Asexuality and the mental health sector: a submission to the Royal Commission into Victoria's Mental Health System

Please note: A list of suggested recommendations is included at the end of this submission.

About this submission

I provide this submission, as an asexual person, to provide a voice to the commission for the approximately **191,000 people** in Victoria who are asexual. Asexual people experience significant **barriers to good mental health**, as well as **barriers to accessing appropriate person-centred mental health care**. These barriers and difficulties have barely improved in modern times, with social progress in protecting the rights, wellbeing and health of asexual people languishing in the shadow of continued pathologisation of asexuality, pervasive lack of awareness, discriminatory attitudes, stigma, and relative social invisibility due to the very real health, social and safety risks to people who are identified as asexual.

Sadly, the mental health sector has traditionally been the purveyor of athologising beliefs and attitudes that underpin the oppression and mistreatment of asexual people, in the health sector, and in society as a whole. This is a tragic injustice, and has resulted in a great deal of suffering, as well as mental illness, suicide, and crimes against asexual people. This is an unfortunate legacy. But it is also presents **a significant positive opportunity for the mental health sector** to be the leader in transforming the experiences of asexual people in society. This transformation must start with transforming the way asexual people are characterised, regarded and treated by the mental health sector.

Personally, I have suffered immensely, and continue to suffer, due to the damaging way that asexuality, and asexual people, are characterised, regarded and treated by mental health practitioners, services, and the wider mental health system. Currently, I cannot access appropriate physical or mental health care, due to the immense stigma associated with my orientation, which results in most **interactions with health professionals being simultaneously futile and harmful**.

I wish very deeply that I could publicly put my face and name to the evidence I am providing to you, in order to humanise us as an invisible group, and show that I am proud, not ashamed, of who I am. However, as described below, the risk of violent hate crime, and life-destroying harassment and discrimination against 'outed' asexual women is so devastatingly high, that I cannot out myself without placing my physical and mental safety at serious risk. I would warmly welcome the opportunity to give further evidence to the commission, but cannot safely do so in a way that would see me publicly identified. It is my hope that, with the help of the commission and its recommendations, **one day I can live without fear**, and live freely and openly as who I am.

What is asexuality?

Asexuality is a **sexual/romantic orientation** in which a person does not experience sexual attraction to people of any gender. Like any sexual/romantic orientation, **it is not a choice**, nor the result of negative life experiences, but a fundamental element of who a person is. The majority of asexual people identify as having been 'born this way', and have been aware of their orientation from an early age, even if they did not know learn the word for it for many years. Due to the relative invisibility of asexuality as an orientation, many asexual people may go decades, or even a lifetime, without knowing that there are words that describe their experiences, or that there are other people like them.

Like any orientation, asexuality is an inherent predisposition that forms part of a person's innate identity and experience of life. It is different from celibacy or chastity, which are behavioural choices not to seek out or engage in sexual activity in certain circumstances. These choices may be made by sexual or asexual people for various reasons. While many asexual people are celibate, not all are.

Asexual people are as diverse as people of any other orientation, and are capable of living full, productive, happy and fulfilled lives, of which our orientation is just a part. Research has estimated that between **one and three percent** of people are asexual. Therefore, there may be as many as **191,000 people** in Victoria who are asexual.

Asexuality is still considered a mental illness

Asexuality is still **widely considered a mental illness**, despite no evidence that it causes distress, ill health, harm to others, or other negative effects, in and of itself. This classification has had, and continues to have, **devastating consequences** for the mental health of asexual people.

The belief that asexuality is a mental illness is captured through both its formal classification as such (see below), as well as extremely pervasive attitudes among healthcare professionals, and the wider community, that a person who claims to be asexual is at best a liar, confused or socially incompetent, and at worst broken, mentally ill and in need of 'fixing'. Unfortunately, attempts to 'fix' asexual people are not limited to health professionals, with a 2016 survey[1] of over 9000 asexual people finding that **45% reported attempts or suggestions by others to fix or cure them**.

