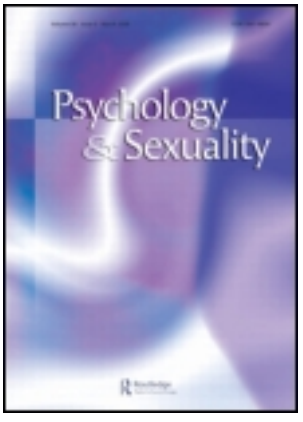

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How is asexuality different from hypoactive sexual desire disorder?

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Since around 2000, asexuality – conceptualised as a sexual orientation – has begun to emerge as an identity and a movement. Hypoactive sexual desire disorder (HSDD), which emerged in the late 1970s with the rise of sex therapy and is currently listed in the DSM, has gained increasing attention – promotion and a backlash of criticism – with the increased influence of the pharmaceutical industry in sex research. The relationship of these categories has often been noted but largely unexplored, and when explored, authors have tended to focus only on how much they do or do not overlap. This article examines the relationships and differences between asexuality and HSDD by examining the histories of each, the conceptual sources that each has primarily drawn on (various clinical/medical traditions vs. LGBT discourses and reactions against dominant beliefs about sexuality that asexuals find incongruent with their experiences); it examines how each functions in the primary contexts where they are used (asexual spaces and clinicians' offices, respectively) and in larger social discourses.

Keywords: asexuality; hypoactive sexual desire disorder; sexual interest/arousal disorder; medicalisation

Introduction

In media articles on asexuality, it is not uncommon for hypoactive sexual desire disorder (HSDD), a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 2000) to be mentioned alongside it (e.g. Duenwald, 2004; Westfall, 2004). As one article states, 'Prior to this research [on asexuality], and even until today, asexual tendencies were generally assumed to be a sign of hypoactive sexual desire disorder (HSDD) – in other words, a low sex-drive. It is a distinction with which the psychological community still wrestles' (Childs, 2009).

A major goal of the asexual community is for asexuality to be seen as a part of the 'normal variation' that exists in human sexuality rather than a disorder to be cured. As HSDD labels lack of sexual interest (at least sometimes) as a disorder, this is problematic for that goal. The first major response on the part of the asexual community occurred in 2008–2009 when a few members of the asexual community formed the 'AVEN DSM Taskfoce' and interviewed experts in human sexuality about how (and whether) to make the DSM more asexual-friendly; using these interviews, a report was submitted to the DSM-V Sexual Dysfunctions Subworkgroup, recommending that HSDD should have explicit exception for asexuals (Brotto, 2010a). I was one of the main authors of that report, although I did not endorse this particular recommendation. During that process, I received

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the question, 'How is asexuality different from HSDD?' At the time, I was unprepared for this question and gave a brief response that I was deeply unsatisfied with. This article is an attempt to give a more satisfactory answer.

Previous discussions

DSM-IV-TR provides the following diagnostic criteria for HSDD:

(1) Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgement of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.
(2) The disturbance causes marked distress or interpersonal difficulty.
(3) The sexual dysfunction is not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g. a drug of abuse and a medication) or a general medical condition.

HSDD has acquired lifelong subtypes as well as situational and generalised subtypes. A number of papers have briefly addressed the relationship between asexuality and HSDD (e.g. Bogaert, 2004; Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010; Cerankowski & Milks, 2010; Prause & Graham, 2007; Scherrer, 2008). The most extensive discussion of the matter has been by Bogaert (2006), so this will be my point of departure.

Bogaert defines asexuality as a lifelong lack of sexual attraction to anyone or anything. Acknowledging that asexuality may have considerable overlap with a number of sexual dysfunctions in DSM-IV-TR, he focuses on HSDD as that seems to be the one most closely related to asexuality. He observes three main differences. First, HSDD – but not asexuality – requires distress or interpersonal difficulties for the label to apply. Second, a lack of sexual attraction may not necessarily involve a lack of sexual desire – here he highlights the concept of an 'undirected sex drive' that exists in asexual discourse.[1] Third, unlike asexuals, most people with HSDD have previously been interested in sex; he speculates that a large number of people with lifelong HSDD may be asexual.

