, and displeasure (i.e. “Having to deal with this is really upsetting”). If the post contained neither positive nor negative language, and the OP or commenter remained purely factual rather than emotive in their contribution, the post was coded as neutral.

A single post often contained a variety of these codings, since it was common for a single experience to encompass a range of both positive and negative discourses. Furthermore, a single post almost always described more than one experience or interaction with medical practitioners. Thus, the discourse was grouped by type of interaction. Because the majority of described interactions were at least in some part negative, it was necessary to differentiate between (1) a generally negative discourse, (2) a negative discourse which specifically involved pathologization of asexuality, and (3) a negative discourse where some form of "corrective" therapy was prescribed. The frequency of each coding type across all three platforms can be seen in Table 1. In the next section, I present the findings from each platform separately, and consider possible trends contributing to these findings.

AVEN: Impressions and Observations

Table 2: Coded Statements: AVEN (29)

Type	Percentage
Neutral	21%
Negative (General)	58%
Negative (Pathologizing)	7%
Negative (Corrective)	0%
Positive	14%

Compared to the Tumblr and Reddit posts considered for this project, the tone of the discourse on AVEN's forums leaned towards academic and analytical. Given AVEN's founding in 2001, it is possible that the overall discourse has had more time to mature than those discourses found on the other two platforms. Members of AVEN are also intentionally seeking out and participating in a platform designed specifically for asexual individuals to discuss asexual topics, and are thus more likely to feel confident in their identity on the asexual spectrum. Furthermore, unlike Tumblr or Reddit which house a myriad of diverse communities, AVEN's website is strictly focused on the spectrum of asexuality (as well as the spectrum of aromanticism).

In the forums analyzed for this thesis, AVEN contained relatively high levels of self-pathologizing discourse, in the sense that forum contributors often speculated about connections between neurodivergence or neuro-atypicality, and asexuality or aromanticism. Neurodivergence is generally used to refer to developmental disabilities, while neuro-atypicality was established by the autistic community and then adapted by other communities to refer to neurological disorders. Many OPs and commenters were explicit in stating that their neurodivergence or neuro-atypicality had absolutely no connection to their asexuality. Although this need to separate asexuality from disability is certainly steeped in identity politics, I believe it also indicates a heightened awareness of the "asexual archive" I discuss in my theoretical framework.

As an archival space, AVEN is far more intentionally curated. After all, the site's central goals, included in its name, are to provide educational content on asexuality as a way of garnering visibility, acceptance, and support. With archived polls and census data, AVEN’s members tend to exhibit a heightened awareness of the “asexual archive,” and their role as curators. Posts and comments leaned more towards the rational, rather than the emotional; When experiences with health care practitioners were discussed, members were more likely to rationalize or philosophize why these practitioners were resistant or simply clueless to asexuality. These conversations considered the history of discourse on asexuality, and its prevalence in more dominant societal and medical discourses. For example, when one AVEN member expressed concern that her psychologist had mistakenly diagnosed her with Asperger’s due to behaviors linked to her aromantic identity, another member responded:

> I think a lot of times people expect health care providers to be mind readers, and mental health providers most of all. All they have to go on is the combination of our presentation, our affect, and what we choose to tell them/ not tell them. They are trained to make assessments and recognize patterns. Those patterns aren't clear the minute we walk in the door, and sometimes an assessment is just that: an assessment. If you say something that may be significant, she would be remiss not to examine it further. It may be that the line of assessment ends up leading to nothing; it may not, but that doesn't mean it's wrong or unnecessary. (SaturnOOO)

In the same forum thread, yet another AVEN member gave his opinion on the state of psychology and its relationship with asexuality:

> My impression is that since people didn't really start to talk much about asexuality until 10-15 years ago, there's a good chance many older doctors

> simply haven't heard of it, and are likely to share the same compulsory sexuality bias that many uniformed [sic] people have. There really should be some continuing education in the medical profession on this issue, since unfortunately I've heard many stories like yours. (Pramana)

As will become evident in my overview of Tumblr and Reddit, this style of analytical discourse was unique to AVEN's forums.

Tumblr: Impressions & Observations

Table 3: Coded Statements, Tumblr (51)

Type	Percentage
Neutral	18%
Negative (General)	50%
Negative (Pathologizing)	14%
Negative (Corrective)	10%
Positive	8%

While the AVEN health care discourse primarily discussed asexuality as intersecting with mental health or neuro-atypicality, the discourse identified on Tumblr included a more diverse array of intersections. Although Tumblr participants also addressed things like obsessive compulsive disorder (OCD), anxiety, depression and other mental health topics, these posts and replies also included considerations of disability and chronic pain, immigration status, religion, weight and body size, and various queer identities. It stands to reason that because Tumblr is not a platform strictly centered on asexual and aromantic discourse, Tumblr asexual discourse on health care could and would reach a larger and more diverse constituency. Tumblr was often used as a platform to make public service-like announcements to folks in the asexual community, with recommendations about how and when to access health care services.

Despite the possibility that Tumblr's asexual community is more diverse, it was in analyzing this platform's posts that I began to notice a particular pattern—the majority of posts were written by or about sex indifferent, averse, or repulsed individuals. Discussions of "virginity"—and how this construct has a very real impact on asexual patients' interactions with their practitioners—were ubiquitous. Though it first became evident on this platform, this aspect of the discourse was ultimately found across all three platforms, as I discuss in my themes below. Nevertheless, it is evident that this particular topic was especially prevalent on Tumblr when we consider that the following post received over 800 unique notes:

> Me: *goes to doctor for a physical*
>
> Doc: Are you sexually active?
>
> Me: *snorts* No.
>
> Doc: Saving it for marriage?
>
> Me: No, I'm not getting married and I'm not interested in it.
>
> Doc: Oh, cool. That's good. (confessionsofanasexual)

The majority of the notes on this blog post were likes and reblogs, as is often the case on Tumblr. Therefore, although few Tumblr users added their voices to this post, it was nevertheless made clear that many Tumblr users found the post relevant or relatable.

Of the three platforms, Tumblr’s structure is arguably the least suited to serve as an “asexual archive.” Although Tumblr updated its search feature in 2013 to allow users to search for words, tags, or even multiple tags (as opposed to prior, where a user could only search for one tag at a time), the function remains fairly limited. In completing my data collection for Tumblr, I actually found it easiest to search for relevant Tumblr posts using Google, as opposed to Tumblr’s own search function. The structure of Tumblr as a microblogging site, rather than a forum, means posts on Tumblr are more ephemeral—posts which do not receive much attention are quickly forgotten, and their lack of popularity means they are even less likely to appear in a Google search.

Reddit: Impressions & Observations

Table 4: Coded Statements, Reddit (66)

Type	Percentage
Neutral	11%
Negative (General)	43%
Negative (Pathologizing)	16%
Negative (Corrective)	4%
Positive	26%

It has often been hypothesized that clients and consumers are far more likely to take to online forums and review boards in reaction to a negative customer experience—though there is no conclusive evidence to support this hypothesis. While only 14% of the coded statements on AVEN, and 8% of the coded statements on Tumblr were positive, Reddit seems to defy this hypothesis with 26% of the comments being coded as positive (Tables 2–4). In addition to the increased mentions of positive patient-practitioner interactions, OP-commenter interactions on the selected Reddit forums were especially supportive—when an OP shared their experience with health care generally or with a specific practitioner, commenters often exchanged stories, as well as words of encouragement and validation. There is an archival aspect to this style of discourse in that it naturally collects similar stories under one theme or topic, typically decided by what the OP has shared. Although Reddit does not have the kind of hyper-intentional curation found on AVEN, the structure of the platform, as well as the culture of the Reddit ace community, make the site a very accessible "asexual archive." Relevant posts were extremely easy to identify via Reddit's search function, and many similar stories were often grouped together under one post.

Reddit discourse on health care experiences was especially nuanced, both in tone and content. Many members of the asexuality subreddits cited both negative and positive experiences with health care practitioners in the same post, or at least in the same comment thread. It was also common to note that their practitioner was very helpful in other areas of care, but not in accepting their asexuality or behaviors connected to their asexuality (i.e. lack of sexual engagement). It is critical to take note of this trend, as it indicates a keen ability among ace patients to identify skilled practitioners, and suggests that few approach the health care environment with strong biases against providers more generally.

Of the three platforms explored in this thesis, Reddit appeared to have a higher number of participants who were either questioning their identity, or needing support to understand the asexual identity of an intimate partner. Whereas AVEN's members included more "experts," and discussions thus leaned heavily toward the macro, Reddit's forums were more likely to act as a space for questioning folks to pose queries, and thus focused more on the micro. Because of these perceived demographics there was more confusion among commenters—many grappled with clearly separating desire and libido, even when it was clear they understood these were fundamentally separate.

Like Tumblr, Reddit contains many sub-communities congregating around a multitude of topics and interests, and the discourse was also noticeably more intersectional in nature. In particular, many participating Reddit community members expressed struggling with chronic genital pain—including vulvodynia, vaginismus, pelvic floor dysfunction, polycystic ovary syndrome and other types of medical challenges related to the female-assigned reproductive system (FARS). In this thesis, I refer to this kind of chronic pain as assigned-female-at-birth genital pain, or AFAB genital pain. I discuss this particular intersection in depth in the section entitled "Asexual Intersections," located in the second half of this chapter.

In addition, the language used on the asexuality subreddits had clear influences from other subreddits. As a millennial and an active internet-user, I consider myself to generally be fluent in online language. However, as I was analyzing the collected data on Reddit, I came across a term I had not seen before—"bingo," used as both a noun and a verb. Though I could certainly infer the meaning from the context of these posts, I confirmed that the language had originated on the "Childfree" subreddit, or r/childfree. Self-described as a place for "[d]iscussion and links of interest to childfree individuals," the term childfree “refers to those who do not have and do not ever want children (whether biological, adopted, or otherwise)” (reddit.com/r/childfree/). In this context, the word “bingo” was typically used to describe the common reactions childfree people must field (i.e. “You’ll want children one day”).

Ace community members have adapted the word “bingo” to describe common reactions to asexuality (i.e. “You just need to find the right person” or some form of pathologization). There were two instances of this language being used in the collected Reddit forums: “So I told [the gynecologist] that I was asexual. She then *gave me every bingo in the book* and reminded me that students get two free counciling [sic] sessions per semester!” and “But she wanted to keep seeing me to explore my sexuality, We talked a lot, and sometimes we argued, *she bingo'd me a lot*, and I often thought of walking out and never coming back” [emphasis added] (nobodys_somebody, mundabit). This vocabulary was never used in the collected AVEN or Tumblr data, suggesting that ace culture on Reddit has been, in part, shaped by other subreddits, particularly those with some overlap of experience (for example many ace people are also more likely to be childfree).

In this section, I have described my observations of the unique cultures of ace communities and how the platform’s structure and location on the web has potentially impacted these cultures and their discourse. In the second half of this chapter, I identify common themes that emerged across AVEN, Tumblr, and Reddit—despite the differences in culture and discourse. The themes pull together personal accounts from all three platforms to consider cultural perceptions of “virginity,” how and why ace individuals “come out” to their doctors, and the relationships of mistrust between practitioners and their patients. In addition, I analyze the systems of power and privilege present in these interactions and their corresponding discourses.

