Measuring Social Invisibility and Erasure:
Development of the Asexual Microaggressions Scale

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ABSTRACT

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The purpose of this dissertation was to create a psychometrically sound measure of asexual prejudice through microaggressions that can be used to document and identify the unique experiences of asexual people (i.e., those reporting a lack of sexual attraction towards others). Asexual prejudice encompasses anti-asexual beliefs and attitudes that stem from sexual normativity which promotes sexuality as the norm while positioning asexuality as deviant (Carrigan 2011; Chasin, 2011; Flore, 2014; Gupta, 2013). Applying Sue’s (2010) description of microaggressions, asexual microaggressions are conscious and/or unconscious daily occurrences of insults and invalidation that stem from implicit bias against asexual people and asexuality. Development of the scale included creating items with content that was derived from close readings of the literature on asexuality and related measures of discrimination, prejudice or bias as well as expert review for clarity and verifying applicability of content. A total of 738 participants participated on-line and half were randomly assigned to Phase 1 for the Exploratory Factor Analysis (EFA) while the other half was assigned to Phase 2 for the Confirmatory Factor Analysis (CFA). Results of the EFA indicate a 16 item four-factor structure for the AMS that capture expectations of sexuality, denial of legitimacy, harmful visibility, and assumptions of causality as descriptors of the types of microaggressions that occur. The CFA revealed support for the AMS total score with good internal consistency and strong validity as reflected in strong positive relationships with stigma consciousness, collective self-esteem, and another measure of discrimination and bias. Combined, the AMS is a valid and reliable measure of asexual
prejudice. Contextualization of these results as well as implications for future research and clinical practice are discussed
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DEDICATION

To my family and friends for everything.
Chapter 1

INTRODUCTION

Sexuality is a dimension of life and a cultural institution that is linked to sources of sociopolitical power and privilege that permeate both public and private spheres (Fahs, 2010; Rubin, 1996). This conceptualization of sexuality is necessary to understanding how sex and sexuality operate as cultural tools that dismiss and marginalize asexuality and helps to frame the importance of asexuality studies as a whole. The following chapter elaborates on the population and topic of interest then concludes with a statement of purpose for the entirety of this dissertation.

Asexuality

Asexuality is a sexual orientation defined by a lack of sexual attraction towards others. Lack of desire frequently, but not exclusively, coincides with having no desire for sexual contact with another person. As of now, the literature is mixed on the biological and psychosocial developmental factors that lead to an asexual identity. Prevalence of asexuality ranges from 1% to 5% depending on what definition is being used to classify a person as asexual. In psychological literature, asexuality has been operationalized as “no attraction towards men or women” (Bogeart, 2004), low libido or sexual desire (Brotto, Yule, & Gorzalka, 2013), or personal identification (i.e., “I am asexual). However, the most discussed statistic is that, approximately one percent of people in the US and UK are asexual (Bogeart, 2004; Poston & Baumle, 2011). While the prevalence of asexuality indicates a numerical minority status, it is the perception and conceptualization of asexuality that supports its status as a marginalized minority identity as well.
Additionally, important to conceptualizing asexuality, is understanding what it is not. Asexuality is continually conflated with more prominent terms or experiences such as celibacy or incorporated under an umbrella of pathology. Given its emphasis on lack is often misrecognized as a form of sexual dysfunction or as a symptom psychopathology. Asexuality is often conflated with celibacy mistaken for asexuality; most significantly celibacy is described as a choice where asexuality is considered essential and a life-long process (Scherrer, 2008). Asexuality is not a sign or symptom of a disorder and is distinguishable from sexual dysfunction (Bogeart, 2006; Brotto, Yule, & Gorzalka, 2015b; Chasin, 2013; Hinderliter, 2013). Asexuality has also been conceptualized as an act of retaliation against expressions of sexuality (Chu, 2014) and sociopolitical act of rebellion against compulsory heterosexuality (Fahs, 2010). This is not the same as an essentially asexual experience (Scherrer, 2008). While self-identification is valued and important aspect of the experiences of asexual people, it is not merely the choice in identifying in this way but the lack of choice in living in another way. Lastly, asexuality is not the same as romance or desire for romantic activity, many asexual people have a gender-object of choice and identify along a continuum of romantic identities (Scherrer, 2008). Assumptions made about asexuality are discussed in greater detail in Chapter 2 of this dissertation.

**Asexuality in context.** Research on heterosexuality, homosexuality, and bisexuality has advanced over time. Asexuality, though not the focus of this research does appear in various forms in across time. For example, Michael Storm’s (1978) two-dimensional model of sexual orientation incorporated ‘aneroticism’ (e.g., lack of erotic feelings). More recent review of this work identifies aneroticism as a synonym of asexuality (Hinderlitter, 2009). Paula Nurius (1983) described an ‘autosexual orientation’ as one of six dimensions of sexual preference and activity. Ray Blanchard (1985) wrote about asexuality as a subtype of heterosexuality male
transsexualism and coined the term ‘automonosexualism’ to denote a self-directed sexual interest that coincides with a lack of erotic interest in others. This term was later re-popularized as autochrissexualism or an “identity less sexuality” (Bogeart, 2012). Interestingly, several of these sources align asexuality with bisexuality such that they are seen as opposites of one another (e.g., asexuality as not sexually attracted to either gender and bisexuality as being attracted to both or all genders; see Storms, 1978) or by grouping them together in order to form a triadic model of sexual orientation (see Blanchard, 1985). The inclusion of asexuality in sexuality research reveals a historical acknowledgement of a fuller range of possibilities for human sexual expression. Even still, for a number of reasons discussed in depth in the next chapter, absence of sexual desire and/or attraction is left unattended in identity-related literature in comparison to other sexual orientations and aspects of identity.

‘Rediscovering’ and redefining asexuality. In contemporary research, there has been a preoccupation with defining asexuality. Since its empirical ‘re-discovery’ in Anthony Bogeart’s (2004) population-based work, asexuality has become a flourishing topic within popular and academic discourse through asexual community efforts to increase visibility in popular media and academic scholarship (Pryzbylo, 2013, 2014). When considering a universal definition of asexuality; it is difficult to strike a balance between thinking of asexual as a meta-category underneath the sexuality umbrella and as a concept located beyond or outside of traditional understanding of sexuality (Chasin, 2011). Asexuality is most often referred to as a sexual orientation where a person is not sexually attracted to others. However, a deeper understanding of what is meant by asexuality in the empirical literature remains lacking, partially due to implicit sex-normative biases of researchers about sexuality and the methodological issues of measuring ‘lack.’ Asexual community efforts have increased visibility of asexuality both in
popular media and academic scholarship (Pryzyblo, 2014). Asexuality disentangles sex from other ways of creating meaningful intimate relationships thus revealing the complexities of human sexual identities. For this reason, asexuality has become an intriguing topic among sexuality and psychology researchers for its ability to challenge present paradigms of sexuality.

For the purposes of this dissertation, to fully grasp asexual-specific stigma, marginalization, and discrimination, it is necessary to think of asexuality in plural terms to underscore the complex and diverse mechanisms of asexuality and of the lived experiences of asexual people. Specifically, that asexuality is both a social identity as well as a tool of deconstruction; it is both practice and political (Ceranowski & Milks, 2010; Emens, 2014). Similarly, this understanding of asexuality also suggests that issues brought up by minority experiences (e.g., how important is sex in relationships?) are not merely specific to that minority but are applicable to the majority as well (Emens, 2014). Thus discussing the lived experiences of asexuality, particularly those of regarding stigma and marginalization, necessitates a thoughtful and critical examination of the sociocultural environment through the lens of asexuality.

**Sexual Normativity**

*Sexual normativity* is a worldview based on positioning sexuality as normative and compulsory. Under this ideological framework, sexuality signifies a vital component of a person’s place in society rather than as a trait or attribute that they might possess (Carrigan, 2011; Chasin, 2014). Thus, sexual normativity includes the assumption that a person is sexual unless otherwise identified. Combined, sexual normativity eclipses asexuality by making the presence of sexual attraction, desire, and frequent sexual activity normative. To illustrate the role of sexual normativity in asexuality issues, it is possible to compare it to heteronormativity.
Similar to the way that heteronormativity privileges heterosexuality and begets homophobic and heterosexist beliefs, sexual normativity privileges sexuality as the norm. In doing so, asexuality is positioned as a deviation from this norm. Because of sexual normativity, asexual people are constantly bombarded with messages that invalidate and seem to negate their asexuality. As a result, asexuality is marginalized and rendered invisible due to its failure to uphold social expectations. This marginalization is a manifestation of *asexual prejudice*. Research has yet to empirically investigate this concept.

Asexual prejudice encompasses anti-asexual attitudes and beliefs that affects both asexual-identified people and potentially asexual people, and is exemplified in discriminatory behaviors, microaggressive statements and actions from others. While sexual normativity represents the uncontested belief that the sexual self is the only viable and healthy self, sexual prejudice—more specifically, asexual prejudice—manifests as both conscious and unconscious bias that asexual people are comparatively inadequate (Chasin, 2013). In the context of sexual normativity, asexual and potentially asexual people may be subject to discrimination Though their experiences of stigma may be similar to LGBTQ people there may be differences in the ways that asexual people are persecuted by institutional structures such as religion, marriage, or the law (Bogeart, 2004; Chu, 2014; Emens, 2014). Thus subtle forms of discrimination may be a better way to describe incidences of asexual prejudice.

**Microaggressions**

Microaggressions are the often subtle, verbal, visual, and environmental slights made towards another group, typically a minority group. Beginning with the work of Chester Peirce and colleagues (1978) racial microaggression literature has proliferated. Literature has expanded

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1 The acronym LGBTQ refers to lesbian, gay, bisexual, transgender, and queer people as a community. Alternates of this acronym, such as LGB or LGBT, reflect the specific groups being referred to by the source.
to document the microaggressive experiences of lesbian, gay, and bisexual (LGB) people (Nadal & Griffin, 2011; Nadal, Issa et al., 2011; Nadal, Wong et al., 2011; Platt & Lenzen, 2013; Sarno & Wright, 2013; Shelton & Delgado-Romero, 2011, 2013; Wright, & Wegner, 2012) and more recently transgender people (Nadal, Skolnik, & Wong, 2012).

At face value, specific themes from the literature with sexual minority microaggressions appear to coincide with experiences of asexual people. For example, out of the eight themes of microaggressions originally theorized (Sue, 2010), assumption of sexual pathology/abnormality, is one clear microaggression that may overlap. However, it should be noted that asexual experiences would not be captured sufficiently by prior measures of microaggressions developed for LGBT people, because some asexual people are also LGB and transgender (thus, their experiences of marginalization are intersectional). Thus a multidimensional approach to understanding microaggressions and asexual prejudice is necessary to capture this complexity.