For decades, asexuality (although under different names) **has been classified as a mental illness** by virtue of its defining features being classified as such. Recent editions of the World Health Organisation's International Classification of Diseases (ICD) have included the official diagnoses of 'frigidity', 'hypoactive sexual desire disorder', 'hypoactive sexual desire dysfunction' and 'anhedonia (sexual)'. Recent editions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) have included the official diagnoses of 'inhibited sexual desire', 'female sexual interest/arousal disorder', 'hypoactive sexual desire disorder', 'female sexual arousal disorder' and 'male hypoactive sexual desire disorder'. Thus, the right and expectation for asexual people to be able to live free of medical oppression is over 30 years behind that of same-sex attracted people, with homosexuality being officially de-pathologised and removed from the DSM in 1973. In 1973, the Australian and New Zealand College of Psychiatry Federal Council was world-leading, as the first professional body to declare homosexuality not to be an illness. I hope that Australia, led first by Victoria, will once again **be a world leader in liberating people from medical oppression based on sexual orientation**.

Only in recent editions of the DSM and ICD have required that a person must be experiencing significant distress as a result of their 'symptoms' in order to be diagnosed with disorders such as those listed above. However, in practice, the requirement for innate distress is little-known and little-supported among practitioners. And it is rarely if ever actually applied before pathologising non-distressed asexual people, and labelling them with the above diagnoses, or other more general psychiatric diagnoses. Thanks to the advocacy of some brave asexual individuals, recent editions of the DSM have finally included an exclusion from the diagnosis of 'hypoactive sexual desire disorder' for people who self-identify as asexual. However, this exclusion is widely unknown, dismissed or directly opposed by health practitioners, and the long shadow of the **cultural legacy of pathologising asexuality** remains overwhelmingly dominant in medical culture, and the mental health sector. Furthermore, due to the pervasive social invisibility of asexuality, many people are unaware of its existence, and thus are unable to protect themselves from inappropriate mental illness diagnosis by self-identifying

Alongside these asexuality-specific diagnoses, some traits, behaviours or lifestyle factors that may stem from some asexual people's orientation (for example lack of sex drive, disinterest in sexually intimate relationships, and lack of interest in social activities that occur in highly sexualised environments) are also often **inappropriately attributed to more general psychiatric diagnoses**, such as depression or social anxiety, or other diagnoses such as autism spectrum disorder. This problem is heightened by standardised clinical surveys and questionnaires which

[1] 2016 Asexual Community Survey Summary Report, Bauer et al. 2016
https://asexualcensus.files.wordpress.com/2018/11/2016_ace_community_survey_report.pdf

unintentionally capture asexual traits, and erroneously attribute these to mental illness. For example, survey items that refer to 'loss of sex drive' or 'disinterest in sexual relationships'.

'Conversion therapy' remains the dominant and accepted clinical response to asexuality

Due to the official classification of asexuality (under various names) as a mental illness, as well as general medical and community acceptance of the notion that a person claiming to be asexual is broken or mentally ill, there is widespread acceptance of **the notion that asexual people must be 'fixed'**.

The notion that asexuality must have its 'root cause' identified, and then must be 'treated' and 'fixed', is widely accepted and promoted as best practice care in the medical community and healthcare system. The most common and first line responses to the disclosure or discovery of a person's asexual identity, traits or behaviours are pathologising and interventionist in nature.

In mainstream physical and mental health services, **asexual people are often coerced** into repeated hormone tests, invasive physical examinations, use of invasive physical devices, coercive mental health interventions and medications in misguided and ultimately vain attempts to 'fix' our orientation. We are oppressed not only by the mainstream mental health and general health systems, but also by more fringe players such as non-clinical religion-peddling interventionists. These practices are as futile, and as harmful, for asexual people as they are for people of other orientations. This systematic oppression, coercion, prejudice, invalidation and shaming – even if well-intentioned – can and does cause **devastating harm** to asexual people's mental and physical health.

There has been increasing awareness of the devastating harm caused by attempts to change the sexual orientation of people who experience same-sex attraction through so-called 'conversion therapy'. However, asexual people and the harm they experience from these practices have been left out of the conversation, and look set to be left out of the protection afforded to LGBTI people under the Victorian government's proposed ban on conversion therapy. As such, due to entrenched stigma, prejudice and invisibility, which sustains inertia and casual discrimination among the public and health practitioners, **asexual people remain 'fair game' for conversion therapy and medical intervention.**

No widely influential healthcare professional organisation, government entity, mental health or patient advocacy group, or other widely influential entity, is on record with a strong, public statement specifically supporting asexual people's right to be protected from the devastating harm of conversion therapy and pathologisation. The government needs to **show social and cultural leadership by denouncing conversion therapy being inflicted on asexual people**, and ensuring the wording of the proposed legislated ban on conversion therapy encompasses and protects asexual people.