In this article, I will divide differences between asexuality and HSDD into what I call extensional differences (who is in which category) and non-extensional differences. Bogaert's discussion of differences focuses entirely on extensional differences between asexuality and HSDD, which I argue misses many of the most important differences between them – their different histories, functions, and values. Any adequate understanding of the relationship between asexuality and HSDD must consider these: Why did these categorisations come into being? What ideas and conceptualisation were drawn on for their creation? What is their function in the main contexts where they are used and what are the larger sociological impacts of these categorisations?

Definitions and brief histories

To begin to address the questions just raised, I will briefly consider the historical background and development of the category 'HSDD' and of 'asexuality.' There has been some historical work on the history of HSDD (e.g. Angel, 2010; Irvine, 2005; Moynihan & Mintzes, 2010), although none does so with primary interest in HSDD or with interest

in its relevance to asexuality. There is presently no academic work on the history of the asexual community.

A brief history of HSDD

DSM-I (APA, 1952) did not specifically list any sexual dysfunctions, though it did include a category for psychophysiological genitourinary disorders. In DSM-II (APA, 1968), impotence and dyspareunia were added to this category's list of examples. In Masters and Johnson's (1970) book *Human Sexual Inadequacy*, they listed a number of sexual dysfunctions generally dealing with arousal, orgasm (or ejaculation), and pain. Following their work was the development and growth of sex therapy in the 1970s (Irvine, 2005). In 1977, two sex therapists independently of each other both proposed diagnoses based on not being interested in sex/the right kind of sex (Kaplan, 1977; Lief, 1977). Kaplan proposed the diagnosis on the basis of examining failures of sex therapy and noticing that a large number of these involved lack of sexual interest. Leif's motivations are less clear. Both Leif and Kaplan were on the DSM-III Psychosexual Dysfunctions committee (Kaplan, 1995, p. 7), and they jointly proposed to include this diagnosis in DSM-III (APA, 1980), which it was under the name inhibited sexual desire (ISD), the name proposed by Leif (1977). The core of the diagnosis was 'persistent and pervasive inhibition of sexual desire' (APA, 1980, p. 287). In DSM-III-R (APA, 1987), this was renamed 'hypoactive sexual desire disorder' reflecting Kaplan's (1977) proposed name (hypoactive sexual desire). Sexual aversion disorder was added as well. HSDD was defined as

> Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life. (p. 292)

The change in name from ISD to HSDD was intended to avoid psychodynamic associations with the name of the former. The part about sexual fantasies was added because there were minimal data then available, and Helen Singer Kaplan 'was a dominant source . . . who felt that absence of sexual fantasies was a key feature of [HSDD]' (R. Segraves, personal correspondence, March 2, 2010).

The part about 'fantasies' is problematic because, interpreted literally, it means that someone who has no desire for partnered sex but regularly masturbates with sexual fantasies does not have HSDD, even though such situations are supposed to be situational HSDD. Indeed, in discussing generalised versus situational HSDD, Kaplan (1995) writes, 'In the more common situational clinical form of HSD, the patient's desire is inhibited or he/she is repelled only by one or a certain class of partners, but retains interest in masturbating, fantasy, and/or other partners' (p. 56, emphasis added). Presumably, the part about fantasy is intended only to refer to generalised HSDD, and this problem is one of a lack of careful attention to language. If this is the case, then it is a mismatch between the operationalisation (the diagnostic criteria) and the construct (that the criteria aim to operationalise). An alternative interpretation is that HSDD is intended to cover multiple constructs (i.e. situational and generalised HSDD) and the diagnostic criteria only describe one of these.

In DSM-IV (APA, 1994), a criterion was added that states, 'The disturbance causes marked distress or interpersonal difficulty.' This criterion was added after two epidemiological studies had found rates of psychopathology in the general population that many felt to be too high and must be indicative of a large number of so-called false-positives.

To address this problem, a clinical significance criterion was added to many diagnoses, so that over half of the diagnoses in DSM-IV have them (Spitzer & Wakefield, 1999). The decision to add these to the sexual dysfunctions was a matter not long discussed by the Sexual Dysfunction committee, and some members of that committee do not even remember discussing the matter (Segraves, Balon, & Clayton, 2007).

