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"Your Brain Isn't All Backwards": Asexual Young Women's Narratives of Sexual Healthism

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Abstract

Scholarship on asexuality is a growing but underexplored area in the social sciences. In the U.S., asexual people (i.e., individuals who do not experience sexual attraction) navigate a society in which being a sexual person is regarded as a normal and even compulsory aspect of human health and subjectivity. Utilizing an asexual subsample from a broader study of queer young women, this article integrates Foucault’s theorizing around sexuality and repression with scholarship on healthism to examine how discourses of sexual healthism operate among asexual young women in the U.S. South. We argue that in rejecting theories of sexual repression and compulsory “healthy” sexuality, asexual young women both confirm and resist the moral authority and power of religious and health discourses to affirm their identities and find language and communities to make their experiences more intelligible to themselves and others. Our analysis advances emerging scholarship on sexual healthism and its discursive and material effects on marginalized groups.

Keywords

asexuality, asexual identity, in-depth interviews, identity formation, healthism

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"Your Brain Isn't All Backwards": Asexual Young Women's Narratives of Sexual Healthism

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Scholarship on asexuality is a growing but underexplored area in the social sciences. In the U.S., asexual people (i.e., individuals who do not experience sexual attraction) navigate a society in which being a sexual person is regarded as a normal and even compulsory aspect of human health and subjectivity. Utilizing an asexual subsample from a broader study of queer young women, this article integrates Foucault's theorizing around sexuality and repression with scholarship on healthism to examine how discourses of sexual healthism operate among asexual young women in the U.S. South. We argue that in rejecting theories of sexual repression and compulsory "healthy" sexuality, asexual young women both confirm and resist the moral authority and power of religious and health discourses to affirm their identities and find language and communities to make their experiences more intelligible to themselves and others. Our analysis advances emerging scholarship on sexual healthism and its discursive and material effects on marginalized groups.

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Introduction

In Foucault's (1978) pathbreaking book, *The History of Sexuality: An Introduction, Vol 1.*, he debunked Freud's (1915) "repressive hypothesis"—the notion that sexuality has been silenced in Western society. Foucault theorized that rather than repressing some inherent, underlying sexual drive (as Freud argued), Western society's moralistic and religious discourses on sex produce specific norms and practices of sexuality, rendering some expressions of sexuality normal and natural, and others abnormal and unnatural. Sexual discourse proliferated in multiple ways throughout the nineteenth and twentieth centuries, allowing sexuality to seep into all aspects of social life and, importantly, to become understood as a core dimension of the modern self. As a result of these dynamics, the concept of sexual identity—and the binary of "heterosexual" and "homosexual"—was invented (Katz, 2007). Since the late 1800s, sexual identity categories have multiplied and proliferated under the "rainbow umbrella," including but most certainly not limited to: lesbian, gay, bisexual, queer, pansexual, and asexual.

By conceptualizing a relationship between power and knowledge that produces what we think we know to be true about sexuality, Foucault theorized how the facile acceptance of the repressive hypothesis exercises power in people's lives (Foucault, 1978). Too often, acceptance of the repressive hypothesis, as a commonsense truth about human sexuality, generates a false binary in which people perceive themselves as either internalizing or resisting this repression of their presumed inherent sexual drive. By exhorting people to think

about sex beyond the simplistic binary of sexual "repression" and sexual "liberation," Foucault revealed how the production of what sexuality "is" – or that we imagine it to be – has material consequences for all, but especially those deemed sexual "others" (Epstein, 2003; Seidman, 2014).

Beginning in the 1990s, the discourse on sexuality contributed to the production of the concept of "sexual health," which has since proliferated across multiple domains, creating a curious, ideologically-inflected relationship between sexuality and health (Epstein & Mamo, 2017). Its appearance in discussions of sexual rights, sexual responsibility, sexual violence, sexuality education, sexually transmitted infections, and contraception, to name but a few arenas, highlights how the term "sexual health" is "remarkably plastic" (Epstein & Mamo, 2017, p. 176). Further, Epstein and Mamo note that its flexibility has allowed to produce "sexual healthism."

Bridging sociological theorizing on medicalization with Foucault's (1991) writings on governmentality, Robert Crawford defined healthism as "a preoccupation with personal health as a primary focus for the definition and achievement of well-being; a goal which is attained primarily through the modification of life styles" (Crawford, 1980, p. 368). Healthism thus captures a phenomenon that emerged in the 1970s in Western society: a scientific and religion-influenced moral "obligation" for individuals to maximize and promote their health, in part through their work to reduce perceived risks that threaten it (Brian et al., 2020; Crawford, 1980; Epstein & Mamo, 2017; Metzl & Kirkland, 2010).

