2022

Asexuality and Demisexuality: Clinical Implications of Sexual Identity

Michael Scott Fiorini

Asexuality and Demisexuality:

Clinical Implications of Sexual Identity

A DOCTORAL PAPER PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
OFFICE OF GRADUATE STUDIES
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
Michael Scott Fiorini, M.A.
May 3rd, 2022

APPROVED: _____
Laurie Ivey, Psy.D., Chair

_____
Joseph de Lappe, Ph.D.

_____
Jennifer Tippett, Psy.D.

Acknowledgements

The demisexuals who I've known over the course of my life showed me that research into this identity needed to be undertaken.

This paper could not have been written without the care and support of Drs. Laurie Ivey, Jennifer Tippett, Fernand Lubuguin, and Joseph de Lappe. I would also like to thank the Asexuality Visibility and Education Network, the Society for Descriptive Psychology, the Society for the Scientific Study of Sexuality, and the faculty of the University of Denver Graduate School of Professional Psychology for providing crucial support for this work.

Special thanks to Loecir Fiorini, Kathryn Freund, Dr. Lyndsey Keyte, Tomoko Miwa, Dr. Alex Fernandez-Ortega, Matthew Saks, Alaina Puff, and Dr. Kristen Schrijver for their feedback and support during the writing of this paper. Gratitude towards Alexandra Horton for reading and providing suggestions for the structure of the paper in its late stages of edits.

My friends and family motivated me to write this and gave this meaning.

Abstract

This paper considers demisexuality as an identity and sexual orientation for use by psychologists. It incorporates historical, sociological, and psychological perspectives. It discusses the clinical implications of demisexuality as an identity and orientation distinct from asexuality. The paper goes on to discuss applications and limitations of defining and identifying demisexuality in a clinical population, as well as demisexuality's social, scientific, and contextual significance. The paper compares what can be observed with existing diagnostic guidelines present in the DSM-5 for the identification of Female Sexual Interest/Arousal Disorder (FSIAD) and Male Hypoactive Sexual Desire Disorder (MHSDD). Finally, the paper proposes guidelines for the diagnosis and the ethical clinical treatment of demisexuals.

These goals were achieved by conducting a literature review of asexual studies, historical understandings of sexual expression, studies of psychological outcomes in under-represented identities, and accepted diagnostic approaches. These were considered alongside portrayals of demisexuality in popular journalism including magazines, blogs, and newspaper websites. The data collected was analyzed using a parametric analysis, an approach taken from Descriptive Psychology, to consider human sexuality. The data and analysis can be used to aid psychological treatment and diagnostic assessment of demisexual and clinical populations. It is a novel approach for conceptualizing human sexuality that digresses from existing assessments.

The analysis found significant evidence that demisexuality is distinct from asexuality and warrants a sufficiently adapted approach to psychotherapeutic treatment. The current diagnostic criteria of the DSM-5 for FSIAD/MHSDD were found to be insufficient to treat demisexuals. It

further suggested that demisexuality should be ruled out for FSIAD/MHSDD diagnosis, as is currently the case for asexuality. The findings identified demisexuality as an area of study which requires further psychological research and refinement of accepted diagnostic approaches.

Keywords: Demisexuality, asexuality, sexual orientation, sexual identity, Descriptive Psychology, FSIAD, MHSDD, assessment

Introduction

Individuals identifying as demisexual are becoming more publicly and clinically visible as awareness of the identity grows and it becomes more socially accepted. Despite that, there is very limited extant empirical psychological research on demisexuality and any research undertaken on the topic is nascent. To address the needs of demisexual clients in a clinical setting it is nevertheless essential for clinicians to garner familiarity with the identity and its individual relevance. Potential obstacles to this include a general lack of awareness of demisexuality amongst clinicians, ongoing discourse over the legitimacy of demisexuality as a sexual orientation, variability of how it may present in each person, and DSM-5 diagnostic criteria which may pathologize demisexual experiences. There are aspects of demisexuality discussed in this paper which cannot currently be informed by previous research, because in many cases none exists.

A demisexual is defined in this paper as an individual who does not experience sexual attraction to others except in specific circumstances. These circumstances are described as being related to emotional connection or significance. This means that when a demisexual person does not have a significant emotional connection with another person, they cannot feel sexually attracted to that person. (Hille et al., 2020) There is a growing body of literature and research suggesting that this is a distinct sexual orientation. Demisexuality is seen here as an entirely novel experience of human sexuality which cannot be described as being entirely asexual nor sexually normative, a position which digresses from existing conventions on the identity.

This paper aims to address diagnostic and theoretical challenges in the treatment and case conceptualization of demisexuals within clinical settings. To do so, the paper first

establishes distinctions of demisexual identity versus asexual identity via a comparative literature review. It establishes evidence of public awareness of and phenomenological evidence for the existence of demisexuality. The review also explores controversies surrounding demisexuality as well as the psychological and sociological research undertaken within asexual studies applicable to it. The literature review concludes with discussion of existing psychological approaches applicable to conceptualization of demisexuality and asexuality. The paper then explores potential domains of presentation for demisexuality via a parametric analysis of human sexuality. In doing so, the paper identifies some of the ways that a demisexual's experience may manifest for use in treatment planning and follow up. This can be applied in many ways with demisexual clients, including assisting clinicians in ruling out a Female Sexual Interest/Arousal Disorder (FSIAD) or Male Hypoactive Sexual Desire Disorder (MHSDD) diagnosis. It concludes with a discussion of existing rule-outs for an FSIAD/MHSDD diagnosis currently employed in the DSM-5 for asexuals which are considered here as adaptable to demisexuals.

Literature Review

Asexuality and Demisexuality Definitions and Overview

Asexual studies uses many terms potentially unfamiliar to readers from other disciplines, so a list of terms and definitions used throughout this paper is included in Appendix A which were taken directly from the AVENwiki (AVENwiki, 2022). Some of these terms are also discussed here more extensively where appropriate or necessary using additional sources. An asexual is a person who does not experience sexual attraction to others (Asexual Visibility and Education Network, 2016). Asexuality was misdiagnosed as a pathological sexual experience within clinical psychology and psychiatry until revisions first published in the DSM-5 in 2013 (American Psychiatric Association, 2013; Brotto & Yule, 2017). Demisexuality is not discussed at all in the DSM-5 and can consequently be misdiagnosed as Female Sexual Interest/Arousal Disorder (FSIAD) and Male Hypoactive Sexual Desire Disorder (MHSDD) despite the changes in how the DSM-5 conceptualizes asexuality (American Psychiatric Association, 2013). In recent years asexuality has garnered a considerable research focus in psychology, sociology, and sex and gender studies to illustrate its features, suggesting that its clinical comprehension remains an area of growth within psychology (Bogaert, 2015; Decker, 2014; Cerankowski et al., 2014). The predominant scientific viewpoint coming out of asexual studies is that lifelong lack of sexual interest is not in itself an illness. Nevertheless, there is a notable absence of research on demisexuality in clinical psychology despite its emergence and increasing recognition amongst the general population around the world. Asexuality and demisexuality both gained significant visibility during a period in time and broader social movement which strengthened their mutual

association. Psychologists stand to gain insight for clinical application by investigating them independently given that they may present as distinct from one another (Pryzbylo, 2019).

Demisexuality and asexuality are often grouped together within what is termed the "ace spectrum." Ace is shorthand for someone who is asexual, and the ace spectrum encompasses asexuality and related identities. When demisexuality is included in scholarly work, it is typically discussed alongside asexuality given its presumed membership on the "ace spectrum" (Copulsky, et al., 2021). There is sufficient evidence that demisexuality is a distinct identity from identities included in the ace spectrum related to the experiential parameters it is predicated upon. Demisexuality's status as a subgroup of asexuality is a recurring theme in healthcare research which is, in part, a result of demonstrable gaps in practitioner knowledge of asexuality itself (Jones et al., 2017). A review of clinical research on asexuality is included later in this literature review to provide further context for the consideration of demisexuality as an independent identity, due to this established relationship.

Despite it not being representative of all asexual-identified individuals, asexuals are commonly thought of as being both asexual and aromantic, that is, not experiencing sexual or romantic attraction. This mistakenly implies that being asexual inherently and necessarily means having an aversion to both sexual and romantic experiences. Furthermore, experiences of asexuals and those on the ace spectrum are heterogeneous within and between these identities. Not all individuals who have asexual experiences use asexual as an identifier (Prause et al., 2014; Pryzbylo, 2019). Lexical understanding is a significant component in studying emerging identities and indicates how people differentiate themselves. For example, of 10,184 ace spectrum reporters in the most recently available AVEN-sponsored asexual 2019 population surveys, 9.5% identify as demisexual (Weis et al., 2021). Regarding the characteristic

experiences of the ace spectrum identities, a wealth of biographical narrative and demographic data is publicly available on the internet via the Asexual Visibility and Education Network, among other such forums (Asexual Visibility and Education Network, 2016; Weis at al., 2021).

The ace spectrum encompasses identities and orientations which have features of asexuality (Pasquier, 2018). Some of these include but are not limited to asexuality, demisexuality, and gray asexuality. Some of these identities are occasionally considered asexual "subgroups" (Asexual Visibility and Education Network, 2016, 2020; Steelman & Hertlein, 2016). The use of a spectrum model for sexual identity is limited in its scope because spectrum models rely on categorical binaries that may not be able to encompass all relevant means of sexual expression and orientations, as noted for example in criticisms of the Kinsey Scale (Weinrich, 2014). The ace spectrum is nevertheless constructed as shorthand to denote some of the ways that asexuality might manifest for an individual. It accounts for case-specific or patterned exceptions where sexual attraction and behavior are experienced. Examples include what is ascribed to by demisexuals, as well as experiences of sexuality that don't follow recognizable patterns. The latter describes the reported experiences of gray asexuals, meaning those who report some or sporadic sexual interest without ascribing it to any consistent preconditions (Hille et al., 2019). Different identities within the ace spectrum may also represent examples of sexual fluidity, that is, a changing or dynamic relationship to sexuality and romanticism (Brotto & Yule, 2017). Although ace spectrum identities are grouped together because of their similarities, they are all distinct in their defining features, reported impact on individual experiences of sexuality, and applications based on personal resonance.

Demisexuality emerged conceptually in a fashion like other sexual identities and orientations. It originated as a means of garnering recognition and community that was facilitated

by the advent of the internet. It is reflective of a broader trend of community creation and behavioral facilitation for online sexual and identity expression. (Cover, 2018; Gray & Moore, 2018) The first known use of the term demisexuality was in 2006 in a post made on the forums of the Asexuality Visibility and Education Network (AVEN) (Asexual Visibility and Education Network, 2016; AVENwiki, 2019; Barton, 2019). In the post, a user expressed their frustrations with using the asexual identity, because it did not seem to characterize their experiences fully. The user, and later other members of the AVEN forums, reflected upon the limitations of only having the term asexual to describe what they were experiencing. This post is significant to clinicians, as it represented a departure from the asexual narrative up to that point and a move towards individualization. It indicated that terms like asexuality may not satisfy demographic needs and nuances present in the broader population. As a result of this first post, the term demisexuality saw more widespread use online. The expansion of use was first visible on the online asexual forums of AVEN, where individuals from around the world were beginning to report that demisexuality, as described, resonated with their lived experiences (Asexual Visibility and Education Network, 2020). This indicated some descriptive overlap as well as potential variability in how demisexuality may present narratively and behaviorally, as is also the case with other ace spectrum identities (Carrigan, 2011; Steelman & Hertlein, 2016; Jones et al., 2017).

As noted in multiple bodies of research on the identity, some asexuals have formed an activist movement that questions the social and political ramifications of sexual society. A feature of asexual activism is individuals seeking recognition of the orientation by self and others. Asexual identity is based on a presumptive commonality of orientation (de Lappe, 2018) and the same dynamic may be present for demisexuals (Demisexual Resource Center, 2015).

This reflects earlier work in philosophy and sociology discussing the construction of identity through interaction with others. Interaction with others has been influentially conceptualized as necessitating our differentiation as well as the recognition by self and others of those distinctions (Goffman, 1959; Laing, 1961). Asexuality within such discourse is sometimes seen in contrast to expanded sexual liberties and "sex-positivity," or the idea that sexual expression is good, desirable, and should not be repressed or looked down upon (Milks, 2014).

Though sex-positivity was constructed to de-pathologize sexual behaviors, it assumes an "allosexual" stance. Allosexual and "allosexuality" are terms employed by the asexual community to denote sexual individuals. It has a dichotomous relationship with asexuality, and it is also used within asexual research to represent the social norm of sexual expression as healthy and desirable (Asexual Visibility and Education Network, 2020). As sex-positivity is often embraced in LGBTQIA+ narratives and some demisexuals identify as LGBTQIA+, it potentially problematizes or invalidates asexual and demisexual experiences within their own expanded communities. Marginalization and discrimination have clinical implications across cases and therefore may signify increased desire for or use of therapy or psychiatric services by demisexuals and asexuals relative to other populations, however further research is needed to support this assumption.