**Purpose and Overview of the Dissertation**

The purpose of this dissertation is to create a scale that measures the frequency that asexual microaggressions occur and how distressing they are to the recipients. Little attention has been paid to the compulsory nature of sexuality and even less have attended to bias, prejudice and microaggressions exemplifying this pervasive worldview. Numerous measures of sexual prejudice are available including: Modern Homonegativity Scale (MHS; Morrison & Morrison, 2002), Attitudes Towards Lesbians and Gay Men Scale (ATLG; Herek, 1988), Homonegative Microaggression Scale (HM; Wright & Wegner, 2012), and the Anti-Bisexual Experiences Scale (ABES; Brewser & Moradi, 2010); however, all current scales measuring sexual prejudice or sexual orientation microaggressions have excluded asexuality. In fact, few studies have explicitly undertaken the task of investigating the subjective experiences of asexual people regarding
stigma, marginalization, or discrimination. One major limitation is that these studies have relied on measures created for members of LGBTQ communities and as CJ Chasin (2015) states succinctly:

[These] findings illustrate that the kinds of discrimination faced by lesbian women might not be equally or similarly relevant to asexual/ace people; moreover, their results reflect the limitations of existing measures and their insensitivity to the diverse kinds of discrimination specific and most salient to asexual/ace people” (p.170).

Thus, asexuality-specific measures are necessary to enumerate these experiences and obviate the insidious nature of sexual normativity that permeates various aspects of human experience. To date, this dissertation is the first to develop a measure of asexual prejudice for the use with asexual-identified people in order to initiate further research asexual marginalization. Two dimensions of asexual prejudice, social invisibility and erasure, will serve as the foundation for the proposed measurement development. Examining the scale’s relationship with measures of distress, identity development, collective self-esteem, and social desirability will help establish its validity. These data can be used to inform clinical practice, educational literature, and future research. Importantly, this study is an initial step towards understanding sexual normativity as a phenomenon that affects all sexualities. In the context of this dissertation, in addition to specifying and illustrating microaggressions, scholarly literature is critiqued for its role in perpetuating sexual normativity approaches to asexuality.
Chapter 2

LITERATURE REVIEW

In order to understand how asexual microaggressions develop, manifest, and are experienced by asexual individuals, it is necessary to first define asexuality and differentiate it from other concepts of non-sexuality such as celibacy. Following these definitions is a review of the empirical literature on asexuality. This section is divided into two parts in an effort to characterize emergent themes: etiological and phenomenological. Sexual normativity is discussed in detail and used to demonstrate how asexual prejudice and microaggressions come to be. In addition, this section describes previous research on (normative) sexual orientation microaggressions and possible overlaps with asexuality. Next, asexual microaggressions are described and illustrated using data pulled from identified community members. Further, the importance of this work is further explicated through discussing the impact of microaggressive experiences. Finally, the problem with the previously described research and gaps in the literature are reiterated and hypotheses are described.

Understanding Asexuality

Defining asexuality. In contemporary psychological and sexualities discourse, asexuality is a sexual orientation defined by a lack of sexual attraction. In addition to attraction, asexuality has been conceptualized in terms of a lack of desire (Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010), lack of sexual behavior (Aiken, Mercer & Cassell, 2013; Bogeart, 2004; Poston & Baumle, 2007), lack of attraction directionality (Bogeart, 2012; Hanson, 2014), and as “permanent, identity-based sexual refusal” (Fahs, 2010, p. 447). However, research suggests that most people, who identify as asexual, define their asexuality as simply a lack of sexual attraction (Van Houdenhove, Gijs, T’Sjoen, & Enzlin, 2014).
These definitions of asexuality have been critiqued because of their conceptual emphases on lack (Pryzoblo, 2011), absence (Bogeart, 2004), and essentialism (Chasin, 2013; Scherrer, 2008)—all which seem to automatically emphasize that something is lacking. Similarly, asexuality is sometimes thought to be the lack of a traditional sexual orientation (Aiken, Mercer & Cassell, 2013; Bogeart, 2004; Pryzbylo, 2011). The term ‘asexual’ literally means without or ‘away from’ sexuality; which places it in opposition to ‘normative sexualities’ (Haefner, 2011). These sexualities include heterosexuality, homosexuality, and bisexuality and are sometimes referred to as sexuals or allosexuals (e.g., refers to those who are sexually attracted towards other people) to unify those defined by the presence of sexual attraction (Cyprès, 2012). Thus an asexual to sexual binary is created. This binary is problematic because it omits the possibility of a “grey area.” For example, this binary excludes the existence of gray-aseuality or gray-As (e.g., those individuals who place themselves in this “gray” area) and demisexuality (e.g., orientation in which sexual attraction is develop almost exclusively in the context of romantic relationships). Thus, an asexual spectrum will also be used to encompass demisexuality, gray-aseuality, and other diversity within asexual communities.

Lacking sexual attraction does not prevent one from engaging in sexual activities or forming intimate relationships with others. In fact, some asexual people are sexually active with themselves (via masturbation) and/or with other people, while other asexual individuals may be sex averse or repulsed (Brotto et al, 2010). Asexuality often coincides with a lack of desire for partnered sexual contact, but not desiring partnered sexual contact does not necessarily preclude one from forming or desiring meaningful romantic relationships (Bogeart, 2012; Chasin, 2013, 2014a; Scherrer, 2008). For this reason, many asexual people find that a romantic orientation provides a fuller picture of their asexual identity (Chasin, 2014a; Gazzola & Morrison, 2011;
Haefner, 2011; Scherrer, 2008). *Romantic orientation*, pattern of desire to express love towards another, often designated by gender, varies along a continuum that includes aromantic (i.e., lack of romantic attraction), homoromantic (e.g., same-gender romantic attraction), biromantic (e.g., romantic attraction towards both genders), panromantic (e.g., romantic attraction towards others regardless of gender), and heteroromantic (e.g., romantic attraction towards another gender different from one’s self). Some asexual individuals may refer to their romantic orientation in normative terms including lesbian, bisexual, and pansexual. Combined with an asexual orientation, a person could identify as a ‘pansexual asexual.’ This might mean that s/he is not sexually attracted to anyone, but is romantically attracted to others across genders (Scherrer, 2008; Sundrud, 2011). From these definitions, asexuality helps disentangle love and sex, sexual preference and affective affinity, and opens the door for a more complex understanding of identity and relationships. Even still, the variations among these definitions suggest multiple avenues of categorization and identification. A glossary of terms is included in Appendix A for reference.

In an effort to offer a positive reconceptualization for this dissertation, *asexuality* will be understood as an umbrella term that captures the attraction, experiences, and fantasies that privilege emotion and nonsexual intimacy in the context of infrequent or no sexual attraction (Foster, 2012; Hinderliter, 2013; Carrigan, 2011).

**Differentiating asexuality.** Within psychological research, those who self-identify as asexual are typically distinguished from people whose non-sexuality is a result of some level of distress or choice (Chasin, 2011; Gupta, 2013; Scherrer, 2008). This differentiation is driven by an emphasis on essentialism and creates another binary of asexuals versus nonsexuals. Concepts such as celibacy and virginity are all more socially accessible terms for *nonsexuality* or instances
in which sexual desire, attraction, or behavior is absent but an asexual identity is not present (Gupta, 2013), though there is evidence that one might be both asexual and nonsexual (Chasin, 2013). Asexuality is differentiated from celibacy by asserting that one chooses to be celibate but one does not choose to be asexual and therefore is essentially asexual (Scherrer, 2008).

Essentialism, sometimes referred to as biological determinism, is the notion that a person is inherently asexual and is most often used to legitimize asexuality as an identity (Scherrer, 2008). This notion of essentialism is further illustrated via the emphasis on having a “lifelong lack” is part of the definition of asexuality as an orientation.

However, this focus on essentialism occludes the possibility of individuals who may have once experienced a lack, who may identify as asexual potentially as a choice, or those whose asexuality may incorporate physical, emotional, medical trauma (Chasin, 2013; Labuski, 2014). As well as those who have not yet, taken up the term (Brotto & Yule, 2009). These individuals are best be referred to as “potential asexuals” and this term will be used to distinguish those who self-identify from those that do not (Chasin, 2011). This paper is focused primarily on those who would willingly place themselves on the asexual spectrum, though the experiences of potential asexuals will be discussed when implicated. In sum, asexuality is understood as a fluid and multidimensional social location that has its own unique challenges.

An extensive portion of asexuality literature is devoted to differentiating asexuality from Hypososexual Desire Disorder (HSDD) (Bogeart, 2006; Brotto, Yule, Gorzalka, 2015b; Chasin, 2013; Hinderliter, 2013). Researchers appear to agree that the core of the difference between asexuality and sexual dysfunction—specifically Hypososexual Desire Disorder is the level of distress that one feels in the context of their lack of attraction or desire. Further, Bogeart (2006) reiterates that asexuality is a lifelong lack, which is meant to use biological and genetic links to
legitimize asexuality; but that HSDD is an acquired lack suggesting the lack of permanence and treatability of the disorder. Brotto and colleagues also discuss extensively how asexuality should not be considered a dysfunction of sexual desire (Brotto et al., 2010; Brotto & Yule, 2011; Brotto, Yule, Gorzalka, 2015b). For example, Lori Brotto writes:

[I]t is possible that the woman with lifelong lack of sexual attractions and interests and who is unbothered by her sexual status may better fit the asexuality label, whereas the woman initially labeled as asexual who, after declaring distress linked with her lack of interests, and also experiences sexual attractions, better fits the sexual dysfunction category of HSDD, and might therefore seek appropriate treatment” (Brotto et al., 2010, p. 614).

These studies are helpful in that they support efforts of asexual community activists in de-pathologizing their identity. However, merely identifying interpersonal difficulty or subjective distress does not suffice to obliterate the links between asexuality and sexual dysfunction disorders.

Feminist and queer scholars have offered critiques of psychiatry and the field of psychology as a whole. For example, in a critical essay on how asexuality has been defined by psychiatric science and language, Flore (2013) uses asexuality as a tool challenge the field’s tendency to “enforce pathological interpretations of asexuality” (p. 12). To illustrate a similar point, Chasin (2013) creates several case studies to represent the various ways that asexuality, distress, and HSDD intersect for an individual experience. To put their² argument simply, “ze³ is not feeling that distress in a vacuum” (p.416). Writing as both an asexually identified person and a psychologist-in-training, CJ Chasin urges psychologists to explore the nature of distress rather

² Author self-identifies as non-binary gender.
³ Single subject conjugation of the gender neutral pronoun ‘hir’.
than simply noting that it exists. The source of distress and how it manifests could be due to numerous issues that are not purely intrapsychic but have tangible environmental ties such as being seen as “withholding of sex” within a romantic relationship, being in the early stages of identity development (prior to “coming out”) and a myriad of other environmental contributing factors (Brotto et al., 2010; Foster & Scherrer, 2014; Hill, 2009).