The ideology of healthism hinges on the assumption of an individual's personal responsibility to engage in healthy behavior as a moral responsibility (a core tenet of religious philosophy). This "imperative of health" (Lupton, 1995) or health-as-religion (Pelters & Wijma, 2016) emerged as the state retreated from its role in providing healthcare and meeting the basic social and economic needs of members of the nation. By shifting the burden onto individuals to manage their health, by assimilating to social norms regarding what is deemed healthy via the medicalization of everyday life, including "problems with sexual functioning" (Crawford, 1980, p. 370), the structural underpinnings of health inequities are erased and those who are deemed "unhealthy" are held responsible by society due to perceived health risks.

As Metzl and Kirkland (2010, p. 5) write: "American society's incessant talk about health produces and regulates itself and its subjects, while making it increasingly difficult to get outside of health." Just as the discursive power of sexuality as a scientific fact permeates multiple areas of social life, so too does the powerful notion of health as a moral imperative and nearly-religious doctrine—a "correct" way of being and living. "Health," therefore, is not simply an absence of disease or a "desired state," but a "prescribed" state, which ultimately determines what kind of person you are (Metzl & Kirkland, 2010). Building on this understanding of healthism, "sexual healthism" refers to the way sexuality is constructed as a "biomedical and lifestyle issue" that is often stigmatized when perceived as deviant; however, it can be managed and optimized by individuals, provided they undertake normative practices to achieve "sexual health" (Epstein & Mamo, 2017, p. 178; see also, Brian et al., 2020).

An important element of sexual healthism is the culturally-specific assumption that experiencing sexual desire and engaging in (responsible) sexual behavior is a normal part of being a healthy adult (Kim, 2010). One sexual identity group that disrupts this notion is asexual people — those who do not experience sexual attraction, desire, and/or interest in engaging in sexual behavior (Bogaert, 2015). Thus, while the binary of heterosexual and homosexual (i.e., straight and gay, to use more contemporary terms) endures, so too does the binary of sexual and asexual, which similarly positions the former as normal, natural, and healthy and the latter as abnormal, unnatural, and potentially in need of a (medicalized)

treatment or cure. Practices of "sexual self-expression," through the pursuit of sexual pleasure and enjoyment, may also contribute to sexual healthist discourse through the supposition that "the opposite of sexual health…is a lack of enjoyment" (Epstein & Mamo, 2017, p. 183), thereby implying that asexual people lack sexual health precisely because they do not desire or enjoy sex.

While medical professionals have attempted to diagnose asexual individuals with disorders such as hypoactive sexual desire disorder (HSDD) or female sexual interest/arousal disorder (FSIAD), asexuality has never been deployed as a medicalized category in the way that homosexuality was (Carroll, 2020; Chasin, 2013; Fishman, 2004; Van Houdenhove et al., 2014). Nonetheless, embracing an asexual identity can still be understood as a mode of resistance against the medicalization of non-normative sexualities in part because the very existence of asexuality contests the ideological assumption that people must experience sexual attraction and an interest and/or engagement in sexual activity in order to be considered "healthy" (Kim, 2010; Scherrer & Pfeffer, 2017). By carving out their own unique vocabulary, in which absence of sexual attraction is constituted as a way of being rather than a disorder to be cured, asexual people construct identities that simultaneously draw on a discourse of sexual healthism while refusing what we might call "the will to sex."

In the following pages, we draw upon interviews conducted with a subsample of asexual young women, drawn from a larger study of LGBTQIA+-identified young women's experiences, to examine the social construction of asexuality. We offer an analysis of young asexual women's narratives regarding the intersection between asexuality, their identities, and healthist discourse. While scholars have attended to the complexities of coming to an asexual identity and myriad classifications of asexuality, limited attention has been paid to how these processes affect asexual individuals' understandings of their sexual health. By analyzing asexual young women's narratives about their identities in the context of broader (scientific and religion-infused) discourses on sexual repression and sexual healthism, this article advances the burgeoning literature on asexuality.

Constructions of Asexuality

Significant contestation exists in the academic literature regarding the most appropriate way to classify asexuality (Brotto & Yule, 2017; Scherrer & Pfeffer, 2017). One major, community-based voice that is often referenced in the academic literature surrounding this contestation is that of the Asexuality Visibility and Education Network (AVEN), an online community space for individuals on the asexual spectrum (Carroll, 2020; Dawson et al., 2018; Van Houdenhove et al., 2014). AVEN founder David Jay created the site to be a positive space for asexually identified individuals to connect and share experiences with each other and with those who may be questioning their own (a)sexuality. Due to the lack of shared spaces and visibility for asexual individuals in the social world, AVEN has become a central mechanism for asexual individuals to identify and describe their views, experiences, and, more than anything, their identities.