Demisexuality is distinct from other identities in the ace spectrum in that it has the consistent feature of sexual attraction to others following an emotional connection of personal significance. This pertains solely to interpersonal sexual relationships, as the same conditions are not uniformly reported for auto-erotic stimulation (Asexual Visibility and Education Network, 2020a, 2020b; Demisexuality Resource Center, 2015; Pryzbylo, 2019). Masturbation studies on individuals reporting partnered sexual dysfunction have also shown elevated masturbation habits,

indicating potentially separate but related sexual processes for partnered and non-partnered sexual expression (Gerressu et al., 2008). Demisexuality, furthermore, does not fit an entirely allosexual model driven by sexual attraction, and demisexual accounts describe highly conditional sexual responses. There is some existing precedent for this within cognitive psychology. Notably amongst these is that familiarity has been shown to correlate with preferences, as shown in cognitive research by Zajonc. This tendency may play a role when selecting sexual and romantic partners (Zajonc, 1968). This indicates that demisexual experiences of familiarity as a condition for intimacy and sexual preference are compatible with accepted cognitive models in psychology.

Public Awareness, Visibility, and Phenomenological Evidence of Demisexuality

Public visibility, term usage by individuals, and self-identification gave credence to the existence of a functionally distinct demisexual identity. As the term demisexuality entered the popular lexicon, it was acknowledged on dictionary websites, public forum resource pages, and video blogs, being featured for example on YouTube, Reddit, and Wikipedia (Dictionary.com, 2017; Reddit, 2010; Tinder, 2019; “Gray Asexuality,” 2021). This was significant because it indicated that the term became publicly understood prior to widespread understanding in clinical practice. Over the course of the late 2010s, demisexuality was well-known enough as an identity and concept that multiple media and news outlets began covering it. The websites covering it used very similar terminology to define demisexuality, and in most articles where sources are available, they referenced the initial forum post on AVEN as their primary source of information. Other media sources used more personalized accounts or incorporated perspectives from the medical, psychological, and scientific communities. When no direct citations were used, summaries of the orientation and what it entails were nevertheless comparable. Although there is

relatively little scholarly work conducted on demisexuality as an orientation, the public forum from which the term emerged has given credence to demisexuality's existence and validity. This is significant for clinicians from a cultural competence perspective despite sparse extant research within clinical psychology (Ashley, 2018; Colvin, 2019; Demaionewton, 2017; DePaulo, 2016; Ferguson & Brito, 2019; Fletcher & Brito, 2020; Hosie, 2017; Macmillen & Pugachevsky, 2019; Nelson, 2018; Katehakis, 2017; McGowan, 2015; O'Malley & Burgum, 2019).

Individuals publicly identifying as demisexual have become more common (Iqbal, 2019). In addition to blog and forum posts, there are many videos, podcasts, and books published which describe the myriad experiences of demisexuals. While there are experiential similarities across cases, what is also apparent is how diverse the population is regarding sexual and romantic behaviors. This can be observed via cursory searches of the AVEN forums. For example, a common theme of demisexuality discussions involves users asking the community if they believe their personal experiences qualify as demisexual. This is used as a means of validating their experiences. This can involve questions around what qualifies as an emotional connection, personal courting practices and conditions, masturbation habits, among others, with varying degrees of cohesion between user perspectives. How the orientation impacts the lives of demisexuals is discussed in highly individualized terms as well. Demisexuality, as a result, is discussed in terms of individual narratives and meaning (Asexual Visibility and Education Network, 2021). For clinicians to adequately assess and treat demisexual clients, they therefore need to understand what the identity signifies on a case-by-case basis and how it interacts with other aspects of their clients' lives.

The existence and use of demisexuality as a distinct identity are evident in contemporary phenomenological data. Individual presentations vary across contexts and may be socially

constructed. Although its status as an orientation is implied, demisexuality as a sexual orientation cannot be distinguished via purely phenomenological data. Lacking overt definition, widespread acceptance, and recognition in clinical psychology research, demisexuality nevertheless has symbolic relevance for many individuals. The concept of "sexual scripts" posited by Gagnon & Simon (1973) discusses sexuality as a performance adapted to social contexts, with identity and the meaning of sexual acts being symbolically relevant for individuals. Amongst its users and supporters, the use and meaning of the term demisexual holds a role similar to any other sexual identity (e.g., having pride in oneself, finding support, use in the courting process, meaning-making, and community construction). All sexual identities and experiences can potentially be considered symbolically meaningful within such a framework. Supporting symbolic meaning is consistent with existing ethical practices in clinical psychology. The approaches of therapists are generally informed by normative scripts that inform how they conceptualize people and their behaviors. This is also part of the process of diagnosis and assessment, as these aspects of therapy require comparison of clients to generalized norms. Normative sexual scripts are particularly problematic because they are exclusionary and, in clinical settings, contribute to pathologization (Rubin, 2011). The sexual scripts used by demisexuals are not always understood or accepted and may prompt demisexuals to seek services for support. This is not a challenge limited to demisexuals, as changing sexual mores and expression often prompt individuals to seek or need support (Barker, 2012). It is imperative that clinical responses to demisexuality are able to adapt to the novel sexual scripts of demisexuals.

Many articles covering demisexuality indicate its contrast due to its visibility during the rise of "hook-up culture" and the mainstream use of online dating. The sexual scripts of demisexuals and the sexual scripts of hookup culture may therefore differ significantly. How

demisexuality interacts in the online dating space is an area of research significance, as it may indicate demisexual-specific challenges in finding acceptable romantic and sexual partnerships (Dent, 2019; Duncan, 2019; Knight, 2019; Kovacs, 2019; Kliegman, 2018; McGowan, 2015; OkCupid, 2020). This reflects the emotionally connective quality of the orientation, wherein the case-specific exceptions for sexual attraction can be nuanced and highly personalized (Asexual Visibility and Education Network, 2020; Demisexuality Resource Center, 2015; Rose, 2017; Tinder, 2019). This parallels existing evidence of the highly individualized nature of sexual and gender experiences in general (Galupo et al., 2014). With hook-up culture becoming more prevalent and the sexual scripts it uses becoming more common, it may exacerbate the instances of alienation and courting challenges already faced by demisexual clients. This could also result in an increase in their use of clinical services, a dynamic which warrants further study and increased cultural competency by psychologists. In order for clinicians to promote a fuller and more positive sex-life for demisexuals, they will need to challenge presumptions that they're broken, lesser-than, or not good enough (Rubin, 2011). To do this effectively, they will also need to challenge the negative messaging demisexuals can receive from the normative scripting of sex-positivity, the asexual community itself, and themselves (Davies et al., 2015). This is in line with current APA standards of care prescribed for work with LGBT clients (American Psychological Association, 2021).

Demisexuality as an identity is readily visible in its use on dating apps and websites. Demisexual identity is for example currently included as an option on two of the most popular online dating apps in the United States, OkCupid and Tinder (OkCupid, 2020; Tinder, 2020). Individuals utilizing the identity can be found across the United States and abroad via these apps, although the total number of demisexual identified users has not been made public in either case.

Both companies feature blog postings and discussions of demisexuality on their websites for those looking to learn more about it (Kovacs, 2019; OkCupid, 2020). This is significant clinically, as it provides evidence of the desire for demisexuals to discuss relationships, sexuality, and dating through a demisexual framework outside of and within a clinical setting. This suggests that, within an online dating context, demisexuality is used as an indicator of sexual orientation for the individuals who use it. This can be seen as an example of a demisexual-specific sexual script. Demisexuality is an option for users of these sites to select alongside other already acknowledged and accepted sexual orientations (OkCupid, 2020; Tinder, 2020). The visibility and integration of demisexuality into public social and romantic life is increasing and this may also increase their willingness to discuss it in clinical settings, in particular due to misunderstandings arising from perceived incompatibility or differing sexual scripts.

Debates Surrounding Demisexual Identity

While phenomenological data on demisexuality is present, there is ongoing debate present within the asexual community and asexual studies around the validity of demisexuality as a sexual orientation and how to conceptualize it (Barton, 2019). Demisexuality shares this with asexuality, where ongoing debate persists on definitions and the relationship between identity and orientation (Pryzbylo, 2019). This also presents potential challenges on behalf of clinicians and individuals distinguishing asexuality in healthcare settings (Steelman & Hertlein, 2016). The current contested status of demisexuality as a legitimate sexual orientation draws some historical parallels with bisexuality. Both demisexuality and bisexuality challenge sexual binaries of gender preferences and sexual attraction, respectively. This has historically presented

challenges for the acceptance and acknowledgment of bisexuality as an orientation, as is currently being seen in the discourse around demisexuality (Elizabeth, 2013).

The Kinsey Scale is a notable example of a commonly employed clinical tool that recognizes bisexuality but excludes identification with asexuality and orientations outside of the boundaries of gender binaries. The scale and its limitations have been criticized in sex research for some time, yet it's use remains widespread (Weinrich, 2014). This is indicative of the limitations that psychological assessments have had when applied for use outside of traditionally acknowledged expressions of sexual identity. Attempts to update the Kinsey Scale have fallen short of being able to account for the diversity observable in reported sexual experiences (Bowins, 2016). The novel approach used later in the paper uses a parametric analysis to further account for potentially excluded identities and presentations in ways which may not be possible using existing scale or spectrum models for conceptualization. This is employed in the paper due to nuances present in individual accounts of sexuality and extant challenges with representing that accurately (Savin-Williams, 2014).

Broader discourse on asexuality, its features, and how it is responded to clinically, medically, and socially have changed significantly over time. The shared experiences of asexuals and what constitutes "real" asexuality also remain a subject of some debate (Bogaert, 2015; Cover, 2018; see also Kahan, 2013). Some self-identified asexuals report sexual attraction and behavior, and they still feel the identity is accurate for them. Other asexuals report no history of sexual attraction or behavior, taking a neutral or indifferent stance on the subject. There are also asexuals who report an aversion to sex and disavow sexual experiences altogether (de Lappe, 2018; Pryzbylo, 2019). The clinical significance of this variability is an indication that asexual models may not suffice for treatment or diagnostic purposes with demisexual clients in a

therapeutic setting. Clinical efficacy with asexual patients in healthcare settings is already affected by a lack of cultural competence, and this effect carries over into related groups (Jones et al., 2017). As a direct result of ongoing debates regarding demisexuality's validity, clinical understanding has been slow to tailor interventions for it specifically and none have yet formed to address the unique service delivery needs of the population.

Demisexuality has consistently occupied a position of distinction from other identities in the ace spectrum. This has been established by the nature of its features, as is the case with the other extant identities described therein (Carrigan, 2011; Pryzbylo, 2019). Current online trends sometimes associate demisexuality with "gray-asexuality," partly facilitated through the format of the AVEN forums incorporating "gray" identities into a single portal. The immediate impact of this can be seen exemplified by the relatively recent removal of the demisexuality page on Wikipedia, after which point it became, and currently remains, a noted subsection on the "Gray asexuality" page (Asexual Visibility and Education Network, 2020; "Gray Asexuality," 2021). Gray-asexuality, as an identity, does not delineate specific conditions for asexuality or sexual expression (Pryzbylo, 2019). This is significant because it potentially obscures the distinctness of the consistent conditional markers of demisexuals. Such conditions may necessitate distinct therapeutic needs and treatment models. For example, if a demisexual requires emotional connections to experience sexual attraction, emotion-focused discussion around how they interact with potential partners may be warranted more so than it might be with a gray-asexual who is less specific about the circumstances of their attraction. This necessitates more specificity via inquiry and fostering the ability of clinicians to tailor approaches to individualized experiences for demisexuals, asexuals, and gray-asexuals.

Formulation of specific practical clinical approaches for demisexuals does not require evidence distinguishing it as a sexual orientation versus an identity. The individual variability in its presentation functionally blurs such distinctions and prevents broad definitional generalizations. Even without clarifying specific demographic information or definitions, it remains evident that demisexuality is a widespread identity that is actively being used in the courting process for sexual and romantic relationships (OkCupid, 2020; Tinder, 2020). Identity and sexual orientation can be linked and are both independently clinically significant. Identity on its own is employed as a clinically significant factor when diagnosing in a clinical setting (American Psychiatric Association, 2013). Based on the narratives of self-identified demisexuals, demisexuality may represent a distinct sexual orientation, but such distinctions cannot be made here given the limited scope of available data. In spite of limited recognition, individuals still identify as demisexual contemporaneously, still face possible discrimination, rejection, or misunderstanding as a result, and many will seek services to garner support to navigate those experiences. A clinical prevalence and service usage study has not been done yet, and this data could help to better assess the unique service needs of this population in the future. Clinicians today are nevertheless in a position of being able to provide care for demisexual-identified persons and, as a result, need to understand what the identity means on an individual basis in order to be effective in their support despite evolving discourse surrounding identity.

Asexuals and Demisexuals in Clinical Psychology Research and Intervention

Aside from definitional differences, there are some reported psychological differences between self-identified asexuals and self-identified demisexuals. Recent peer-reviewed research has been published via the American Psychological Association on demisexuality and asexuality in the form of a survey done on individuals across different sexual orientations and gender

identities (Borgogna et al., 2018). The survey measured the incidence of averse psychological and emotional experiences. In contrast to all other groups, including the asexual, homosexual, and transgender cohorts, the demisexual cohort reported higher incidences of both anxiety and depression. The sample size was relatively small (n = 55) and may only represent piecemeal data, but it does indicate that some demisexual identified respondents experience psychopathological symptoms. This may also indicate a higher risk amongst demisexuals for comorbidity of psychological disorders. It also indicates potential differential outcomes for demisexuals when compared to asexuals. The findings highlighted a need for further research on the incidence of demisexuality and mental health outcomes for this population. It is of particular concern given potential client hesitancy to discuss asexual identity, experiences, and attitudes (Jones et al., 2017).