A Necessary Vulnerability: “Coming Out” to Our Doctors

Many OPs and commenters noted that a medical practitioner was the first person to whom they had “come out.” The coming out process for ace-identifying individuals is complicated by the prevalence of both compulsory sexuality and amatonormativity in Western society, which both invisibilize and pathologize asexuality (Gupta, Brake). Amatonormativity, coined in Elizabeth Brake’s “Minimizing Marriage: Marriage, Morality, and the Law,” describes “the assumption that a central, exclusive, amorous relationship is normal for humans, in that it is a universally shared goal, and that such a relationship is normative, in the sense that it should be aimed at in preference to other relationship types” (88). Though asexuality is often invisible due to these false assumptions, like any sexuality it still has a significant impact on an individual’s overall lifestyle and daily habits—and compulsory sexuality coupled with amatonormativity in health care make these habits all the more visible.

For those who shared their stories online, “coming out” to a practitioner as ace was often prompted by the ubiquitous yet ambiguous medical question, “Are you sexually active?” asked both by specialists and general practitioners (GPs). It was often expressed that ace patients came out because they were exasperated with this question—for example one Tumblr user posted, “Since my gynecologist won't stop asking me about my sex life, I came out to her as asexual today” (lis-beths-deactivated20160317). More than one commenter also mentioned that simply telling their doctor they were not sexually active or interested in becoming active was met with a surprisingly homonormative response: nudging the patient to “come out”—not as asexual, but as gay or lesbian.

With therapists, counselors, and psychologists, OPs and commenters emphasized that it was often necessary to “come out” both to discuss asexuality, or to identify asexuality as being *not* relevant to addressing their health and wellness needs. Robotpolarbear, a contributor on Reddit, expressed the need to move asexuality to the margins in order to address their most pertinent mental health needs. They explained, “…I wasted about a month in therapy before finally realizing that all I had to say to my therapist was ‘Hey, I’m actually here to work on my anxiety, and while coming out is contributing to that anxiety, my sexuality is not actually the problem.’” This comment articulates how the now well-documented relationship between non-normative sexualities and mental health disparities is also an outcome that applies to asexuality. In addition, Robotpolarbear’s comment implies that once asexuality was addressed in this manner, the quality and focus of the therapy was improved.

Robotpolarbear, who explained that they have experience on both sides of the “therapeutic relationship,” advised others in the Reddit forum to take this direct approach:

> The most important thing is that you directly tell your therapist that your sexuality is not an issue and that you do not have any therapeutic goals related to your asexuality. Tell them very clearly that you are only sharing this aspect of

> yourself with them so that they can better understand you as a person and not because your asexuality is an issue that needs to be addressed.

Another Reddit contributor, Canas_the_Shaman, replied to this advice, stating, "I made a point of this when I came out to my therapist who turned out super accepting of it. So I'll definitely second that." A third contributor, Pomeranian-Missile, echoed having this kind of positive coming out experience with their psychiatrist of three or four years, and described the interaction thusly:

> Me: Well, I identify as asexual, which means that I don't experience sexual attraction towards other people, and I'm still figuring out my romantic orientation.
>
> Her: So, to clarify, you're not interested in a sexual relationship
>
> Me: Yes.
>
> Her: but you're still open to the idea of a romantic relationship.
>
> Me: Yes.
>
> Her: Actually, another client of mine described the exact same thing to me, where she wasn't interested in a sexual relationship, but still wanted a romantic relationship. You know, this is new to me, but it's very interesting. I don't think this is a new phenomenon, either think of people like spinsters in decades past. Asexuality could be a reason why they didn't get married.
>
> Me, elated: Yeah, exactly.

Pomeranian-Missile proceeded to explain how their experience is proof that "not every therapist is going to view your asexuality as a problem that 'needs to be fixed' … There are genuinely caring, open-minded therapists out there who will accept you for who you are." Each of these Reddit contributors described having had positive experiences in therapy situations, as a result of "coming" out, coupled with a supportive response from their provider. In addition, all three of these individuals expressed optimism about the field of therapy more generally, and encouraged others to have open and honest discussions with providers they trust.

When the interaction was neutral or positive, OPs and commenters also suggested that "coming out" to their practitioner at least mildly—if not substantially—improved the effectiveness of their care. ZeroDagger on Reddit explains that "…When I told my therapist I was asexual, she just said 'oh' and moved on. It was a good thing to come out to her, because then she knew that I wasn't interested in the sex issues that most of her patients had. It gave us time to talk about more important things." Coming out—especially to someone like a medical practitioner, who is often essentially a stranger to the patient—is a particularly vulnerable act. One Reddit user noted that even though they identified a therapist who they "legitimately clicked with" and felt very comfortable talking to, coming out in person was still too intimidating, they explained: "So, I came out over email to her because there's no way I would have done it well in person…" (Canas_the_Shaman). In this particular scenario, the therapist "was super accepting, and even mentioned to me having done a little research on her own a few meetings later," yet again supporting the belief that "coming out" as ace can have its benefits in a medical context (Canas_the_Shaman).

However, negative responses to an ace patient’s coming out could also have an impact on care—namely, on an individual’s desire to continue pursuing care. An individual on AVEN who expressed being in the process of questioning their identity and considering asexuality articulated this when stating, “I haven't disclosed my asexuality with anyone else this frankly and judging by [the therapist’s] response, I might stop going for therapy” (confusedblue). Though another AVEN user did not directly state intentions to avoid further interaction, their story nevertheless indicates how distressing it can be to come out to a practitioner and receive a less-than-supportive response:

> The other day, I went to speak to a doctor about depression and during the conversation, he asked me if I was in a relationship. When I told him that I wasn't he asked why not and I explained that I'm asexual and so that made it more difficult to find someone or to believe someone would want to be in a relationship with me. His response to this was along the lines of, ‘what's asexual? I don't know all these new terms.’ I was really taken aback by this, especially as he then proceeded to ask me four times if I actually had secret same-sex attractions that I couldn't admit to. I don't tend to talk about my sexuality and he was the first person I've come out to face-to-face. I thought it would be easier than it was and that he'd, if not understand, at least know what the word meant. (monkeyfish)

This particular community member experienced pressure to “come out” to their practitioner as gay, suggesting a need on the practitioner’s part to explain the patient’s lack of attraction. As I note in Chapter 2, the “the deadly elasticity of heterosexist presumption" that Eve Kosofsky Sedgwick interrogates in *Epistemology of the Closet* necessitates that the queer individual "come out of the closet" time and again (68). In the case of asexuality, the individual must always be "coming out" in resistance not only to heteronormativity, but also to compulsory sexuality. As the following theme suggests, the prevalence of compulsory sexuality in Western society and medicine means that "coming out" is not reserved for gender and a/sexuality alone.

Medical and Cultural (Mis)understandings of "Virginity"

As I note in the previous theme, an individual's asexuality—though mostly invisible in the eyes of others—can sometimes emerge when the individual discloses their sexual history, or lack thereof. Although virginity is not a concept inherently tied to asexuality (just as not all virgins are asexual, not all asexuals are virgins), virginity is tangentially related as a common characteristic among ace-identifying individuals. My analysis of the data revealed that much of the visible discourse comes from ace folks who are sex indifferent, averse, or repulsed—and therefore have never engaged in consensual sexual acts and plan not to in the future. However, it is important to stress that there are individuals who both identify as asexual and have sexual histories for a variety of reasons—including a desire to participate in sexual acts. To be clear, I use virgin in this paper to mean an individual who has never engaged in *any* consensual sexual acts, though I also recognize that "virginity" is socially constructed and as such, is defined differently by many. Some of the experiences shared occurred before the OP or commenter identified as asexual, but are included because whether or not they had a name for their experience, it still likely impacted their choices.

While many online community members recounted their experiences as “coming out” to their practitioners as asexual, an even greater number *also* described having to “come out” as a virgin—to a mix of receptions including surprise, skepticism, and concern. In many OP and commenter narratives, at least a modicum of judgement on behalf of the practitioner was apparent. However, this judgement was not always condemnatory in tone—some practitioners were merely a little taken aback. For example, Tumblr user swankivy shared that “my doctor… seemed a little confused that I’m a woman in my thirties who is not sexually active and has never been.” Nevertheless, swankivy expressed a high level of satisfaction with the provider, especially because, despite his being surprised “he didn’t ask WHYYYYY and he didn’t act like I must have a problem.” A provider’s confusion and surprise had a more negative impact on a 21-year-old Reddit user named syrupptitiously, who admitted that they were not yet aware of their asexuality when they scheduled a routine gynecology appointment. The Reddit contributor explained,

> When I told the doctor that [I was a virgin], her face had this look of incredulousness. Apparently, she didn't have any experience doing an exam on someone like me, and another woman doctor came in and do the exam. She seemed nicer, but I was horrified and felt so awful about myself afterwards.”

Though syrupptitiously acknowledged that their second gynecologist experience—with a different provider—was far less upsetting, the language used in this post suggests a relatively long-lasting negative impact.

While the saying goes that “sticks and stones may break my bones, but words will never harm me,” the discourse and attitude utilized by practitioners in regards to virginity refutes this age-old argument. Reddit user donuts_foshonuts describes an interaction that “really pissed [them] off,” and addresses the issue directly, stating, “It's not the [gynecology] exam that's uncomfortable as much as the constant prodding from the GYN about me not being sexually active, even after I've said no a few times.” This user recounted a gynecologist appointment where the practitioner passive-aggressively noted that donuts_foshonuts’ hymen was broken (a trait which is now commonly recognized as an unreliable indicator of “virginity”) and states that the nurse unceremoniously gave the patient “a bag of condoms” at the end of the visit. Just as “Sticks and Stones” dismisses certain kinds of suffering, so too did one gynecologist, described by cekci on Reddit: “I have always had pain during exams. My first GYN basically said I should use tampons… and then heavily implied that I should be having sex to stretch things out. I was 15 or 16…” As I explore in the final theme of this chapter, a dismissal of AFAB genital pain was extremely common among the practitioners. The disturbing suggestion put forth by this practitioner—prescribing sex as treatment for AFAB genital pain—was not isolated to this Reddit contributor’s experience.

The narratives above were among the mildest of the practitioner reactions, while other online community members recounted far more directly disrespectful experiences. Tumblr user appalachian-ace articulated one such interaction, and the highly unprofessional discourse employed by these practitioners:

> …I was told I was lying about my sexual history, slutshamed, bullied about the need to use birth control, and that was just dealing with the nurse before I even put the paper gown on … for just saying I was a virgin. I didn't know I was asexual at the time, I thought I was just a late bloomer. Early-twenties college student. Which meant I then got dirty looks from the doctor herself and a one-word answer after the exam when she asked if I had any questions and I asked her one of the most typical virgin-at-her-first- pelvic questions ever. No more questions permitted. [The nurse and doctor] were both women, living in an area where a HUGE portion of the population has religious beliefs that mandate celibacy before marriage.