Asexuality is somewhat distinct, however, from other sexual identities and what is often referred to as "sexual orientation." While many individuals choose to refer to themselves as "asexual," the fact that asexual individuals may experience romantic and/or sexual attraction to varying degrees creates a multitude of identities that asexual community members occupy. For example, "grey-asexuality," or "grey-A," functions as a spectrum-within-a-spectrum, encompassing those whose identities fall in a "grey area" between sexuality and asexuality (Carrigan, 2011; Chasin, 2013). Some asexual individuals choose to denote their experiences of romantic and sexual attraction within their identities more specifically, occupying identities such as "heteroromantic asexual"—romantically attracted to

other genders, though still not experiencing sexual desire and/or attraction, "sex-neutral"—not experiencing either a specific desire or aversion toward engaging in sexual activity, and "demisexual"—experiencing sexual attraction only in relationships with serious romantic and/or emotional connections with partners (Carrigan, 2011).

Asexuality often transcends simple categorization of the presence or absence of sexual attraction, desire, or behavior. Asexual women's identities, in particular, have been conceptualized by some as politically radical, insofar as they resist or contradict social expectations of sexuality and reproduction associated with women's bodies, which disrupts existing social systems (Chasin, 2013; Fahs, 2010). Others, however, refute such claims, instead interpreting asexual identities as having relatively little impact on majoritarian life and politics; in this view, asexuality is an innate aspect of some individuals' human nature, which has been problematically radicalized in support of minority political beliefs (Dawson et al., 2018).

In this paper, we do not conceptualize asexuality—or any sexual identity, for that matter—as a biologically-determined characteristic with which human beings are born. Maintaining a Foucauldian framework, we understand asexuality as an identity category and community produced by and through discourses on sexuality, rather than a "sexual orientation," a construct which relies on an essentialist understanding of sexuality (Scherrer & Pfeffer, 2017). That said, while it is important to give weight to individuals' own constructions of the political significance of their identities, it is also necessary to recognize that these identities emerge in the context of a discourse that is a dense point of exchange for power and knowledge (Foucault, 1978). All our identities—and perhaps especially asexual identities—have potential for radical disruption of the normative discourse of sex. How one chooses to interpret that potential, and how they relate that to their understanding of their core "self," is a matter of one's own practices, views, and experiences.

The institutions of health and medicine are a critical example of what happens when a harmful (albeit at times invisible) narrative around a community's identity is perpetuated in the service of the nexus of power and scientific knowledge. Significant scholarship has sought to make sense of what McGann (2011) terms diagnoses of "disorderly desire" as they relate to the asexual community (Guz et al., 2022). The diagnoses of HSDD and FSIAD are key examples of how these diagnoses have been weaponized against asexual individuals (Cuthbert, 2022). Whether these diagnoses have validity for individuals who do not occupy asexual identities has been interrogated elsewhere (Chasin, 2013; Fishman, 2004; McGann, 2011). However, the fact that asexual individuals do not uniformly experience distress or desire to change around their absence of sexual attraction makes these diagnoses particularly harmful and problematic when they are assigned to individuals on the asexual spectrum (Scherrer & Pfeffer, 2017). As feminist scholars have theorized, assigning such diagnoses to those who are asexual presents sexuality as compulsory rather than voluntary, disrupting the very notion of consent around sex and sexuality (Gupta, 2017; Przbylo, 2019). Further, some asexual individuals may experience or display distress around their absence of sexual desire as a result of the dominant narrative around the necessity of sex or as a result of pressure from romantic and sexual partners and other significant others, further blurring delineation around what is an "appropriate" diagnosis of "disorderly" desire (Brotto & Yule, 2017; Gupta, 2017).

Medicalizing responses to asexual identities speak to a powerful notion that is produced through sexual healthism discourse: not only that sex is a natural, "healthy" part of life, but that a "healthy" life is a social imperative that can undercut the affirmation of identities deemed outside the bounds of normativity. Our sexual identities and our health statuses, then, become important interrelated aspects of "who we are" as individuals in contemporary Western society. This important intersection, despite its powerful implications

for individuals' identities, remains relatively underexplored in sociological literature. While scholars have attended to the complexities of coming to an asexual identity, and the problematic medical and academic classifications of asexuality, little attention has been paid to how these processes affect asexual individuals' understandings of their (sexual) health and their perceptions of the relevance of the construct of asexuality for their identities. By analyzing asexual young women's narratives about their identities in the context of a broader discourse regarding sexual repression and sexual healthism, the present study begins to address this gap in sociological literature.