The DSM-5 and its historical antecedents have been criticized for diagnoses pathologizing sexual experiences as well as their flawed diagnostic criteria for sexual disorders, some of which are still endorsed. Regarding the DSM-5 and its diagnostic criteria for FSIAD/MHSDD, the 2013 amendments have addressed asexual identity as a rule-out factor and no longer considers asexuality a diagnosis itself. However, this does not address demisexuality and other ace spectrum identities (American Psychiatric Association, 2013). As understanding of asexuality can be limited, effective use of current diagnostic guidelines without tailored approaches and culturally competent care is questionable even without considering supposed "asexual subtypes" (Steelman & Hertlein, 2016; Jones et al., 2017). Diagnostic criteria for female sexual disorders have furthermore been criticized for being rooted in poorly understood psychosocial and biological factors that can be pathologized when emphasizing a male-centric sexual response framework (Graham, 2010a, 2010b). Recommended revisions of the DSM-IV-

TR for the DSM-5 also cited the need to not pathologize the normal variation of sexual experiences, given that diagnostic language heavily relies on a clinician's judgment and what is considered a pathological sexual response is potentially affected by it. Graham (2010b) also noted that "assessing distress in a clinical situation, including the distinction between so-called 'personal' distress and 'interpersonal' distress, is clearly important and can inform treatment decisions." The distress factor is notable when discussing demisexuality and other emerging identities because the social acceptability of sexual expression and practices can influence self-perceptions of sexuality (Cover, 2018; Tanner et al., 2009).

There are currently no clinical guidelines or therapeutic approaches tailored specifically for demisexual clients. Some research on demisexuality has been done, but it is limited in scope and not related specifically to clinical intervention strategies or case conceptualization. Some extant research has discussed demisexuality as a contested sexuality, or one which is likened or linked to asexuality in how it is covered in the media and researched (Barton, 2019; Brotto & Yule, 2017; DePaulo, 2016; Hille et al., 2019; Iqbal, 2019; Jones et al., 2017). This tendency is also reflected in media articles often referencing demisexuality and asexuality alongside one another, with limited distinctions made (Kliegman, 2018). The community-building and activism exemplified by individuals with shared marginalized identities exists in part to challenge existing social, research, and clinical approaches to respond more adequately to their needs. Arguably, this suggests that demisexual-specific community-building and online activity exists to challenge dismissal, oppression, and marginalization. If the term asexual sufficed to describe demisexuality, then the term and identity demisexual would not exist in the first place. The pattern in clinical psychology and medicine up until this point has been to adapt, albeit after varied challenges to such efforts, and no longer see previously marginalized sexual and gender

identities as illnesses. Given that, efforts to ameliorate extant shortcomings in clinical practice have required not only recognition and backing of demisexual distinctiveness but also recognition of those very shortcomings as such. The activist aspects of the asexual community and the social implications of it are discussed extensively in the works of Joseph de Lappe and parallel what has been seen in the demisexual community (de Lappe, 2018).

The validity and health of asexuality and demisexuality within a sex-positive discourse share some parallels with earlier discourse in the psychiatric community, where asexuality was listed as a diagnosis in the DSM. Asexual activism also parallels aspects of homosexual and transgender activism undertaken from the mid-twentieth century to today against discrimination, stigma, pathologizing, and negative health outcomes associated with those responses (Chu, 2014; Hubbard & Griffiths, 2019). Asexuality was dropped as a formal diagnosis in the DSM in 2013 with the publishing of the DSM-5, just as homosexuality was in 1973 (American Psychiatric Association, 2013). Gender dysmorphia was introduced in 2013 as well to remove the stigma with labeling transgender experiences disorders. In the DSM-5, asexuality became a clinically valid rule-out for FSIAD/MHSDD diagnosis when a person in question endorses “lifelong lack of sexual desire” for FSIAD and “self-identification” for MHSDD (American Psychiatric Association, 2013, pp. 434, 443). No such exceptions exist for demisexuals, and the current language used for diagnostic rule-outs may bar demisexuals from qualifying. This may be partially due to the identity’s relatively recent emergence and lack of professional awareness of it (American Psychiatric Association, 2013; Drescher, 2015).

The ongoing relationship between LGBTQIA+ populations and the science and practice of clinical psychology is well established. This relationship is affected by how clinicians approach the diagnosis and pathologizing of experiences and behaviors for LGBTQIA+

individuals (Hubbard & Griffiths, 2019). The history of diagnosis and pathologizing has caused an aversion in some communities to seek psychological services, suggesting that a reduction in such practices may remove such barriers to psychological services (Hughto et al., 2018; Jones et al., 2017). This approach has been shown to be effective for expanding access to care in comparative studies of psychological service use between heterosexual and homosexual cohorts (Razzano et al., 2006). In recent years, the psychological community has moved against pathologizing and diagnosing these experiences (Suess-Schwend, 2017; Winter et al., 2016). A recent prominent example in this effort is the approach towards transgender and gender-nonconforming clients, suggesting that the same clinical rationale can be applied to demisexuals and other emerging identities to avoid pathologizing them (American Psychological Association, 2015). The American Psychological Association has directly supported a therapeutic approach to reduce stigma in working with sexual minorities to improve health outcomes.

Asexuality and Demisexuality in Society

Diagnostic criteria for sexual disorders are in a constant state of change as new research is conducted. Popular and cultural relationships to sexual behaviors change over time as well and influence the variance of consideration of sexual orientations and identities (Hubbard & Griffiths, 2019). This can be observed from the outset of modern scientific psychological research on human sexual expression and psychopathology (Foucault, 1976; Foucault & Khalfa, 2006; Krafft-Ebing, 2011). How clinicians approach sexuality has been revised in myriad ways since the inception of psychotherapy and continues to the present day (Hubbard & Griffiths, 2019). A recent example of the fluidity of diagnostic approaches is evident in the WHO's recent decision to remove gender incongruence entirely from the ICD-11, again citing efforts to reduce stigma and improve social acceptance (Ravitz et al., 2019). These changes are often reflective of

the context of their time periods, and as such, they are intertwined with society, culture, religion, politics, and history (Hubbard & Griffiths, 2019). The methods and practice of therapy have historically been intrinsically linked with social and contextual change, and such changes are constant.

There are many extant and historical examples of culturally sanctioned celibacy. Today, examples include but are not limited to unmarried single adults, priests, nuns, spouses of the deceased, the elderly, and children. Characterizing the role of the aforementioned subjects as asexual may not be accurate based on the criteria set forth by self-ascribed asexuals today, however not having sex has had functional cultural acceptance within societies and predate the contemporary push for asexual recognition. Demisexuality may be also be presumably acceptable or assumed by some to be typical depending on context. A fairly common assumption is that demisexuality or demisexual behaviors are acceptable when attributed to women and unacceptable or unusual in men, depending on the cultural context and expectations. It may furthermore be mischaracterized as “pickiness” or idealized as “playing hard to get” within Western culture (Hayes, 2017).

What can be considered socially acceptable celibacy is limited to when it is explicitly voluntary. This is extremely limited in scope, doesn’t apply to sexually-mature adults, and when applied to any demographic it doesn’t account for or condone the absence of sexual desire in. Demographics studies typically do show a significantly and predominantly female population reporting asexual or questioning experiences, and this has been reflected in the most recent population data available (Weis et al., 2021). Having acknowledged the available data, it is nevertheless challenging to discern to what extent the statistical evidence is affected by cultural or societal attitudes and biases. There is a need for further investigation into confounding factors

to help avoid assumptions based on individual identities, demographics, and culture. It remains important to recognize in clinical practice that a lack of sexual desire is demonstrably ostracized in society.

Once sexual expression becomes expected or acceptable in a social context, a lack of adherence to these sexual norms may generate interpersonal difficulties. A double standard can therefore exist where asexual behavior is acceptable only if it is socially or culturally acceptable, as opposed to being merely individually acceptable (Kahan, 2013; Steelman & Hertlein 2016; Jones et al., 2017). Nevertheless, lack of or lowered interest in sex persists diagnostically if it causes reported distress and is observable by clinicians (American Psychiatric Association, 2013). Such distress has been conceptualized as a psychological symptom of the social expectations of behavior and sexuality outside of the control or desires of individuals (Buirski et al., 2020; Steelman & Hertlein, 2016). Conceptualizing clinical approaches for demisexual clients is needed to address the identity's public emergence, practical use, and potential for misunderstanding, pathologizing, and misdiagnosis.

Asexuality and demisexuality represent a paradigm shift away from social and medical expectations in defiance of what is considered "healthy" and acceptable sexuality. Acceptable sexuality is malleable across social and cultural contexts, however, in general, refers to the desire for sexual activity and the physical ability to engage in sex at will. As a subtle example of how this can be used to pathologize asexuality, the DSM-5 lists asexuality as a rule-out for MHSDD by listing it in a section titled "Other sexual dysfunctions" (American Psychiatric Association, 2013, p. 443). Expressions of asexuality that are desired, accepted, or not rejected by the individuals experiencing them have been discussed as introducing a narrative that is person-centered, necessitating the shifting of clinical practices and social understandings of what is

healthy and acceptable (Kahn, 2014). The use of a term as an identity, and in this case as an identity implying a sexual orientation, has parallels across the ace spectrum as well as with other identities and sexual orientations not included in it. Symbolic-interactionist accounts of asexuality suggest that approaches for conceptualizing identities in the ace spectrum can also be applied to other emerging identities more broadly (Cover, 2018; Scott & Dawson, 2015). The significance of this for clinical practice is that tailored clinical approaches for demisexuality may also be adapted for changing social, political, and sexual landscapes to work with clients with emerging identities. The use and recognition of these identities have supportive and prosocial effects, as has already been discussed and exemplified with qualitative data from asexual clients in healthcare settings (Jones et al., 2017). Moreover, the use and support of distinct prosocial client identities has longstanding support within clinical practice.

Physiological responses, masturbation habits, and interpersonal histories of self-identified asexuals, gray-asexuals, and demisexuals have been reported to not be uniform in population studies (Hille, 2019; Hille et al., 2019). This serves as direct evidence for there not being one-size-fits-all behavioral markers for these identities. This heterogeneity is consistent with findings on other sexual minority respondents regarding sexual orientation, behavior, and gender identity (Galupo et al., 2014). There is evidence that shows that a significant minority of individuals in the UK acknowledge an absence of interest in sex, however (Mercer, et al., 2013). This indicates that having an absence of or lesser interest in sex is widespread in the general population (Aicken et al., 2013). There are extant studies with asexual respondents on classification and clarification of their experiences, but they are sometimes inconsistent in their findings on asexual demographic and behavioral correlates. Sexual desire and arousability levels do show some comparative differences with the general population, but these do not correlate with reported

amounts of sexual experiences. Of clinical concern is that individuals with asexual experiences may pathologize their own experiences due to societal pressures and conventions outside of their control, giving rise to the clinical distress that has historically warranted an FSIAD/MHSDD diagnosis. Responses of healthcare providers may compound this (Steelman & Hertlein, 2016). Notably, asexuals do not report differences in the prevalence of sexual distress when compared to non-asexuals, and this may be the same for demisexuals (Prause et al., 2007).

While biomarkers provide evidence for presumably asexual responses, they cannot capture all asexual experiences or make definitive presumptions about them (Prause et al., 2014). Currently, the ways in which asexuality, the ace spectrum, and demisexuality are attended to in a clinical framework are influenced by a medical model which presumes the inherent health and normality of having sexual desires and the need to address their absence diagnostically (Pryzbylo, 2019; Steelman & Hertlein, 2016; Graham, 2007). Furthermore, a correlation is often assumed between genital functionality and the desire for sex. However, based on existing narrative evidence, this is not necessarily present for asexuals, demisexuals, or other members of the ace spectrum. This can result in a pathologizing approach to reduced or absent sexual desires by suggesting a psychological disorder prior to the discussion of asexuality or, by extension, demisexuality (Flore, 2014). In instances where fMRI imaging studies have been used (for example, to measure asexuality via psychophysiological markers associated with sexual arousal), some asexual subjects did not display neural activation, suggesting they lacked sexual arousal when exposed to sexual imagery. Despite this, it was noted that the ways that individuals report and attend to their physical, psychological, and emotional experiences are highly personalized and the measurable results cannot be generalized to sexual identity (Prause et al., 2014; Steelman & Hertlein, 2016).

Descriptive Psychology and Parametric Analysis

This paper draws extensively from the methods and approaches of Descriptive Psychology to construct a conceptual framework to discuss human sexuality and sexual expression. As such, a brief discussion of this school of thought is warranted for clarity and brevity. Summarily, Descriptive Psychology (DP) explicates concepts in a way that honors language, reference, context, and contradictory understandings inherent to different perspectives about what is observable, experienced, and imagined by individuals. In other words, concepts are described such that all their associated aspects are recognized and incorporated. A fundamental aim of DP is to articulate real-world existing concepts through a systematically related set of distinctions, rather than posing theoretical assertions. Moreover, DP is a conceptual system that does not have truth value, and not a theoretical orientation which does have truth value. Distinctions are refined so that when a subject of interest is examined, the various facets of the subject are acknowledged in an understandable framework that does not obscure what is knowable about it. One conceptual tool for examining a phenomenon is a Parametric Analysis, where parameters are the essential and distinct aspects of the subject of discussion. It serves as a conceptual device for distinguishing one phenomenon from another, as well as differentiating among the possible instances of a given phenomenon through its parameters. The general approach taken within Descriptive Psychology can and is applied to psychological and non-psychological concepts (Lubuguin, 2010; Ossorio, 1983).