Pathologisation, discrimination and the persistence of conversion therapy are major barriers to accessing mental health care

Like people of all orientations, asexual people can and do sometimes require mental health support, or experience mental distress or illness. These difficulties may be related to the pervasive stigma, discrimination or oppression they face in connection with their orientation, or they may nothing to do with their orientation at all. There is increasing understanding that higher rates of mental distress and illness among same-sex attracted people reflect preventable negative experiences in society (e.g. discrimination and harassment), rather than being the innate consequence (or indeed cause) of their orientation in and of itself. However, due to the shadow of pathologisation, **practitioners and lay people alike remain primed to attribute asexual people's psychological and emotional distress to their alleged 'sexual disorder'**. This approach is also common among mental health services and practitioners.

Research shows that asexual people's interactions with health professionals, if their orientation or related traits become known, are often and repeatedly **harmful, unhelpful and alienating**. When asexual people disclose their orientation to healthcare professionals, or aspects of their asexual lifestyle become apparent to those professionals (such as being well into adulthood and never having been sexual active), the responses are often damaging, stigmatising, invalidating and pathologising. Responses range from **dismissal** ('asexuality doesn't exist', 'you just haven't met the right person yet') to **derision** ('maybe you can't accept that you're gay', 'maybe you need to make more of an effort with your appearance', or even just laughter) to well-meaning but completely

misguided **attempts to 'save' or 'fix'** the person ('we need to check your hormones', 'you should see a psychologist', 'you need to try this medication').

Health practitioners – including mental health practitioners – also often become **fixated on a person's asexuality**, to the exclusion of being able to focus on any other aspect of the person, or the person as a whole. This occurs even when the person's orientation has little or nothing to do with the reasons they are consulting with that practitioner. The concept of an asexual person is so alien, and the compulsion to fix them and restore the practitioner's sense of a universally sexual social order so strong, that practitioners can become blinded by it. A person's orientation can also become the default explanation for almost any issue the practitioner can plausibly (or indeed implausibly) connect it to **– reducing the person to their orientation alone**, and denying them the dignity of full personhood.

Health practitioner fixation on asexuality can be highly problematic for individuals experiencing mental distress, who can find their actual concerns sidelined by the practitioner's desire to change their orientation. For example, in my 20s, I once attended a mental health service to seek help after I was a victim of a physical assault by a person in a public setting. My goal was to be able to once again comfortably visit similar settings, without fear or flashbacks. Early in my first appointment, the practitioner asked whether the assault was affecting my intimate relationships. After clarifying that she meant sexual relationships, I stated that did not have such relationships. She then asked if I thought it might affect my ability to form such relationships in the future. I explained that I did not anticipate wanting to form such relationships in future, so that was not a relevant problem. From that moment, she became fixated on my lack of interest in sexual relationships, and insisted that fixing that 'problem' must be the goal of my treatment. She insisted that if I did not accept that goal, I was not truly committed to healing my trauma. I told her I was proud of and grateful for my orientation, and did not wish to pursue a change in orientation as a goal of treatment. She refused to continue to provide care if I would not **submit to the goal of 'awakening my sexual self'**. Versions of this experience are common for me, and research shows they are common among asexual people generally.

Facing these kinds of issues repeatedly, asexual people are **often forced to withhold the truth about our orientation, or actively lie about it**, in order to access mental health care (or indeed physical health care) that focuses on the issues that are important to them, rather than their asexuality. We are hesitant to disclose our orientation to health professionals – with the 2016 survey finding that **76.8% of asexual respondents were 'out' to "none" of their medical professionals** (with only 2.8% out to all of them), and **75.7% were out to "none" of their counsellors** (with only 3.9% out to all of them). This well-founded disclosure hesitancy negatively affects the quality of the care we receive, and also prevents us from being able to access support for distress we may experience as a result of discrimination, stigma, harassment etc related to our orientation.

Pathologisation is a major barrier to accessing physical health care

Similar problems with the pathologisation of asexuality also occur when asexual people seek physical health care. The pathologisation of asexual people in physical health care settings also contributes to poor quality care, poorer health outcomes, impaired access to services, inappropriate referral to mental health services, and the need to withhold and/or lie about one's orientation in order to receive required care.