Methods

The data for this paper derive from a broader study conducted in 2019 with young women who self-identified as members of the queer community (see Sheppard & Mann, 2021). Between March and June of 2019, the first author conducted semi-structured, individual interviews with a purposive social network sample of twenty-five queer women, ages 18 to 24, living in the Southern U.S. The primary aims of the larger study from which the data are drawn were to understand how young queer women made sense of their health and sexual identities in relation to (1) medicalized and gendered social norms about bodies and health, (2) body image, and (3) practices of body and health management. We utilized a qualitative design for this research because we wished to center participants' perspectives and accounts of their own body management practices to uncover how these practices give meaning to their subjective embodied experiences, with an eye toward the relevance of their sexual identities in these management processes.

We recruited participants via multiple social media platforms, including Facebook, Twitter, and Instagram, using recruitment flyers. While these digital flyers were originally posted through the authors' personal accounts, they were distributed more broadly by participants and their social network contacts as well as through snowball social media network contacts of the authors. Interested participants then contacted the first author via email, who used a demographic screening survey to determine their eligibility to participate in an in-depth interview. To be eligible to participate, prospective participants had to identify as women, regardless of their sex category assigned at birth, ages 18-24, and reside in states located in the U.S. South. The first author shared key demographic characteristics with some participants (including age, gender, and a queer sexual identity).

The first author conducted all the interviews in person, via telephone, or over a video conferencing platform. To facilitate rapport and transparency with respondents, the first author disclosed her own queer identity to research participants at the outset of each interview using the following script:

> I identify as queer, but also use the word "queer" to refer to the broader community of people who are not heterosexual. Is there a specific term that you would like me to use for LBQ+ women for the purposes of this interview?

Approval for the study was granted by the University of South Carolina Institutional Review Board prior to recruitment and data collection. To ensure participant confidentiality, all names appearing in this manuscript are pseudonyms and only aggregate demographic information is supplied for each participant. At the end of each interview, participants received $25 to thank them for their time.

The interview protocol for the broader study included questions focusing on: participants' experiences living in the U.S. South; their gender and sexual identities; their thoughts about how they think others perceive their gender and sexual identities; experiences

with healthcare providers connected to their identities; their sexual and sexual health education, experiences and practices (including consent); feelings about health and body image; their relationship with food, eating, exercise, and weight-management attempts; and substance use. Interviews lasted between 56 and 129 minutes in length, and averaged 79 minutes, and were audio-recorded and transcribed verbatim by a professional transcription service. The first author deidentified and fidelity checked all transcripts and interviewer memos and then imported them into Atlas.ti qualitative data analysis software.

The authors, informed by Braun and Clarke's (2013) six-step thematic analysis, first familiarized us with the data, reading all transcripts several times. Second, the first author coded each transcript. Third, the first author discussed the codes with the second author and, together, they began combining codes into broader themes. For the initial thematic analysis of the entire dataset, we utilized a combined inductive and deductive approach. Deductively, from the broader dataset we hoped to develop better understanding of how queer identities may be functioning as a protective factor against harmful body-management practices in the lives of young LGBTQIA+ women living in the Southern United States. Inductively, as we entered the thematic analysis, we noticed unexpected patterns and themes. This occurred during the fourth and fifth steps of the thematic analysis process, during which all three authors reviewed the set of initial themes and then considered the significance of these themes by analyzing the frequency with which they were mentioned both within each transcript as well as across transcripts (across participants and participant groups). We also attended to patterns in how participants described their experiences during these steps of the analytic process. Rigor and trustworthiness in the analysis was established using multiple triangulated data collection and analytic processes (Denzin, 2006) that involved the use of memoing, fidelity-checking transcripts, reliance on multiple investigators, sharing findings with research participants (i.e., member-checking), and utilization of the peer-review process for disseminating and publishing findings.

In conversations about the initial themes, we noticed and discuss unique patterns in how the study's asexual participants (n=6) described coming to terms with their identities. Of the study's initial 25 participants, six identified somewhere on the asexual spectrum (asexual, grey-asexual, and/or demisexual). Several of these participants described overcoming "repression" in coming to terms with their identities; at the same time, we noticed resilience in how these participants rejected harmful norms around women's bodies, reproduction, and minoritized sexual identities in general.

Based on these preliminary findings, we conducted a more focused critical discourse analysis (Clarke, 2005) of the interviews with the six asexual-identified participants. We employed a Foucauldian approach that integrated the frameworks of healthism and the repressive hypothesis in our analysis and interpretations of the interview data. We used critical discourse analysis to examine how the asexual participants engaged in identity work vis-à-vis "sexual healthism" discourse. As Clarke (2005, p. 158) describes: "Here the problematic is how discourses are taken into account in situations where identities and subjectivities are on the line – at issue." In other words, the objective of our analysis at this juncture was to understand not which thematic consistencies and inconsistencies existed in the ways asexual participants talked about their identities, but to situate their narratives in the context of broader discourses around health and sexuality and the nexus of the two (i.e., sexual healthism, both in terms of how participants drew from the discourses and informed them when producing meanings about their experiences and practices associated with their asexual identities).