Demisexuality is multifaceted given its emotional preconditions, lending itself to exploration via existing descriptive approaches. To accurately discuss how demisexuals might relate to sexuality, it is pertinent to recognize the numerous ways it might be understood and

related to by them. In addition to Descriptive Psychology, sociological understandings of the presentation of self in cultural and situational contexts can be employed to formulate the parameters of human sexuality as we currently understand them (Goffman, 1959). Understanding self-concept is significant in the Descriptive Psychology approach to the treatment of averse psychological and emotional experiences by offering further avenues of focus for potential exploration in therapy and clinical intervention. (Bergner, 1993; Bergner, 1998; Ossorio, 2006). Descriptive Psychology has been used in the emotional and contextual analysis for clarification in marital dysfunction and sexual misunderstanding (Bergner & Bergner, 1990). Given its potential for mischaracterization, demisexuality can benefit from a similar analytical approach. Emotions have previously been explored in Descriptive Psychology as relational concepts not only designating feelings but also individualized motivations (Bergner, 1983; Hegi & Bergner, 2010). Psychological treatments using individualized approaches have been shown to reflect and respond to the diversity of presentation ethically and beneficially; this is a widely accepted practice for psychologists and psychiatrists (American Psychiatric Association, 2013, American Psychological Association, 2017).

Emotional connections and significance between individuals are fundamentally based upon the relationships and interactions between them. Descriptive Psychology has been employed to explore the basic elements and different facets of psychological and emotional experiences (Ossorio, 1983). In doing so, aspects of human experience can be considered for their emotionally significant components on a per-client basis reflective of their unique cultural and contextual experiences (Bergner, 1993). Emotions in Descriptive Psychology represent person-specific paradigms that require specification for proper understanding and clarity. These can be extended to human sexuality as experienced by demisexuals (Ossorio, 2006).

Recent sociological discourse has suggested that an ethical and practical clinical approach for conceptualizing asexuality requires the utilization of a symbolic-interactionist account of experience in lieu of making assumptions or broad-based conclusions (Scott & Dawson, 2015). Such approaches can be integrated with Descriptive Psychology's parametric analysis approach to identify elements of an individual's experience and utilize them in psychotherapy. This is particularly significant for demisexuals in a clinical setting given the diversity of their experiences and the risk faced by those who have them to be mischaracterized, misunderstood, politicized, or generalized (Steelman & Hertlein, 2016; Dawson, et al, 2018). As previously noted, this can lead to pathologizing asexual experiences, a misunderstanding of demisexual experiences due to existing diagnostic conventions, a broader and longstanding vulnerability in clinical psychology to pathologize human experiences in general, and the potential to conflate demisexuality with allosexuality or asexuality (Rubin, 2000). Psychological approaches for the treatment of sexual problems are also sometimes overlooked in favor of medical models of treatment despite medical interventions not being consistently effective for treating reported sexual dysfunctions (Graham, 2007). Parametric analyses may reduce vulnerability to conceptual and experiential mischaracterization.

A parametric analysis of human sexuality can help to alleviate some ambiguity when it comes to characterizing or describing sexual experiences within a clinical setting. Calls for a framework to address many psychological and experiential facets of sexuality are not new and have been recommended for incorporation into future diagnostic and intervention models. Sexual excitation and inhibition have been explored as separate processes with noted conditional variations across different ages, sex, and gender demographics. Although what influences excitation and inhibition in different contexts varies between individuals, psychological factors

can be significant (Bancroft et al., 2009; Carpenter et al., 2008; Fortenberry et al., 2005; (Graham et al., 2004; Graham et al., 2006; Jozkowski et al., 2016; Lykins et al., 2006; Sanders et al., 2007). Inhibitory cognitions, relationship importance, arousability, partner characteristics and behaviors, and setting factors have been shown to influence sexual excitation and inhibition in both men and women in self-report studies (Milhausen et al., 2010).

A dimensional model for characterizing sexual dysfunctions was recommended for the DSM-5 prior to its publication to address existing diagnostic limitations regarding pathologizing variations of sexual experience. Despite it not being directly incorporated, a dimensional model can still be adapted for use to characterize human sexual experiences in a clinical setting (Mitchell & Graham, 2008). The development and adoption of a dimensional approach to characterizing sexuality may improve clinicians' ability to address psychological factors affecting clients' experiences of sexuality. This approach may present a less pathologizing means for discussing sexual experiences. It can provide nuances to better understand the many contextual, psychological, and biological factors involved. A parametric analysis of human sexuality can therefore be a starting point for such a model, in lieu of other encompassing clinical or assessment precedents.

Synthesis of Literature Review

There has been little empirical work dedicated to distinguishing between demisexuality and asexuality for use in clinical psychology. This is the first work to do so explicitly for diagnostic and therapeutic application. Demisexuality is a widely referenced and publicly acknowledged identity that strongly suggests its function as a sexual orientation, however, as of this writing, there is limited empirical research exploring it. Previous research has been collected in the form of surveys of demisexuals, their affects, and behaviors. Demisexuality is typically

linked to asexuality as a related subset. There have also been limited numbers of formal surveys conducted to gauge the demographics of the demisexual population. As a result, a phenomenological approach was taken in this conceptualization which relies on three domains of information as evidence of the existence of demisexuals and their distinctiveness. These included public awareness in the form of articles sourced from contemporary media and academic sources, demisexual-specific communities including contemporary accounts of their experiences, and evidence of use of the demisexual identity in contemporary romantic and sexual life.

The literature review indicated that demisexuality satisfied all three areas of inquiry. This indicates that demisexuality is, from a functional perspective, a potentially significant identity factor that is explorable in psychotherapeutic and clinical settings. Demisexuality as an identity can, for some clients, be functionally interchangeable with sexual orientation. Existing diagnostic guidelines and approaches in clinical psychology and psychiatry are currently tailored only for asexual-identified clients. Diagnostic criteria for sexual dysfunction diagnoses can be potentially conflated with demisexual experiences. Accepted ethics in clinical psychology recommend a non-pathologizing approach to the treatment of individuals with differential identities. Demisexuality qualifies for such an approach. Construction of a tool for diagnostic, assessment, and conceptual purposes that can serve as an adjunct to clinical intervention for demisexuals is therefore warranted. It can be used to guide therapeutic interventions, circumvent undue diagnosis, and can also aid in case conceptualization and treatment planning.

To help conceptualize the unique experiences of a demisexual person, a parametric analysis is employed in this paper. The parametric analysis of human sexuality included below breaks down the concept into its most basic representative forms and has been adapted from previous work and methods employed in Descriptive Psychology. This same method has been

applied to analyze various concepts, for example, socio-economic status (Kennedy, 2018). Such an analysis serves here to assess components of sexuality relevant to individual clients and is not limited to applications for demisexual-identified individuals only. It can also be adapted for other related assessment purposes as needed. The demisexual experience is discussed as a reciprocal relationship between emotional significance and sexual attraction. Given that an emotional connection or significance can arise from several factors, the parameters here can serve as indicators for clinicians as areas of focus. This analysis can similarly be used by demisexuals and others to assist in improved self-understanding as it pertains to sexuality.

Parametric Analysis

Introduction to Parametric Analysis

The parametric analysis of human sexuality shown and discussed in the following section is designed to analyze and encompass all dimensions of human sexuality as currently understood. This was constructed to illustrate demisexuality as an example of how this might be used in assessing clients in psychotherapeutic settings. As such, it is at best incomplete given the possibility that how we think of sexual expression may change over time. Because it does not diagnose in any formal way, it has potential use as a non-pathologizing tool that emphasizes the recognition of lived experiences. Each parameter listed is discussed in greater detail to clarify for clinicians its distinctiveness and relevance to the topic of sexuality. Examples of each parameter are shared to provide applications of each concept. The parameters included here can be adapted for other purposes and modified as needed to provide for improved descriptive depth in related areas of inquiry. To see a visualization of the parameters and how they might relate to one another in an assessment or case conceptualization, please see Appendix B & C.

Parametric Analysis

Human Sexuality = <P, PC, O, OC, C, CC, B, E, R, RC, H, A >, where...

P = Person

PC = Person Characteristics

O = Object

OC = Object Characteristics

C = Context

CC = Context Characteristics

B = Behavior

E = Experience

R = Resonance

RC = Recognition

H = History

A = Appraisal

Parameter Descriptions

Person

The individual engaging with sexuality. For human sexuality to exist, a Person is required to engage in it and appraise it as such. Sexuality requires and is defined by the Person. When applied to a case formulation, the Person refers to a client or patient.

Person Characteristics

The characteristics of the Person, of which the behavior in question is an expression. These characteristics include powers (abilities, knowledge, and values), dispositions (traits, attitudes, interests, and styles) or derivatives (capacities, embodiments, states), as well as statuses, (e.g.,

Anna's love for her boyfriend, her desire to spend time with him, and her preference for private, intimate, conversational dates). The biological and physiological reactions and responses of the body recognized by the Person as sexual can also be considered Person Characteristics. This can include but is not limited to orgasm, pulse rate, or other signs of arousal. This parameter was based on the previous work by Peter Ossorio (Ossorio, 1982, 1983, 2006).

Object

That towards which sexuality is engaged. This can include human beings, non-human beings, and inanimate objects (e.g., sex toys & machines). This can also include media, depictions of Objects, conceptual or imagined Objects, and may include one or more Objects.

Object Characteristics

This can be described as those characteristics of an Object which affect the Person's expression of sexuality. It includes size, shape, color, availability, cost, safety, etc. These can also include imagined or related conceptual characteristics applied to the Object. To further illustrate how this might manifest, an object's characteristics can be significantly influenced by how it is perceived or responded to by the person's perception of that object. An example of this is the perception of physical attractiveness of an Object on behalf of a Person.

Context

This can be summarized as the nature of the relationship between Person and Object. Examples include both voluntary and involuntary relationships. Context can also be passive (e.g., accidentally seeing something), reflexive, or automatic (e.g., physiological response). Examples of conventional sexual relationships between Persons and Objects are casual, committed, time-limited, utilitarian, pragmatic, etc.

Context Characteristics

These are the characteristics of the context in which sexuality occurs. They serve as a mitigating factor enabling or disabling behaviors of sexuality. Examples relevant to case conceptualization include but are not limited to place, time, and society. Depending on the context in question, it is also feasible to use mental constructs like fantasies as a context characteristic.

Behavior

This encompasses how sexuality is enacted or performed. It includes both thought and actions. Examples include sexual expression via intercourse, oral sex, kink, BDSM, fetishes, etc. This can also include flirting, sexting, smiling, and other sexually associated behaviors.

Experience

This is the quality and intensity of attraction, as well as the experience of sexuality for the Person. Persons are not attracted to Objects in uniform ways or for the same reasons across cases, and each experience of attraction holds with it a uniquely subjective experience. This can include but is not limited to an emotional response. Even if the quality of attraction is similar between cases, the intensity of that attraction may fluctuate or change over time.

Resonance

The subjective experience of a Person being drawn or attracted to an Object, or lack thereof. This is sometimes referred to amongst demisexuals as “the spark” that signals attraction. Examples of resonance patterns include sexual preference and orientation in its many forms, as well as examples of individuals drawn to those outside of their stated orientation, for example, men who have sex with men (MSM). The MSM example is noted here as an instance where Resonance may be contradictory as it relates to sexual preference versus sexual orientation. Others may

describe this as having or not having a “type,” or as having specific preferences or needs to experience sexual attraction.

Recognition

This is the acknowledgement of sexuality by self, others, and society. This can include but is not limited to the recognition of sexual behaviors, orientations, and statuses. This can also include involuntary recognition by self and others, as well as recognition of identity and statuses outside of one’s awareness by others in various contexts by assigning statuses. For example, an observer may believe a Person is gay despite them not identifying as such.

History

This can be summarized as the prior experiences of a Person with sexuality or lack thereof. It serves as a mitigator of behavior, where some Objects, Contexts, or other parameters may hold certain appeal or lack of appeal. Traumatic response in human sexuality is directly related in this formulation to History. It can also be interpreted as cultural, societal, or personal history more broadly.

Appraisal

This is essentially how a Person, Object, or Context appraises any given parameter of sexuality. It can be affected by a complex interaction of parameters that is fluid and malleable, ergo it may change over the course of a Person’s life. History may serve as a mitigating factor to Appraisal. Examples include loving a sexual experience, or self-hatred following sexual behaviors. It may in some cases influence a Person irrespective of Context Characteristics, as appraisal can contradict attitudes and Contexts.

Case Vignettes and Diagnostic Recommendations

Case Vignette 1

A psychologist sees a client in their early twenties who feels depressed and anxious regarding their difficulty finding a suitable romantic partner. They identify as demisexual, and they believe that because they are demisexual they are having this difficulty. They cite their friends using dating websites and apps to find their partners, and they report feeling chastised or dismissed when explaining that they aren't willing or able to engage in casual sex or hookups like their friends. They have often not been able to garner a sense of comfort and familiarity with potential partners when in public or at social events. They feel like they won't be accepted by partners because it takes longer for them to establish a romantic connection with them than others may be willing to wait for. They describe attempting to date and feeling pressured to have sex, citing challenges communicating with partners about being demisexual. After attempting to have sex with partners who they believe may be suitable, they often find themselves insufficiently aroused to engage with them sexually. They report that, on occasion, this has been anxiety-provoking for them and that they fear that their dating attempts and sexual responses are disappointing to others. They elaborate that they masturbate and feel sexual, but that this is limited to specific kinds of expression and that they don't sexualize other individuals in their daily life. While their friends often point out individuals in public being sexually desirable, they report feeling strange because they have never felt this. When their friends talk about celebrities and public figures with whom they would want to have sex, the client is never able to relate to it. They add that they nevertheless desire a fulfilling sexual relationship. They report having had several fulfilling romantic and sexual relationships in the past, stating that they felt closer and more emotionally connected to those partners.