Stories like appalachian-ace's are particularly valuable because they clearly point towards larger societal opinions in the Western world about virginity and being sexual active. This comment effectively situates the issue in a larger context, and makes it clear how standard it is for these kinds of patient-practitioner interactions to be deeply rooted in stigma, double standards, and false dichotomies (i.e. the slut/prude dichotomy).

The findings suggest that these societal expectations continue to impact both patient and practitioner. Many patients, particularly patients who are women, have long adopted the strategy of lying about their sexual history as a tactic of survival. While Western society dictates that "good girls" remain virgins until marriage, and suppress their sexual desires for a lifetime, compulsory sexuality simultaneously suggests that there is something inherently "wrong" with any individual past a certain age who is not sexuality active. This paradoxical context seems to result in a wide range of inconsistent experiences with practitioners. For example, while appalachian-ace felt shamed and bullied by a practitioner, nobodys_somebody on Reddit shared quite a different experience where the gynecologist at the college clinic “tried to talk me into being sexually active as she went about the exam. So I told her that I was asexual. She then gave me every bingo in the book” (i.e. the common responses to coming out I describe in “Reddit: General Impressions and Observations). The Reddit contributor additionally stated that this “terrible experience” was also their “first (and last) gyno exam.”

Although nobodys_somebody noted that the therapist (recommended by the “concerned” gynecologist) was “nothing but supportive of asexuality,” the negative interaction with the former practitioner was so off-putting that they stopped going to the gynecologist altogether. It is generally considered unnecessary for an individual with AFAB anatomy who has never engaged in sexual acts to visit a gynecologist for annual check-ups. However, nobodys_somebody had admitted, “I really should; I lost a grandma to cervical cancer,” making it clear that not all aces—or even all virgins—can afford to skip the gynecologist. On Tumblr, writingfromfactorx effectively summarizes the findings of this section:

> My experience with medical officials, especially obgyns, is that if you bring this information up you should expect quite a bit of pushback from medical health providers about not being sexually active or having a history of sexual activity… I find that doctors are often unwilling to accept that no, I have the same definition of sex that most of them do. Having to deal with this once a year or

> just not seek treatment for my actual medical issue is really fucking upsetting and aggravating.

Like nobodys_somebody, writingfromfactorx suggests that this lack of acceptance among medical practitioners, and the lack of faith that their patient is telling the truth, is enough to turn asexual folks off—not just from a particular practitioner, but from doctors in general. The next theme addresses this shaky patient-practitioner relationship, and the role it plays in asexual patients' experiences.

Relationships of Mistrust: Patients, Practitioners, and the Internet

Although it is clear that there is more than one sociocultural factor at play in the diverse experiences documented in the previous theme, a lack of trust between patient and practitioner emerges time and again in the discourse. Among these experiences, it was common for providers to assume that their patients would lie about their sexual history, and to either communicate this mistrust directly, or simply fail to validate the patient's story. Furthea on Reddit noted that "my doctor said I should get [a Pap smear] but then I'm pretty sure she didn't believe me when I said I wasn't sexually active." The contributor adds that, "for this and multiple other reasons" they stopped seeing this practitioner shortly after the aforementioned interaction. A community member on Tumblr shared a similar experience: "I recently had a physical where the doctor didn't quite believe me when I said that I've never been sexually active. I got the feeling that she didn't think I was lying, but she didn't believe that it was the truth, if that makes any sense" (cool-asexual-things). The kind of language used by Furthea and cool-asexual-things suggests that, if their practitioners *did* believe what the patient had shared, they had not done enough to express as much to the patient. Such situations were not reserved purely for conversations about virginity or sexual activity, but also commonly extended to moments when patients directly addressed their asexuality at appointments.

Language expressing uncertainty about having the support of their practitioner was extremely common in the discourse across all three platforms—so much so that even when the overall interaction was positive or neutral, OPs and commenters were still not confident they had their providers full support. For example, magicLEDlights on Reddit admitted of two separate experiences: "I'm not sure if either of [the therapists] fully believed I was asexual, but neither of them made any attempt to fix it," noting the lack of clarity in the exchange. While this Reddit user was simply relieved to avoid pathologization, that was not necessarily the case for all patients. Indeed, as I mention in the previous theme, many online community members stressed that having a practitioner validate their asexual identity was paramount to a positive health care experience. When this did not occur, doubt on the part of the provider could have a critical impact on the quality of care. On Tumblr, community member epochryphal explained that, as they were coming to a better understanding of their identity as non-binary and ace-umbrella, "…my CBT-based therapist kept hinting that i was overthinking labels. in fact i remember him saying that '*we both know, when you have access to sex, you're normal*' …his attitude of i-won't-bring-it-up-but-you-can-tell-i-don't-believe-you're-ace was the biggest roadblock for me in therapy" [emphasis added]. It is understandable that this attitude on the practitioner's part would impact the patient's progress in therapy. After all, the comment made by epochryphal's therapist—suggesting that participating in sexual acts is "normal"—implies that asexuality is not only an invalid label based on the patient's behaviors, but also extremely abnormal.

Following a patient-practitioner interaction like the one described above, it may be in the patient's best interest to seek a different provider, but this is not always possible—nor is it always preferable. Finding the right "fit" in a doctor can be a daunting task—insurances often have a limit to their "network" of providers, and identifying a provider who is supportive of non-normative identities narrows the field even further. In addition, the trial and error typically required to locate a mental health provider is a challenge that is often exacerbated by the very mental health challenges one is seeking to address. On Reddit, Name_Not_Submitted succinctly explained the arduous task of finding a doctor who respects their asexual identity, stating, "My new [gynecologist] is male so I'm still a little uncomfortable but at least he believes me. (unlike the three I went to before him)." Name_Not_Submitted's comment suggests that some of their personal comfortability had to be sacrificed in favor of a trusting patient-practitioner relationship. The fact that this was the *fourth* gynecologist they had tried—yet the first to support their identity—is significant. Another member on Reddit, Kitteas, expressed a similar sentiment: "unfortuately [sic], [the therapist is] excellent in helping me with other issues like anxiety and depression, but strangely will not believe me when I say asexuality is real … This isn't the first therapist to not believe me." While Name_Not_Submitted had to set aside comfortability to find acceptance, Kitteas was forced to choose between addressing their anxiety and depression, or having their asexuality validated. Both of these situations put the patient in a very difficult position—they can begin the provider search all over again, set aside other needs as a patient, or suppress/avoid any connection to their asexuality during appointments (even if it might be relevant to their treatment).

For some, avoidance can be an effective strategy for working with a practitioner that is otherwise a good fit—as Reddit community member NutM3G82 explained in this comment:

> I had a therapist who also didn't believe me when I told her I was asexual. She said I was not asexual, but too unwilling to become romantic with someone. *After she said that, it never came back up because I never brought it up again.* Instead, we focused on working on the issue that brought me to her office, and it wasn't my sexual identity." [emphasis added]

Although this strategy seemed to work for NutM3G82, it is certainly not the solution for someone who needs to directly address their asexuality in relation to other health and wellness challenges. Additionally, I would argue that any patient-practitioner relationship where important aspects of the patient's identity are off-limits is stunting the potential quality of care. According to *Intensive and Critical Care Medicine*,

> "The bond of trust between the patient and the physician is vital to the diagnostic and therapeutic process. It forms the basis for the physician-patient relationship. In order for the physician to make accurate diagnoses and provide optimal treatment recommendations, the patient must be able to communicate all relevant information about an illness or injury." (Besso et al.)

With trust as the crux of the patient-practitioner relationship, it should come as no surprise that a practitioner's lack of trust in their patient's competency—to understand themselves, to articulate identity, to process information—would have negative outcomes. For example, one Tumblr user describes the experience of coming out as asexual to the gynecologist: "She wouldn't believe me; talking about 'having to learn a language' and 'a phase', I really stopped feeling respected when she compared being ace to having an eating disorder…" (lis-beths-deactivated20160317). A lack of respect can leave a patient annoyed, angry, or even devastated. Minya_Nouvelle on Reddit articulates the result when a lack of trust couples with a power imbalance between patient-practitioner, explaining "…I do still feel okay with the being asexual, but having a doctor, a person I was recommended because he was 'an expert', tell me that I have a dysfunction made me feel miserable."

Though this mistrust was clearly evident between patient and practitioner, it was also commonly found between practitioners and the internet (and the ways their patients use it). AVEN member Cermin documented this interaction with his doctor:

> …I told the doctor that even though I have met many women in my life, I have never felt sexually attracted to any of them.
>
> Doctor: Maybe you are interested in men then? (winking)
>
> Me : No, I have not felt any attraction to men either.
>
> Doctor: I'll be honest with you. I don't believe you. Everyone likes someone…"

Following this not-so-subtle attempt to “out” the ace patient as gay, the practitioner claims that the patient’s “only problem” is a lack of self confidence, and recommends that the patient not suppress his desires. Cermin responds:

> I explained to the doctor that I never desired to have sex with anyone, and that I had come across the term asexuality which I believe describes me very well.
>
> Doctor: Don't believe everything you read on the internet. Just because you read something, doesn't mean that it is true.

Another AVEN community member shared a similar experience in the same comment thread, stating, “My therapist … was not very understanding that never in my life have I desired sex with anyone. She told me not to trust things I read off the internet” (confusedblue). Not only does this discourse on the practitioner’s behalf express a distrust of the internet as a source of information, it also suggests a complete lack of confidence in the patient’s critical thinking skills and their ability to apply these skills.

Given the levels of formal education practitioners must complete, there is automatically an undeniable power imbalance between patient and practitioner. This does not create the ideal environment to build a foundation of trust. Blanket statements about “the internet” made by medical professionals are particularly troubling when we consider that *most* of the information about asexuality and *most* of the asexual community is only accessible online. If patients cannot trust the internet for information on asexuality, they have nowhere else to look. That practitioners are attempting to deter their patients from seeking information additionally suggests a lack of regard for the varying social circumstances of their patients. A patient’s barriers to accessing traditional avenues of education (i.e. class, race, disability, and so on) can mean that the internet is their most viable source of information. In the next section, I elaborate on these intersections which are not being attended to by health care education or policy.

No Ace is an Island: Asexuality as Intersectional Identity

In this theme, I highlight intersectional focal points that arose from the data. From my observations of the discourse, both for this project and more generally as a member of the online ace community, intersectional considerations are not at the forefront nearly enough. For this reason, the final theme of this chapter seeks to highlight the sparse yet absolutely vital discourse seeking to have these intersectional conversations. The first subsection of this theme, “Medical Citizenship” centers three key comments from the discourse to attend to issues of gatekeeping in health care practices. The second, entitled “The Misogyny of Chronic Pain” details the narratives of asexual community members who communicated their experiences with chronic pain in the medical industrial complex. Although these comments emphasize important intersections with asexual identity, as a researcher I have also taken notice of rather large holes in this small subset of intersectional topics. However, it is my intention to present the findings only in this chapter, and in the next to discuss these gaps at length.