Our analysis provided preliminary answers to the following questions, which emerged inductively from the analysis and were not originally the primary focus or research questions guiding the interviews: How do discourses of sexuality, health, and sexual health operate in

the lives and identity-formation processes of asexual young women in the Southern United States during their transition to adulthood? How do participants' narratives and reported experiences shed light on how sexual healthism may exercise power in young women's lives within queer communities in the Southern United States? Finally, based on these initial themes and their patterned significance, the authors drafted a report of these thematic findings and then completed several revisions of this report, resulting in the present manuscript.

Results

Our analysis uncovered three broad themes connected to most asexual-spectrum participants' perspectives on their identities: (1) Resisting the Repressive Hypothesis, (2) Language as Validation, and (3) The Search for Community. Below, we present vignettes that illustrate these respondents' various engagement with and perspectives on each of these three themes. These vignettes offer deeper insight into the spectrum of possibilities for how asexual women understand their identities and the sometimes-arduous journey they take to achieve those understandings.

Resisting the Repressive Hypothesis: "You're Not Repressed, You're Not Immature… Your Brain Isn't All Backwards."

Western discourse on sexuality, and specifically the repressive hypothesis, has produced a multitude of meanings about sexualities (Epstein, 2003; Foucault, 1978). In denying the necessity of sex as a part of the human experience, asexual people can disrupt some taken-for-granted understandings while at the same time drawing on a discourse of sexual healthism to resist the implication there might be something "abnormal" about their asexuality. The dominant discourse frames sexuality as compulsory and the absence of sexual attraction or desire among asexual young women as a product of sexual repression. This is further pathologized into assumed inability to self-actualize as sexual beings for whom sex is expected to be a "healthy," "mature," and "natural" aspect of adult lived experience. By affirming their identities as simply part of an array of (a)sexual possibilities, and explicitly rejecting the repressive hypothesis, respondents in this study attempt to resist these invalidating, harmful, and infantilizing narratives.

Hope, an asexual woman in her 20s from Florida, discussed one frightening way that Christian uptake of asexuality, as a form of women's sexual repression simply needing to be overcome, could manifest. Hope recalled, earlier in her life, conducting internet searches about whether a person could be both Christian and asexual. She said:

> I was like, "Am I the only one that feels this way? I don't want to kiss my boyfriend, is that weird?" I found a page [on the internet], and it was a Christian page… It was like, oh, you know, "We have asexual people, and you should solve that by raping them." By, you know, *making* them have sex and raping them. And so, I remember like *just* figuring out what asexuality was and reading *that*.

In recounting this formative experience, as she was attempting to reconcile her Christian and asexual identities with one another, she discovered a particularly troubling outgrowth of the sexual repression thesis: that one potential solution or "cure" for such presumed sexual repression in women's lives is to force sex and sexuality upon them, as a matter of Christian women's perceived sexual duty and obligation to their male partners.

Joan, an asexual woman in her 20s from rural South Carolina, highlighted her process of trying to make sense of conflicting messages about female sexuality to which she has been subjected over the course of her life. As was the case with most of the asexual participants, Joan expressed genuine fear about the potential relationship between her upbringing in a conservative Christian environment in the South and her (a)sexuality. Before coming out to herself as asexual, Joan described feeling distressed because she drew heavily upon sexual repression scripts that are common when considering Southern religious upbringings. She explained:

> Maybe growing up in the rural South has just botched my brain, and all my internal[ized] guilt, like old Southern Baptist Guilt, like, maybe that's what's—or maybe I'm just immature. That kind of thing…I thought I was just like; I'm just being an immature child; I've just been repressed my whole life. It was awful, it took a lot out of my mental health, and I was concerned... I was like, am I ever going to be able to be in a relationship with a person?

As the interview went on, Joan described how connecting with the LGBTQ+ community and learning about the spectrum of sexual and asexual identities helped shift her interpretation of her asexuality to transform it from a woeful product of Southern religious sexual repression to actively resisting this trope and grounding her assessment, instead, in the lived experiences of others within the diverse asexual community:

> [M]y first introduction into LGBTQ community was YouTube and Tumblr, stuff like that. That was what I did, that's what I went back to when I had my questions. Because it's just people sharing their stories and I just was trying to figure out if this was something I identified with. I think it's so easy to access those stories with social media and to be able to understand what you're feeling, and how you function, through somebody else's journey. I think that's an incredible tool and has been a big help to me. I just needed to hear and to see that you're not repressed, you're not immature, you're not being childish or scared. Your brain isn't all backwards and eat up [*sic*] with conservative bullshit. There are other people like this and like you, which was nice.