After discussing that demisexuality for the client means that they need to feel emotionally connected to someone before feeling sexually attracted to them, the clinician relates this to many individuals being "picky." The clinician believes that the issue may be related to psychopathology affecting sexual performance and explores this with the client. Upon confirmation of sexual dysfunction, anxiety, and depression criteria, they settle on an FSIAD/MHSDD diagnosis. They recommend follow-up with a psychiatrist and general practitioner for medication assessment and exploring potential medical causes. The clinician thereafter focuses in sessions on how the client might be manifesting a psychological block against sexual contact due to anxiety or depression as a self-protective response. The clinician also considers past sexual trauma a possibility, inquiring about this on several occasions with the client despite the client assuring them that no trauma has occurred. The client acknowledges with the clinician that some of their sexual experiences have been very uncomfortable for them, however, because of the challenges they have had in expressing their sexuality.

Case Vignette 2

An eighteen-year-old heterosexual male who has recently relocated to a new state for college comes to see a psychologist after being referred by a therapist at his school clinic for depression. The client reports feeling tired, unmotivated, has had difficulty sleeping, often feels hopeless about the future, and has been having trouble making friends at his new school. He says he has found it especially hard to relate to what he calls "bro culture," feeling like he doesn't fit in. He has had two different potential sexual partners who he has courted since beginning his classes, however, in both cases, he reports experiencing erectile dysfunction. This is despite "wanting to hook up with them." He complains that many of his interactions feel superficial and lack the depth that he was used to amongst his previous group of friends back home. He also

states that he feels less connected to women in his new school, but he is uncertain if it is because of cultural differences or not. He often talks critically about others, resenting them for the ease at which they appear to connect and engage with one another when he can't seem to connect himself. He denies using any drugs or drinking to excess, although he discloses that he does drink at a local bar with his roommates on the weekends even though he "doesn't enjoy the vibe of the crowd." He reports missing his ex-girlfriend from high school because they connected intellectually and emotionally. He reported being sexually active with her when they were together and being able to masturbate regularly on his own, but that he doesn't usually feel sexual around other individuals and generally considers himself asexual most of the time. The client shares that he often feels sad and lonely because he is single and desires physical and sexual contact, but does not desire it from anyone around him, something which he brings up frequently in initial sessions.

After assessing for risk and determining other diagnostic rule-outs, the psychologist decides to get more information before proceeding with a formal diagnosis as required by their client's student health insurance plan. They are initially unsure of what might be influencing their client's depression symptoms. The psychologist believes the client's ongoing sexual and romantic frustrations are related, but they are not certain if they necessitate a differential diagnosis. They determine that more information and a brief informal assessment might help them clarify what they need to know. After asking further about his history of feeling like this, the therapist learns that their client has always had close and deep emotional bonds with his female partners. When asked about what this bond meant for him, he shared that he enjoys discussing French music and art with his partners, as well as regularly going to see independent movies from abroad. Sharing in this makes him feel inspired and understood, though it is

something many other freshman students around him find odd and in conflict with their taste and sensibilities. When talking about his orientation the client somewhat defensively states that he "is and has always been straight." When his response style is asked about, he elaborates that he doesn't like his orientation being questioned, as in his family culture sexuality is not discussed openly. He states that he doesn't really think about sex formally and that he "just wants to be happy like how things used to be, not having to second guess myself all the time because of this rough patch."

The psychologist acknowledges the challenges of talking about sexuality, normalizing what the client has been experiencing, and offering several different interpretations of what might be affecting him. The psychologist offers that he may be adjusting to school and living in a new place, could be experiencing depression symptoms that are also manifesting as challenges with feeling aroused or interested in partners, or just may not have met anyone compatible with him yet. They also offer that what the client is experiencing might be better explained by their identity, personality, or orientation. Curious about this last part, the client asks what the psychologist means. The psychologist talks about how some individuals identify as demisexual, as an example for their client of individuals who need a significant emotional connection with others to feel sexually attracted to them. The psychologist adds that it can be challenging or confusing for some demisexuals if they aren't aware of this orientation, as there are often expectations and assumptions that individuals make or have been taught about sexuality. The psychologist acknowledges that men might face challenges with self-esteem and positive masculine identity if they experience erectile dysfunction or have a hard time embodying others' expectations of how they're supposed to feel and act.

The client expresses curiosity upon hearing demisexuality being described and proceeds to share that the psychologists' description sounds like what he feels. The psychologist diagnoses their client with moderate depression and continues their discussion about the clients' expectations and desires in relationships for the next few sessions. The psychologist discovers that much of their clients' challenges appear to relate to having difficulty expressing their sexual needs and boundaries with their partners. They also discover that their client has a concurrent tendency to idealize their potential partners during the courting process. The client sometimes attempts to engage sexually with partners before they are ready. The client sometimes ends up disappointed after getting to know potential partners better, finding themselves unattracted to their personalities. The client and psychologist work together on a behavioral intervention and workshop different scenarios together to discuss the client's boundaries, needs, and feelings, addressing their idealizing tendencies as they come up and are reported in follow-up sessions.

Diagnostic Recommendations

In the vignettes above, both clinicians' approaches can be considered intuitive and valid within accepted treatment guidelines. The clinician in the first example is not being intentionally malicious in their assessment, but they are potentially mischaracterizing what is occurring for their client. A clinician is well within the scope of acceptable practice to question a client's experiences, the causes of their experiences, their behaviors, and any number of aspects of their dynamics with friends and potential partners. A distinction in the discussion of emerging or intersectional identities is whether the clinician accepts the client's identity or experience as valid and healthy on its own merits. In the second example, the clinician acknowledges the many potential influences on their client's sexual expression and provides space for discussion which can aid in their diagnostic assessment and treatment planning. Importantly, it does not necessitate

ascribing a demisexual label onto someone just because it seems like it might fit for them. The role of client choice and preference is paramount in both examples. The second example additionally illustrates how a Parametric Analysis may be incorporated into case conceptualization and how it can draw attention to aspects of a client's sexuality in ways that might otherwise be overlooked. Although not explicitly stated, the aforementioned informal assessment mentioned in the vignette could be one derived from or influenced by Parametric Analysis, an illustrated example of which can be found in Appendix C.

Practitioner Applications

Clinical Psychology Theory Considerations

Demisexuality presents unique challenges to clinicians and our notions of what can be considered healthy or pathological behavior. It furthermore raises questions around what we can and should do to treat symptoms in individuals identifying as demisexual. The detrimental effects that holding a marginalized identity may have on clients are already well established. How, then, can clinicians avoid conflating healthy and unhealthy behavior when a client's perspective can so completely change its context? For example, depressive symptoms experienced by a demisexual client due to their inability to connect sexually or romantically with others can, on its surface, be seen as a sexual disorder. To remain consistent with the ethical standards proscribed for psychologists, it is imperative that demisexual clients not have their identity or sexual orientation be a sign of psychopathology.

A feeling of difference from or lack of understanding by others can and often does generate depressive, anxious, and alienating experiences for clients. Such feelings and experiences can understandably hinder romantic and emotional connectivity, to say nothing of what it might do for a person's feelings towards others more broadly. Within current diagnostic

conventions, an approach that can pathologize discordant or demotivating romantic and sexual experiences is not only considered valid but is, in fact, currently prescribed in some cases. Treatment for recurrent lack of or diminished sexual arousal is commonplace in psychological, psychiatric, and medical settings. If a client is identifying as demisexual and finds this identity to be helpful, healthy, clarifying, and integrating for their personal identity, then a system that is oriented towards potentially pathologizing this same identity is ineffective to address the client's needs. A major goal of this paper was to discuss this possibility and provide an alternative model for assessment and intervention.

Another major question raised following the review of existing literature, the visibility of demisexuality and its usage in online dating settings, is one of validity and adequacy. Demisexuality represents an example of a recently acknowledged kind of sexual identity, and it is not without its detractors and those who question its fundamental existence. This is despite the growing number of individuals who have embraced it and have extensively clarified its distinctness from asexuality and allosexuality in the public forum. A major empirical challenge that demisexuality raises for clinicians regards our recognition of it and the notion of validity. Do I get to say what I am, or do you? Does a demisexual get to identify as such without adorning additional, potentially pathologizing, epithets? Must a demisexual settle for being described as asexual or allosexual and run the risk of misunderstanding and misinterpretation? For some, this seems to be the case. Does our current diagnostic pedagogy allow for individuals to clarify for themselves identities and experiences which supersede diagnoses? This also, ostensibly, seems to be true. Declarations of acceptance and flexibility in clinical and diagnostic practice exist, and the public establishes ever-changing methods of self-expression and identification.

Clinicians are sometimes ill-equipped to address changes in how individuals self-identify when adhering strictly to suggested diagnostic guidelines and language in the DSM-5. Demisexuality is not asexuality, nor is it necessarily a sexual dysfunction, despite what diagnostic guidelines suggest. Some individuals who present with demisexual experiences, furthermore, may be unaware of the orientation and not use it despite benefitting from similar interventions. To be effective in our treatment approaches, clinicians need to appreciate and allow for such distinctions. Inclusion of contrasting case vignettes and interventions used earlier in this paper may assist this point. These were constructed via an amalgamation of various accounts from self-ascribed demisexuals and, though unable to encompass all potential presentations in clients, serve to indicate gray areas that emphasize the impact of clinical judgement on treatment outcomes. The most consistently workable and ethical response appears to be to focus on symptomology of greatest concern to the client and allowing for flexibility in case conceptualization for areas of experience that lack sufficient clarity to the parties involved in treatment. Ultimately, the perspective taken here is that what clients choose to identify with operates independently of diagnostic approaches. So long as there is sufficient time and care put into honoring what is learned and acknowledged, integrating cultural competence into the treatment modality appears sufficient in addressing major practical concerns.

Assessment and Intervention Recommendations

The extant DSM-5 diagnoses Male Hypoactive Sexual Desire Disorder 302.71 (F52.0) and Female Sexual Interest/Arousal Disorder 302.72 (F52.22) can potentially describe the experiences of demisexuals. A revision of the exclusionary criteria to acknowledge demisexuality and other ace spectrum identities are therefore warranted. Such a change would also be consistent with revisions carried out between the DSM-IV TR and DSM-5 to reduce

pathologizing of differential sexual and gender experiences. The dimensional approach utilized in the parametric analysis can be adapted to address a lack of dimensional conceptual approaches in the DSM-5 to sexual experiences. Without direct inclusion, it can still be used in an adjunct fashion by clinicians to assess clients' sexual experiences.

Given that the key defining feature of demisexuality is the requirement of an emotional connection or attachment for sexual attraction to occur, there are opportunities for variance in its presentation in the demisexual population. What constitutes an emotional connection for one person may be discussed or experienced as entirely different, even seemingly contradictory, for another. Differences in how these experiences are related to and discussed can complicate broad comparisons even further. In utilizing the included parametric analysis, clinicians can potentially avoid stereotyping or typecasting demisexual clients by allowing them to define its significances for themselves. The analysis was designed to reflect the many domains within which an individual could experience an emotional connection or attachment, as well as those domains which may be activated or negated depending on circumstances to promote a sexual response or sexual experience.

The parametric analysis of human sexuality included here has many other potential uses and applications for clinicians and social scientists. It is not limited to describing the relevant features of demisexuality, and it can be applied to any extant or emerging domain of sexual expression and experience. It may be similarly adapted to other areas of social, emotional, and psychological life depending on contextual needs. It may serve on its own as a potential diagnostic tool, in the construction of sexuality assessments, or to determine the form and function of an individual's orientation and subjective experiences of sexuality. The formulation of the above parametric analysis was intended to organize each parameter of human sexuality in

a non-hierarchical fashion. As such, no single parameter included is taken as having overt precedent over any other, despite the ways in which they may be related to one another. The intent here was to explicitly illustrate the potential dynamics of such parameters as case dependent.

The analytical perspective taken in this paper is individualistic in that it cannot and will not attempt to define all the features or experiences of every, or any, demisexual person. What can and cannot be defined as demisexuality is reliant on how the term is adopted and used by individuals, whether or not an individual resonates with demisexuality as their sexual orientation. Any future revisions, considerations, or derivatives of this paper are therefore inherently tied into the many evolving contexts within which it may occur. As noted in the literature review, how individuals and societies relate to sex and identity changes over time, sometimes drastically so. Demisexual-identified persons and other interested parties are encouraged to question, critique, and expand upon this work as scientific and clinical understanding expands, changes, and improves in service of what progress can be made in this relatively new area of study.

Discussion and Limitations

Demisexuality As Distinct Sexual Orientation

Substantial phenomenological evidence was found for demisexuality in all three information domains. It can therefore be stated that demisexuality is acknowledged in public life, has developed a community based upon identity, and is being utilized as an identity in romantic and sexual life. For purposes of explicit establishment, demisexuality is, therefore, conceptualized here as both a functional sexual orientation and identity. Given the distinctiveness of experiential accounts of demisexuality when compared to asexuality, for some demisexuals demisexuality may constitute an identity and an orientation which cannot accurately

be described with the term asexual. Because diagnostic criteria in clinical psychology only acknowledges asexuality, such a distinction needs to be made to prevent undue pathologizing of demisexual experiences for demisexual-identified individuals. This is the first paper to suggest a clinical distinction between asexuality and demisexuality explicitly.