Medical Citizenship: Accessing Health Care, and Health Care as Access Point

For the safety and wellbeing of patients, there is a certain standard of gatekeeping necessary within the medical industrial complex. For example, a number of requirements have been put in place to monitor a patient’s access to controlled substances in an attempt to prevent instances of substance abuse. However, it is critical to recognize that the medical industrial complex was originally constructed—and continues to be maintained—with a dominant, white, Western, settler colonial rhetoric in mind. Thus, gatekeeping often extends beyond the realm of patient safety to restrict marginalized peoples' access to what I refer to here as "medical citizenship." This sub-theme thus considers how health care is accessed by asexual individuals who are multiply marginalized, as well as how the medical industrial complex sometimes acts as an access point to other privileges.

As I establish in the previous themes, much of the medical discourse in online asexual communities discusses gynecological health. Many individuals expressed distress about being required to undergo an annual Pap smear, the routine cervical screening used to detect precancerous and cancerous cells in the cervix. Those with anxiety and sensitivity issues were understandably averse to the idea of an exam which is quite invasive. While many online debated who exactly was required to seek out an annual Pap smear and who should be exempt (the requirements vary wildly even within the United States), one Tumblr user interjected with the following comment:

> "FYI you might need to do this anyway for immigration purposes. When I was asked to submit a full health check for Australian Immigration one of the things they asked for was a Pap Smear. Doesn't matter what your sexual behaviour is. (The health checks for immigration purposes can be pretty invasive - one of the things Australia makes you do is a HIV test - but it's good to keep that in mind in

> case you're planning to move to a new country and/or are looking for a visa stronger than a tourist visa.)" (creatrix tiara)

This comment, posted by a self-identified Bangladeshi-born creative based in Melbourne, Australia, brings to light a whole host of challenges asexual immigrants and refugees may face. To gain access to housing and other resources in Australia, any ace person with a cervix emigrating to the country would not have a choice in undergoing what can be a very painful and distressing examination—regardless of their sexual history.

On Reddit, community member pleurocarp highlighted another choice inaccessible to some ace individuals, pointing out, "I don't have a doctor that wants to help me, because I don't have health insurance. Getting to choose to forget or remember to get a gynecological checkup is not a privilege most lower-class rural asexuals have." Though these two comments address opposite struggles—accessing the choice to opt out and the choice to opt in—both creatrix tiara and pleurocarp successfully emphasize just how limited the choices are for multiply marginalized ace individuals when it comes to their health care. In one scenario, the individual cannot become a national citizen without undergoing an invasive medical exam and in the other, the individual is barred from gaining citizenship in the medical industrial complex. Both of these gatekeeping systems disproportionately impact ace folks of color, aces with disabilities, and transgender aces due to other intersectional oppressions impacting social location.

Another aspect of citizenship in health care was brought to the forefront by Mezzo Forte, a self-identified "FtMusician," asexual, and aromantic individual and community member on AVEN. Mezzo Forte describes the societal pressure they experienced—as someone who is transitioning—to conform to heteronormative standards, including compulsory sexuality and amatonormative assumptions. Mezzo Forte describes two interactions in the comment—one with a doctor, and another with a nurse:

> Only doctor I ever felt compelled to tell is the doctor who prescribes my hormones. She does my general care too, monitoring my health as I transition, and she asked early on about sex when she wanted to do a Pap smear. I mentioned that I was ace, and she just said "okay" and didn't make a big deal of it. She would still tell me sexual stuff I needed to know, (like how I can still get pregnant on testosterone) but she did it in a way that wasn't implying that I wasn't ace.
>
> My nurse who gave me my shots (until I started self-injecting), on the other hand, was really frustrating. There was always a "don't worry, you'll find love" tinge to what she would say even as I explained to her that I just wasn't interested. She would go out of her way to tell me stories of FtM patients who had given up on finding love, but ultimately found a partner. That nurse is otherwise really sweet, but I hit the point where I just shut off whenever she talked about that stuff.

What Mezzo Forte details in their narrative echoes back to Robert McRuer's "rehabilitative contract," described in Chapter 2. The contract stipulates that, in return for integration or societal citizenship "no complaints will be made, no suggestions for how the world… might be molded differently" (McRuer 112–113).

The narratives of Mezzo Forte, pleurocarp, and creatrix tiara, when grouped together, describe the many ways gatekeeping in the medical industrial complex is used to regulate populations, but especially those in multiply marginalized and "non-normative" communities. These narratives provide important commentary which asks us to consider who is permitted to access health care, and what hoops they must jump through to attain that access. In the next subsection, another kind of gatekeeping is described—that which determines whose bodies are deserving of treatment.

The Misogyny of Chronic Pain and Illness: Deserving Treatment

As I was analyzing the data collected for this project, I began to notice a theme that I could not have anticipated—numerous OPs and commenters included in their narratives that they suffer from chronic pain. Chronic pain specifically linked to AFAB (assigned female at birth) anatomy was especially prevalent on Reddit, though narratives of chronic pain more generally were also found on Tumblr. There has been much critique in recent years, particularly from feminists, about the gender biases present in medical research. The lack of funding and interest in "women's health" is experienced by those with AFAB anatomy in their daily lives—the dearth of treatment options, and the terrible side effects of medications being just two examples. The pain and suffering AFAB individuals too often bear comes in second to more "important" research projects—such as those aiming to ensure the virility of straight white men.

Name_Not_Submitted on Reddit describes the difficulty of accessing treatment, clearly in part influenced by notions of compulsory sexuality:

> I’m not a virgin but I haven’t had sex in many years. I had a doctor refuse to treat my pmdd [premenstrual dysphoric disorder] because she thought the problem was I needed sex. The problem is I get depressed & suffer from horrible pain 25% of the time. I just want to be able to walk during my period. *Why does my lack of sex life mean I don’t deserve treatment?* [emphasis added]

This Reddit contributor was not the only individual denied treatment for this reason—not by a longshot. Contributor quincycheese on Reddit, who describes herself as a 25-year-old cis woman living in Brazil, said in one forum, “after I told the [gynecologist] I was a virgin, she refused to examine me and started teaching me how to use condoms. Now, years later, I have to deal with debilitating period cramps and don't know what could be causing it.” This particular community member documented their health care journey across multiple Reddit forums. This first comment was posted about a year before the data was collected. In a more recent post, quincycheese explained that “every gyno I ever went to refused to do [a Pap smear] once I told them I was a virgin. Ultrasounds are easier to get though, which is how I found out I have PCOS [polycystic ovary syndrome].” The contributor does not describe why virgins are denied pap smears, but it appears to be a common practice based on the multiple instances of this that she describes. Her most recent post on the matter is perhaps the most telling of the three, as it emphasizes the compulsory sexuality behind the discrimination she experienced from each of these practitioners:

> Okay, this one gynecologist wasn't my main one, but an emergency appointment since I needed a new prescription for my birth control [to address symptoms of

> polycystic ovary syndrome… and I was worried about some side effects. He never assumed I was a virgin until I told him, then he said ‘you need to eat less bread and screw more men’, possibly implying that my condition was interfering with my sexual desires.

The discourse utilized by this practitioner was significantly more directly extreme—and more rare—than the majority of other posts analyzed for this thesis. However, all of the negative interactions discussed in this chapter have a foundational element in common—they should not only be rare, but non-existent.

Like quincycheese, mundabit also provided a lengthy narrative regarding their diagnosis and treatment on Reddit. Mundabit was diagnosed with vulvodynia, a chronic and typically unexplained genital pain, and was “referred to a sex therapist… as part of a mandatory process before receiving physical treatment.” For mundabit, this gatekeeping practice did nothing to improve the situation, and was no different than previous interactions with psychologists and psychiatrists

> who all believed there must have been some kind of sexual abuse for me to … experience emotional ‘sex aversion’ and physical pain. After I said “No, nothing like that” 3 times each, I just stopped listening to each of them and nodded until the session was up. I realise that was very uncooperative of me, But honestly, *I was not there to be told I must have been raped, I was there to find out why it suddenly hurt to wipe after I pee*. These therapists annoyed me greatly, as I don't experience ‘sex aversion’. I'm very sex-positive, and I have had sex, It's just not for me. [emphasis added]

What mundabit expressed in this statement encompasses many of the trends seen throughout the data. These providers conflated sexual attraction with libido, and sex aversion with sex indifference. Despite the patient's efforts to communicate, none of the patient-practitioner relationships mundabit describes appear to have established a foundation of trust—leading to multiple misdiagnoses and ultimately to ineffective treatment. Mundabit describes the latter in another comment on Reddit:

> The biggest problem I have had is physio's and doctors assuming that my asexuality is caused by my inability to have sex on a physical level … it just goes around in circles. They feel that because I'm not having sex, I'm not recovering … They get hung up on the fact I'm not having sex and start repeating treatment stages.

Mundabit endured this ineffective treatment regimen with multiple providers—all while struggling to afford this expensive therapy, which is not covered by insurance in her home country of Australia.

Eventually, mundabit was able to locate a more affordable physiotherapist closer to home, and finally experience the kind of positive health care interaction deserved by all. In a session with the new physiotherapist, mundabit was asked how her husband feels "about the lack of sex" in their relationship. When mundabit explained that her husband is "a platonic soul mate" and mentioned that she has "never felt like [she] needed sex, not even as [she] was having the best sex ever," the physiotherapist responded in a way almost no other provider documented in this research project had: "have you heard of asexuality?" Mundabit was so relieved to have found a provider who not only accepted asexuality, but willingly offered it up to the patient as a valid identity, that she says, "I think I almost cried."

This respectful and supportive interaction had an immense impact on mundabit's treatment and recovery progress, as the new physiotherapist suggested they "speed through a few stages because sex isn't a goal," allowing them to leave sexual function to last, and instead prioritizing the pain and incontinence mundabit had been seeking to address all along. Needless to say, mundabit shared, "its [sic] already going really well." The provider's respect and recognition that, for her patient, asexuality and chronic pain are separate, had an invaluable impact on mundabit's life. This is evident in the comment mundabit made at the conclusion of her narrative, saying, "I'm getting teary just thinking about it, I have been in pain so long, and all it took to get the treatment I needed was for one person to realise that 'wanting sex =/= sexual function'." All it took was a little faith on the part of the practitioner.

Another key narrative which touched on the theme of chronic pain was that of Tumblr user hawkelf, whose personal blog states: "ace, arospec, disabled/chronically ill, geek, artist/craftsperson. she/her. raised rural, city living." hawkelf disclosed in her narrative that she has fibromyalgia, suffering from chronic pain which has intermittently required her to use a cane. Although fibromyalgia is not always linked to AFAB anatomy, it does impact women disproportionately—it is estimated that 80–90% of those who suffer from fibromyalgia identify as women, and the symptoms of this chronic disease are typically experienced more severely by women (Wolfe et al.). In seeking therapy for anxiety disorders, hawkelf decided to try a therapist she had met "through a local college queer group" who was familiar with asexuality and claimed he was willing to respect it.