Joan's narrative speaks to the enduring power of the repressive hypothesis in the discourse on sexuality; however, it also illustrates the influence of contemporary sexual healthism discourse, especially for those categorized as "sexual minorities." In her social context, it was incumbent upon her to seek out social support and information to not only make sense of how she was feeling but also to develop a discursive repertoire that posits asexuality as simply one natural expression of human sexual diversity among a range of possibilities. Through social media platforms, Joan was able to affirm that her brain wasn't "all backwards" and her asexual identity was something that she shared with other members of an identifiable community.

Joan continued:

> I think people just need to know it's a thing and that there's nothing wrong with you, [be]cause that's what I thought… I just think letting people know that it's around and it's okay would be cool…like people just need to know that it exists and it's an option. You're not just being a child. Some bodies just don't do the libido thing and it's fine.

By referring to the concept of "libido," Joan invokes the essentialist idea of (a)sexuality as a biologically determined phenomenon and therefore a natural aspect of her body's functioning. While this was a useful way for Joan to understand and affirm her identity as an asexual woman, her essentialist conceptualization of asexuality remains grounded in a normative framework in which the social acceptance and validation of (a)sexual minorities hinges on the argument that their sexual "otherness" is immutable and thus cannot be changed.

The implication of this line of reasoning is that it implies something is wrong with being asexual (or gay, lesbian, bisexual, etc.), because if people could change their sexual orientation to conform to heteronormativity, they would—but they can't, so they deserve both rights and respect. Further, Joan's interpretation of the ontology of asexuality has concerning implications for other members of the asexual community. What, for example, does this imply about grey-asexual or demisexual individuals, whose bodies *do* "do the libido thing," yet who still consider absence of sexual attraction or desire to be an important aspect of their identities? By embracing an essentialist understanding of asexuality and, by extension, sexual healthism, Joan may inadvertently negate and devalue the experiences of other asexual individuals.

Language as Validation: "I Didn't Have a Word for How I Felt."

Most of the participants on the asexual spectrum discussed how coming to an asexual identity was often made more challenging due to a lack of language available to express their feelings and experiences in a sex-saturated culture that generally views sexuality as compulsory and taken for granted. Erin, a demisexual woman in her 20s living in Georgia, offered the following narrative for how she came to understand and accept her asexuality, emphasizing the role that gendered norms and expectations about adolescent sexuality played in her experience:

> Society teaches young girls that we're not supposed to be interested in sex, stuff like that, guys are gonna pressure you into sex, that kind of thing. So, in high school, I still had that idea of like, girls aren't interested in sex, so like, there's nothing wrong with me for not being interested in that, even when I'm dating someone. But then my [girl] friends started being interested in sex, and started talking about it, and I was very much like, "What, wait, you all…experience that?" So that was a very weird concept to me. And then I started feeling very, kind of weird about it, like there was something wrong with me. For a while, I thought it was like, my religious upbringing, and all of that. I didn't have a word for how I felt.

Erin's description of what is often called the "sexual double standard," which is especially amplified during adolescence and young adulthood in the United States (Kreager et al., 2016), highlights the gendered dimensions of the repressive hypothesis and its influence on her early understandings of sex and sexuality. However, as time goes on and Erin sees her friends exhibiting an interest in pursuing sexual relationships, her interpretation of the normalness of her experience of the absence of sexual desire is disrupted. Lacking the vocabulary to describe her demisexuality, Erin instead referred to the repressive hypothesis, assuming that there must have been something fundamentally wrong with her because of her religious upbringing and its presumed silencing of (female) sexuality.

Like both Joan and Hope, who relied on the internet to learn more about asexuality, Erin's use of social media—and YouTube specifically—was an important tool for her when

seeking language to describe her demisexuality. She described her experience of finding a demisexual YouTuber in the summer before her senior year of high school as follows:

> I was like, "Oh, okay, I'm not the only one who's experienced this. There are other people who've experienced this, there's a name for it." It all kind of clicked into place for me, that I'm not, I guess, quote unquote, "fully straight" in that way.

Erin realized that finding a vocabulary to describe her experience with sexual and romantic attraction was an important step in the process of coming to accept her demisexuality. At the same time, Erin was cognizant of the fact that this process would not be the same for everyone, and that her positive feelings upon discovering the meaning and existence of demisexuality was not a universal experience. She said:

> It felt so good and affirming to have a label that fit for me, which is not to say that everyone needs a label, or everyone has to have a label. I just spent high school feeling so weird and out of touch with everybody around, it was a very good feeling to have that positive experience.