By nature of demisexuality being a semantically and functionally different identity from asexuality, this reaffirms the notion that current diagnostic criteria in the DSM-5 are insufficient in addressing the needs of this population. By having exclusory criteria requiring "lifelong asexual identity," for example, it can on a semantic level potentially pathologize self-identified demisexuals. (American Psychiatric Association, 2013) As the identity has not been recognized in public and private life for more than 15 years, it is improbable that all demisexual clients would be able to satisfy the "lifelong identity" requirement proscribed in the DSM-5. Even if a hypothetical client did have a lifelong demisexual identity, the orientation itself is still potentially distinct from asexuality and may currently lack explicit recognition or diagnostic credibility. As more and more clinicians become aware of this orientation, such discrepancies can and should be addressed to more closely follow the APA's own ethical guidelines for LGBT clients (American Psychological Association, 2021). Despite these ethical expectations and guidelines, however, the diagnostic language and conventions currently used are too semantically rigid to do so across all cases. It is therefore similarly inadequate to address other orientations commonly placed on or related to the asexual spectrum.

Theoretical Challenges for Demisexuality Recognition in Clinical Practice

Another challenge raised in reframing demisexuality is practical. If we treat demisexual clients and our current diagnostic and clinical scopes are insufficient, this suggests a necessary revision of the tools at our disposal. Hence, the description of what we are working with comes

into play. By mapping out different aspects of human sexuality, a parametric analysis is not merely providing a laundry list of potential areas of clinical exploration. Rather, it can be applied in a much broader sense to all sexual experiences as a means of understanding, categorizing, and clarifying novelty that we might otherwise take for granted. For example, if someone identifies as gay, does that give you much of an idea of what that means for them? What about how being gay is enacted, related to, and so forth? It is a longstanding weakness of sexual evaluation that we reduce recognized labels into a shorthand. A meaningful advantage of using Parametric Analysis to address this is by preventing overemphasis and underemphasis of particular aspects of human sexuality. It furthermore recognizes some aspects which might otherwise be outside of a clinician's or client's awareness despite being relevant or useful to acknowledge and discuss during treatment. By mapping out the relevant aspects of sexuality, we might get closer to the personalized aspects of it and be more clinically effective in response, regardless of individual client differences.

The fields of psychology, sociology, and sexology are in a constant state of development and change. Encompassing stances on social issues are challenging to establish or ascertain. The parametric analysis of sexuality provides a framework for the recognition of potential sexual experiences and contexts. It is not restricted to otherwise limited methods of interpretation, though by design it also necessitates further and justifiably more extensive investigation on the part of clinicians. One may make the argument that the current system of diagnosis is flawed by design and is incompatible with such a broad approach. How individual practitioners might adapt the analysis to their own approaches is a matter of clinical judgment. Because it is atheoretical in nature, the analysis can be applied across modalities, settings, clinical orientations, and stages of treatment. The intent of its design is to show what might be overlooked when discussing relevant

aspects of a client's experience, as what clients discuss in treatment can sometimes transcend assumptions about and conventions of sexuality. This is a basis for inquiry to signify nuance in sexual conceptualization.

Regarding demisexuality, there exists some potential for misinterpretation based upon misleading conventions. As is the case with any sexual orientation or identity, it is also important to not simply impose a demisexual identity or framework on a client if they endorse some of its features but do not explicitly resonate with it. Identity, as indicative of a client's experiences, may be challenging as it interacts within a contemporary social context. Identity does not, however, necessitate FSIAD/MHSDD-tailored treatment, nor conceptualization of the identity itself as being inherently dysfunctional or pathological. At the same time, it does not warrant dismissal or generalization either. As opposed to diagnosing FSIAD/MHSDD, clinical interventions can instead focus on how to navigate the client's circumstances in adaptive ways which honor their disposition and experiences without invalidating or pathologizing their identity.

Limitations

There were several limitations noted during the research and composition process of this paper. This includes the limitations inherent in theoretical work, the limited extant research conducted on demisexuality, piecemeal clinical data, and disputes surrounding agreed-upon criteria for demisexuality and asexuality. The parametric analysis, though intended to be exhaustive, is potentially subject to change as our understanding and conceptualization of sexuality changes over time. It might not be easily understood by some clinicians, and it might be cumbersome for those unfamiliar with such forms of conceptualization to incorporate it into their work. Demisexuality, at the time of writing, continues to be a disputed sexual orientation

and may remain so for the foreseeable future, thus potentially limiting the clinical application of this work. Education on and awareness of demisexuality on behalf of clinicians has improved, but still may not be sufficient to support broad changes in diagnostic approaches. Significantly, the adoption of demisexuality as a functional sexual orientation in this paper is by no means an overt declaration of the orientation, nor is it a repudiation of the orientation either. This position may dissatisfy some interested parties within the debates.

It is the opinion of the author of this work that physiological response is a limited dictate as it pertains to our understanding of human sexuality. This statement intends to speak to physiology's qualifying, illustrating, and restricting functions within what can be known and explained scientifically when discussing sexuality. A declaration of experience or identity can be explained via physical considerations, but it may not necessarily correlate with physics either. Such explanatory efforts are also limited to what is observable, measurable, and definable. It is observable from available data outlined here that each experience of demisexuality is novel and not reliably or solely relegated to descriptions and observations of physical responses. Individual descriptions and self-reporting of experiences are difficult to correlate with or draw conclusions from about reality. Observations made by others, including clinicians, are also limited at best in this regard. For the purposes and potential applications of this work, the adequacy of using observed or reported physiological responses, or lack thereof, to explain asexual or demisexual experiences, is therefore also limited. Other researchers may disagree with this assessment, and rightfully so. This work is only one of many possible descriptions, explanations, and analyses of demisexuality and human sexuality.

Regarding the structure and methodology of this paper, there is also some limitation in how much can be said and suggested for a burgeoning and not well-researched topic. It would be

irresponsible to suggest clinical guidelines definitively, and at present, we can only assume best practices based on closer examples, hence the parallels drawn with other LGBTQIA+ populations. Presenting a broad parametric analysis, as opposed to purely describing demisexuality, may similarly pose challenges to integrating the two parts of the paper in lieu of the ability to operate within diagnostic conventions. Emphasis on highlighting diagnostic inconsistencies and weaknesses relies heavily on the appropriate application of clinical judgment, something the paper repeatedly acknowledges is inherently imperfect.

As this paper pertains to demisexuality, extant sources and the narrative that has been constructed thus far has always included demisexuality within the ace spectrum. Though the existing ace spectrum paradigm was utilized, this is not intended to be considered an endorsement of demisexuality's definite inclusion in it. The association makes sense from a pragmatic point of view, however demisexuality may constitute an entirely separate family of experiences and identities which are only now becoming visible and understood. It may speak to underlying psychological dynamics, changing social theaters, or illustrate a previously unknown mechanism of sexuality that has been taken for granted or mischaracterized within existing psychological research. For demisexuality to receive recognition for its distinctiveness, a place will need to be carved out for it. This paper attempts to do so, though it is unclear what developments will arise in its study as a consequence.

Conclusion

Demisexuality can be considered an identity and sexual orientation which is distinct from asexuality for the purposes of clinical interventions in psychotherapy. Various perspectives for conceptualizing and addressing demisexuality were considered via the use of a parametric analysis and case examples. The parametric analysis can be employed as a dimensional approach

to consider human sexual experiences for both diagnostic and therapeutic purposes. This analysis can be used to assist with case conceptualization and intervention planning with emerging identities. As a clinical tool, it is not limited to the assessment of sexual experiences. Diagnostically, assessments of demisexuality can draw distinctions between functional impairments, individual dispositions, sexual preferences, and identity.

Recommendations for Future Research

As previously stated, there is relatively limited demographic information available on demisexuals and demisexuality. Any future research into demisexuality will need to consider and address this deficiency. Areas of exploration can include but are not limited to the incidence in the general population, socio-economic status and outcomes, relationship composition, and comorbidity of psychopathology where present. Narrative studies and qualitative research can expand on what is already available across internet community discussions. Any further exploration of demisexuality as an identity, sexual orientation, or population of therapy clients will be bolstered by expansion of such data.

Regarding the applications and adaption of the parametric analysis, this is an ongoing process that can and should be altered depending on a needs-basis. It can be used freely by researchers, clinicians, and others directly or as a starting point to create new diagnostic tools and criteria. This analysis was intended for, but not limited to, practical application by mental health professionals. As is expected in the mental health field, it is intended for use by qualified professionals using clinical and professional judgment as deemed appropriate by their respective professional boards and organizations.

References

Aicken, C., Mercer, C. H., & Cassell, J. A. (2013). Who reports absence of sexual attraction in Britain? Evidence from national probability surveys. *Psychology and Sexuality*, *4*(2), 121–135. https://doi.org/10.1080/19419899.2013.774161

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* (Fifth ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2015). Guidelines for psychological practice with Transgender and Gender Nonconforming people. *The American Psychologist, 70*(9), 832–864. https://doi.org/10.1037/a0039906

American Psychological Association. (2021, September 13). *Guidelines for psychological practice with lesbian, gay and bisexual clients*. http://www.apa.org/pi/lgbt/resources/guidelines

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code/

Ashley, S. (2018, Oct 1). *When I say I'm Demisexual.* Medium. https://medium.com/awkwardly-honest/when-i-say-im-demisexual-d5050c6f8026

Asexual Visibility and Education Network. (2016). *An Asexual person is a person who does not experience sexual attraction.* http://www.asexuality.org/

Asexual Visibility and Education Network. (2020a). *Definitions.* https://asexuality.org/?q=general.html#def

Asexual Visibility and Education Network. (2020b). *The gray area, sex and related*

discussions. https://www.asexuality.org/en/forum/72-the-gray-area-sex-and-related-discussions/

Asexual Visibility and Education Network. (2021). *Showing results for 'Demisexuality.'* The https://www.asexuality.org/en/search/?q=demisexuality&quick=1

AVENwiki. (2019). *Demisexual*. http://wiki.asexuality.org/Demisexual.

AVENwiki. (2022). *Main Page*. http://wiki.asexuality.org/Main_Page

Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The Dual Control Model: Status and future directions. *The Journal of Sex Research, 46*(2-3), 121–142. https://doi.org/10.1080/00224490902747222

Barker, M. (2012). *Rewriting the Rules: An Integrative Guide to Love, Sex and Relationships* (1st ed.). Routledge. https://doi.org/10.4324/9780203097663-10

Barton, A. (2019). Demisexuality as a contested sexuality. *New Views on Gender*, *19*, 25–35. https://scholarworks.iu.edu/journals/index.php/iusbgender/article/view/29295

Bergner, R. M. (1983). Emotions: A conceptual formulation and its clinical implications. *Advances in Descriptive Psychology, 3*, 209–227.

Bergner, R. M. (1993). *Studies in Psychopathology: The Descriptive Psychology approach* (pp. 3–8). Descriptive Psychology Press.

Bergner, R.M. (1998). A therapeutic approach to destructive self-criticism. In H.J. Jeffrey and R.M. Bergner, (Eds.), *Advances in Descriptive Psychology, Vol. 7* (pp. 249-273). Ann Arbor, MI: Descriptive Psychology Press.

Bergner, R. M., Bergner, L. L. (1990). Sexual Misunderstanding: A descriptive and pragmatic formulation. *Psychotherapy, 27*(3), 464–467. https://doi.org/10.1037/0033-3204.27.3.464

Brotto, L. A., & Yule, M. (2017). Asexuality: Sexual orientation, paraphilia, sexual

dysfunction, or bone of the above? *Archives of Sexual Behavior*, *46*(3), 619–627. https://doi.org/10.1007/s10508-016-0802-7

Bogaert, A. (2015). *Understanding Asexuality*. Rowman and Littlefield.

Borgogna, N. C., McDermott, R. C., Aita, S. L., Kridel, M. M. (2018). Anxiety and depression across gender and sexual minorities: Implications for Transgender, Gender Nonconforming, Pansexual, Demisexual, Asexual, Queer, and Questioning individuals. *Psychology of Sexual Orientation and Gender Diversity*, *6*(1), 54–63. https://doi.org/10.1037/sgd0000306

Bowins B. (2016). A Four-Component Model of Sexual Orientation & Its Application to Psychotherapy. *American Journal of Psychotherapy*, *63* (3), 251-276. https://doi.org/10.1176/appi.psychotherapy.2016.70.3.251

Buirski, P., Haglund, P., & Markley, E. (2020). *Making sense together: The intersubjective approach to psychotherapy* (2nd ed.). Rowman & Littlefield.

Carpenter, D., Janssen, E., Graham, C., Vorst, H., & Wicherts, J. (2008). Women's scores on the Sexual Inhibition/Sexual Excitation Scales (SIS/SES): Gender similarities and differences. *The Journal of Sex Research*, *45*(1), 36–48. https://doi.org/10.1080/00224490701808076

Carrigan, M. (2011). There's more to life than sex? Difference and commonality within the asexual community. *Sexualities, 14*(4), 462–478. https://doi.org/10.1177/1363460711406462

Cerankowski, K., &. Milks, M. (Eds.). (2014). Why Asexuality? Why now?, *Asexualities: Feminist and Queer Perspectives* (pp. 1–14). Routledge. https://doi.org/10.4324/9781315882673

Chu, E. (2014). Radical identity politics: Asexuality and contemporary articulations of identity, In Cerankowski, K., &. Milks, M. (Eds.), *Asexualities: Feminist and Queer Perspectives*, pp. 79–99. Routledge.