Unfortunately, despite being an "LGBT-friendly" therapist, hawkelf's practitioner had not been unsusceptible to the narrative of compulsory sexuality so prevalent in the narratives of this theme. As such, things did not go well with the therapist, and hawkelf asserted in the post, "I have no doubt that my visible disability exasperated the situation." She described the first few sessions thusly:

> During my first therapy session with him, the subject of asexuality came up because I was doing a lot of ace activism at the time. It was the primary thing getting me out of the house, so it was pretty important to me. I think I only went to this guy three or four times, but at some point in the first two sessions my disability came up. He wanted to know about the cane. About what fibromyalgia was. About my pain. He asked me if I was sure that my asexuality wasn't caused by the fibromyalgia, by the pain. He suggested that I might try sex, to see if it was worth pushing past the pain for. He suggested that sex would help my pain.

Hawkelf described maintaining her composure in these sessions, "politely, calmly, [and] firmly" refuting each and every point. However, this barrage of highly problematic suggestions would not be without impact, and hawkelf shared that "I left the sessions and cried and screamed the entire drive home." The therapist additionally attempted to suggest that perhaps hawkelf had been sexually assaulted as a child—a traumatic suggestion for someone "who experiences unclear thinking and memory problems" due to the fibromyalgia. Hawkelf explained that, from her position, it seemed that the therapist “was trying very hard to make me question my orientation, [and] assign it as a symptom of something else.”

Hawkelf’s experience was the last straw, and she admitted in her narrative, that not only did she end her relationship with this therapist, but “I also haven’t been in therapy since. He was the sixth therapist I’ve been to for depression and/or anxiety, and he is absolutely the reason I’m scared to go back.” Although I have separated the findings into themes in this chapter, many of the narratives, including hawkelf’s overlap. These overlaps call attention to the many underlying societal assumptions behind these themes, which permeate all ace individual’s experiences with health care providers—be they neutral, negative, or positive.

Conclusion

It is clear from these findings that ace-identifying individuals participating in online discourse know what they need from their health care practitioners and are perfectly capable of articulating these needs. As a researcher, I have merely collected these articulations for the benefit of my community, and for those scholars who do not yet recognize the valuable discourse to be found in online spaces. Themes emerged effortlessly from these findings, and both forum and blog contributors attended to a diverse array of challenges and gaps in care. It would seem that practitioners need only ask—and authentically care about and respect the answers—to receive this critical feedback from patients. In addition, medical gatekeeping rooted in notions of compulsory sexuality perpetuates invisibility of the ace community and stunts the growth of the patient-practitioner relationship. This practice of gatekeeping must be shed before asexuality can gain any significant level of acceptance in the medical community. In addition to these findings, I also observed some vital themes which were missing—both from the discourse addressing health care interactions, and from asexual discourse more broadly. In the next chapter, I discuss the larger implications of the findings described here, but also interrogate what is largely absent from the identified discourse.

Chapter 5: Discussion

"Medical knowledge about the topics of asexuality and sexuality circulates into public awareness in a way that privileges the professional point of view over individual experiences and their creative interpretations"

—Eunjung Kim, "How Much Sex Is Healthy?" p. 167

Implications

In the previous chapter, I present the findings of this thesis research and group the findings by themes—focusing on the "coming out" process in health care, medical misconceptions of virginity, patient-practitioner relationships of mistrust, and asexuality as an intersectional identity. In this chapter, I discuss the larger implications of the findings—considering mainly what these findings indicate about the current state of health care for ace individuals, and its impact on health and wellness within ace communities. In the implications section, I discuss asexuality as a matter of health, consider the potential impact of "ace-friendly" health care practices, and imagine online contributors as curators of the "Asexual Archive" proposed by Przybylo and Cooper. I conclude the chapter with some brief recommendations, both for practitioners and ace activists.

Engaging and conversing with health care providers is a seemingly straightforward practice—an individual seeks out a practitioner for a particular health and wellness need, the doctor runs a series of diagnostic tests, provides a diagnosis, and suggests a treatment. However, this process is complicated greatly both by an individual's unique health needs, as well as larger structures of power and privilege at play in the medical industrial complex. As evident from the previous literature, the discrimination sexual and gender minorities face more generally in society also commonly extends to the health care environment. It has been contested whether or not asexual individuals experience discrimination on the same or similar plane to other sexual minorities, given that asexuality's biggest obstacle is often identified as invisibility. This research was designed to discern what interactions between ace individuals and their health care providers look like, and to identify what kinds of discourse are commonly used in these interactions.

The findings of this research indicate that asexual individuals, like other sexual minorities, do experience discrimination in their interactions with health care providers, despite asexual identity manifesting differently than other sexual minorities in this and other contexts. The findings also reveal that the form of discrimination most commonly experienced by ace individuals in health care settings is a discourse of compulsory sexuality; When employed by health care providers, such a discourse is (at best) limiting the potential quality of care given to asexual patients and (at worst) damaging the health and wellness of asexual patients.

A/sexuality as a Factor of Health

Although a number of themes arose from the data, the findings ultimately reveal two key outcomes for asexual health, both of which resulted from a flawed or non-existent discourse. Firstly, poor or lacking communication combined with distrust in the patient-practitioner relationship has resulted in ineffective—or potentially harmful in the case of sex being used as a treatment method—health "care" for asexual-identifying individuals. This kind of ineffective care extended to asexual-identifying patients who did not "come out" to their doctors, as even the more common habits among ace folks, while severed from the asexual identity, are still stigmatized. Secondly, a dismissive, pathologizing, and/or generally ignorant discourse employed by health providers resulted in an avoidance of further interaction with a particular practitioner—and/or an aversion to health care more generally—on the part of the ace individual. In this instance, rather than receiving ineffective care, the ace patient then receives no care at all, perceiving this to be the lesser of two evils.

In Eunjung Kim's "How Much Sex is Healthy? The Pleasures of Asexuality," the author strives to reposition the way we understand and experience pleasure by "refusing to think about sexuality as a matter of health" (Kim 167). Although I agree with Kim's call to separate asexuality from pathologization, I believe the findings of this thesis indicate that even when direct pathologization is absent, a/sexuality remains a *factor* of health in a heteronormative society. So many online ace contributors expressed in their posts and comments that the relationship between their asexuality and other health and wellness needs was and is incredibly nuanced and complex. The ubiquity of this sentiment suggests a dire need for practitioners to confirm a patient's attitude towards their asexuality before offering a diagnosis or treatment.

According to the findings, very few practitioners acknowledged the deeply-rooted and complicated relationship between health and non-normative a/sexualities. This relationship has now been widely recognized in LGBTQ health scholarship, though asexuality has not typically been included in such studies. As explored in my review of the literature, living on the margins (of sexuality, race, class, ability, and so on) takes its toll on an individual's mental and physical health. Therefore, when a patient does express unhappiness or dissatisfaction in regards to their asexuality, practitioners should make an effort to work with the patient to identify the source of these feelings—to consider how societal expectations, invisibility, and barriers to "coming out" may be contributing to a general discontent with one's a/sexual identity.

The findings of this thesis indicate that we must not sever the tie between a/sexuality and health, but instead reimagine it as a complex relationship which defies dualities of cause and effect, symptom and disease. Moving away from such dualities and expanding a/sexual conceptualizations in health care contexts is beneficial not just for ace-identifying patients, but for all who seek care within these systems. Because "neither sex nor gender [nor sexuality] is purely biological or purely social, and both manifest along a continua that defy binary classification," providing care for ace-identifying patients must place an emphasis on "individual autonomy and self-determination" (Norton 601). This allows the patient to make an educated decision about their own particular relationship to asexuality, and guides the practitioner in addressing the true needs of the patient.

Based on my analysis, there was no indication that any particular field of medicine was excelling at, or even attempting, "ace-friendly" health care. Instead, a failure to provide "ace-friendly" health care was relatively consistent across therapy, gynecology, and general practice. This consistent shortcoming likely stems from the trivial amount of attention paid to LGBTQQIA in medical education for any of these fields, as discussed in my review of the literature in Chapter 2. Although the type of practitioner had little to no effect on the (poor) quality of care, this factor does seem to impact the rate at which patients avoided a practitioner or type of health care entirely. A significant number of OPs and commenters noted that they would not be returning to a therapist or gynecologist after a negative encounter, yet none made this claim in regard to general practitioners. While it is likely that this tendency was influenced by a number of internal and external factors, it would seem the *particular nature* of the patient-practitioner relationship in these two fields may be a significant component. To receive effective care in gynecology or therapy, a much higher level of vulnerability is required of the patient; For gynecology this vulnerability is mostly physical, while for therapy it is mostly mental. Given this heightened vulnerability, a negative experience in this context can have a far more traumatic effect.

Although general, preventative care can be critical to health overall, the kind of specialized care provided in the areas of gynecology and therapy is equally (if not more) valuable. These findings indicate that negative interactions with therapists and gynecologists, especially if they result in avoidance of future interaction, put ace individuals' health significantly at risk. Therefore—in the long tradition of the "self-fulfilling prophecy"—practitioner attitudes towards asexuality (and those who identify with it) effectively make asexuality a *factor* of health. By employing discriminatory and distrustful language, practitioners who doubt or invalidate their patient's asexuality means asexuality *is* a health risk, just not in the way these practitioners suggest—as a medical condition (Kim 158). It is therefore necessary to address asexuality as a health risk, and to restructure health care practice and discourse to address this risk, rather than exacerbating it. In the next section, I make the case for why making asexual-centered improvements to these fields can benefit allosexual (non-asexual) patients as well.

Making Gynecology "Ace-Friendly" Makes it "Patient-Friendly"

As is made evident by the existing scholarship on LGBTQ health outcomes, centering marginalized populations in research of all kinds is vital to improving the larger structures of our society for all people. Like most research centering marginalized populations, the findings of this thesis reveal a number of flaws in general health care practices, the impact of which is likely to extend far beyond ace-identifying patients. Similarly, health-related research centering marginalized populations is critical because it almost always reveals gaps and shortcomings in health care services that have the potential to impact all kinds of patients, not just those centered in the study. The findings of this study specifically indicate shortcomings in gynecological care that, if addressed holistically, have the potential of benefitting all those who seek out such services, regardless of their a/sexual identity.

The online discourse surrounding gynecology reveals gross inconsistencies in recommending Pap smears. After analyzing the data, a number of important questions were left unanswered—or were answered inconsistently—including, "Who needs a Pap smear?" "How often are they needed?" and "When should they start?" While OPs and commenters sometimes noted a "rule of thumb" meant to cover such questions, the rule often varied over time and by location—even within a single country. In the U.S., the rule was often (but not always) that any person with AFAB anatomy should schedule their first Pap smear when they turn 21 or become sexually active—whichever comes first.

