THE SOCIETY FOR THE PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY

ASEXUALITY FACT SHEET

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Key Terms

Asexuality (ace): A sexual orientation characterized by little to no sexual attraction to others. Also, an umbrella term for a spectrum of related identities.

Demisexuality: Experiencing sexual attraction only after the formation of an emotional bond.

Graysexuality: Experiencing sexual attraction rarely or only under specific circumstances.

Allosexuality: Experiencing sexual attraction to others at levels presumed typical. Allonormativity is the cultural assumption that this level of sexual attraction is universal.

Aphobia: Prejudice against asexual people, expressed cognitively (e.g., asexuality as illness), affectively (e.g., pity), or behaviorally (e.g., exclusion, sexual violence).

Compulsory Sexuality: The cultural assumption that sexual activity is normal and expected for all adults. A foundational element of aphobia.

What Is Asexuality?

Asexuality is a sexual orientation characterized by little to no sexual attraction to others (AVEN, n.d.). It is both a specific identity and an umbrella term for a spectrum of related identities, including but not limited to demisexuality and graysexuality. People who are not asexual are referred to as allosexual.

Asexuality is not the same as celibacy, which is a behavioral choice. Asexual individuals vary widely in their experiences of arousal, desire, and sexual behavior; some engage in sexual activity for reasons such as emotional intimacy, reproduction, or personal pleasure, and these behaviors do not negate an asexual identity, as physiological arousal and behavior are distinct from sexual attraction (Cowan & LeBlanc, 2018; Schneckenburger et al., 2024).

Who Are Asexual People?

Asexual individuals are represented across racial and ethnic groups, genders, ages, religious backgrounds, disability statuses, socioeconomic statuses, national origins, and geographic regions. Approximately 1% of adults identify as asexual (Bogaert, 2004, 2015), though rates among sexual and gender diverse youth and adults may be higher. For example, as many as 10% of sexual and gender minoritized youth (The Trevor Project, 2020, 2024), 1.7% of sexual minoritized adults (Rothblum et al., 2020), and 10% of transgender and gender diverse individuals identify as asexual (James et al., 2016).

Minority Stress: Stress associated with chronic, pervasive stigma and prejudice, including distal or external stressors (harassment, stereotyping, discrimination) and proximal, internal, or anticipatory stressors (internalized stigma, identity concealment, vigilance; Meyer, 2003). Minority stress has been documented in asexual populations (Chan & Leung, 2023).

Sexual Orientation Change Efforts (SOCE): Practices that attempt to alter sexual orientation, condemned by the American Psychological Association (APA) as unethical, unscientific, and harmful (APA, 2021a). Asexual individuals may face SOCE at higher rates than other sexual and gender diverse communities (UK Government Equalities Office, 2021).

Stigmatizing Experiences

Asexual people frequently encounter aphobia: prejudice that may be expressed cognitively, affectively, or behaviorally. In many Western and U.S. cultural contexts, aphobia is shaped by compulsory sexuality, although compulsory sexuality does not operate uniformly across communities and subcultures (Gupta, 2015). Stigmatizing attitudes produce both distal (e.g., harassment) and proximal (e.g., vigilance) minority stress (Meyer, 2003) and have been documented in asexual populations (Chan & Leung, 2023). Many asexual individuals feel obligated to educate others to reduce aphobia; mental health professionals can help alleviate this burden by pursuing their own ongoing learning, providing asexual-affirming care, and challenging aphobic assumptions when they arise in clinical or institutional contexts (Kelleher et al., 2023; Mollet, 2020).

Common Myths and Clinical Responses

Myth: Asexuality is a phase or will resolve with the right partner.
Asexuality is a valid sexual orientation, not a phase to outgrow or something a partner can change (Bogaert, 2015; Brotto & Yule, 2017). Treating asexual identity as a developmental stage invalidates identity and may constitute a microaggression (Flanagan & Peters, 2020; Kelleher et al., 2023; Mollet, 2020).

Myth: Asexual people do not experience intimacy or love.
Many asexual people experience romantic attraction, and many form deep, lasting romantic relationships (Antonsen et al., 2020; Brotto et al., 2010; Carvalho & Rodrigues, 2022). Love and intimacy do not depend on sexual attraction and take many forms, from romantic partnerships to other committed bonds (Bogaert, 2015; Kelleher et al., 2023).

Myth: Asexuality results from trauma, hormonal imbalance, or mental illness.
Asexual people, like anyone, may have trauma histories, medical conditions, or mental health concerns, but these do not cause asexuality (Brotto & Yule, 2017; Skorska et al., 2023; Yule et al., 2013). Treating asexuality as a symptom to be explained, rather than an orientation to be affirmed, invalidates identity and may cause harm (Boot-Haury et al., 2024; Chan & Leung, 2023; Flanagan & Peters, 2020).