Importantly, there is a distinction between identifying as asexual and having the term erroneously imposed upon one’s experience. For example, women who are unable to engage in penetrative heterosexual sex due to chronic pain are considered asexual by default (Labuski, 2014). Assumptions of asexuality are also ways of stereotyping and stigmatizing different ethnic and racial groups and people with disabilities. Asian people are often associated with a submissive asexuality and thus eroticized as an opportunity for sexual fulfillment and domination (Gross & Woods, 1999). Further still, during-and post-slavery, black women were portrayed as asexual mammy figures in juxtaposition to being hypersexualized as jezebels (Owen, 2014). Individuals with disabilities (visible physical and mental illness), young children, and older adults are also associated with asexuality as well demonstrating how sexual normativity intertwines with ageist and ableist narratives (Kim, 2011, 2014). For these groups, asexuality has been used as tool of oppression to reinforce what is normal and healthy (Kim, 2014; Owen, 2014). Thus asexuality is both implicated in and impinged upon by mechanisms of power and privilege. This multiplicity highlights the complexities of what it means to be a person in the world (asexual or otherwise) under the oppressive forces of sexual normativity.

Discourse focused on distinguishing asexuality from HSDD and other sexual dysfunctions, evokes memories of arguments that led to the removal of homosexuality from the Diagnostic Statistical Manual (DSM) in 1974 (Scherrer, 2008). Struggles for civil recognition,
identity invalidation, and empirical scrutiny are all similar at the onset. However, the use of paradigms, measures and other empirical research tools designed for lesbian, gay, bisexual and queer (LGBTQ) people is an incongruent match for asexual people. This tendency to assume that asexual people’s experiences will map on to the experiences of other sexual minorities misses the uniqueness of asexual experiences (Chasin, 2011; Chu 2014). As such, measures and methodological approaches that are sensitive enough to capture these nuances are an important next step in asexuality scholarship.

**Literature Review on Asexuality**

Overwhelmingly, discussion of asexuality within psychology outnumbers other disciplines such as public health, women and gender studies, clinical sexology, and law. Notably, most of the literature pulls from multiple disciplines creating an interdisciplinary approach to the study of asexuality (Ceranowski & Milks, 2010; Przybylo, 2011, 2012). As such, asexuality has taken on meaning as a social phenomenon and a lived experience, and this meaning has been interpreted and analyzed differently throughout the literature (Przybylo, 2013). While some are etiological in nature and others emphasize the phenomenological aspects of asexuality, the majority of studies address characteristics and development of asexuality. The overall importance of examining these studies is to understand the demographic, psychological, and bio-neurological profiles of asexual people so that potential psychosocial stressors and socio-emotional strengths can be identified in order to best serve these communities. Research and analyses focus on internal psychological processes (e.g., alexithymia; Brotto, Knudson, Inskip, Rhodes, & Erskine, 2011), physiological processes (e.g., arousal, vaginal pulse aptitude; Brotto & Yule, 2011), physicality (e.g., Bogeart 2004, 2013), demographics (e.g., Aiken, Mercer & Cassell, 2013; Bogeart, 2004, 2012), biological markers (Yule, Brotto, & Gorzalka, 2013), and
sexual activity (e.g., masturbation; Yule, Brotto & Gorzalka, 2014). Left out of this review are non-empirical articles that use asexuality as a tool of cultural deconstruction rather than the lived experiences of asexual and potentially asexual people. However they are used throughout this dissertation to inform empirical findings and interpretation.

**Etiological focus.** Using data from a national survey in the United Kingdom (UK) on the sexual needs and experiences of people with sexually transmitted infections (STIs) (see Johnson, Wadsworth, Wellings, & Field, 1994), Bogeart (2004) described several factors that independently predict what he labeled asexuality (e.g., socioeconomic status, gender, age, disability status). Among 20,000 participants, 195 (1%) were classified as asexual because they endorsed “neither males nor females” for a question asking about sexual attraction. Bogeart labeled the remaining people in the sample, those endorsing attraction towards one or both genders, were identified as ‘sexuals.’ The study investigated sexual attraction, sexuality (including age of first sexual experience and frequency of current sexual activity), health, physical development, and religiosity. Compared to sexuals, Bogeart (2004) found that there are fewer asexual men but more asexual women. In terms of sexual behaviors, asexual people were more likely to have less sexual activity, fewer partners, and were older during their first sexual encounter. Regarding demographics, asexually identified respondents were more likely to be older, female, shorter, in worse health, from lower SES, more religious, and less educated; and were less likely to be in a relationship. Interestingly, Bogeart notes that the rate of asexual attraction was similar to same-sex attraction at approximately one percent of the sample. This statistic becomes frequently piece of evidence to corroborate asexuality’s existence and minority status. In conclusion, Bogeart states that there might be several developmental pathways, both biological and psychosocial, that lead to asexuality. For example, lack of sexual attraction may
be associated with disadvantaged socioeconomic conditions that limit access to positive orientation models or sufficient resources needed to maintain good health. This is the first empirical study to identify asexuality as an orientation and led to several similar population studies with the goal of replication. Despite its seminal findings, overtime, this study has become the focus of much criticism because of its implicit emphasis on typifying asexuality and reducing asexual people to stereotypes (Chasin, 2011; Gressgard, 2013).

In the first study with self-identified asexual people, Prause and Graham (2007) expanded on previous findings from population studies. Using a mixed methods approach, an initial qualitative study was used to develop hypotheses for the subsequent quantitative study. Study 1 included a sample of four participants (ages 31-42 years old) who were all single, college educated, heterosexual, and from a Midwest city in the US, while Study 2 used data from convenience sample of over 1,100 (511 women and 635 men) participants aged 18-59, and mostly college educated. In Study 2, 41 participants self-identified as asexual. Major themes emerging from Study 1 included: experience and labeling of sexual behaviors, defining asexuality, motivations for engaging in sexual behaviors, and concerns about being asexual. For example, participants indicated how self-identifying as asexual is stressful for many because they worry they there is something ‘wrong’ with them. In combination with findings from Study 1, researchers found that an absence of a desire for sex was a strong predictor for self-identifying as asexual in Study 2. Also, less than one quarter of the sample in Study 2 endorsed “lack of sexual attraction” as their personal definition of asexuality. This is similar to findings that emerge later regarding asexual classification (Poston & Baumle, 2010). Furthermore, Prause and Graham found age-related effects (i.e., asexuals were older than non-asexuals) and education effects (i.e., asexuals were more educated non-asexuals). Findings regarding educational level and gender
contradict previous findings that asexual people are more likely to be less educated (Bogeart, 2004; Poston & Baumle, 2010). But they also demonstrate the usefulness of self-identification as the definition of asexuality. Following this study, researchers incorporate self-identification rather than simply categorizing people as asexual based on a lack of expected behavior or experience.

In 2010, researchers analyzed data from over 12,000 respondents ages 15-44 in the US National Survey of Family Growth (NSFG) in a follow-up and extension of Bogeart’s (2004) study. Poston and Baumle (2010) operationalized asexuality as having three main dimensions: (1) desires, (2) behaviors, and (3) self-identification. This article found similar rates of asexuality as defined by attraction in both female (0.8%) and male (0.7%) portions of the sample. In addition, researchers found that significantly less people could be classified using all three criteria (between 0.6-0.9%). Poston and Baumles’ analysis involved similar demographic, health and sexual behavior measures, producing correlate rates for each dimension across gender. For example, on the behavior and identification dimensions, asexual people were less educated and healthy compared to sexual people in the sample. Though they replicated several findings regarding health status, age, and gender composition, Poston and Baumle assert that Bogeart’s (2004) definition of asexuality was insufficient in capturing participant experiences. Overall this study reiterated Bogeart’s assertion that there may be different developmental pathways to asexuality. In addition, researchers emphasized the role of gender and its social construction when interpreting their results.

In order to elaborate on the accepted definitions of asexuality and link them back to previous demographic and etiological findings, Brotto, Knudson, Inskip, Rhodes, and Erskine (2010) used a mixed methods approach to highlight the role of distress in the experiences of
those who identify as asexual. Study 1 was a quantitative Internet study that included a demographic questionnaire, measures of sexual behaviors and response, and several measures of psychiatric symptoms and personality characteristics. The sample included 187 college-educated men and women recruited solely though AVEN; the average age for men was 30.1 years and 28.2 years for women. The most widely cited finding from this study is the rate of masturbation among participants, approximately 77% of asexual women and 80% of asexual men reported masturbating. Study 2 was designed to expand upon these quantitative findings with data from 15 asexual respondents who also participated in Study 1 between the ages of 20 and 57. Notable demographics suggest that their sample was largely female, atheist, and introverted. In addition, researchers found that social withdrawal and alexithymia are potential correlates of asexuality. Finally, researchers found that asexual people are not distressed by their (low) level of sexual desire and are enjoying the sex they are having. Thus, Brotto and colleagues conclude that asexuality is not synonymous with a disorder of sexual desire, but cannot rule out other levels of sexual dysfunction because there is a possibility that asexual people lack traditional cognitive appraisals of sexual stimuli. These findings reveal important avenues for future research including a need for psychophysiological perspective and distinguishing asexuality from sexual dysfunction.

In order to examine possible cultural shifts due to increased visibility of asexuality, Aiken, Mercer, and Cassell (2013) used data from the National Survey of Sexual Attitudes and Lifestyles (NASTAL) a probability survey of the British general population from the years 1990-1991 (NASTAL-I) and 2000-2001 (NASTAL-II), which is the same survey that Bogeart (2004) used. Aiken and colleagues used this data to identify changes in the demographic characteristics of those reporting an ‘absence of sexual attraction.’ This is the first study to explicitly attend to
non-White ethnicity as a viable demographic variable. Results demonstrated that among non-White groups (specifically Pakistani and Indian), gender was a significant predictor of asexuality with women more likely to report asexual experiences. This result parallels findings in previous population studies regarding gender (Bogeart, 2004; Poston & Baumle, 2010). In addition, asexual people were not more likely to be religious than sexual people, similar to the percentage of atheists in previous studies (Brotto et al, 2010). However, among those who were religiously affiliated, a significant proportion of asexual people identified as Muslim. Regarding sexual behaviors and experiences, asexually identified people reported being in long-term relationships, sexually engaged and satisfied with the amount of sex they were having. These findings challenge many of the previously established assumptions about asexual people and complicate the field’s ability to identify central characteristics of asexuality.