In the U.K., the National Health Service (NHS) does not send out Pap smear appointment reminders until an individual is nearing their twenty-fifth birthday, without any addendum for "sexual activity." In addition, the recommended frequency of such exams spans from every year to every three years for those under 50. In March of 2017, the Australian government's Department of Health—based on "new evidence and better technology"—announced that "[t]he two yearly Pap test for women aged 18 to 69 will change to a five yearly human papillomavirus (HPV) test for women aged 25 to 74." (cancerscreening.gov.au). While the time between tests will change from two to five years, "the age at which screening starts will increase from 18 to 25 years" (cancerscreening.gov.au). The National Cervical Screening program's website makes no mention of sexual activity impacting these new recommendations, though it does note that "[u]ntil the renewed National Cervical Screening Program is implemented [in December of 2017], women aged between 18 and 69 years *who have ever been sexually active* should continue to have a Pap test when due" (cancerscreening.gov.au).

These already perplexing and erratic recommendations were further muddled when shared within online ace communities, as it was not always explicitly stated that the recommendations can vary by country. Additionally, the narratives of online ace community members also suggest that practitioners themselves were uncertain of how to treat patients who did not quite "fit" these parameters or suggestions, leading to vast inconsistencies in treatment and expectations. For example, a post from purple_pear on Reddit explained that their doctor did not recommend a Pap smear, stating that "there was no need or point to it unless I have had PIV [penis in vagina] sex, so no Pap smear for me (yay!),” yet other commenters online noted that STDs can be contracted through sexual contact outside of PIV sex. At the same time, many described interactions where they had experienced pressure to schedule a Pap smear, even when waiving out was an option, and they had not engaged in any form of sexual contact, as ace-muslim describes in this post:

> If your healthcare is provided by the NHS, they will not pester you until you turn 25. But then when you do turn 25, they will start sending you postcards, and the postcards say that if you don’t want one, then you can just sign a waiver– It is the “just” in this sentence I object to. You don’t just sign the waiver; you have to make an appointment with a nurse practitioner. Who will then do everything in (her) power to pressure you into the test. We literally started out with “you know, it’s faster just to do the test than the waiver, really.” Then, you must provide them with the reason you do not want the test. And apparently “I have never had sex ever no not even fingers” is not good enough.

While it can be helpful to have general guidelines or recommendations for seeking exams like a cervical cancer screening or pap smear, the discourse above suggests that such guidelines are ultimately more hindersome than helpful. It would ultimately seem the “rule of thumb” recommendations are confusing for both patients and practitioners; All patients could therefore benefit from a system that recognizes the complexity of individual experience, educates patients on the nuances of sexual health and sexual activity. This system would have the added benefit of instilling confidence in practitioners that their patients will tell the truth about their sexual history and thus positively contribute to the health care process.

Although much of the work advocating for safe sex education has been established by queer communities, women's health and gynecology have long engaged in the movement to de-stigmatize sexuality in the name of establishing safer sex practices. Because of this history, a foundation already exists for the field of gynecology to lead the way in expanding and critiquing conceptions of virginity by resisting compulsory sexuality, including the social values and expectations surrounding sexual experience. Such a commitment could therefore reinvigorate a conversation on societal expectations, and de-stigmatizing both sexuality *and* asexuality.

Curating the Asexual Archive

As I have discussed previously, online spaces have an inherent archival quality to them; However, this can make online discourse a tricky thing with which to engage. Ianna Hawkins Owens describes the complicated and sometimes messy process of engaging with online asexual archives in this way:

> One of the frightening things about the internet is its (possible) permanence. Everything we ever did wrong, there for all to see. But one of the simultaneously most promising things is that as an archive of our failures, an archive of our process, the messy work of building community together is also available for all to see. How have we tried, how have we failed, how have we tried again? What tools have we developed that might help other people, struggling toward communion and political change?

Therefore, though online spaces have often been disregarded by academia as unreliable and frivolous, it is in fact critical that we recognize the important archival work happening in such spaces, and give credit to online contributors as the archival curators they are. In this section, I return to Cooper and Przybylo's conception of the asexual archive to discuss the qualities of the OP-commenter discourse—in addition that of patient-practitioner—to highlight trends in online ace discourse, as well as to identify gaps in the conversation.

The analysis undertaken for this research has revealed that online ace discourse is not generally negative, even though the majority of the interactions were. As noted in the findings subsection "A Necessary Vulnerability: 'Coming Out' to Our Doctors," many OPs and commenters were perfectly capable of recognizing a good experience or a skilled practitioner, and did not hesitate to do so. While OPs and commenters expressed excitement about encounters with "ace-friendly" practitioners, their comments about practitioners who were not "ace-friendly" was nevertheless nuanced. Those with negative experiences often noted that these were talented, effective practitioners *except* when it came to asexuality, or made sure to mention when they had experienced a positive encounter with a different practitioner. In other words, the discourse was not generally inflammatory in nature—these online spaces established themselves as a place not only to express frustration or confusion, but to also share good news, or offer support and encouragement to others. I think this is important to recognize, as it indicates that OPs and commenters were by no means feeding on negativity.

In addition to this positive tone, another key characteristic of the online discourse was its self-awareness. Given the frequency of pathologization and invalidation experienced by asexuals who have "come out," many online contributors exhibited a heightened awareness of the impact online asexual discourse can have on outsider perceptions of the community. This was especially the case when hormones, mental health, and disability were being discussed; A concern was often expressed that an outsider might make logical leaps with the information, assuming that since some asexuals also grapple with other health issues, asexuality must always be a symptom of these other issues. As com_port described it on Reddit: “The way I see it people who are just discovering or having issues with asexuality are probably going to be visiting this subreddit and as such this subreddit becomes a representative for the asexual community.”

In a poll that was established on AVEN to identify how many folks in the community have mental health challenges, a number of contributors speculated about the possible relationship between asexuality and mental health. In response, shinyostrich called attention to the difference between causation and correlation, stating that they did so because “I just wanted to make sure that no one jumps to the conclusion that asexuality causes anxiety and depression, or that depression and anxiety cause asexuality, when they are simply correlated. Another contributor, Mysticus Insanus, was more direct in voicing their concern, simply posting, “I'm afraid that some folks are going to have a field day with that poll result” because the poll indicated that over 90% of the 270 respondents had responded affirmatively to the poll’s only question, “Do you ever had have [sic] any mental health issues?” Whereas the discourse in other queer communities is generally protected from outsider manipulation (when the community can meet in a physical location), much of the asexual discourse is online and therefore wholly public.

Therefore, online contributors have made a concerted effort to curate online spaces in a way that would make the discourse less susceptible to exploitation.

While this kind of archival curation is partially a strategy of survival, as well as an attempt to foster greater visibility for asexuality, it can also easily transform into a discourse steeped in identity politics. Kim explains that "pathologizing asexuality puts asexual people on the defensive and leads them … to insist on their normality by using the language of their critics," effectively perpetuating ableist binaries. Across all three platforms there was still some disagreement about whether or not asexuality *can* sometimes be a symptom of a health condition—and whether or not this matters. I noted that some OPs and commenters were occasionally conflating sexual attraction and libido, which appeared to contribute to the disagreement. As curators of the asexual archive (intentionally or unintentionally), online contributors are certainly not obligated to agree. However, it would seem that the discourse could benefit from a transcendence of these kinds of debates which are rooted in identity politics, and can quickly alienate people with other health struggles. Kim elaborates on the impact of such discourse when she says

> Speaking of sex and its absence in the name of health easily falls into the moral and ableist binary of the *good body* and the *bad body*, and it relies on dominant able-bodied (hetero)sexual sex and gender expectations rather than presenting sex as composed of unpredictable and diverse practices, emotions and reasons. (160)

Engaging in these kinds of asexual identity politics, therefore, could be erasing asexual people who experience illness, disability, and neurological differences (160). This discourse has the added effect of potentially alienating asexual people who belong to groups which have long been labeled as *not* sexual—because of their age, disability, health, race, gender, class, or appearance—giving the example of Asian American men (161).

The Decentering of (R)ace Discourse

There were other instances where it appeared the asexual archive was not being curated so intentionally. Overt identity politics were *relatively* sparse in conversations of health care experiences, and many of the blatantly discriminatory posts were at least a few years old. However, just because the identity politics were not blatant does not mean they do not exist in these online spaces. A direct discussion of race was completely absent from the online ace health care discourse, which is telling when we consider the critiques Ianna Hawkins Owen has laid out online and in her scholarship. I find this erasure shocking and counter-intuitive, particularly because compulsory sexuality is certainly informed by race dynamics and stereotypes, and therefore manifests differently for asexuals who are white and asexuals of color.

Online ace discourse centering on virginity and how it plays into health care practices and perceptions is rife with opportunity to discuss who, by society’s standards, is an “acceptable” virgin, populations that have higher levels of celibacy (and why), and especially how race and virginity (and therefore race and asexuality) interact. With prevailing stereotypes labeling black folks of all genders as hypersexual, Latinas as “spicy,” and Asian women as sexually submissive, white ace-identifying patients who “come out” to their practitioner (either as asexual or as a virgin) are likely to receive a different reaction than would a person of color. Furthermore, the general research shows that, like the LGBTQ community, there are significant health disparities within communities of color. However, because this was never addressed as a factor in the existing discourse, it is impossible to say how much race may have been a factor in these interactions.

There are plenty of ace scholars and activists calling for a larger conversation about the role of race in asexuality—Ianna Hawkins Owen is just one of these scholars. Vesper, a prominent YouTube content creator and Tumblr contributor with the handle “QueerAsCat” has been at the forefront of these discussions for many years—integrating lived experience with queer and feminist theory on both platforms. It is promising that they have gained significant visibility in the online community, but there is still much to be done to center race in ace discourse. During my data collection, I came across multiple forums where aces of color were questioning why this was not a more prominent topic of discussion. Given the persistence of racial-sexual stereotypes, and the AVEN censuses which show that the majority of its users are white, it is the responsibility of all of us in the community to be interrogating these racially-charged barriers to accessing identity.

A 2011 forum on AVEN entitled “Race and asexuality,” created by an online contributor called Siggy, is one of a small grouping of forums and posts which attempt to directly address the intersection of these identities. Siggy begins the forum by asking, “What are the issues at the intersection of asexuality and race/ethnicity?” admitting that they don’t know of any, yet recognizing the naivete of “assum[ing] that there are none just because I haven't heard of them.” As this research—coupled with my own personal experience in online asexual spaces—has revealed, it is uncommon for a contributor to bring attention to this intersection. Confusion about or resistance to such a discussion was evident within the 2011 forum post, where other members openly questioned whether there *truly was* an intersection between ethnicity or race and asexuality. These members often drew on personal experience, but Siggy pointed to the bigger picture, putting forth the observation that, while “[t]here are very few visible asexual people at all,” within this category of visible asexuals, “they’re mostly white.” Perhaps most importantly, Siggy suggests that it is necessary to address and remedy this lack of diverse asexual visibility “for the long-term health of this movement.” Siggy’s use of “health” language of “health” to refer to asexual movement-building effectively reinforces the goals of this thesis to address both literal and figurative asexual health.