Colvin, C. (2019, Aug 20). *Am I Demisexual? Here's how to tell, according to a sexuality expert*. Elite Daily. https://www.elitedaily.com/p/am-i-demisexual-heres-how-to-tell-according-to-a-sexuality-expert-18649823

Copulsky, D., & Hammack, P. L. (2021). Asexuality, Graysexuality, and Demisexuality: Distinctions in Desire, Behavior, and Identity. *The Journal of Sex Research*, 1–10. http://doi.org/10.1080/00224499.2021.2012113

Cover, R. (2018). *Emergent identities: New sexualities, genders and relationships in a digital era*. Routledge. https://doi.org/10.4324/9781315104348

Davies, D. & Barker, M. J. (2015). How gender and sexually diverse-friendly is your therapy training? *Psychoanalytic Dialogues*. 61. 8-10. http://oro.open.ac.uk/46105/

Dawson, M., Scott, S., & McDonnell, L. (2018). '"Asexual" Isn't Who I Am': The politics of Asexuality. *Sociological Research Online*, *23*(2), 374–391. https://doi.org/10.1177/1360780418757540

de Lappe, J. (2018). *"Asexy and we know it": The emergence of Asexual activism as a sexual and gender social movement* [PhD thesis, The Open University]. Open Research Online. http://oro.open.ac.uk/58665/1/Asexy%20and%20we%20know%20it.pdf

Decker, J. (2014). *The invisible orientation: An introduction to Asexuality*. Skyhorse.

Demaionewton, E. (2017, May 19). *Not friends? Then no benefits*. The New York Times. https://www.nytimes.com/2017/05/19/style/modern-love-not-friends-then-no-benefits.html?_r=0

Demisexuality Resource Center (2015). *About.* http://demisexuality.org/articles/what-is-demisexuality/

Dent, G. (2019, Sep 21). *Today's demisexual kids are swimming against the tide of hookup culture. Good luck to them*. The Guardian. https://www.theguardian.com/lifeandstyle/commentisfree/2019/sep/21/demisexual-kids-swimming-against-tide-of-hookup-culture

Depaulo, B. (2016, Sep 5). *Asexuality Is a sexual orientation, not a sexual dysfunction.* Psychology Today. https://www.psychologytoday.com/us/blog/living-single/201609/asexuality-is-sexual-orientation-not-sexual-dysfunction

Dictionary.com. (2017). Demisexual. *Gender and Sexuality Dictionary.* Retrieved February 17, 2021, from https://www.dictionary.com/e/gender-sexuality/demisexual/

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, *5*(4), 565–575. https://doi.org/10.3390/bs5040565

Duncan, T. (2019, Oct 17). *What is Demisexuality and how is it changing dating?* Mic. https://www.mic.com/p/what-is-demisexuality-how-is-it-changing-dating-19224121

Elizabeth, A. (2013). Challenging the binary: Sexual identity that is not duality. *Journal of Bisexuality*, *13*(3), 329–337. https://doi.org/10.1080/15299716.2013.813421

Ferguson, S., & Brito, J. (2019, Sep 17). What does it mean to be Demisexual? *Healthline*. https://www.healthline.com/health/demisexual

Fletcher, J., & Brito, J. (2020, Jan 15). *Demisexuality: What to know.* Medical News Today. https://www.medicalnewstoday.com/articles/327506

Flore, J. (2014). Mismeasures of Asexual desires, In Cerankowski, K., &. Milks, M. (Eds.), *Asexualities: Feminist and Queer Perspectives*, pp. 17–34. Routledge.

Fortenberry, J. D., Temkit, M., Tu, W., Graham, C. A., Katz, B. P., & Orr, D. P. (2005). Daily mood, partner support, sexual interest, and sexual activity among adolescent women. *Health Psychology, 24*(3), 252–257. https://doi.org/10.1037/0278-6133.24.3.252

Foucault, M. (1976). *The History of Sexuality*. Pantheon Books.

Foucault, M., & Khalfa, J. (Ed.) (2006). *History of madness* (J. Murphy & J. Khalfa., Ed. and Trans.). Routledge. (Original work published 1961)

Gagnon, J., & Simon, W. (1973). *Sexual conduct: The social sources of human sexuality*. Adine.

Galupo, M. P., Davis, K. S., Grynkiewicz, A. L., & Mitchell, R. C. (2014). Conceptualization of sexual orientation identity among sexual minorities: Patterns across sexual and gender identity. *Journal of Bisexuality, 14*(3–4), 433–456. https://doi.org/10.1080/15299716.2014.933466

Gerressu, M., Mercer, C. H., Graham, C. A., Wellings, K., Johnson, A. M. (2008). Prevalence of masturbation and associated factors in a British national probability survey. *Archives of Sexual Behavior, 37*(2), 266–278. https://doi.org/10.1007/s10508-006-9123-6

Goffman, I. (1959). *The presentation of self in everyday life*. Anchor Books.

Graham, C. A. (2007). Medicalization of women's sexual problems: A different story? *Journal of Sex & Marital Therapy, 33*(5), 443–447. https://doi.org/10.1080/00926230701480307

Graham, C. A. (2010a). The DSM diagnostic criteria for Female Orgasmic Disorder. *Archives of Sexual Behavior, 39*(2), 256–270. https://doi.org/10.1007/s10508-009-9542-2

Graham, C. A. (2010b). The DSM diagnostic criteria for Female Sexual Arousal Disorder. *Archives of Sexual Behavior, 39*(2), 240-255. https://doi.org/10.1007/s10508-009-9535-1

Graham, C. A., Crosby, R., Yarber, W. L., Sanders, S. A., McBride, K., Milhausen, R. R., & Arno, J. N. (2006). Erection loss in association with condom use among young men attending a public STI clinic: Potential correlates and implications for risk behaviour. *Sexual Health, 3*(4), 255–260. https://doi.org/10.1071/SH06026

Graham, C. A., Sanders, S. A., & Milhausen, R. R. (2006). The sexual excitation/sexual inhibition inventory for women: Psychometric properties. *Archives of Sexual Behavior, 35*(4), 397–409. https://doi.org/10.1007/s10508-006-9041-7

Graham, C. A., Sanders, S. A., Milhausen, R. R., & McBride, K. R. (2004). Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Archives of Sexual Behavior, 33*(6), 527–538. https://doi.org/10.1023/B:ASEB.0000044737.62561.fd

Gray, A., & Moore, E. (2018). Understanding the relationship between sexual identity, life satisfaction, psychological well-being, and online community use. *Modern Psychological Studies, 23*(2), Article 4. https://scholar.utc.edu/mps/vol23/iss2/4

Gray Asexuality. (2021, February 18). In *Wikipedia.* https://en.wikipedia.org/wiki/Gray_asexuality#Demisexuality

Hayes, A. (2017). Demisexuality: 8 signs you might be demisexual and what it really means. *Netdoctor*. https://www.netdoctor.co.uk/healthy-living/sex-life/a35865882/demisexual/

Hegi, K., & Bergner, R. M. (2010). What is love? An empirically-based essentialist account. *Journal of Social and Personal Relationships, 27*(5), 620–636. https://doi.org/10.1177/0265407510369605

Hille, J. J. (2019). *Sex and intimacy on the Ace spectrum* [Doctoral dissertation, Indiana

University]. ProQuest. https://search-proquest-com.du.idm.oclc.org/docview/2310307977?pq-origsite=primo

Hille, J. J., Simmons, M. K., & Sanders, S. A. (2020). "Sex" and the Ace spectrum: Definitions of sex, behavioral histories, and future interest for individuals who identify as Asexual, Graysexual, or Demisexual. *The Journal of Sex Research*, *57*(7), 813–823. https://doi.org/10.1080/00224499.2019.1689378

Hosie, R. (2017, Aug 28). What is Demisexuality? *The Independent*. https://www.independent.co.uk/life-style/love-sex/demisexuality-what-is-it-sex-orientation-emotional-relationships-physical-a7912661.html

Hubbard, K., & Griffiths, D. (2019). Sexual offence, diagnosis, and activism: A British history of LGBTIQ psychology. *American Psychologist*, *74*(8), 940–953. https://doi.org/10.1037/amp0000544

Hughto, J., Pachankis, J., & Reisner, S. (2018). Healthcare mistreatment and avoidance in Trans Masculine adults: The mediating role of rejection sensitivity. *Psychology of Sexual Orientation and Gender Diversity, 5*(4), 471–481. https://doi.org/10.1037/sgd0000296

Iqbal, N. (2019, Sep 7). *No lust at first sight: why thousands are now identifying as 'demisexual.'* The Guardian. https://www.theguardian.com/society/2019/sep/07/no-lust-at-first-sight-day-i-finally-realised-i-was-a-demisexual

Jones, C., Hayter, M., & Jomeen, J. (2017). Understanding asexual identity as a means to facilitate culturally competent care: A systematic literature review. *Journal of Clinical Nursing, 26,* 3811–3831. https://doi.org/10.1111/jocn.13862

Jozkowski, K., Sanders, S., Rhoads, K., Milhausen, R., & Graham, C. (2016) Examining the

psychometric properties of the Sexual Excitation/Sexual Inhibition Inventory for Women (SESII-W) in a sample of Lesbian and Bisexual Women. *The Journal of Sex Research, 53*(7), 836–848. https://doi.org/10.1080/00224499.2015.1066743

Kahan, B. (2013). *Celibacies: American modernism and sexual Life*. Duke University Press. https://doi.org/10.1515/9780822377184

Kahn, K. (2014). "There's No Such Thing as a Sexual Relationship": Asexuality's sinthomatics. In Cerankowski, K., &. Milks, M. (Eds.), *Asexualities: Feminist and Queer Perspectives*, pp. 55–74. Routledge.

Katehakis, A. (2017, Jun 15). The Demisexual phenomenon. *Psychology Today*. https://www.psychologytoday.com/us/blog/sex-lies-trauma/201706/the-demisexual-phenomenon

Kennedy, P. (2018). A parametric analysis of socioeconomic status: How SES relates to psychological health [Doctoral Research Paper, University of Denver]. Digital Commons. https://digitalcommons.du.edu/capstone_masters/320

Kliegman, J. (2018, Feb 14). *Online dating isn't easy – especially when you're Asexual.* The Verge. https://www.theverge.com/2018/2/14/17012528/asexual-asexuality-ace-online-dating

Knight, N. (2019, Jan 08). *Hookup culture and Demisexuality*. University Wire. https://du.idm.oclc.org/login?url=https://search-proquest-com.du.idm.oclc.org/docview/2164472195?accountid=14608

Kovacs, C. (2019, May 22). What it's like to date as a Demisexual. *Tinder*. https://swipelife.tinder.com/post/demisexual

Krafft-Ebing, R. (2011). *Psychopathia Sexualis: The classic study of deviant sex* (F. S. Klaf,

Trans.). Arcade Publishing. (Original work published 1886)

Laing, R. D. (1961). *Self and Others*. Tavistock Publications.

Lubuguin, F. (2010) Teaching culturally competent psychotherapy: A Descriptive Psychology approach. *Advances in Descriptive Psychology*, *9*, 41–85.

Lykins, A. D., Janssen, E., & Graham, C. A. (2006). The relationship between negative mood and sexuality in heterosexual college woman and men. *The Journal of Sex Research, 43*(2), 136–143. https://doi.org/10.1080/00224490609552308

Macmillen, H., & Pugachevsky, J. (2019, Apr 25). What does it mean to be a Demisexual? *Cosmopolitan*. https://www.cosmopolitan.com/sex-love/news/a36736/what-does-it-mean-to-be-a-demisexual/

McGowan, K. (2015, Feb 18). Young, attractive, and totally not into having sex. *Wired*. https://www.wired.com/2015/02/demisexuality/

Mercer, C. H., Tanton, C., Prah, P., Erens, B., Sonnenberg, P., Clifton, S., Macdowall, W., Lewis, R., Field, N., Datta, J., Copas, A. J., Phelps, A., Wellings, K., & Johnson, A. M. (2013). Changes in sexual attitudes and lifestyles in Britain through the life course and over time: Findings from the National Survey of Sexual Attitudes and Lifestyles (Natsal). The Lancet, 382(9907), 1781–1794. https://doi.org/10.1016/S0140-6736(13)62035-8

Milhausen, R. R., Graham, C. A., Sanders, S. A., Yarber, W. L., & Maitland, S. B. (2010). Validation of the sexual excitation/sexual inhibition inventory for women and men. *Archives of Sexual Behavior, 39*(5), 1091–1104. https://doi.org/10.1007/s10508-009-9554-y

Milks, M. (2014). Stunted Growth: Asexual politics and the rhetoric of sexual liberation, In

Cerankowski, K., &. Milks, M. (Eds.), *Asexualities: Feminist and Queer Perspectives*, pp.100–118. Routledge.