To also investigate changes in the demographic profiles of asexual people, Bogeart (2013) reexamined findings from his original 2004 study using the NASTAL-II. As expected when compared to non-asexuals, he found that asexual people had fewer sexual partners, less frequent sexual activity with a partner, fewer long-term committed relationships, less education, lower SES, were more likely to be people of color, and religious. These new findings also contradicted his previous findings that asexual were younger and more like to be female; in the 2013 sample, asexual people were older and gender differences were not significant. However, the researcher concludes there is evidence that asexual people lack a target-oriented sexuality, a finding that has significant implications for how asexual people navigate relationships and the difficulties they may encounter. Though, the study appears to take into account the possible systemic factors impacting asexual people, the focus on predictive factors and comparative methods reiterate an underlying skepticism about the existence of asexuality.
Broadening the global scope of asexuality, Hoglund, Jern, Sandnabba, and Santtila (2013) found a similar pattern of results among Finnish twins using survey data from the Finnish Central Population Registry. More than 3,500 people participated in this study, of those 1.5% were men and 3.3% were women reported an “absence of sexual attraction” during the past 12 months. This added temporal component is a major departure from other population-based studies. Overall, these findings parallel previously mentioned ones; an absence of sexual attraction was more prevalent among women, particularly as age increased compared to a control group (this relationship was not significant among men). In addition, those classified as asexual were more like to be single, less sexually active, have fewer sexual partners, and less frequent masturbators. These results were consistent with some previous studies (Bogeart, 2004; Brotto et al., 2010) but contradicted results from a British survey, in which neither gender nor age were associated with asexuality (Aicken et al., 2013). In addition, masturbation rates were less in this sample as compared to a North American sample (Brotto et al, 2010). Hoglund and colleagues concluded that asexual people are either less likely to be interested in partnered sexual activities or apprehensive towards new sexual encounters due to dissatisfying experiences in the past. The former explanation corroborates findings that asexual desire is not partner or target oriented (Bogeart, 2012; Brotto et al., 2010; Hanson, 2014) while the latter explanation suggests a causal relationship between previous sexual experience and current sexual desire. Though discussed in a later in this dissertation, it is important to note that identifying participant reluctance to engage in sexual activities as a characteristic of asexuality is evidential of how asexuality becomes stigmatized in a broader culture.

Taking a different approach to examining asexuality, Prause and Harenski (2014) used fMRI data and measures of subjective distress from a 36-year-old White, heterosexual woman to
test the validity of three etiological theories of asexuality: lack of sexual activation (e.g., recognizing and responding to sexual stimuli), unacknowledged sexual activation (e.g., processing internally but not experiencing the physical arousing effects) and suppressed sexual arousal. Findings support the lack of activation hypothesis and emotional hypo-responsiveness as a possible “common vulnerability” among asexual people (Prause & Harenski, p. 47).

Researchers note that these findings are not to stereotype asexual people, but to offer information about difficulties that some asexual people may face—particularly in relationships.

Taken together, results of these etiologically focused studies suggest not only diversity in the developmental or etiological pathways to asexuality; but potentially among asexually identified people themselves due to the various ways they can come to identify with asexuality. Qualitative studies corroborate these findings and illustrate how asexually identified people develop their identities.

**Phenomenological.** In the first full qualitative study with self-identified asexual people, Kristin Scherrer (2008) highlights vast diversity among asexual communities. This is the first to include individuals who identify outside of the traditional gender binary and to begin to explore the nature of desire among asexual people. Among a sample of 102 mostly White or Caucasian female participants, ages 16-66, three major themes emerged: (1) the meaning of the sexual, (2) essentially asexual, and (3) the romantic dimension. In the first theme, participants identified acts of intimacy as sexual or nonsexual that is similar to themes found in Prause and Graham (2007). Among the ways that participants discussed how they arrived at being asexual in the second theme, biology and biological determinism (essentialism) were discussed as primary ways of how participants understood their asexuality. Scherrer (2008) notes that this emphasis on biology served as a way legitimize asexuality in the context of social stigma. The study’s discussion of
romantic orientation, the third theme, reveals motivations for individuals to pursue relationships with non-asexuals and engage in sexual behaviors similar to Prause and Graham (2007) as well. Notably relationships, particularly romantic relationships, are indicated in later research as a source of significant stress for asexual people due to direct pressure from partners or society in ways that are incongruent with they see their relationship with sex (e.g., increased frequently of encounters) (Carrigan, 2011; Chasin, 2013; Kim, 2011; Przybylo, 2014). This research sparked a proliferation of work on identity development and relationship negotiation as described in the studies reviewed below.

Using grounded theory, one dissertation specifically explores how asexual people negotiate romantic relationships. Carol Haefner (2011) identifies how cultural scripts (i.e., compulsory sexuality), interpersonal scripts (i.e., romantic relationships) and intrapsychic scripts (i.e., coming out as asexual) are articulated and enacted in relationships for asexual people. The sample included 30 mostly atheist or female individuals ages 18 to 55 (majority under 26) with at least some college. According to Haefner (2011), not only is being asexual is stressful but the process of becoming asexual is just as stressful (Prause & Graham, 2007). Meaningfully naming one’s asexuality, or coming out as asexual, is context-dependent and has consequences. These consequences manifested as rejection, invalidation, and dismissal. Further still, this dissertation also notes that asexual participants often used sex as an indicator sincerity of their romantic relationships; and simultaneously described being held to this standard as stressful and defeating. Unsurprisingly nearly three-fourths of participants had felt pressure to be sexual in relationships while more than three-fourths reported that this pressure caused tension in their relationship. This pressure did not stem only directly from partners but was also felt as a societal level pressure. Haefner (2011) refers to pressure to be sexual as compulsory sexuality. These findings are
corroborate previous findings that being in relationships where being sexual is an expectation, causes stress (on both parties) but specifically identity-related stress for the asexual partner (Scherrer, 2008; Prause & Graham, 2007).

Noting a common theme of identity-related stress in previous literature, MacNeela and Murphy (2014) explore the process of becoming asexual and found that, at times, being asexual is seen as a potential threat to one’s self-concept while in other instances, the identity functioned more as a protective factor. Data were collected from 66 self-identified asexual people ages 18-59 most living in the United States and Canada. The majority of the sample was female (47%), though a significant proportion (28%) provided their own gender label (e.g., neutrois, bigender, gender queer). Researchers reported several themes including denial, rejection and invisibility as identity-related stressors that can contribute to apprehension of disclosing one’s asexuality. However, finding on-line asexual communities appeared to resolve a significant portion of this stress through providing opportunities to connect with people with similar experience. Similar to quantitative studies, gender and age emerged as factors contributing to unique asexual experiences. For example, one participant refers to asexual men as “freaks” and asexual women as “frigid” in an effort to illustrate age’s impact. This participant’s response provides a glimpse into how asexual people are dehumanized and invalidated through denial. When comparing findings across cultures represented in the sample, MacNeela and Murphy (2014) found that denial of asexuality was evident in the non-White/Western cultures represented in the sample. Researchers suggest that asexuality challenges aspects of cultural scripts pertaining to family, roles, and responsibilities. Overall researchers concluded that social recognition and acceptance of asexuality are problematically lacking in society.
With a sample of 86 respondents, social recognition and acceptance were reiterated as themes in a qualitative Internet study exploring asexual peoples’ experiences in clinical settings (Foster & Scherrer, 2014). The majority of participants in the sample were white (83.7%) women (80.2%) under 30 years of age (69.8%), and from the United States (55.8%). Researchers identified how a medical model of asexuality leads to pathologization of asexuality, particularly among health and mental health practitioners. As a result, participants in this study insisted that their asexuality is experienced as a healthy and as a social identity. The anticipation of being rejected or pathologized became a deterrent away from treatment for several, while others still pursued assistance. Among those who had seen a primary physician or attended psychotherapy, many reported salient moments of acceptance and openness on the part of their provider. Participants in this study also highlight how becoming asexual was a difficult process and that many consider the possibility of a physical or mental abnormality that contributes to their lack of sexual attraction or desire. This coincides with previous findings that lacking positive representations of asexuality negatively impacts how one learns to recognize themselves as sexual (Prause & Graham, 2007; Scherrer, 2008). In addition, a number of participants shared both the advantages and disadvantages of being asexual. Foster and Scherrer (2014) suggest several strategies for providing affirming and culturally sensitive care for asexual clients including, acquiring knowledge about asexuality, learning appropriate intervention skills, and addressing personal biases that may interfere with the work. These researchers concluded that practitioners and researchers are well positioned to become allies to asexual clients in providing an open and affirming environment as well as conducting research that assists asexual community visibility efforts. This point acknowledges psychology’s role in historically problematized asexuality but
emphasizes the ways in which the field and its research can play a positive role by presenting communities with information in which they actually see their experiences reflected.

Similar to Scherrer (2008) and Haefner (2011), Van Houdenhove, Gijs, T’Sjoen and Enzlin (2015) capture the experiences of some asexual women in three themes: coming to an asexual identity, experiencing physical intimacy and sexuality, and experiencing love and relationships. In semi-structured interviews, participants were asked several questions regarding their sexual practices and experiences including, satisfaction with sexual lives, and if they had disclosed their asexuality to anyone. Participants included nine Dutch-speaking women between the ages 20 and 42. Most women in the sample were single, religiously affiliated and had some higher education. Seven out of the nine participants were ‘out’ as asexual. Researchers highlighted that among those who have had been sexually active did so out of curiosity but none found their first sexual experience to be pleasurable. They speculated that asexual women may have difficulty becoming mentally aroused which is consistent with the lack of activation hypothesis supported in Prause and Harenski’s article (2014). This study also corroborates earlier quantitative data that suggests a relationship between negative sexual experiences and asexuality (Hoglund et al., 2013). This article also reiterates how a conflation of love and sex, social pressures to engage in sex, and lack of awareness of asexuality are a significant source of stress for asexual people.

Attempting to synthesize data from these studies into a coherent and logically product, parallels much of the process of attempting to characterize asexuality. As noted throughout, several of the studies contradict each other on the various demographic factors such as age, gender distribution, and educational level. However, asexuality being experienced as a positive identity though there is associated stress in the process of becoming is an overarching theme.
among all studies. The notion of asexuality as a healthy variation of human sexuality, as opposed to a sexual dysfunction, has numerous implications given the current social context. At the moment, asexuality is gaining some traction and social space to be a viable possibility. Though it may be difficult to identify how a person may become asexual (outside of self-identifying as such) common social experiences can be gleaned from both the etiological and phenomenological studies.

In addition, it is notable that, several significant psychosocial factors are indicated as salient demographic variables to attend to in asexuality studies. Specifically culture (Hoglund et al., 2015; Owen, 2014), gender (Pryzbylo, 2014; Van Houdenhove et al., 2015), and religion (Aiken et al., 2013; Bogeart, 2004) are among variables that have to be articulated as influential in the personal experiences of asexuality. Similarly, there is some evidence that future work should attend to the intersection of these identities, particularly gender and ethnicity (Aiken et al., 2013). However, diversity and heterogeneity of asexual communities is incorporated into how asexuality is understood although it is not often explicitly articulated or attended to. In a fact, many studies are conducted with samples of White women between the ages of 18-30 (Foster & Scherrer, 2014; Yule, Brotto, Grozalka, 2013). Failure to incorporate these salient characteristics when discussing asexuality and asexual communities coupled with an over reliance on possible stereotypes of asexual people (Chasin, 2011) are ways that researchers themselves participate in and contribute to the marginalization of asexuality. With the exception of Haefner (2011), few empirical researchers have explicitly explored the nature of distress among asexual people and its possible sources.