The more recent posts utilized for this research project reveal that common discourse on asexuality and race has not evolved significantly since this 2011 forum was posted. It is evident that although intersectionality has become a greater part of the common discourse in online activist communities since 2011, there nevertheless remains a sizeable need for more complex understandings of the concept. It is therefore necessary to make concerted efforts to integrate race into online asexual discussions on a wide variety of topics—health care and asexuality included. Such an effort could enhance understanding of the ways in which race and a/sexuality are nearly always interacting with one another—on the individual level, the structural level, or both simultaneously. In the next section, I discuss recommendations based in the research findings; While my discussion of race and asexuality is primarily located here, in the implications of this thesis, I nevertheless put this topic forward as a critical element of any future studies on asexual health and wellness, as Siggy suggests it should be.

Recommendations

The following recommendations are intended not just for health care practitioners, but also to serve as a tool for ace activists, and to support further research on asexuality and health using an intersectional lens. In this section, I address the need to build relationships of trust between patient and practitioner, the potential of more intentional coalitions between asexual and other marginalized communities, and the opportunity for resource-building within *and for* the asexual community. This discussion includes a consideration of the work practitioners must take up to foster better communication in health care, making distinctions between LGBTQ- and asexual-focused health care, and addressing the fraught relationship between asexuality and other identity categories

Health Care Providers: Learning and Listening

The emergence of asexuality as an identity over the past decade or so has brought to light a number of unhealthy assumptions about relationships. Pushing back against compulsory sexuality and amatonormativity, many in the asexual community have stressed that the litmus test for a healthy relationship is not whether or not sex and romance are present. Instead, online asexual contributors suggest that healthy and happy asexual relationships are attained and maintained through communication, trust, and consent. However, such practices hold incredible value for *any* person engaging with others, be it in friendship, romance, or any other kind of relationship. Having exposed the high levels of distrust present in patient-practitioner interactions, and the poor modes of communication enlisted in these interactions, the findings of this study suggest that patient-practitioner relationships could also benefit greatly from the above mentioned values.

To attain a strong patient-practitioner relationship, and thus improve the quality of care, it is necessary for practitioners to practice self-reflectivity. This would allow the practitioner to consider the inherent power imbalances in health care interactions created by difference in education and access to resources. Although patients often do not have the level of medical knowledge typically held by a practitioner, they must nevertheless be trusted to (at minimum) know themselves. Furthermore, practitioners must be willing to engage in conversation with patients about how they access health care information. Rather than dismissing a patient's beliefs or understandings with a flippant "Don't trust the internet," practitioners should take the time to understand what informational resources are accessible to the patient, and perhaps even provide support on finding credible sources. Expressing respect for patients as competent, capable human beings should be the *baseline* of patient-practitioner relationship-building.

Additionally, the health care experiences documented by asexual folks online indicate a dire need for practitioners to interrogate their assumptions, which have been heavily informed by compulsory sexuality and amatonormativity. While LGBT-competent gynecologists, therapists, and general practitioners were sometimes also more “ace-friendly,” this was not always the case among the narratives. Instead, these narratives revealed that homonormativity *as well as* heteronormativity were present in practitioner discourse—more than one doctor assumed that if the patient was not sexually active, they must therefore be a closted LGBTQ individual. Therefore, in addition to improved listening and comprehension skills, quality of care for asexual patients could be improved via a commitment to lifelong learning and self-reflection.

Finally, it was made clear from the findings that practitioners need to be more explicit in expressing their acceptance of, or support for, asexuality. AnnaLogology on Reddit, a self-identified trans woman who is also a therapist herself expressed this need, stating, “I honestly don't trust another person to take my sexual identity seriously until they have expressed affirmative understanding and support. Which happens extremely rarely.” As noted in the findings, even asexual patients who described neutral or positive experiences were often insecure about having their practitioner’s full trust and support in regards to their identity.

Although the ultimate goal expressed in much of the online discourse was for asexuality to be normalized as “no big deal” in health care, the present invisibility and persistent challenging of asexuality necessitates a more explicit verbal confirmation of support made by the practitioner. However, we cannot expect a widespread adoption of this supportive approach without first establishing asexual-competent training in health care and clinical settings. At present, asexual patients take on most of the labor in educating their practitioners about asexuality. Although it was expressed in the findings that this one-on-one educational process ultimately yielded positive health care results for many ace patients, this should not be their burden to bear. Therefore, in addition to introducing more comprehensive LGBTQ cirriculum in health care as noted in Chapter 2, a much greater emphasis must also be placed on interrogating compulsory sexuality in medical training curriculum.

Asexual Activism: Coalition-Building Efforts

In her interview with *The Asexual Agenda*, Ianna Hawkins Owen puts forth the following: "Asexuality will never exist in a vacuum and so, as an activist-minded group, how does the mobilization of an asexual orientation speak to other struggles for justice?" Hawkins Owen's comment, when paired with the findings of this thesis, alludes to the potential for asexual communities to build coalitions with other communities and activist movements. In regards to health care specifically however, there are many marginalized populations disproportionately impacted by the flaws in these systems. In this section, I draw a number of parallels between asexual and other marginalized communities to argue for a more intentional web of queer memory, so that we might better learn from the successes and failures of queer activism and theory, both throughout time and across communities/landscapes (Irving 15). To address Hawkins Owen's proposal, I briefly consider asexuality's relationship with the following: Indigenous movements for decolonization; crip theory and activism redefining disability, chronic pain and illness; advocacy for survivors of sexual violence; transgender and nonbinary folks.

Because of the ways asexuality as an identity inherently pushes back against compulsory sexuality, asexual activists also have a responsibility to challenge Western conceptions of sexuality through an intentional support of the decolonization efforts being made by Indigenous and Two-Spirit movements. As I have noted previously, a larger conversation of race is absent from the discourse. If we in the ace community don't stimulate an early intervention, not only is there the possibility that asexual politics will remain/become "normatively white and non-Native," but the potential for exploring this way of being and doing in complex and positive ways could be lost by ignoring gender and sexuality as colonial constructs (Morgensen 137).

Gender and sexuality have been formulated as colonial constructs in large part to manage Indigenous peoples' gender roles and sexuality—a practice which was "key in remaking Indigenous peoples into settler state citizens" (Arvin, Tuck, Morrill 15). This process included the regulation of land rights through marriage, the residential school system's enforcement of Western gender roles (and participation in sexual violence), and the blood-quantum policy. Analyzing constructs of asexuality in this manner is therefore to the benefit of all parties—non-Indigenous aces, Indigenous aces, and allosexual Indigenous peoples.

Using Indigenous activist frameworks to reveal gender—in addition to sexuality—as a colonial construct is also rife with coalitional possibilities. Trans scholarly and activist critiques of "the lasting legacy of the medicalization of trans people" are particularly pertinent to asexual movement- and coalition-building strategies—especially when coupled with Indigenous commentary on the colonization of supposedly "abnormal" bodies (Irving 38). Both trans and ace communities have felt the heavy burden of pathologization, and both communities have faced significant vitriol in queer spaces—simultaneously located in ambiguous territory (both trans and ace identities are not always inherently queer in the way that LGB identities are) and perceived as threatening to the “validity” of queerness. Such shared experiences can build bridges between movements for trans and ace health care reform, can complicate conceptions of asexuality and trans-ness as pathological and in need of treatment, and can center Indigenous and queer of color critiques and voices in the process.

Eunjung Kim writes extensively on the relationship between asexuality and disability, and her critique of a system which puts these communities in a position to mutually oppress one another suggests there is far more to gain if we instead build coalitions to resist this system. This particular kind of coalition is described at length in Chapter 2, but it is important to reiterate, as the findings of this project provide further support for such coalitions. Many OPs and commenters shared that they were managing disability and neuro-atypicality, but there was a hesitancy to include this and asexuality in the same conversation. A fear of associating with the “other,” when overcome both by asexual folks and those experiencing disability, can thus lead to powerful coalitions that can simultaneously de-stigmatize disability and asexuality.

There is also significant overlap between asexuality and survivors of sexual violence. Compulsory sexuality and the use of “corrective” rape have contributed to higher rates of sexual assault committed against ace-identifying people (Mosbergen). Conversely, the findings of this study indicate a tendency among practitioners to misdiagnose asexual individuals as suffering sexual trauma. As with asexuality and disability, this practice suggests an essential link between the two, and can provoke both survivors and asexual folks to argue that the two experiences are mutually exclusive—and in doing so invalidate the experience of ace survivors of sexual assault. However, this too can be reframed as a site for coalition-building, rather than one of mutual invalidation.

I draw parallels between the aforementioned communities—not to make an overarching statement about how “we” are all more similar than different—but to argue for stronger alliances across identities. In relation to this research project and its focus on online communities specifically, Tumblr and Reddit have been revealed as platforms for coalition-building through intentional cross-community conversations—which ultimately become intersectional archival practices. And of course, it should be stated that there is significant overlap between these identities on an individual level—a concept which seems to be continually forgotten and/or ignored despite Crenshaw and the work and writings of so many women of color. The findings of this research are proof of Hawkins Owens claim that asexuality does not exist in a vacuum—neither on the individual nor the community level. Therefore, in addition to “inheriting the legacies” of our queer and marginalized ancestors, we must also “inherit” the challenges of our queer and marginalized peers, assuming the mantle of their struggles (Irving 15–16).

In Namaste and Sitara’s chapter, “Inclusive Pedagogy in the Women’s Studies Classroom,” the authors call for a “broader conception of justice,” one that moves beyond “the identity-based frame of reference” (223). This is not to say that identities should necessarily become obsolete or homogenous; Instead, we must envision a “relational, historicized model of the self that remains sensitive to context while… encompass[ing] ‘technologies of the self’—a term defined by Foucault as technologies which

> permit individuals to effect by their own means or *with the help of others* a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or *immortality* [emphasis added] (Heyes 206, Foucault 16).

That is to say, the "technology" of "queer collective memory" which Irving suggests is born from these alliances, and simultaneously creates new possibilities. This "technology" thus makes space for a more radical movement that has the capacity to extend across identities, and across time, to both remember what has come before and to ignite a "desire [for] a future we can't even imagine" (Bassichis, Lee, and Spade 665). When applied online, a technology of memory built across communities becomes an important addition to the asexual archives—documenting processes, challenges, and failures of our coalition-building endeavours. Thus, such coalitions allow us to draw on the asexual archive—to intentionally reflect on the premises upon which we base our arguments and visions for health care reform, to call for a truly intersectional and holistic kind of care.

To return to Cooper and Przybylo's notion of an asexual assemblage of "personal asexual archives," I believe this assemblage could take the form of digital activism and participation to encourage an interrogation of "public and personal disinterest in asexuality [that] leads to broader questions" outside of standard identity strategies (311). However, as I have elucidated here, such a digital assemblage has great potential—and responsibility. As the most recent (though hardly comprehensive) demographic data shows, the community of folks identifying as asexual or on the asexual spectrum (i.e. demisexual, greyasexual, etc.) online is overwhelmingly white. The Asexual Visibility and Education Network's (AVEN) 2014 census revealed that 63.6% of its members were American, and 77.3% identified as white (Ginoza et al.). Though this is certainly being questioned by asexual scholars and activists of color, my research has shown that it is by no means a dominant discourse. Given what we know about the histories of whitewashing in other social movements—feminist and LGBTQ+ rights, for example—I believe there needs to be a far more intentional centering of women of color in asexual activism. In addition, and assuming that every digital activist/participant who identifies on the asexual spectrum has an archival responsibility as I have argued, all quotidian discourse in online asexual spaces—whether explicitly activist or not—must strive to center women of color to resist the very possible whitewashing of yet another social movement.