In the years since the mid-1990s, there has been an increasing role of the pharmaceutical industry in treating and researching sexual problems. Given the huge profitability of Viagra, this led to a search for the 'Viagra for women,' demonstrating to sexual scientists how poorly they understood female sexual problems (Bancroft, 2009). This led to the creation of female sexual dsyfunction (FSD) and a large growth in collaboration between industry and sex researchers. In 2000, Leonore Tieffer, a psychologist and feminist activist, created the New View Campaign in reaction against what she saw as an excessive focus on the biomedical aspects of sexuality – to the determent of considering relational, social, and political factors – as a result of the role of the pharmaceutical industry in funding sex research, conferences, and education. Moynihan and Mintzes (2010) have well documented this history and criticise the vast web of financial ties with the pharmaceutical industry as having the effect of blurring the line between science and marketing.

In the wake of the increased role of the pharmaceutical industry, as well as a greatly increased amount of research on female sexuality and female sexual problems, there has been considerable controversy surrounding how to conceptualise female sexual problems. The New View Campaign has entirely rejected the current system, proposing one of their own. Among those working closer to the DSM framework, controversies about diagnosing low sexual desire have focussed on a few issues. First, the DSM's classification of sexual dysfunctions is based on a linear model of sexuality, specifically Helen Singer Kaplan's triphasic (desire, excitement, orgasm) model, which was derived from the human sexual response cycle of Masters and Johnson. Basson (2001) has proposed a cyclic model instead, and it focuses more on what is termed 'responsive desire' and is contrasted with active desire. Second, many women cannot/do not distinguish between sexual desire and subjective sexual arousal, drawing into question whether it makes any sense to treat these as distinct phenomena. Third, some have argued for removing the clinical significance criteria from the sexual dysfunctions. Fourth, many want to divide the sexual dysfunctions into one group for men and another group of diagnoses for women.

Currently, the DSM-5 Sexual Dysfunctions Subworkgroup[2] is proposing to divide the sexual dysfunctions into separate diagnoses for men and women and remove (female) HSDD and (female) sexual arousal disorder, replacing them with (female) sexual interest/arousal disorder (SIAD; Brotto, 2010b; Graham, 2010). For men, the proposal is to replace HSDD with HSDD in men and leave the diagnostic criteria essentially unchanged (APA, 2011). If these changes are adopted, it would likely shift the extension of HSDD, thus having effects on extensional differences between asexuality and HSDD/SIAD, but many of the non-extensional differences would be largely unaffected.

A brief history of asexuality

The definition of asexual has had a very different history. In 2000, a Yahoo group called Haven for the Human Amoeba (HHA) was created, and the number of members grew to critical mass in July 2001, such that online asexual discourse has continually been created since then. In the spring of 2001, David Jay, then a college freshman, created a website called the Asexual Visibility and Education Network (AVEN), which originally consisted of only static content. On that site, he gave the definition of asexual as 'A person who

is sexually attracted to neither gender.' He then emailed the page to the heads of several campus-based LGBT groups around the United States, thinking that they would likely know something about asexuality. While they did not know much about asexuality, one told him about transgender issues and problems with the phrase 'either gender.' On the basis of this, the definition was modified to 'Asexual: A person who does not experience sexual attraction,' which is still the definition on AVEN's front page.

At this time, there were a few asexual websites, but these only had static content, such that HHA, with its listserv and a chatroom, was virtually the only place for asexuals to have conversations with each other (other than individually emailing each other). While doing online searches for asexual sites in order to make a web-ring, someone on HHA found AVEN and emailed David Jay to tell him about HHA, which David Jay then joined and actively participated in. Eventually, the number of people and amount of language generated on HHA became too great to be usefully conduced on an email list, so David Jay obtained the domain asexuality.org in May 2002, moved AVEN there, and set up forums.

In David Jay's time in college, he saw numerous 'queerer than thou' discussions, discussions of 'who is really a lesbian,' etc., and on AVEN, he wanted people to be able to talk about asexuality in a way that avoided this. He also had a number of friends in college who were 'sex positive queers,' and he felt they would have a strongly negative reaction to any sense of asexual elitism (personal correspondence, January 11, 2011). Related to these were two areas of controversy early in the history of the online asexual community, which were formative in the community's development. In Jay's (2006) account of this history, the first division that occurred concerned 'anti-sexuals,' who thought that people who were asexual were better than those who were not. The second division involved a group who thought that only people who did not masturbate could be asexual.