**Sexual Normativity**

Asexuality is marginalized based on its failure to adhere to hegemonic sexual scripts. One
of those sexual scripts is heteronormativity, which “regulates those within its boundaries as it marginalizes those outside of it” (Martin & Kazyak, 2009, p. 316). Implicit in heteronormativity are assumptions of monogamy, penetrative heterosexual sex and compulsory sexuality (Hanson, 2014; Przybylo, 2014; Scherrer, 2010a, 2010b). Whereas LGBT individuals exist in a society of heteronormativity (e.g., cultural bias in favor of heterosexual relationships over relationships among gender and sexual minorities; positions heterosexuality as the norm), asexuals exist in a society of ‘sexual’ norms in which significant emphasis is placed on sex. Like heteronormativity, sexual normativity highlights sexuality as subject to normative processes (Gupta, 2013; Sundrud, 2011). Sexual normativity is the unchallenged ideology that normalizes sexuality as a universal trait and privileges sexuality above non-sexuality and asexuality (Carrigan, 2012; Chasin, 2011; Hanson, 2014) and promotes having sex and sexuality as central to one’s self-concept and fundamental humanity. Sexual normativity is based a “ubiquitous affirmation of sex” (Carrigan, 2012, p. 474). Conceptualizing sexuality and sex cultural institutions encompasses the pervasiveness of sexuality and its resistance to exposure as an oppressive force. This pervasiveness is illustrated through the scientific and empirical study of sex because it has produced the “master narrative of sexual normalcy” that ascribes normal sexual functioning to the meaning of being human (Flore, 2014, p.19). Compulsory sexuality (Bishop, 2013; Chasin, 2013; Emens, 2014), sexusociety (Przybylo, 2011), and erotonormativity (Hanson, 2014) are all terms that have been used to refer to this and other similar phenomenon. For example, compulsory sexuality is used to refer to the cultural assumption everyone is defined by some kind of sexual attraction (Emens, 2014) and may be used interchangeably with sexual normativity throughout this dissertation.
When sexuality is seen as normative, it becomes immediately conflated with positive human disposition or health and seen as a “prerequisite for human flourishing” (Carrigan, 2012, p. 474). Sexual normativity works insidiously by privileging sex above other forms of intimacy, reiterating that the sexual-self is the only viable self, while making sexual behavior healthy and preferred, and placing the perceived sincerity of romantic relationships on sexual consummation (Pryzbylo, 2014). Thus it becomes imperative that one be sexual in order to be considered a fully functioning person in the world or else be considered deficient or deviant. Asexuality scholars attribute the rise of sexual normativity to sexology’s contributions to health and clinical disciplines (Flore, 2013, 2014). Though there are models of sexuality that include asexuality (Storms, 1978), laden in most models and their interpretations is the assumption that all people should have some attraction or desire for another person either romantically and/or sexually though this may not be the case. As a result, these models are critique for their tendency to misconstrue difference as deviance or deficiency (Herek, 2010). The clinical implications of compulsory sexuality will be discussed later in this dissertation.

These are not the only ideological frameworks that affect asexual people. For example, Chasin (2013) identifies homophobia and transphobia as oppressive forces that affect asexual people. In addition to perpetuating heterosexism and policing gender identity and presentation, these ideological frameworks also eclipse asexuality by making the presence of sexual attraction, desire, and frequent sexual activity normative. Thought the literature problematizes these forces as potential producers of psychological distress among sexual minorities, few attend to normative sexuality and its mechanisms of power and privilege.

Based on findings that asexual people often seek causes of their sexuality, Prause and Graham (2007) suggest that asexual people may feel forced to conform to hegemonic sexuality.
This may be an example of how asexual people internalize traditional notions of how to be a sexual being in the world; which then may lead to stress for those who find themselves not fitting into this paradigm. The focus on heteronormativity and compulsory sexuality, contributes to the erasure of non-binary experiences such as bisexuality, pansexuality, and asexuality. The term *sexual prejudice* may be a better term to identify negative attitudes based on sexual orientation across the board (Herek, 2000). However, for asexual individuals, this may be insufficient due to the fact that is difficult to conceptualize a lack of behavior.

In the presence of sexual normativity, abnormality and dehumanization arise as prominent themes related to marginalization and stress for asexual people. For example, asexual people are subject to public and scientific scrutiny and, potentially, diagnosed for treatment while sexuality remains an invisible norm (Chasin, 2013; Przybylo, 2011). Thus, sexual normativity is at the core of asexual invisibility and erasure (Hanson, 2014) and makes asexual prejudice possible. *Asexual prejudice* will be used to denote asexuality-specific sexual prejudice. A similar term, ‘asexophobia’, has been used to refer to the irrational fear of asexuality (Kim, 2014). However, this term is limited in its implications. Asexual prejudice is related to, yet not, synonymous with heteronormativity or compulsory sexuality. While compulsory sexuality represents the normative belief that the sexual self is the only viable and healthy self, asexual prejudice manifests as both conscious and unconscious bias that asexual people are comparatively inadequate.

Interestingly, the onus of shedding light on disparities, ill-fitting paradigms, binaries, and other manifestations of problematic hegemony is often placed on those who these mechanisms fail to speak for. Here, asexuality helps to undermine sexual normativity in its most basic form (everyone is sexual attracted to someone) and also pushes against normative
monogamy, erotic acts, and intimacy. However, the unseen and insidious nature of compulsory sexuality misconstrues asexuality in a cycle of erasure and invisibility such that society continues to operate as though asexuality does not exist (Chasin, 2015). As a result, sexual people often go unaware of asexuals’ experiences. Further still, potentially asexual people go unaware of the possibility of being asexual and risk internalizing negative messages about themselves as “broken.” As a result they unconsciously reestablish sexuality as the norm. In addition to the theoretical work specifically outlining mechanisms of power driven by compulsory sexuality, the creation of validated measures and instruments can concretize and quantitatively document this invisible force.

**Subtle Discrimination**

In the context of heteronormativity, heterosexism, compulsory sexuality, ace and potentially asexual people may be subject to discrimination. Asexuality deviance is predicated on a lack of normative sexuality that makes it less visible in comparison to non-heterosexuals. In addition, there are socially acceptable scripts for non-sexuality, which may suggest that asexual people are not subject to the same levels of asexophobia as gay men and lesbians experience homophobia and bisexuals experience biphobia. Thus subtle forms of discrimination may be a better way to describe incidences of asexual prejudice.

Research with marginalized groups has demonstrated that subtle discrimination can have as much of a deleterious effect as overt discrimination. In a study examining heterosexist remarks overheard by LGB people (not directly spoken to them), Burns, Kaldec, and Rexer (2005) found that participants were still offended by the statements provided in the study. Participants were asked to rate the level to which they felt offended by a given scenario (e.g., a heterosexual calls a man who is crying a “fag”). Not only did respondents find the scenarios to
be offensive and indicative of prejudice, but also perceived offensiveness was associated with a decreased likelihood of coming out. In comparison to gay men, lesbian women and bisexuals found the scenarios more offensive and more indicative of prejudice. These results indicate that even non-direct experiences of oppression can be negatively impactful on the lives of non-heterosexuals.

Increasing intolerance for overt discrimination has allowed researchers to attend to subtle forms of discrimination. For example, using a sample of social workers, Berkman and Zinberg (1997) found that, though participants were less homophobic (less explicitly biased against homosexuality), they still held heterosexists beliefs (implicit bias towards heterosexuality as the norm). They used these findings to illustrate the shift away from overt biases towards sexual minorities and towards covert bias perpetuated by oppressive worldviews. This study also detailed the development of the Subtle Heterosexism Scale (SHS) to measure instances of subtle discrimination (Berkman & Zinberg, 1997). Similarly, the Heteronormative Beliefs and Attitudes Scale (HBAS) was created to assess heteronormativity and its influence (Habarth, 2015). Taken together, the HBAS and the SHS illustrate the need for measures that quantify experiences with sexual prejudice and help to demonstrate how sexual hierarchies misconstrue human diversity and complexity.

**Microaggressions.** Perhaps the most well known term for subtle discrimination is *microaggression* (Sue et al., 2007; Solorzano, Ceja, & Yosso, 2000). Microaggressions are the often subtle, verbal, visual and environmental slights made towards another group. Beginning with the work of Chester Peirce and colleagues (1978), racial microaggressions literature has proliferated. Currently there is documentation of microaggressions towards monoracial groups including African Americans (Constantine, 2007; Franklin, & Boyd-Franklin, 2000), Asian
Americans (Sue, Bucceri, Lin, Nadal, & Torino, 2009), and Latino Americans (Rivera, Forquer, & Rangel, 2010), as well as multiracial groups (Johnson & Nadal, 2010; Nadal, Wong et al, 2011) have found similar themes regarding these indignities. In addition to race, microaggressions based on gender (Capodilupo, Nadal, Corman, Hamit, Lyons, & Weinberg, 2010), disability status (Keller & Galgay, 2010), and religious minorities (Nadal, 2008) has been conducted.

Microaggressions can be classified into three categories: microassaults, microinsults, and microinvalidation (Sue et al., 2007; Nadal, Issa, et al., 2011). Microassaults, most akin to traditional, overt, types of discrimination, are defined as explicit, derogatory statements or gestures deliberately used to demean a person. Unconscious communications (either verbal or non-verbal) meant to be insulting or belittling to a person are considered microinsults. Microinvalidations are also considered to be unconscious and include communications that exclude, negate, or nullify the realities of individuals of oppressed groups (Sue et al., 2007). This taxonomy of microaggressions makes it evident how social-minorities are subject to representativeness bias and erroneously homogenized and invalidated.