Asexual activists, both on- and offline, are already doing the work of challenging colonial definitions of and assumptions about sex and sexuality. However, to be authentically decolonial and anti-racist in this work, and to avoid erasing and/or appropriating activist of color histories and strategies, there must be an intentional commitment to activism/archivism as curanderismo. Drawing on Indigenous concepts of time and responsibility, we as asexual activists participating in online spaces must acknowledge our status as future ancestors who are presently in the act of telling our stories.

Expanding Support Networks, Developing Resources

There are a fair number of existing asexual resources which have been curated specifically to educate practitioners—for example the "Asexuality & Mental Health" page on AsexualSurvivors.org, and a PDF handout entitled "Asexuality: Basics for Health Professionals," also provided by the same website. These materials are suggested for practitioners who are seeking to learn more, and are also offered as a resource ace folks can take with them when visiting the doctor. However, my research suggests that there are very few resources aimed at making it easier for ace-identifying people to find "ace-friendly" practitioners. While nearly every forum and comment thread alluded to at least one positive experience with a practitioner, there is no aggregate platform where the names and contact information for such providers can be documented and widely accessed by community members.

I am by no means the first person to suggest such a resource—while a few of those who cited positive experiences also offered to provide contact info (one post even mentioned the provider by name), it was also proposed by more than one online contributor that such information should be collected on a larger scale. The findings of this research suggest that a great deal of trial and error went into identifying an "ace-friendly" (or at least "ace-tolerant") practitioner—online contributors cited cycling through as many as four providers before finding such a practitioner. This kind of trial and error is not only mentally exhausting, but can additionally be incredibly expensive. There is a clear need for a kind of centralized platform where community members can (anonymously) submit practitioner information, and perhaps even provide ratings and reviews. This would also create a space where practitioners themselves could advertise that their services are open and welcoming to asexual patients seeking care.

Although the issue of asexual health and wellness could benefit from being addressed in a myriad of ways, both scholarly and practical, the findings of this study show that many ace-identifying people could directly benefit from the kind of resource guide I allude to here. In creating such a guide, we as a community can begin to address health disparities in an intersectional manner—making access to safe, effective, and "ace-friendly" care a reality for aces with diverse experiences and from a multitude of social locations. Folks in the ace community have already created so many powerful online spaces which foster fruitful dialogue and offer wonderful resources. Based on the findings of this study, a comprehensive "ace-friendly" provider resource guide would be an excellent addition to these resources.

Limitations of the Research

A shortage of demographic data on asexual populations—online or otherwise—presents a significant barrier for this thesis project. As noted in the Chapter 3 section entitled "Positionality," doing research in online communities at present necessarily means that the diversity of the population in question will be unknown and/or limited. In one sense, the demographic data is irrelevant because the online discourse reveals that at least some asexual individuals are experiencing barriers to health care because of their asexual identity, when ideally *none* of these individuals should be encountering such barriers. This is in line with Aurora Levins Morales' concept of curandera-based history, which centers *testimonio* and “seeks to be provocative rather than comprehensive, looking for potency, more than accumulation of information” (25). However, in another sense—and given that regular internet access remains out of reach for over half of the world’s population—there are *many* voices missing from the conversations collected and analyzed for this thesis, and these absences must be made visible according to Levins Morales. In Levins Morales’ “curandera’s handbook of historical practice,” the author points out that

> [w]hen you are investigating and telling the history of disenfranchised people, you can’t always find the kind and amount of written material you want. But in medicinal history the goal is as much to generate questions and show inconsistencies as it is to document people’s lives.” (27)

While valuing online discourse does in some ways refuse to “accept an immense body of experience as unavailable,” it is nevertheless still relying on written forms of documentation, and thus maintains the Western, colonial assumption that written histories are most valuable (Levins Morales 29).

Therefore, it is critical to interrogate how the systemic barriers faced by many marginalized populations and individuals are likely to lead to a lack of internet access—for people of color, people living in rural areas, people with disabilities, people living on or below the poverty line, and so on. Recognizing such barriers emphasizes whose voices are generally not present in online asexual discourse, and therefore in this study. Although demographics regarding online asexual populations are rare, AVEN’s most recent census from 2014 seems to support this hypothesis about the absence of particular voices. For example, a majority of the census respondents were either high school, undergraduate, or graduate students, and a majority of non-student census respondents had earned either an associate's, bachelor’s, and/or master’s degree (Kame Ginoza et al. 3). Pairing this with the census finding that 77.3% of AVEN’s 2014 census respondents identified as non-Hispanic white reveals that much of the discourse has been created and curated by educated white asexual individuals (Kame Ginoza et al. 5).

Although there is not yet any comprehensive demographic data on Reddit’s or Tumblr’s asexual community, the lack of diversity indicated by the AVEN census suggests that this thesis has been shaped by particular voices, and is therefore limited in its scope and ability to be generalized in certain ways. Additionally, AVEN’s 2014 census data suggests that the majority of people accessing asexual resources and forums on AVEN’s website are in their early 20s (Kame Ginoza et al. 2). This means that the voices of older asexuals navigating health care systems are generally missing from the discourse, and thus a number of topics which impact older people disproportionately have likely not been represented by this thesis. Since it is known that other marginalized populations experience shortcomings in health care services due to their social location and various identities, further research is needed to explore the experiences of a more diverse asexual population. Ideally, such research would combine quantitative and qualitative methods to collect more demographic data *in tandem with* the collection of personal narratives.

Chapter 6: Conclusion

In the previous chapter, I summarize the implications and recommendations of this research study. I show how the findings highlight asexuality as a factor in negative health outcomes, discuss the gaps in gynecological care for both ace and allosexual patients, and position online contributors as curators of the asexual archive. In addition, the results of this study present an opportunity for practitioners to enhance their approach to patient-practitioner dialogue and culturally competent care and training. I also suggest that there remains a need for asexual communities to build stronger, more intentional coalitions with other marginalized communities, and to expand support through the creation of additional online health care resources. In the following and concluding chapter of this thesis, I review the material which has been covered by the research, and conduct a final synthesis of this material.

The qualitative research approach employed in this study used online discourse to document and assess the experiences of asexual- or ace-identifying individuals with practitioners in the medical industrial complex. Through this process, the thesis sought to address the following research questions: (1) How do ace individuals approach and navigate discussions about their health and wellness with health care providers? and (2) What is the relationship between asexual identity and the ways one accesses health care? Although the sample size of this study by no means represents the experiences and attitudes of all ace individuals who interact with health care systems, the findings nevertheless demonstrate that a significant number of ace individuals have had negative experiences with health care practitioners as a result of their asexual identity.

Results of this study indicate that many ace individuals were moved to "come out" to their providers, but their motivation for doing so varied; While some ace individuals cited that their identity as asexual was a key component in addressing their overall health and wellness needs, others were merely exasperated, and used their identity as asexual to put an end to relentless questioning by their practitioner. Additionally, while some ace individuals came out to their providers as asexual, it was additionally common for aces who were also virgins to "come out" as virgins. Results show that when patients felt comfortable including their asexual identity in the health care process—and were supported by their practitioner in doing so—the quality of care produced higher satisfaction rates. Conversely, patients who "came out" and were met with doubt, resistance, or invalidation were less likely to return to a practitioner, or to a type of health care service more generally.

The findings also demonstrate that social constructions of virginity, rooted in notions of compulsory sexuality, affect medical attitudes and approaches to care. When ace patients who have never been sexuality active revealed as much to their practitioners, reactions ranged from incredulousness to denial, shock to slut-shaming. The research suggests that reactions such as these may be influenced by cultural norms which prompt patients to lie about their sexual history, resulting in heavy skepticism on the part of the practitioner. However, these cultural influences are no excuse for the derogatory discourse utilized by some practitioners, which dismissed patients' lived experience and trivialized their bodily autonomy. Narratives analyzed for this project show that this discourse, paired with treatment regimens based in compulsory sexuality, had a negative impact on asexual patients' quality and focus of care. Relationships of mistrust were commonly noted in the online discourse, with many contributors not being certain of having a practitioner's full support, respect, or trust. Even when interactions were described in a neutral or positive manner, OPs and commenters frequently noted this lack of feeling believed.

Additionally, results demonstrate that asexuality intersects with other identity factors, significantly altering the nature of encounters in the medical industrial complex. Narratives detailed the ways in which medical citizenship can and is denied to asexual individuals based on class as well as a/sexual identity, and that for ace immigrants, health care requirements may take away their bodily autonomy or impact their access to resources. These narratives additionally indicate that asexual individuals with chronic AFAB (assigned female at birth) genital pain and illness faced additional barriers, revealing the misogyny of ineffectively or wholly failing to address these experiences in the health care context.

The implications derived from the compiled themes outlined above reveal that though asexuality should not be pathologized, it *should* be considered a health risk factor given the discrimination faced by asexual patients in the health care context. The narratives in this study illustrate that the increased vulnerability asked of a patient in the fields of gynecology and therapy put asexual patients at increased risk in these situations. However, the findings also revealed that general approaches to gynecology could be doing a disservice to allosexual patients as well as asexual, and that making changes to this approach (such as revising the Pap smear "rule of thumb" and advocating for the freedom to express a/sexuality) would be to the benefit of all who seek gynecological services.

Finally, this study highlights the immense value of online asexual discourse and those that contribute to it—both in regards to health care and more generally. Asexual communities have created rich archives which document the history, progress, and quotidian experience of asexual individuals transnationally. However, academic scholarship is generally lacking in literature which earnestly values the work of online contributors. While the academy has always been slow to change, the internet is no longer a new and unfamiliar entity—for much of the world, it is an inescapable part of day-to-day reality. Therefore, future research should continue to further recognize the value of online community discourse, while also incorporating the voices of online contributors reflectively and intentionally. In regards to scholarship on asexual communities specifically, future research must strive to consistently situate asexuality in a web of intersecting identities—to consider race, class, gender, ability and more, no matter the project's focus. As the findings have elucidated, this kind of commitment is needed to resist what has too often become a homogenization of asexual identity, as well as its movement-building efforts and scholarly endeavors.

To conclude, the results of this study illustrate the immense need for a greater commitment to communication—as well as an openness to new concepts and identities—on behalf of health care providers. Building patient-practitioner relationships of trust is key to improving health outcomes for asexual communities (as well as for patients more generally). However, findings indicate that there is also a great deal of opportunity for asexual communities to come together with other overlapping marginalized communities to build coalitions for better health care services. Expanding these networks of care, and creating resources to assist with access, has the potential to enrich ace communities and their discourse—as well as to begin the much-needed processes of imagining and building more inclusive, consensual, and approachable health care services.

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