This second view is exemplified by a Dutch woman named Geraline Levi Jones (Miss Geri), who joined HHA in early 2002. She was keenly interested in promoting asexual visibility, especially through performing arts. She and David Jay tried to collaborate, but were ultimately unable to do so because of disagreement over whether people with a sex-drive/people who masturbate can be asexual. Miss Geri took the position that they cannot. As David Jay's primary interest was in constructing asexuality as an identity that people found to be helpful in making sense of their lives and navigating relationships, he strongly believed that anyone who felt that identifying as asexual made sense for them should be allowed to do so. Feeling that what people do or do not do in private with respect to masturbation has little consequence for their social relationships, he held that it made perfect sense for masturbation to be consistent with an asexual identity.

At some point, Miss Geri made her own website: The Official Asexual Society. It had forums that were rarely used, and it even had a survey people could fill out, which would then be sent to Miss Geri who would tell people if they were asexual or not. In December 2004, the site's name was changed to The Official Nonlibidoism Society.

Independently of either AVEN or Haven, a genderqueer identified individual named Nat Titman created the community Asexuality on Livejournal in April 2002 to be an explicitly sex-positive community about asexuality. The community was created to talk about asexuality, and its creation was motivated by Nat's sense that another LiveJournal Community (Asexual) was overly anti-sexual. The initial language for describing asexuality was based on discussions Nat had had in online transgender communities. They also found discussions of who was 'really' whatever queer identity to be unhelpful and favoured the most inclusive definitions possible. David Jay found this community and contacted Nat, and the two then collaborated together on AVEN – for instance, Nat wrote the Big FAQ for AVEN, much of which is still used in AVENs FAQs.

In Nat's version of the history of the early asexual community (personal correspondence, February 2, 2011), the early splits in the asexual community were somewhat different than the ones in David Jay's recounting of the history. According to Nat, there was no early rift over anti-sexuality; rather anti-sexuality is an inevitable part of any asexual community that does not actively fight it – people who have felt rejected by dominant society's views of sexuality will often react against it negatively, especially when first coming to accept their own asexuality. The first major split in the asexual community was, in fact, led by David Jay and Nat. In the early asexual community, what connected people was not having sex. By defining asexuality in terms of sexual attraction rather than behaviour, and explicitly positioning it as a sexual orientation, a much different vision of asexuality was offered. According to Nat, the second major division in the asexual community concerned whether people who masturbate can be asexual, and this occurred when the Official Asexual Society eventually came to recognise that AVEN's vision of asexuality was much more widely accepted.

As AVEN developed on asexuality.org, it was built around a philosophy that rejected both anti-sexuality and overly narrow definitions of asexuality. Presently on AVEN, there is a prohibition against telling people who identify as asexual that they are not asexual, and people are told that only they can decide if they are asexual or not. For various reasons (discussed in Jay (2006)), AVEN came to be the main site about asexuality, and its vision of asexuality has come to dominate. Since then, the site has grown enormously, a number of other asexuals sites and blogs have emerged, along with some YouTube channels active as of writing this. Asexual communities in a number of different languages have also emerged, but (English) AVEN remains the hub of the asexual community. Off-line asexual meetups have been increasing in number, but the asexual community remains a predominantly online community. In recent years, there has come to be a considerable asexual presence on tumblr.com.

The Official Asexual/Nonlibidoist Society became defunct in late 2006, but it was discussed a number of times on AVEN while it still existed, and it is generally considered an important part of the history of the asexual community. My own impression is that it was never a serious rival to other asexual communities or their visions of asexuality, but it has served as a useful foil for AVEN and its vision of asexuality. When it was discussed on AVEN while it was still active, many people said how they liked AVEN's more open view of asexuality so much more.

The way AVEN defines asexuality has several important implications. First, it makes asexuality broad enough to include people who do not experience sexual attraction but do/feel other things often considered sexual, such as masturbation and non-sexual attraction. Second, by making it about sexual attraction, it is not about behaviour, thereby contrasting asexuality with celibacy and making having sex consistent with an asexual identity. Third, it positions asexuality as a sexual orientation, thereby encouraging people to think about asexuality with terms similar to other non-heterosexual sexual orientations (for those who are accepting of these), such as the importance of acceptance, understanding, respect, not assuming pathology, not trying to change sexual orientations, etc.