**Sexual Orientation Microaggressions.** Next to race, the next largest theme among microaggressions literature is that describing the experiences of lesbian, gay and bisexual people (LGB; Nadal & Griffin, 2011; Nadal, Issa, et al., 2011; Nadal, Wong, et al., 2011; Platt & Lenzen, 2013; Sarno & Wright, 2013; Shelton & Delgado-Romero, 2011, 2013; Wright, & Wegner, 2012). More recently, transgender microaggressions have been articulated (Nadal, Skolnik, & Wong, 2012). In addition, research has begun to include intersections of identities and microaggressions (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). In these studies, microaggressions are experienced in a variety of settings including clinical and counseling,
family, school, and work. Nadal and colleagues (2010) created an initial theoretical taxonomy of microaggressions specifically for lesbian, gay, bisexual and transgender (LGBT) people of included eight themes including:

- Use of heterosexist and transphobic terminology occurs when someone uses derogatory heterosexist language toward LGBT persons.
- Endorsement of heteronormative or gender normative culture/behaviors transpires when an LGBT person is expected to act or be heterosexual or gender conforming.
- Assumption of universal LGBT experience occurs when heterosexual people assume that all LGBT persons are the same.
- Exoticization microaggressions take place when LGBT people are dehumanized or treated as objects.
- Discomfort/disapproval of LGBT experience occurs when LGBT people are treated with disrespect and criticism.
- Denial of societal heterosexism or transphobia transpires when people deny that heterosexism and homophobia exist.
- Assumption of sexual pathology/abnormality microaggressions come about when heterosexual or nontransgender people oversexualize LGBT persons and consider them as sexual deviants.
- Denial of individual heterosexism/transphobia occurs when non-LGBT people deny their own heterosexist and transgender biases and prejudice (Nadal, Issa et al., p.237).

Three additional themes have also emerged in the literature as part of sexual minority everyday experiences: undersexualization (i.e., surface level acceptance of same-sex affection), microaggressions as humor (i.e., humor used to reduce the impact of the statement), and threatening behaviors (i.e., assaults and other aggressive behavior) (Nadal, Issa, et al., 2011; Platt & Lenzen, 2013). Wright (2012) also identified eleven types of microaggressions that will be discussed in greater depth later in this section.

Experiencing microaggressions, across types, has been positively linked with measures of psychological distress such as self-esteem (Wright & Wegner, 2012) as well as processes such as identity disclosure (Platt & Lenzen, 2013) and identity development (Nadal, Issa, et al., 2011). Invisibility and ambiguity of negative messages can lead to self-question which may give way to
an overall negative self-concept. Microaggressions pervasively manifest because they are often invisible, or out of conscious awareness, to both the perpetrators and the microaggressed (Nadal, Rivera, & Corpus, 2010). Thus microaggressions are perpetuated by nearly everyone, and are by definition, often unconsciously committed by well-intentioned or well-meaning people (Banaji, Hardin, & Rothman, 1993; DeVos & Banaji, 2005; Sue et al., 2010). As previously highlighted, asexuality is used as tool to marginalize people of color and those living with disabilities. Expecting that a person may be asexual because they are Asian or a person with a disability are racist and ableist microaggressions. However, the impulse of an Asian person or a person with disability to reject asexuality on the basis that one is “normal” is also an asexual microaggression and manifestation of sexual normativity (Kim, 2014). Among these studies, ideological frameworks such as racism, sexism, and ableism are implicated as the attitudinal biases that underlay microaggressions. However, none conceive of nor attend to the possibility of asexual microaggressions.

Though using previous LGBT frameworks for work on asexuality has been problematized earlier in this dissertation, it is necessary to briefly identify how these experiences of have affected other sexual minorities in order to delineate experiences that may be unique to asexuality as well as those that may overlap. The implications of this research are not only related to experiences of asexual people, but also arguably important for all people regardless of identity or experiences. Currently there are two scales describing the microaggressions that LGBT people experience: homonegativity microaggressions (Wright, & Wegner, 2012), and LGBT people of color microgressions (Balsam, Molina, Beadnell, Simoni, & Walters, 2011).

The Homonegative Microaggressions Scale (HM) was developed using Sue’s taxonomy of microagression (Wright & Wegner, 2012). It consists of 45 items distributed among 11
themes pulled from prior microaggressions literature including: (1) microinvalidations, (2) microinsults, (3) microassaults, (4) alien in own land (e.g., “How often have people assumed you were straight?”), (5) ascription of intelligence (e.g., “How often have people assumed you were skilled in stereotypically gay tasks), (6) color blindness, (7) criminality/assumption of criminal status, (8) denial of individual racism, (9) pathologizing cultural values/communication styles, (10) second-class citizen, and (11) environmental microaggressions. Respondents were asked to rate both past and current frequency and impact on two 5-point Likert-type scales. Researchers concluded that the HM is a reliable measure of experiences and related to similar measures of discrimination and prejudice as well as mental health outcomes such as self-esteem. Notably, a later study highlights the “alien in own land” type of microaggression as most prevalent among bisexual men and women as compared to gay men and lesbians (Sarno & Wright, 2013).

Using themes culled from a qualitative study, Balsam and colleagues (2011), created the LGBT People of Color Microaggressions Scale (LGBT-PCMS). This measure consists of 18 items grouped into three subscales: (1) Racism in LGBT communities, (2) Heterosexism in Racial/Ethnic Minority Communities, and (3) Racism in Dating and Close Relationship. Researchers note the measure’s good reliability and indicate appropriate links to psychological distress. Respondents were asked to rate their level of distress and the frequency of examples on a 5 point Likert-type scale. Interestingly, they also note that significant gender, sexual orientation and ethnicity differences among the participants such that men (compared to women), Asians (compared to other ethnic groups), lesbians and gay men (compared to bisexual men and women) were scored higher on this scale. This is the first study to address microaggressions that occur across identities, in doing so; researchers highlight some of the complexity of LGBT experiences. Particularly, the experience of being simultaneously microaggressed on multiple
dimensions is an important finding that can be linked to asexual people who experience prejudice from both heterosexual and non-heterosexual communities.

At face value, some of these specific themes appear to coincide with experiences of asexual people. In particular, assumption of sexual pathology/abnormality, undersexualization, microaggressions as humor, and threatening behaviors, alien in own land, second-class citizen, and environmental microaggressions all illustrate the potential for overlap between LGBT and homonegative microaggressions and asexual ones. However, these scales are missing key dimensions of microaggressive experiences that are unique to asexual people above and beyond those experienced by LGBT people. Thus a multidimensional approach to scale development to understanding these microaggressions and asexual prejudice is necessary to capture this complexity.

**Asexual Prejudice**

Asexual prejudice encompasses anti-aexual attitudes and beliefs that affects both asexual-identified people and potentially asexual people. Research posits that, though conceptually similar to LGBT people in regard to experiences of stigma, asexual people are not persecuted in the same way via institutional structures such as religion, marriage, or law (Bogeart, 2004; Chu, 2014; Emens, 2014). Etiological studies of asexuality allude to discrimination in discussion of psychosocial and environmental factors that may contribute to the individual recognition of asexuality; conversely, phenomenological studies highlight how these factors are interpreted and therefore experienced by asexual people. As noted previously in this dissertation scientific interest is one form of recognition of asexuality as a viable sexual orientation (Scherrer, 2008). Though this form of recognition is important, it is insufficient in capturing these experiences of discrimination and prejudice primarily due to failure to reflect and
acknowledge ways that analyses can undermine many asexual people’s experiences (Chasin, 2015). Documentation of asexual prejudice is scarce, however there are two notable studies that provide concrete examples of how this construct manifests.

In a two-part experimental study, MacInnis and Hodson (2012) document that anti-LGB prejudice is also directed at asexual people, and that there appear to be more biases against asexuals as compared to other sexual minorities. The sample for Study 1 included 148 participants while Study 2 included 101 participants. Most participants resided in Canada or the United States (98%), were not students (70%), and were employed (66%). In addition, women significantly outnumbered men in both studies. Their study examines the potential bias against asexuals given the perception of asexuals as “deficient” or abnormal because of their lack of something that was been deemed one of the most basic human drives and needs. Compared to a lesser-known sexual orientation, sapiosexuality (e.g., sexuality in which sexual attraction is based on intellect or intelligence), heterosexuals demonstrated more bias and prejudice towards asexuals. In conclusion, researchers state that asexual people are met with indifference because their identity is based on the lack of behavior versus the possession of or active participation in ‘deviant’ behaviors (Emens, 2014; MacInnis & Hodson, 2012).

To date, only one empirical study examines the direct experiences of stigma for asexual-identified individuals. Gazzola and Morrison (2011) describe experiences of discrimination faced by asexual individuals using a sample of 39 asexual-identified people recruited vis online techniques. The small sample was overwhelmingly White (85%), hetero-sexual (88%), and female (67%). To assess for discrimination, the study modified the Heterosexual, Harassment, Rejection, and Discrimination Scale (HHRDS; Syzmanski, 2006) and asked participants to rate how stressful each experience was on a scale from 1-10. In addition to the HHRDS, researchers
used the *Outness Inventory* (OI; Mohr & Fassinger, 2000) to assess disclosure and concealment of asexual identity. Findings suggest that asexuals predominantly experience verbal insults either heard directly or indirectly and in the form of derogatory names or anti-asesexual remarks. However, the majority of participants did not find these experiences to be particularly stressful. Out of a possible 10, verbal insults were deemed the most stressful occurrences of discrimination with an average rating of 4.67. Among participants who were “out” to new and old heterosexual friends, old non-heterosexual friends, parents, and romantic partners were the main individuals to receive this information. However, researchers found that those who were more “out” also experienced more discrimination. Strikingly, 65% of sample indicated that most items were “non-applicable.” This finding indicates that, despite their attempt to make the measure more applicable to this population, the measures were not sensitive enough to reveal nuanced experiences. Taken together, most instances of discrimination were subtle, verbal and independent of one’s level of outness (Gazzola & Morrison, 2011). Therefore, the best way to understand bias towards asexual people may be to examine microaggressions.

Of note, several qualitative studies have identified numerous ways that discrimination towards asexuality manifest despite this not being the primary research question. For example, among three hetero-acesexual men in Canada, Przybylo (2014) found that discrimination is experienced in the form of social exclusion and isolation, disbelief and invalidation of their asexual identification, unwanted sex, bullying and teasing. Prause and Graham (2007) identified four attributes that are most often associated with asexuality—both by (potentially) asexual people and sexual people: (1) a psychological problem, (2) a very negative sexual experience, (3) no/low sexual desire, (4) no/little sexual experience. Although the first and second attributes overlap with microaggressions identified towards LGBTQ people, the latter two are unique to
asexual people’s experiences. In addition, asexual community activist and writer (known predominantly as ‘Swank Ivy’), Julie Decker (2014) identifies several areas of discrimination within the legal system including: consummation laws, adoption denial, employment and housing discrimination, discrimination by mental health professionals, and unavailability of marriage equivalents (Decker, 2014). Of this list the one institution that has been documented as a promoter of sexual assumptions, is the medical or clinical field. Foster and Sherrer (2014) found that asexual-identified people had numerous fears about disclosing their asexuality to primary care and mental health providers due to the history of pathologization throughout medical and psychological history. For example, Ana, a participant from the study states, “Telling [practitioners] that I consider myself asexual is risky; I don’t want to be treated like I have a problem” (Foster & Scherrer, 2014; p. 422). Statements such as Ana’s illustrate discriminatory experiences that asexual people face. Thus, as increases in individual and collective visibility of asexuality are made there may be more evidence of intense rejection and invalidation.