Myth: Asexuality is just low libido.
Libido refers to sexual drive; asexuality refers to experiencing little or no sexual attraction to others. The two vary independently: an asexual person may have a high, low, or absent libido (Bogaert, 2015; Brotto et al., 2010; Skorska et al., 2023; Yule et al., 2015). Conflating drive with attraction can lead to medicalization of identity (Boot-Haury et al., 2024; Flanagan & Peters, 2020; Gupta, 2015).

Asexuality and DSM Diagnoses

Three DSM-5-TR diagnoses are commonly relevant when clinicians assess sexual desire-related concerns among asexual people: Female Sexual Interest/Arousal Disorder, Male Hypoactive Sexual Desire Disorder, and Other Specified/Unspecified Sexual Dysfunction. For the first two, DSM-5-TR specifies that the diagnosis should not be made when asexual self-identification better explains the presentation; Other Specified/Unspecified Sexual Dysfunction does not include a parallel asexuality-specific exclusion, but still requires clinically significant distress or impairment. Asexual individuals may experience genuine sexual dysfunctions warranting clinical attention, but diagnostic error can occur when clinicians fail to distinguish orientation-congruent low or absent sexual attraction from dysfunction, or when they misattribute minority stress-related distress to sexual pathology (American Psychiatric Association, 2022; Flanagan & Peters, 2020). Distress in asexual clients often reflects minority stress, and misdiagnosis associated with assumptions of pathology could inadvertently expose clients to SOCE (Boot-Haury et al., 2024). Organizations like the American Association of Sexuality Educators, Counselors and Therapists (AASECT, 2022) affirm that asexuality and ace-spectrum identities are not mental, developmental, or sexual disorders.

Mental Health and Health Disparities

Asexual individuals experience elevated rates of anxiety, depression, and PTSD relative to allosexual people and other sexual and gender diverse subgroups (Borgogna et al., 2019; Parent & Ferriter, 2018; Yule et al., 2013). These disparities are compounded by pathologizing healthcare experiences: as many as one-third of asexual individuals who disclose their identity to a mental health professional report pathologizing responses (Flanagan & Peters, 2020). When seeking affirming care, clients may find LGBTQ+ affirming health professional directories helpful; however, listed providers may be broadly affirming of sexual and gender diverse communities yet still vary in their asexual-specific knowledge, skills, and awareness.

Recommendations for Clinical Practice

- **Examine biases.** Reflect on allonormative assumptions that may shape clinical work, recognizing that biases can compound when minoritized identities intersect (APA, 2021b).
- **Practice affirming assessment.** Adapt instruments to avoid pathologizing asexual experiences (Boot-Haury et al., 2024). Measures like the Asexuality Identification Scale (Yule et al., 2015) can support clinical understanding, but assessment scores should not be used to override a client's self-identified labels.
- **Do not practice SOCE,** or efforts to change, suppress, or eliminate a person's sexual orientation. Clinicians should not presume that asexuality is pathological or adopt a treatment goal of changing or eliminating an asexual orientation (Boot-Haury et al., 2024). When clinically relevant or requested, clinicians may provide psychoeducation about the limitations and potential harms of SOCE. This does not preclude affirmative, open-ended exploration of sexual identity, desire, behavior, distress, relational needs, trauma history, medication effects, libido concerns, or orientation non-congruence, provided that the clinician does not impose a predetermined change-oriented goal.
- **Apply an intersectional lens.** Asexual clients who are also people of color, transgender or gender diverse, disabled, or members of other marginalized groups may experience compounded minority stress (Guz et al., 2022); tailor approaches accordingly.
- **Create inclusive intake forms.** Include asexuality as an explicit identity option (TAAAP, n.d.).
- **Pursue ongoing education.** Seek out training on asexual health equity; engage community voices during Ace Week (last full week of October) and International Asexuality Day (April 6).

Recommendations for Research

- **Include asexuality as an explicit demographic option.** Provide space for write-in responses, and avoid collapsing asexual identity under an "other" category.
- **Assess romantic orientation separately.** Distinguish between sexual and romantic orientation in study design (Antonsen et al., 2020).
- **Review measures for allonormative assumptions.** Revise items that presume sexual attraction or activity, and offer response options that fit asexual experiences (Boot-Haury et al., 2024).
- **Improve sampling and measurement.** Use inclusive sampling to ensure participation of underrepresented ace-spectrum groups, and report ace-spectrum identities with sufficient specificity to examine within-group differences (Antonsen et al., 2020; Guz et al., 2022).
- **Study minority stress and resilience.** Examine minority stressors and protective factors such as community connection and identity affirmation (Schneckenburger et al., 2024).

References

Full reference list — scan the code or open the link

Additional Resources

Organizations and community resources — scan the code or open the link

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