By clarifying that everyone need not have a specific label or identity, Erin rejects the essentialist understanding of asexuality that Joan embraces, and instead frames her search for and discovery of a language with which to make sense of her own seemingly unusual experience of sexual development. In her narrative, Erin emphasizes her positive "feelings" rather than attempting to validate her demisexuality as "inherently" healthy. While Joan and Erin have similar pathways to self-acceptance, these differences in their narratives highlight the possibility of uncoupling asexuality from exclusionary biological-determinist reasoning and its attendant sexual-healthist implications to forge a more inclusive understanding of the spectrum of asexual identities.

The Search for Community: "I Don't Automatically Feel Safer in a Queer Space Than a Heterosexual Space."

While the participants routinely highlighted the adverse impact of growing up in a socially conservative environment and cited social media as a haven and balm for coming to terms of with their asexual identities, the majority of the asexual spectrum respondents also explored tensions within their sense of belonging in/to the LGBTQ+ community. For example, Keegan, an asexual/demisexual woman in her 20s living in South Carolina, described her relationship with the community as follows:

> It's sort of like, if everyone is arguing about what their favorite flavor of ice cream is, then in the corner you go, "I don't really like ice cream." It's just because the whole of the LGBTQ community is like, their whole thing is, "We're inclusive. We want to be here for you if you want a social circle where you can discuss your sexuality." But at the same time, it's like, you're really proud of, "This is who I like, and you can't tell me that that's wrong because it's natural." You're like, "But I can't say that because I don't like anybody." No, it's a little... I feel a little out of place.

Keegan's comment articulates the challenging double-bind of inclusion within a community that is predicated upon sexuality when one's sexuality is, by definition, primarily

understood as the "absence of" some forms of sexuality. It also speaks to the dependence of this inclusion on the rhetoric of the naturalness and essentialism of various sexualities, just as it situates that discourse within sexual healthism. As such, the membership of asexual people and communities within the broader LGBTQIA+ umbrella may be fraught given sociomedical, mainstream, and even some queer community understandings of asexuality as potentially disordered, unhealthy, or pathological.

This sense of potential distance from and misrecognition by others in the queer community was noted by Ruth, a heteroromantic grey-asexual woman in her 20s from North Carolina, as well:

> I would not say that, automatically, I walk into queer spaces and feel comfortable. [Y]ou have people within the LGBT community who believe that aces experience all of the privileges of being heterosexual, and there's that. And then, I think it's just a cognitive dissonance for people to say, like, "Wait a second, you're here, but it's not because you're attracted to women?" Or "Oh, you're a woman and you're not attracted to me?" That sort of thing. Or, like, "We're all sexual beings" is a phrase that's used a lot…All I can say is that I don't automatically feel safer in a queer space than a heterosexual space. Because those still are always going to be allosexual spaces, primarily. Queer spaces, the ones I have seen, are not intentionally ace inclusive. And, since they're allocentric, I don't necessarily feel more comfortable in one than the other.

Other participants described how aspects of their physical embodiment may also render them invisible within queer communities. As Mia, a demisexual woman in her 20s living in Texas described:

> I sometimes do feel some disconnect because I also identify as femme and I think a lot of times I feel that my queerness isn't really noticeable because of how femme I am, and I might appear to be straight. So that definitely sometimes feels like a disconnect.

These testimonies from Keegan, Ruth, and Mia reveal the everyday challenges experienced by some people on the asexual spectrum as their identities are subsumed under the broader queer umbrella. Indeed, their very inclusion may be contested or rendered invisible by the gender and sexually normative and sexual healthist understandings and expectations of some members within this large and diverse group. The implication of this invisibility and exclusion may be a disrupted or contested sense of belonging among some members of the asexual community within LGBTQIA+ spaces, just as it was for Keegan, Ruth, and Mia.

Discussion

The perspectives and experiences shared by the participants have important implications for how asexuality is situated within the broader discourse of sexual healthism. Joan's wielding of a healthist ideal around bodies that "just don't do the libido thing" to affirm her own identity stands in contrast to Erin's expression of a more fluid conceptualization of asexuality to meet the same ends. Both Joan and Erin describe a process of self-actualization achieved through connecting with the broader LGBTQ+ community while Keegan and Ruth describe feelings of frustration and rejection via the community's

hyper-focus on the perceived naturalness and necessity of sex. In this regard, Keegan and Ruth unapologetically achieve self-actualization on their own terms, denying the necessity of broader community acceptance to come to terms with their asexuality. These narratives identify a multitude of potential pathways through which asexual young women accept that there is "nothing wrong" with their asexuality—it is "around and it's okay."