For example, I once consulted a GP about a physical health problem. The physical health problem had an effective treatment, but the treatment was often not tolerated by many patients because it had negative impacts on sexual functioning. He did not mention this treatment option to me, as he had already decided, without asking, that such side-effects would be intolerable to me. When I raised the possibility of accessing the treatment, he told me that I wouldn't want it because of the sexual side-effects. When I insisted those side-effects were not a problem for me, and I therefore wanted the treatment, he found my conviction about this baffling. He repeatedly pressed for an explanation until I had little choice but to disclose my orientation.

From the moment of disclosure onwards, the practitioner could focus on nothing else. Despite my repeated resistance and reassurances that my orientation is one of my favourite things about myself, and that my hormone levels had previously been checked and were normal, I left that appointment with pathology requests for hormone tests, a prescription for a hormonal medication, and a referral to a sex therapist – all of which were forced upon me. I took them to appease him and escape the situation, with no intention to use them. I left with

no treatment, advice or plan for the non-sexual physical condition for which I actually consulted him. I left with false 'solutions' to something that wasn't a problem, and no solutions to the thing that was a problem. This is just one of countless examples, and represents an exceptionally common experience for asexual people.

Asexual people's mental health is detrimentally affected by hate crimes, stigma, discrimination, bullying, harassment and other oppressive experiences in society

Asexual people who are 'out' (or who are 'outed') are particularly at risk of being subjected to hate crimes, discrimination, harassment and bullying – as well as to the wider mental health effects of stigma and oppression. Constant bombardment with oppressive experiences, with **little societal or social narrative that provides hope for change**, opposes this negativity or supports them, has serious consequences for asexual people's mental health. The 2016 survey found **75% of asexual respondents reporting that discrimination and prejudice about their orientation negatively impacted their mental or emotional health**. The 2016 survey found that **49% of asexual respondents had seriously considered suicide**, and **14% had attempt suicide**. Like other people who identify with a sexual minority, it is our negative experiences in society, not our orientation, that drives our elevated risk of mental distress and suicide.

While anti-discrimination and equal opportunity legislation and initiatives often cite 'sexual orientation' or 'sexuality' as protected characteristics, in reality, these protections are rarely extended to or enforced for asexual people. As with the debate between freedom *of* religion and freedom *from* religion, my attempts to invoke anti-discrimination laws to stand up for asexual people have been met with the mean-spirited semantic rebuff that the **laws protect people on the basis on their sexual orientation, not their *lack* of one**.

People who are known to be (or suspected of being) asexual are at **increased risk of sexual hate crimes**, including rape and sexual assault. This is particularly true for asexual women. We are also at higher risk of crimes such as sexual harassment, blackmail, stalking and assault. The risk of these crimes, or the direct experience of them, can have serious impacts on our mental health, as well as our sense of safety, and capacity for full social participation.

Underpinning the increased risk are harmful sexual and gender power dynamics and inequities in society – whereby a person's lack of sexual interest or desire is **seen as a threat to sexual and gender dynamics in society**, and/or the perpetrator's personal social or sexual power or sense of sexual entitlement (e.g. their masculinity). Some perpetrators attempt to justify their crimes by claiming that they can 'convert' the woman through a forced sexual experience. Others believe they are entitled to sexual contact as the 'inevitable' next step after other social interaction with the woman. Others get a depraved thrill out of being the first to have sexual contact with her. Others still express pure misogynist rage at the woman's sexual unavailability and non-participation in sexualised gender roles. There is less information available on sexual hate crimes against asexual men or asexual non-binary people, but these are also known to occur.

The **lack of specific hate crime legislation in Victoria** means that hate crimes against asexual people are not recognised for the aggravated crimes that they are. And the minimal provisions in the sentencing act for considering prejudice in sentencing are applied rarely, and when they are, they are applied almost mostly to instances involving race or religion.

High risk of hate crime, discrimination and harassment, as well as the common experiences of family rejection (often leading to homelessness), healthcare rejection and conversion therapy, mean that asexual people face very real threats to our mental and physical wellbeing, safety, and indeed our lives, if we are out, outed, or suspected as asexual. Therefore many, like me, **feel compelled to keep our orientation secret**, or to disclose it only very selectively. This has profound implications for our mental health. It stifles not only our ability to live with freedom and authenticity, but also to receive **fully-informed and person-centred support** from family, friends and support services.