Contrasting asexuality and HSDD

While this article focuses on differences, it is worth considering some of the similarities between asexuality and HSDD, as some are too easily overlooked, especially by those critical of the medicalisation of asexuality. In addition to the obvious similarity of both having something to do with not being interested in sex, both are categorisations that were created

to help people deal with problems that sometimes result from not being interested in sex in the social contexts where each category was created; both were created and disseminated from the United States in the late twentieth/early twenty-first centuries, stemming directly (as with HSDD) or more indirectly (as with asexuality) out of modern sexological discourses. Both are designed to promote discourse and communication about these issues to address associated problems that people experience.

To explore the non-extensional differences between asexuality and HSDD, I categorise these into a four-way classification I find useful, although there are no strict criteria for category-membership. The categories are local functional, global functional, conceptual sources, and valuational. I first examine local functional differences, then differences in sources of ideas, and then move to global functional ones, relating each to valuational differences. In addressing these, caution is needed: to date, there are no empirical studies investigating these matters, so I must brush with broad, impressionistic strokes.

Local functional differences

Local functional differences are differences concerning the primary settings in which asexuality and HSDD are used: in asexual discourse and clinicians' offices, respectively. Examining these differences in detail is, at present, impossible because of the paucity of research on each. Almost all information available on how HSDD functions at the local level is in chapters in books on sex therapy that contain some descriptions of the author's clinical practice. These are retrospective reports for didactic purposes, and when authors attach their name to a piece, this can decrease how candid they can be. The only study on online asexual discourse to date is by Chasin (2011), which is based on her own experience in asexual discourse, especially on AVEN. Despite these limitations, some observations can be made.

As HSDD is a psychiatric disorder, it is diagnosed (i.e. applied to an individual) by a clinician. If a person presents to a clinician complaining of some sexual issues, the clinician (depending on the clinician's theoretical orientation) will generally ask questions to tease out 'what is really going on,' or at least ask questions to try to get the person to identify 'what is really going on.' By contrast, AVEN strongly insists that asexuality is applied to individuals by themselves; as its FAQ states: 'Only you can decide to use asexual as a label for yourself.'[3] New members regularly come asking the question 'Am I asexual?' Due to the taboo against trying to answer this question for others, it is not directly answered, though suggestions may be given, and the person may be asked additional questions/told things to consider.

This contrast involves differences in the locus of expert knowledge. For HSDD, it is the clinician who possesses it. For asexuality, it is the individual who possesses it. It should be noted that this commitment of the asexual community often stands in opposition to the desires of people coming to the asexual community wanting more established members of the asexual community to give them the answer and decide if they are asexual or not. People often want an 'expert' to tell them 'the answer' and placing the locus of expert knowledge on the individual runs counter to this.

One of the most important differences between asexuality and HSDD is their valuation of lack of sexual interest/attraction. HSDD regards lack of sexual interest as negative, whereas asexuality value's lack of sexual attraction as neutral or positive. The goal with HSDD is, if possible, to get the person (more) interested in sex, whereas asexuality aims at self-acceptance, viewing asexuality as something that does not need to be 'cured.' (In asexual discourse, cured is regularly put in scare quotes.) This

difference, however, can be exaggerated. One of the major difficulties involved with both is problems of desire discrepancy in sexual relationships. Writing about HSDD, Basson (2007) emphasises the importance of considering relationship issues, suggesting that if relationship therapy is deemed necessary, it should precede any specifically sexual recommendations. In its Relationship FAQ, AVEN says that in sexual/asexual romantic relationships, 'Like with any other compatibility issue in a relationship, the key is to establish excellent communication, so that both partners can know and respect the other's situation.'[4]

Differences in conceptual origins

Asexuality and HSDD have largely drawn on different sources for the concepts that they use for understanding and addressing (certain forms of) lack of sexual interest. HSDD/ISD was created in the late 1970s in the wake of the growth of sex therapy. The concepts drawn on for HSDD/ISD are largely concepts from medicine, from sex therapy, and from the various traditions of psychotherapy. More recently, the nature of HSDD (or FSD more generally) has had a peculiar tendency to resemble whatever pharmacological treatment was then being developed for it (Moynihan & Mintzes, 2010).