We argue that embedded in this process of achieving self-acceptance is another, parallel process—that of asexual young women affirming their status as healthy individuals. By coming to terms with the fact that their lack of sexual attraction or desire is not a problem to be treated via the medical model, but rather, an identity to be recognized and respected, our participants' stories speak to the power of the "will to health"—and thus, the broader discourse of healthism—in affirming individuals' identities as inherently "good." In this way, our participants' narratives confirm the "sanitizing" effect of sexual healthism that Epstein and Mamo (2017) argue is a central aspect of the discourse. Asexuality, then, which has the status of a "marked" identity "in need of legitimation" (p. 178), can be seen as garnering and facilitating social acceptance by optimizing this facet of sexual healthism's discursive power.

Perhaps this relationship between asexuality and sexual healthism is most pronounced within the social problem niche, which Epstein and Mamo define as "solving injustices linked to the absence of sexual rights" (p. 182). In this arena of sexual healthism, sexuality is conceptualized as "an integral component of personal identity," while "a state of health" is defined by "freedom from unwarranted external constraint or coercion" (p. 182). By defending this conceptualization of sexuality regarding their own asexual identities, the study participants free themselves from undue pressure to engage in sexual behavior—they engage with sexual healthism discourse to exercise autonomy over their identities and ward off intervention from those who would deem their asexuality "unhealthy."

In terms of implications for practice, these findings highlight several pathways forward for more productively and compassionately rendering discourses on health and sexuality to forge more affirmative experiences for asexual young adults. First and foremost, these findings highlight a need for caution and consideration regarding how people in the lives of asexual individuals (e.g., healthcare providers, family members, the queer community, partners, or friends) navigate conversations regarding sexual repression, health, and asexuality. In reviewing the literature on asexuality, we described the lack of consensus regarding the degree to which asexual individuals experience personal distress regarding absence of sexual desire or attraction. These narratives highlight how broader discourses around sexual repression, especially among religious groups and in the U.S. South, may be creating significant distress and fear among asexual individuals, and how this fear can negatively impact their vision for their futures and their ability to live a fulfilling life. As such, it is critical for the affirmation of asexual individuals that we unpack notions of "repression" before moving forward with diagnoses such as HSDD or FSIAD.

Tangentially related to this finding is a need for increased social media spaces and presence for the asexual community. While Joan and Erin explain how websites such as YouTube and Tumblr served as positive and validating spaces for them to learn more about the asexual community and, by extension, their own identities, Hope discusses finding troubling online assertions about ways to "correct" asexuality. While AVEN has certainly served as a necessary, affirming, and validating online space for the asexual community, increasing visibility for the community in other online spaces could be useful in reaching a broader base and helping more people find the optimal vocabulary to describe their experiences of sexual disinterest distinct from the potentially invalidating and pathologizing language deployed in some medical and religious communities. This is not a responsibility that should fall on the shoulders of asexual people alone; it is also important for their

allosexual allies and supporters to participate in increasing the visibility of this information in the broader "sexusociety" (Przybylo, 2011).

This article also highlights several limitations and potential areas for further research with the asexual community. While we found the experience of growing up in a Southern, Christian, conservative context in the United States to be salient for some participants' understandings and fears about the potential effects of sexual repression on their own asexual-spectrum identities, a much larger and more regionally diverse sample is necessary to understand how locality and upbringing may be functioning in asexual individuals' processes of identity development and affirmation. Due to the first author's personal involvement in her university's undergraduate LGBTQ+ community, and the second and third authors' role as instructors for the few LGBTQ+ focused courses at the same university at the time of data collection, several of the participants in the broader research study were acquaintances and/or former students of the authors. While these overlapping relationships may facilitate participant trust and rapport in the research process, they may also produce sample homogeneity due to homophily within social networks.

Additionally, while the sample for the larger study from which the asexual participants were drawn included transgender women and was more racially diverse, all the participants featured here identified as cisgender women, and all but one was white. The aim of the present work was not to produce generalizable findings, but to engage in an exploratory study of asexual young women's experiences, specifically in the context of the Southern United States. Still, future research regarding asexuality could usefully focus on recruiting a more diverse group of participants in terms of racial and gender identities to better reflect the broad spectrum of experiences that exist within the asexual community.

It is certainly no secret that members of U.S. society talk about sex and health about as much as we talk about anything. What may be less apparent, and what we have drawn attention to in this article, is how those conversations have broader implications for individuals occupying asexual identities. Moving forward, it is imperative that we pay careful attention to our own ways of participating in these powerful, productive discourses if we are to collectively work toward a society that is more inclusive and affirming for individuals across the spectrum of asexualities.

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