As a result of the ongoing pathologisation of asexuality, sustained by mental health professions and the mental health sector, there is **little social momentum or societal narrative** opposing discrimination, stigma, harassment and bullying of asexual people. We remain 'fair game', left behind as social progress towards equality for other sexual minorities marches on. As significant and laudable successes on the road to equality for LGBTI people continue - such as gender-neutral marriage – there is increasing sentiment in the community that the fight for sexuality equality is close to being won. Yet, in the context of this growing complacency, asexual rights remain **at**

least 30 years behind other sexually diverse people. It is only through the first step of de-pathologisation, led by the mental health sector, that progress on the road to our safety, equality and freedom can begin. **Our time has come. And Victoria can be the leader.**

Recommendations

1. Show powerful cultural and social leadership by being the first government in Australia to make a strong public statement in support of asexual rights and the de-pathologisation of asexuality, then taking real unapologetic action to being societal change in this area.
2. Ensure that the proposed Victorian legislated ban on conversion therapy is worded in such a way that conversion therapy aimed at asexuality is included within its scope. Ensure that any associated materials, policies, awareness campaigns etc are asexual-inclusive.
3. Include asexual survivors of attempted conversion therapy in any support or counselling schemes associated with the ban on conversion therapy.
4. Introduce hate crime legislation in Victoria that covers all common protected characteristics in anti-discrimination law, and in addition, is worded carefully to ensure hate crimes on the basis of asexuality are clearly included in its scope.
5. Strengthen the hate crime provision in the *Sentencing Act 1991* to increase its use – and explicitly state its relevance – in cases involving hate crimes based on sexual orientation, including asexuality.
6. Establish, fund and support training and education for staff of the Health Complaints Commissioner and the Mental Health Complaints Commissioner regarding the needs of asexual people, and the challenges they face, including with respect to conversion therapy.
7. Include asexuality within the scope of the Safe Schools Program, to reduce bullying and harassment of young asexual people, and support these young people by helping them to feel visible and validated, and assuring them they are not alone.
8. Expand the portfolio and training of Victoria Police's lesbian, gay, bisexual, transgender and intersex liaison officers (GLLOs) to include supporting asexual people.
9. Support and resource better enforcement of anti-discrimination and equal opportunity laws in instances involving discrimination against asexual people.
10. Fund and resource research into the health, wellbeing, needs and experiences of asexual people.
11. Establish and support a small asexuality-specific program of support and advocacy to establish and continue momentum in the asexual rights movement (e.g. via the Pride Centre).
12. Influential entities including government entities, professional associations and patient/community groups must show cultural and social leadership by publicly supporting the de-pathologisation of asexuality, denouncing conversion therapy for asexual people, and confirming their support of asexual people's innate humanity, legitimacy and rights.
13. Professional associations who represent and support the mental health workforce should publish positive position statements on asexuality, and the need to provide appropriate, affirming care for asexual people. They should also provide training to people regarding asexuality, co-designed with and delivered by asexual people, and (where relevant) provide continuing professional development credit for completion of this training.
14. Establish, fund and support training and education of mental health professionals (and physical health professionals) that is asexual-positive, and raises awareness about how to be a positive practitioner and ally for asexual people.
15. Improve the capacity and resourcing of Switchboard and other like entities, in particular counsellors, social workers, peer support workers and other support workers, to provide appropriately tailored support to asexual people.

16. Establish and maintain an online directory of health practitioners and services (including mental health services) that have chosen to identify themselves as safe, welcoming and understanding of asexual people and their needs.
17. Audit all standardised clinical tools (e.g. surveys, diagnostic questionnaires etc) used in health services to identify those which unintentionally capture asexual traits or behaviours, and attribute these to mental illness. Alter or cease the use of these tools, or give clients the opportunity to explain their answers, to prevent inappropriate pathologisation on the grounds of asexuality.
18. All entities and individuals can improve visibility and understanding of asexuality by including it in public life and initiatives wherever possible. This includes policies, procedures, programs, media, publications, events and initiatives – including those which already include the LGBTI community. This should include seemingly small changes, which together normalise asexuality, raise awareness and increase social acceptance. Examples include adding asexuality as an option in forms, surveys and diversity-positive job advertisement statements, or in acronyms, publications, case studies, media statements etc.