Similarly, misrecognitions and erasure may have a distressing impact on the wellbeing of asexual people. In a critical essay entitled, The Politics of Recognition, Charles Taylor (1994) writes:

“A person or group of people can suffer real damage, real distortion, if the people or society around the mirror back confining or demeaning or contemptible pictures of themselves. Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being” (p. 25).

Misrecognition is the process through which a person’s image or experience are misconstrued or
subjected to distortion. For example, stereotyping is one form of misrecognition that occurs among marginalized groups including asexuals. Furthermore, visibility and erasure characterize experiences of asexual prejudice. Despite endeavors to empirically identify experiences of discrimination among asexual people, these means are ill fit and theoretically inappropriate for the investigation of asexuality. As indicated in this review, there is a need for not only more research with asexual people but also research that is sensitive to the unique aspects of asexual experiences. One step towards addressing this issue is by creating a measure to capture the microaggressive experiences.

**Asexual Prejudice as Microaggressions**

Compared to lesbian and gay people, microaggressions may look different for asexual and potential asexual people due to sexual normativity and are related to social invisibility and erasure (by misrecognition). In addition, these two dimensions may be broken down into more nuanced categories including (1) denial of legitimacy, (2) conflation with LGBTQ experience, (3) harmful visibility, (4) expectations of sexuality, (5) assumption of pathology, and (6) presumed transience. Social invisibility and erasure are further defined and illustrated in this section; moreover, these two dimensions and their categories will guide the creation of the final scale.

**Dimension 1: Social Invisibility**

As a consequence of sexual normativity, individuals who do not follow the specified social scripts for sexuality (i.e., to be *sexual*) are rendered invisible. *Social invisibility* is a state of being unseen or lack of acknowledgement that creates an invalidating environment for asexual and desexualized people. Social invisibility is pervasive, oftentimes ubiquitous, and is deeply felt within asexual communities. The difficulties of navigating visibility are well documented in
qualitative research on asexuality (Carrigan, 2011; Foster et al., *in preparation*; Foster & Scherrer, 2014; MacNeela & Murphy, 2014; Scherrer, 2008). Most significantly, all of these studies document the ways in which being socially invisible requires asexually identified people to constantly need to defend their experiences (or lack of experience) and bear the burdens of social alienation. For example, a 20-something year old female participant in MacNeela & Murphy’s (2014) study, stated, “Most of the time, people find away to dismiss asexuality so that they can continue to claim that all human beings are fundamentally sexual creatures” (p.783). This dismissal reaffirms compulsory sexuality, negating this participant’s lived experience, bringing to mind issues regarding coming out as asexual. Social invisibility manifests in microaggressions pertaining (1) a denial of legitimacy, (2) conflation with LGBTQ experiences, (3) harmful visibility, and (4) expectations of sexuality.

**Category 1: Denial of legitimacy.** This category of microaggressions refers to reactions of others that suggest that asexuality is not a legitimate sexual orientation or identity. Most often, this occurs in the context of disclosure. Disclosure emerged as a recurrent theme among qualitative studies on the subject of asexual prejudice and discrimination was the role of identity disclosure and concealment. There appears to be a general sense of ambivalence related to the subject among asexual-identified people. Some indicate needing and wanting to come out to their partners, friends and family members; while others held that “coming out” is not that important to them (Chasin, 2013; Foster & Sherrer, 2014; Haefner, 2011; Scherrer, 2008). In this context, the notion of “coming out” may be inadequate in describing the experiences of asexual people because sexual assumption forecloses on the possibility of a person being anything but sexual. To illustrate, a 20 year-old female states,

Asexuality is very much closeted and I don’t feel capable of discussing it with other
people, even close friends or family members… it leaves me feeling isolated… I don’t have a local support network who understands what I am going through (Murphy & MacNeela, 2014, p. 804).

In short, it is difficult to come out within context where your identity will be disregarded and invalidated. For an asexual-identified person being out or the process of coming out may also be stressful for them due to the sudden confrontation with their own marginality. However, remaining concealed keeps one from being an active threat to sexual normativity and instead, poses a significant threat to one’s self-concept or community which does motivate some to disclose their identities to combat social invisibility (Foster et al., in preparation; MacNeela & Murphy, 2014).

**Category 2: Conflation with LGBTQ experiences.** Microaggressions in this category are based on the sexual normative belief that sexuality—both heterosexual and non-heterosexual—is the norm and thus eclipses the possibility of asexuality and conflates the confusion around their assumed sexuality with other sexual identities. This asexual possibility is simply the consideration that a person may be asexual (Hanson, 2014). Sexual normativity makes it so that asexuality is not possible but there are cultural scripts for what is possible namely hetero-and non-heterosexuality. Most often this manifests when a person is told to consider if they were gay or lesbian but can also come from within an asexual person. For example, Lucille, a 20-something year old female participant in Haefner (2011) shared, “[I knew] I was not heterosexual because I never had any feelings for males” (p. 90) and for lack of knowledge about asexuality, she adopted an ill-fitting lesbian identity. Lucille’s experience highlights the unattainability of an asexual identity because asexuality does not exist as a viable possibility because it is not afforded the space to do so. Normative sexual identities are the only possible
options outside of heterosexuality. In addition, as a part of the identity development process of coming to an asexual identity (Carrigan, 2011; Decker, 2014; Scherrer, 2008), many asexuals consider the possibility of being gay, lesbian or bisexual. It has been suggested that the global concern for LGBTQ rights may overshadow asexuality and contribute to their invisibility (Aiken et al., 2013). Therefore, the “social space for asexuality as an intelligible alternative” is radically reduced (Chasin, 2013, p.171). Unintelligibility refers to being beyond the realm of possibility and underlies a significant portion of asexual prejudice.

**Category 3: Harmful visibility.** This theme of microaggressions captures asexuality marginalization through misrepresentation or lack of representation, distortion and general stereotyping particularly of potentially asexual characters in the media (Ceranowski, 2014). Colton a 15-year-old respondent in a recent Buzzfeed (2014) article about the needs of asexual people states,

> Our media representation is virtually nonexistent. The vast majority of asexual characters that are in major media are not confirmed to be, and basically all of the officially ace [asexual] characters are either psychopathic or don’t experience sexual attraction until they find The One. If you’re going to have a bi person on your show, don’t portray them as sex-crazed maniacs who can’t establish a lasting relationship...

Representation of asexuality often stems from stereotypes about what people think asexuality is, perpetuating harm visibility for asexual people over all. Visibility is also problematic in some ways due to physical harm result from becoming “too visible.” Corrective rape is the idea that a person’s “sexual abnormality” can be (erroneously) cured through sex with that person (Chasin, 2013; Decker, 2014).

**Category 4: Expectations of sexuality.** This category captures the crux of sexual
normativity’s influence in society and demonstrates an endorsement of sexual normative culture and beliefs. Microaggressions of this category manifest in accusations, insults, coercion and physical harm pertaining to the expectation that a person should be having sex or identify with sexuality. Decker has been discussing this issue for some time, in one interview she states,

I just want to help you,’ he called out to me as I walked away from his car. …He was basically saying that I was somehow broken and that he could repair me with his tongue and, theoretically, with his penis. It was totally frustrating and quite scary” (Mosbergen, 2013).

Coercion can occur within the context of relationships as well, such that, inequality between asexual-sexual relation is inevitable. This inequality manifests in subtle to covert sexual coercion (Chasin, 2014). Engaging in unwanted or feeling obliged to be sexually active with a partner is a salient stressor for some asexual people (Chasin, 2014; Pryzbylo, 2014). For example, Wilfred, a participant in Pryzbylo’s qualitative exploration of asexual men and masculinity, states, “[Sex was] mostly to please another person, you know…but after a while I felt like sex is the most important thing” (p. 231). This category of microaggression reiterates the possibility of internalization of sexual normativity while also indicating how an environment or role can be invalidating by virtue of its expectations of sexuality.

**Dimension 2: Erasure (by Misrecognition)**

Erasure is conceptualized as a being seen but misrecognized and has negative effects on the experiences of asexual people similar to invisibility. This concept of “misrecognitions” and distortion is reiterated numerous times throughout *Asexualities*, a volume devoted to queer and feminist perspectives on asexuality (Ceranowski & Milks, 2014). The examples provided include media representation, book and television characters or narratives, medical diagnostic
terminology, and disability discourse. In these examples, asexuality is misrecognized as something that is biologically or psychologically amiss, as a consequence of trauma or negative initial sexual experience and through research methodology. Erasure manifests in two significant ways: (1) assumption of pathology, and (2) presumed transience.

**Category 1: Assumed pathology.** In this category, asexuality is seen as something repaired through a wide variety of methods including hormonal treatment, psychotherapy, and/or violent methods such as “corrective rape” (Chasin, 2014; Decker, 2014). The most recognizable example of this is in so-called “reparative therapies” which seek to repair the assumed sexual dysfunction (Chasin, 2013). Viewing asexuality in this way creates a dichotomous view of health: that heterosexuality is health and non-heterosexuality and asexuality are unhealthy. Asexuality is most often misrecognized as pathological, as either a biological dysfunction or a psychological symptom (Prause & Graham, 2007; MacNeela & Murphy, 2014). This category captures how, asexuality is pathologized as deviance and invalidated as a socially unacceptable form of sexual identification. Further more, asexual people are seen as those who are “broken” due to their inability to maintain social norms (Foster & Scherrer, 2014). Statements such as “are you sure you aren’t depressed?” are indicative of this source of microagression (Decker, 2014). Also, participant Dov states,

> However, just because people who this might be a “problem” for exist, doesn’t mean that it should be assumed to be a problem for everyone . . . It doesn’t cause me distress so why try and pump me full of drugs and convince me it is a problem” (Foster & Scherrer, 2014, p. 426).

Perhaps, an additional way that asexuality suffers erasure via pathology is through how researchers go about studying and discussing asexuality. The methods used in these studies focus
primarily on the physical aspects of sexuality. The use of medical measurements and psychiatric diagnostic categories reinforce sexuality as healthy and asexuality as deficient (Flore, 2013, 2014). As noted before, empirical articles seem to perseverate on discovering “a true nature of asexuality” where there may not be one; or attempting to expose the secret behind asexuality (Hanson, 2014). Looking for reasons why one might be asexual or how asexuality might be sexuality under disguise undermines agency of self-identification. Although understanding pathways to and characteristics of asexual people are important parts of validating their uniqueness—some of the methods used have been evasive and problematic because they normalize of sexual attraction and desire and, therefore, pathologize asexuality.