With asexuality, the primary source of inspiration for concepts has been LGBT discourses, a fact closely related to seeing asexuality as a sexual orientation, the commitment of the founder of AVEN to building bridges with LGBTQ groups, and the founder and LiveJournal Asexuality having developed the concept of asexuality from transgender message boards. The preceding history of asexuality illustrated a few examples of this, including the strong rejection of anti-sexuality and the implications derived from seeing asexuality as a sexual orientation. The strong insistence that people must decide for themselves if they are asexual and the prohibition against telling people identifying as asexual that they are not 'really' asexual stem from positions held by many LGBT people in response to in-fighting. Using LGBT communities as a source of ideas/self-understanding also has significant effects on how asexuals perceive HSDD.

In 1973, homosexuality was (partially) removed from the DSM (Bayer, 1987) and this has been seen as a major triumph by LGBT activists. The removal of homosexuality has been used to argue for the depathologising of other sexual and gender minorities (e.g. Green, 2002; Hinderliter, 2010; Moser & Kleinplatz, 2005; Winters, 2009). Brotto (2010a) notes that many asexuals would be strongly opposed to removing the clinical significance criterion from HSDD, thereby labelling asexuality a mental disorder. Given a reliance on ideas from LGBT discourse, this should be unsurprising.

Not all of the primary concepts in asexual discourse can be traced directly to LGBT discourse. For instance, a strong contrast is made between sexual attraction (which asexuals experience little or none of) and romantic attraction (which many asexuals experience more frequently). On the basis of analogy with the sexual orientations asexual, bisexual, heterosexual, and homosexual, the romantic orientations aromantic, biromantic, heteroromantic, and homoromantic are used. Increasingly, panromantic – based on analogy with pansexual – is used as well. Another concept is that of 'undirected sex drives.' This idea is used to explain how someone who masturbates can be asexual. The concept stemmed from a need to reconcile the fact that some people who masturbate considered themselves asexual, and this has required making a strong distinction between sexual attraction and sexual arousal.[5] Searching AVEN for 'attraction' reveals that other forms of attraction are sometimes discussed, including emotional attraction, aesthetic attraction, physical attraction, sensual attraction, intellectual attraction, platonic attraction, etc., which may or may

not be contrasted with other, and which people may express feeling and wonder whether this contrasts with sexual attraction.

These concepts do not, in general, derive directly from LGBT discourse but from ideas about sexuality in the larger culture. Many people in the asexual community experience some things typically considered an important part of sexuality but not other things. Given that asexuality has come to be defined in terms of not experiencing sexual attraction, asexuals and people who are questioning need ways to talk about things generally considered part of sexuality that they do experience, either contrasting these with sexual attraction or asking whether they are actually distinct.

Global functional differences

Global functional differences between asexuality and HSDD concern how they function, what effects they have, and the shape of discourses about them outside of the 'local' contexts discussed earlier. This includes media articles, TV spots, and blogs; it includes academic papers, conference presentations, and books, as well as conversations that people have in all sorts of contexts. Perhaps the biggest difference concerns the agency of the group discussed/described. HSDD was created by clinicians to talk about patients, making it a category imposed from above. References to things that patients say may be made in articles about HSDD written by clinicians, but very little of the HSDD discourse comes from people self-identifying as having HSDD. Despite considerable searching, I have been unable to find any active online communities or forums for people with HSDD, nor have I found any patient advocacy groups for people with HSDD. Media articles about HSDD regularly quote experts talking about HSDD, and may even include experts quoting patients, but they rarely have people with HSDD talking about their experiences. In recent times, HSDD has become much more visible because of efforts by Proctor and Gamble to promote the disorder while trying to get a testosterone patch approved as a treatment for HSDD, and then by Boehringer Ingelheim while trying to get a failed antidepressant approved as a treatment for HSDD.

By contrast, asexuality is a category largely constructed by those identifying as such (or considering identifying as such). In discourses about asexuality outside of asexual spaces (e.g. academic work and media articles), it is often necessary for authors to actively work with members of the asexual community, who are then able to have varying degrees of influence over how asexuality is talked about. Furthermore, members of the asexual community often actively seek out means of promoting visibility as well as research on asexuality.