Mitchell, K., & Graham, C. A. (2008). Two challenges for the classification of sexual dysfunction. *The Journal of Sexual Medicine, 5*(7), 1552–1558. https://doi.org/10.1111/j.1743-6109.2008.00846.x

Nelson, J. (2018, May 8). 13 signs you are a Demisexual — someone who needs to connect emotionally with a person before you sleep with them. *Thought Catalog*. https://thoughtcatalog.com/january-nelson/2018/05/13-signs-you-are-a-demisexual-someone-who-needs-to-connect-emotionally-with-a-person-before-you-sleep-with-them/

O'Malley, K., & Burgum, B. (2019, Oct 15). Demisexuality meaning and how it affects physical intimacy and attraction. *Elle*. https://www.elle.com/uk/life-and-culture/culture/a32765/what-it-means-to-be-demisexual/

OkCupid. (2020). *OkCupid* (version 40.1.0) [Mobile app]. App Store. https://apps.apple.com/us/app/okcupid-online-dating-app/id338701294

OkCupid. (2020). Orientation and gender expression as told by real, actual humans. *OkCupid*. https://www.okcupid.com/identity/demisexual

Ossorio, P. (1982). *Place*. Linguistic Research Institute.

Ossorio, P. (2006). *The Behavior of Persons*. Descriptive Psychology Press.

Pasquier, M. (2018, Oct 27). Explore the spectrum: Guide to finding your ace community. *GLAAD*. https://www.glaad.org/amp/ace-guide-finding-your-community

Prause, N., & Graham, C. A. (2007). Asexuality: classification and characterization. *Archives of Sexual Behavior, 36*(3), 341–356. https://doi.org/10.1007/s10508-006-9142-3

Prause, N., & Harenski, C. (2014). Inhibition, lack of excitation, or suppression. In

Cerankowski, K., &. Milks, M. (Eds.), *Asexualities: Feminist and Queer Perspectives*, pp. 35–54. Routledge.

Pryzbylo, E. (2019). Asexuality. *Global encyclopedia of Lesbian, Gay, Bisexual, Transgender, and Queer history*, pp. 134–142. Charles Scribner & Sons.

Ravitz, J., Pickman, B., & Griggs, B. (2019, May 28). Transgender people are not mentally ill, the WHO decrees. *CNN*. https://www.cnn.com/2019/05/28/health/who-transgender-reclassified-not-mental-disorder/index.html

Razzano, L., Cook, J., Hamilton, M., Hughes, T., & Matthews, A. (2006). Predictors of mental health services use among Lesbian and Heterosexual women. *Psychiatric Rehabilitation Journal*, *29*(4), 289–298. https://doi.org/10.2975/29.2006.289.298

Reddit. (2010, Oct 22). *When asexuality doesn't fit.* https://www.reddit.com/r/demisexuality/

Rose, N. (2017). *All That We Are: Asexuality, and the Misconceptions Surrounding It.* Createspace.

Rubin, G. S. (2011). *Deviations: A Gayle Rubin Reader*. Duke University Press Books. https://doi.org/10.1215/9780822394068-006

Rubin, J. (2000). William James and the pathologizing of human experience. *Journal of Humanistic Psychology*, *40*, 176–226. https://doi.org/10.1177/0022167800402006

Sanders, S. A., Graham, C. A., & Milhausen, R. R. (2007). Predicting sexual problems in women: The relevance of sexual excitation and sexual inhibition. *Archives of Sexual Behavior*, *37*(2), 241–251. https://doi.org/10.1007/s10508-007-9235-7

Savin-Williams, R. C. (2014). An exploratory study of the categorical versus spectrum nature of

sexual orientation. *Journal of Sex Research, 51*(4), 446–453. https://doi.org/10.1080/00224499.2013.871691

Scott, S., & Dawson, M. (2015). Rethinking asexuality: A Symbolic Interactionist account. *Sexualities, 18*(1–2), 3–19. https://doi.org/10.1177/1363460714531273

Steelman, S., & Hertlein, K. (2016). Underexplored identities: Attending to asexuality in therapeutic contexts. *Journal of Family Psychotherapy, 27*(2), 85–98. https://doi.org/10.1080/08975353.2016.1169014

Suess-Schwend, A. (2017). Gender diversity in childhood: A human right. *Archives of Sexual Behavior, 46*, 2519–2520. https://doi.org/10.1007/s10508-017-0938-0

Tanner, A. E., Zimet, G., Fortenberry, J. D., Reece, M., Graham, C., & Murray, M. (2009). Young women's use of a vaginal microbicide surrogate: the role of individual and contextual factors in acceptability and sexual pleasure. *The Journal of Sex Research, 46*(1), 15–23. https://doi.org/10.1080/00224490802398407

Tinder. (2019, May 22). *4 Demisexual people explain what "Demisexuality" means to them* [Video]. YouTube. https://www.youtube.com/watch?v=YBW7p8_fT2I

Tinder. (2020). *Tinder* (version 11.13.1) [Mobile app]. App Store. https://apps.apple.com/us/app/tinder/id547702041

Weinrich, J. (2014). Multidimensional Measurement of Sexual Orientation: Ideal. *Journal of Bisexuality, 14*(3–4), 544–556. https://doi.org/10.1080/15299716.2014.960958

Weis, R., Hermann, L., Bauer, C., Miller, T. L., Baba, A., van der Biezen, T., Campos, A., Smiga, J. A., Tomaskovic-Moore, S., Trieu, T. H., Walfrand, A., & Ziebert, J. (2021). The 2019 asexual community survey summary report. *The Ace Community Survey Team.* https://asexualcensus.wordpress.com/2019-asexual-community-survey-summary-report/

Winter, S., De Cuypere, G., Green, J., Kane, R., & Knudson, G. (2016). The proposed ICD-11 gender incongruence of childhood diagnosis: A world professional association for Transgender health membership survey. *Archives of Sexual Behavior*, *45*, 1605–1614. https://doi.org/10.1007/s10508-016-0811-6

Zajonc, R. B. (1968). Attitudinal effects of mere exposure. *Journal of Personality and Social Psychology*, *9*(2), 1–27. https://doi.org/10.1037/h0025848

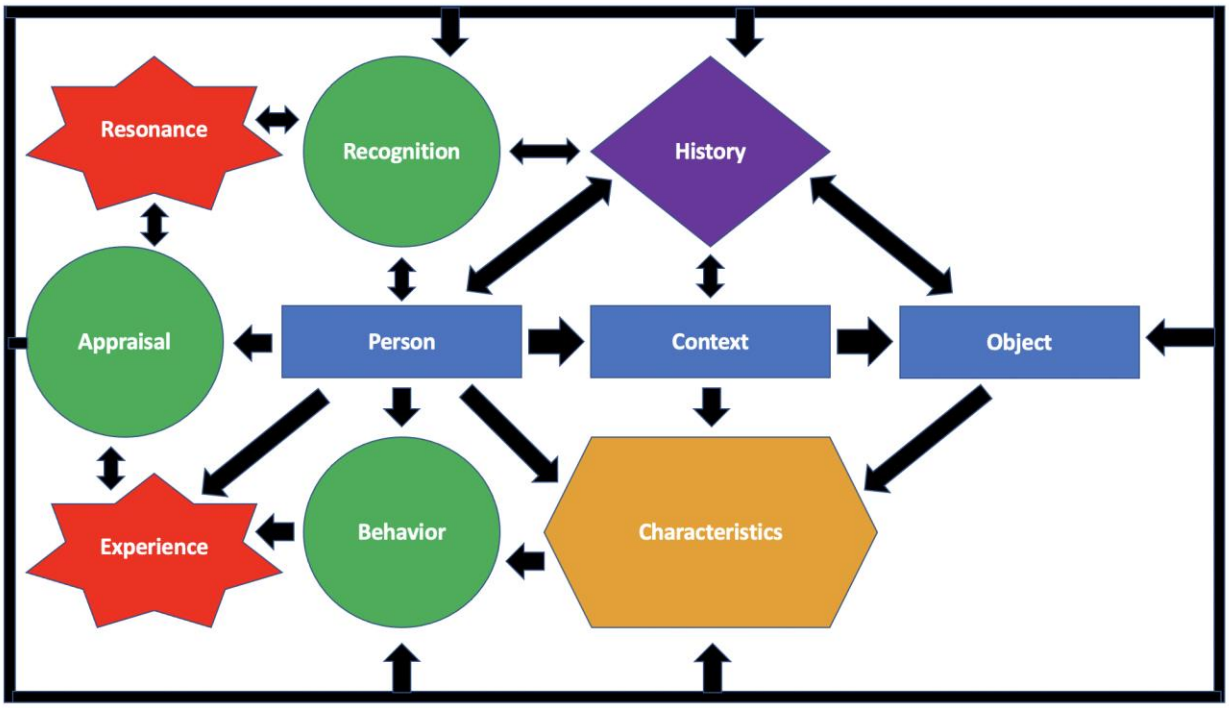
Appendix A

Terms and Definitions Used, via AVENwiki

- **ace:** ace is a popular nickname for a person who is asexual. It is a phonetic shortening of "asexual."
- **ace spectrum:** a spectrum between asexual and allosexual.
- **allosexual:** the opposite of asexual. That is, a sexual person is a person who experiences sexual attraction.
- **aromantic:** a person who experiences little or no romantic attraction to others.
- **asexual:** someone who does not experience sexual attraction.
- **celibacy:** conscious abstinence from sexual activity. Celibacy is a behavior, as opposed to asexuality which is an orientation. Not all asexuals are celibate, because there are reasons besides sexual attraction to engage in sexual activity.
- **demisexual:** someone who does not experience sexual attraction to another person unless or until they have formed an emotional connection with that person.
- **gray-asexual/Gray-A:** people who identify as gray-A can include, but are not limited to those who: do not normally experience sexual attraction, but do experience it sometimes; experience sexual attraction, but a low sex drive; experience sexual attraction and drive, but not strongly enough to want to act on them; people who can enjoy and desire sex, but only under very limited and specific circumstances.

Appendix B

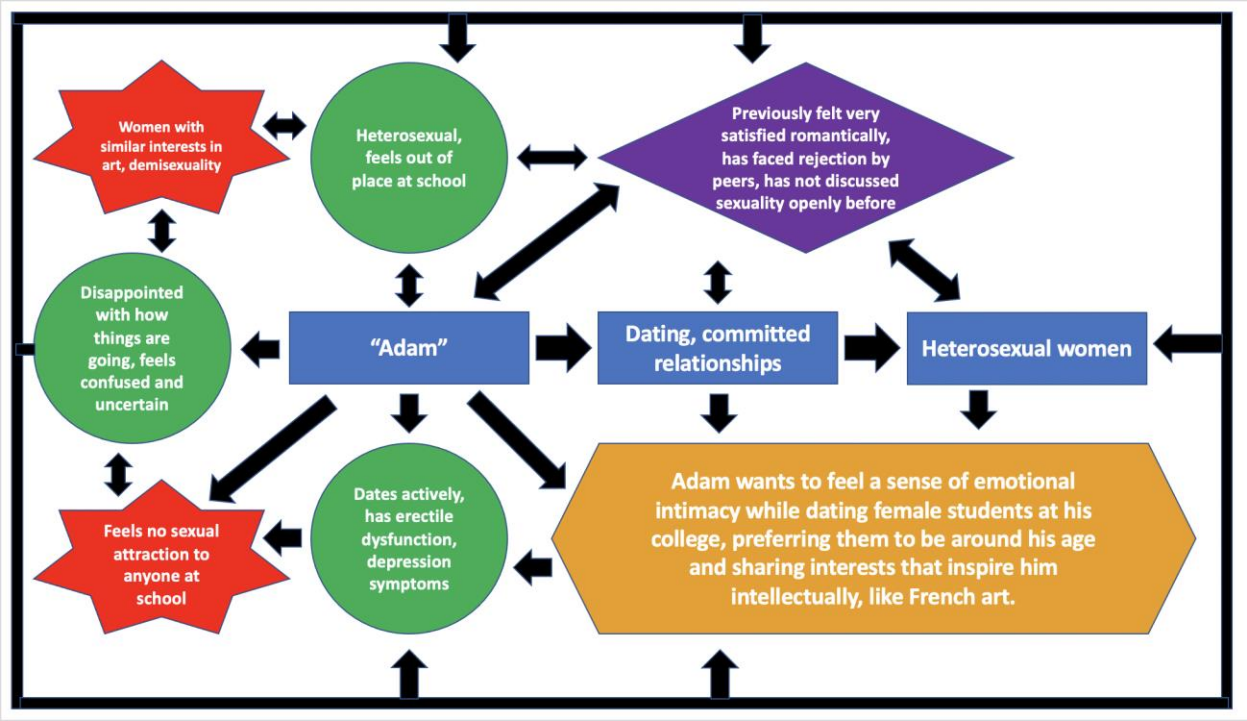
Model of a Parameter Map for Use in Assessment and Case Conceptualization



Note. In this visualization, shapes and colors are used to present categories for ease of use. Blue squares here represent essential elements of human sexuality, and the yellow hexagon represents each of their characteristics in shorthand. The purple diamond indicates history as an existential and referential mitigator. The green circles and red stars indicate cognitive and behavioral mitigators and characteristics. The black arrows connecting the shapes here indicate different possible relationships between the parameters of this analysis. Also note that here, appraisal is a central feature of conceptualization; it is possible that in other conceptualizations appraisal is not assigned the same associations. Shapes and colors were used to illustrate similar parameters in a categorical fashion. This is only one of many possible ways to arrange and consider the parameters discussed.

Appendix C

Example of a Parametric Analysis Using a Clinical Vignette



Note. In this visualization, the visualization model shown in Appendix B is used to illustrate how a simplified clinical vignette can be integrated into a Parametric Analysis model.