Deriving much of its thinking from LGBT discourses, in the asexual community, there is a built-in suspicion of 'expert' knowledge being used in ways seen as invalidating the experiences of asexuals, especially ones doing so with medicalisation/pathologisation. Yet, while there is a suspicion of medicalising scientific discourses, there is also a recognition that scientific research has played a major role in promoting acceptance of various sexual and gender minorities, and it is expected that the same will be true with asexuality. This is illustrated by an observation of Brotto et al. (2010) in their study on asexuality: 'Asexuals were very motivated to liaise with sex researchers to further the scientific study of asexuality' (p. 599). Likewise, AVEN has an open letter 'To Scientists'[6] encouraging researcher:

> We want to understand ourselves as asexuals, and we want to be understood by society. We believe that scientists have an invaluable role to play in achieving that understanding and

> support all types of research, from biological studies of the causes of asexuality to sociological studies of the emergence of asexuality as a sexual orientation.

The purpose of this open letter, however, is not merely to promote research but to dissuade certain kinds of research (e.g. relying on clinical samples) and to get potential researchers to question certain assumptions in current literature (e.g. 'It is important to recognise the limitations of standard questionnaires; many of the questions being meaningless to asexuals' bold original).

Another example is found in my own activity regarding asexuality, which has largely aimed at promoting research and academic visibility. To help promote these, in early 2009 I created the site Asexual Explorations (http://www.asexualexplorations.net/) 'to promote the academic study of asexuality,' which has the most extensive bibliography of literature on or relating to asexuality to date, suggests ideas for future research, and hosts a few articles written by members of the asexual community, with the goal of better incorporating ideas developed in asexual discourse into academic discourses on asexuality.

Because participants in asexual research are generally recruited from asexual websites, the people running these websites (many of whom are asexual) function as gatekeepers. In accordance with this, AVEN created a policy in March 2011 for researchers wanting to recruit from the site, requiring them to get approval from the site before recruiting people for research (which most researchers already did anyway), and also specifying what has to be included in those requests.

While largely impressionistic, considering the differences between asexuality and HSDD in the ways I have begun to do here poses a number of interesting questions for future research. What are the similarities/differences in how asexuality and HSDD are talked about in media articles? What differences/similarities are there in terms of who studies each? What are the research questions asked about each?

Conclusion

I have examined both asexuality and HSDD as conceptualisations of (certain forms of) lack of interest in sex, arguing that attempts to compare them simply by examining overlap and non-overlap are insufficient. Both concepts were created to help address difficulties that people not interested in sex face, but they draw on very different ideologies and conceptual resources for doing so such that they function quite differently.

The emergence of the asexual community in the first decade of the twenty-first century has largely coincided with increased pharmaceutical influence in research on sexual function/dysfunction and consequent increased public attention to (female) HSDD, as well as the increased research, vigorous debates, and reactions that this has caused. Whether HSDD remains in DSM-5 or is replaced with SIAD, it is unlikely that HSDD/SIAD will simply disappear in the near future, just as it is unlikely that the asexual community will disappear, so the two concepts will almost certainly socially co-exist for some time (Chasin, 2011). However, while there is a definite tension between these conceptualisations, it is perfectly possible for both to co-exist in the mind of the same individual – a clinician who is supportive of asexuality could simultaneously feel that HSDD as a diagnosis is useful and provides clinical help to people presenting with complaints of low sexual desire. As asexuals are probably the minority among people uninterested in sex, this greatly complicates matters.

With the increasing visibility of asexuality and the ongoing increase in academic articles on asexuality, it is likely that asexuality and HSDD/SIAD will have increasingly

intertwined histories, making a need for clear thinking about their relationships. This article has attempted to further thinking on this matter and suggest avenues for future inquiry.

Notes

1. This importance of this point is easily underestimated. A major difference between asexuality and HSDD is that the former focuses on lack of sexual attraction, whereas the latter focus on lack of sexual desire.
2. In March 2010, the APA (2010) announced that beginning with the 5th edition of the DSM, Arabic numerals would be used rather than Roman numerals.
3. http://www.asexuality.org/home/general.html
4. http://www.asexuality.org/home/relationship.html
5. While there has not been any research on the question of what asexuals think about while masturbating, the subject of what asexuals think about while masturbating comes up from time to time in asexual spaces, and anecdotal evidence indicates that some do not think about anything in particular and some use some kind of sexually arousing fantasies. Yet I am not aware of anyone using a distinction between 'uses fantasies to masturbate' and 'does not use fantasies to masturbate' as the basis of an asexual typology.
6. http://www.asexuality.org/wiki/index.php?title=To_scientists

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