**Category 2: Presumed transience.** These microaggressions manifest in statements that emphasize asexuality as a “phase.” For example, being seen as in a state of sexual immaturity (Ceranowski & Milks, 2010; MacNeela & Murphy, 2014; Milks, 2014), a consequence of abuse (Decker, 2014; Prause & Graham, 2007), or “regressively pre-sexual or traumatically post-sexual” (Barounis, 2014, p. 180; Bogeart, 2004) are all ways that asexuality is misconstrued as something it is not. Not only is pre-sexuality problematic because it implies sexual immaturity, but it also implies that one is not yet fulfilling an expectation of their role as human (Milks, 2014). To put it eloquently, Jas, 16-year-old respondent states, “I would love for people to understand that asexuality is not just a phase, and there is nothing wrong with identifying with that way” (Buzzfeed, 2014). This form of microaggressive erasure coincides with erasure via pathologization because immaturity is a problem with an accessible solution; pre-sexual asexuality is cured when a person exercises their sexual agency (i.e., engaged in purposeful sexual activity; Chasin, 2013).

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4 This is explicitly stated as a limitation in Brotto et al., 2010.
Impact of Microaggressions

Experiencing sexual orientation microaggressions has been linked to higher psychological distress (Nadal, Issa et al, 2011; Platt & Lenzen, 2013; Sarno & Wright, 2013. Similarly, asexual people experience these constant slights against them as distressing (Chasin, 2013; Decker, 2014). As described previously, differentiating asexuality from diagnosis such as HSDD is reduced to a question of distress. Medical models often suggest that asexuality is a result of distress; however, there have been findings that suggest that asexually identified people are not distressed by their asexuality, but rather the social consequences of that identification. Brotto and colleagues (2010) found the majority of asexual people expressed no distress with their asexual identity and more recently reiterated these findings (Brotto, Yule, & Gorzalka, 2015b). While Prause and Graham (2007) also found no more sexual distress among asexuals than non-aseexuals, they remain curious about the “extent asexuality is problematic in the absence of individual, personal distress” (Prause & Graham, 2007, p. 353). For example, as noted before, other researchers have suggested that personal or subjective distress may occur in the absence of sexual attraction but in the context of a psychiatric diagnosis (Aiken et al., 2013). This section describes several studies that provide evidence of distress and begin to fill the void regarding the nature of this distress (Chasin, 2013).

Though inappropriately portraying asexual people as “dysfunctional,” one early mental health and sexual orientation study found that asexual people reported the highest rates of emotional difficulty compared to lesbian, gay, and bisexual students (Nurius, 1983). However, the same study demonstrated similar endorsement of depressive symptoms and low self-esteem among all sexual minority groups in the sample. Interested furthering discourse regarding distress, researchers investigated psychological distress and interpersonal functioning among
asexual identified people and found that interpersonal problems and mental health correlates occur at similar rates among non-heterosexual samples (Yule, Brotto, Gorzalka, 2013). For example, 26% of asexual participants reported suicidality compared to 24% of non-heterosexual participants in their sample. Asexual men had higher rates of mood disorders than heterosexual men; asexual women and men had higher rates of anxiety than heterosexual men and women. These researchers also provided evidence suggesting that asexuality can be conceptualized as or akin to Schizoid personality type from the *Diagnostic Statistical Manual, 4th Edition* (DSM-IV). Specifically, asexual people endorsed greater social inhibition, coldness/social distance with vindictive and exploitable personality styles. To explain this finding, researchers postulate that asexual people have avoidant attachment styles as children that may have lead to relationship issues as adults. Thus, researchers concluded that asexuality may not be the cause of these factors but may be a product of social functioning. Specifically, that “increased mental health problems may be a consequence of discrimination or a consequence of lacking sexual attraction in an environment that is arguably centered on sexuality” (Yule, Brotto, Gorzalka, 2013, p. 9).

Taken together, these studies demonstrate that asexual individuals may also experience psychological distress as a consequence of their marginalization.

Prior to this study, however, in investigations about mental health concerns among college students, differences between sexual minority groups including asexuality were illustrated. Drawing from two national surveys of college students who have visited counseling services, McAleavey, Castonguay, and Locke (2011) discuss mental health issues among sexual minority college students. This study boasts the highest percentage of asexual-identified individuals at 5.5%. Researchers found that asexual students had the lowest rates of utilization of college counseling services as compared to both heterosexual and non-heterosexual students.
These findings suggest that the needs of each of these groups may differ and require tailored services. In regards to their high percentage of asexual-identified people, researchers speculate that the numbers may be influenced by (1) self-identification as the mode of measure and (2) increase popularity of asexuality. Utilization rates may be low due to a number of factors, most significantly due to perceived asexual prejudice from practitioners (Foster & Scherrer, 2014) or the potential that asexual people may have less mental health difficulties as compared to other sexual minorities.

These results contradict significant findings in a similar study. Lucassen (2011) examined mental health issues regarding those who did not fit within the gay/straight binary using a New Zealand sample of college and high school students. This population based study consisted of over 8,000 participants, mostly below age 15, male and European. This study found that those who reported not being attracted to males or females were reporting significant depressive symptoms, deliberate self-harm, and suicidal ideation when compared to those who are attracted to others. These findings corroborate previous research demonstrating how asexual people may be more apt to experience psychological distress (Nurius, 1983). Combined with the results of McAleavey and colleagues (2011), it may be that distress is a function of time. It has been suggested that those who lack sexual attraction, but have yet to find community may experience more isolation, distress, and confusion (Brotto & Yule, 2009). In line with Yule and colleagues (2013), individuals who have yet to “come out” as asexual, may be in greater distress than those who have reached an integrated asexual identity.

Taken together, it may seem that asexual people may be experiencing similar rates of psychological distress and low self-esteem compared to other sexual minorities. However, they may not be seeking treatment at the same rates due to possible rejection or overpathologization
from clinical practitioners (Foster & Scherrer, 2014). Due to a paucity of research that measures asexual-related discrimination and stigma related experiences, it is difficult to confidently draw links between microaggressive experiences and psychological difficulties. However, based on the information provided, the common occurrence of microaggressions may result in higher levels of psychological distress (e.g., more depressive symptoms, social anxiety or lower self-esteem).

**Statement of the Problem and Hypotheses**

Sexual normativity creates an environment in which the very existence of asexuality or asexual people is undermined and invalidated. This oppressive mechanism erases the possibility of asexuality as a viable asexual orientation and renders it invisible based on common social scripts. These experiences are encompassed in the categories of microinsults and microinvalidation. With the exception of corrective rape, microassaults may not be as applicable in describing contemporary manifestations of asexual prejudice since they are more overt, offensive, and intentional. Therefore, microinvalidations and microinsults will be empirically investigated. In addition, studying the microaggressive experiences of asexual people will have theoretical and empirical implications for field of sexual orientation microaggressions as a whole. It remains to be seen whether there will be evidence of commonalities among microaggressive experiences across groups of sexual minorities.

Although the literature provides some insight into the issues that many asexual people experience, they do so through speculative and comparative means. The need for this specific research has been highlighted (Bishop, 2013; Hill, 2009; Yule et al, 2013). To date, only one study examines the direct experiences of discrimination for asexual-identified individuals. This is a significant gap in the literature on asexuality. Therefore, this study will lay the groundwork
for future exploration of the stigma-related stress for people who identify as asexual. This study found that most instances of discrimination were subtle, verbal and independent of if one was out or not (Gazzola & Morrison, 2011). Therefore, the best way to understand prejudicial attitudes and beliefs towards asexual people is to examine microaggressions. Specifically, asexual people may be more likely to encounter microinvalidations and microinsults with greater frequency and impact.

This dissertation had the following aims and hypotheses:

1. In Phase 1, an exploratory factor analysis (EFA) of items developed for the Asexual Microaggressions Scale (AMS) was expected to result in at least two dimensions: experiences of microaggressions that reflected (a) social invisibility and (b) erasure (by misrecognition) and evaluated with a sample of 369 participants.

   - Validity of the AMS was evaluated in Phase 1. Discriminant validity was examined through unrelated scores between the AMS and a measure of social desirability (SDS; Marlowe & Crowne, 1960; Reynolds, 1982). While convergent validity was evaluated through an observed positive relationship with stigma consciousness (SCQ; Pinel, 1999).

2. In Phase 1, the stability of the factor structure obtained using EFA was reevaluated using confirmatory factor analysis (CFA) with data from a second sample (n = 369). It was expected that the resulting factors would demonstrate strong to moderate relations with one another and reflect their assessment of distinct, but related aspects of asexual prejudice experiences. The internal consistency reliability of AMS factor items was evaluated with Cronbach’s alpha values of at least .70 were expected.

   - In support of convergent validity, AMS scores were expected to correlate
positively with measures of participants’ awareness of social attitudes towards their group (CSES; Luhtanen & Crocker, 1992), and previously used measures of discrimination and bias (HHRDS; Szymanski, 2006).
CHAPTER 3
General Method

Participant Recruitment

Participants were recruited online via various online forums, social networking sites and online communities—both those devoted to asexuality and those that pertain to related interests or identities. Social media sites or forums such as Facebook, Tumblr, Reddit and the Asexuality Education and Visibility Network (AVEN) were also used to recruit. In addition, participants were recruited by snowballing via contacts with asexuality-focused and allied researchers who then posted on various sites as well. Recruitment materials focused on “asexual spectrum” identities to promote inclusivity and to refrain from necessitating that one identifies as asexual to participate (though a person can). Across recruitment sites, Tumblr emerged as most prominent recruitment source (67.07%) followed by Facebook (14.63%), Reddit (7.59%), Twitter (6.78%), and email or newsletter (4.20%), with AVEN unexpectedly be the least endorsed recruitment site (2.71%).

From the online recruitment materials, participants were linked to the study survey. The link to the survey was entered a total of 1396 times, though initial clicks may have been to “check out” the survey and complete it later. Of the initial 1396 clicks, 738 individuals went into the analysis stage. Individuals who did not meet criteria (less than 18 years old, non-North American) or did not provide enough information to be included (greater than 20% data missing) were removed. Of note, people of color, particularly men of color took the survey less frequently than White women. Targeted recruitment efforts improved numbers of men of color; however, white women continued to take the survey. To improve representation of people of color within the sample, white women who took the survey after June 1st 2016 were removed.
Data cleaning and preparation procedures resulted in a final $N$ of 738. These cases were then randomly divided into two groups equaling 369. The demographic break down of these groups is presented in the sections devoted to each phase of this study.

**Procedures for Phase 1 and Phase 2**

All 738 participants participated in the online survey hosted by Qualtrics and were required to complete all measures. Qualtrics is a widely used, secure and HIPPA-compliant online survey database and data management system. The study was approved by the Teachers College IRB (Protocol #16-211). At the start, participants were required to read then acknowledge receipt of Informed Consent and Participants Rights before proceeding to measures. The survey battery included measures of social desirable responding, collective self-esteem, discrimination and bias experiences, consciousness of stigma, and level of identification as asexual as well as demographics. Allowing all participants to complete all measures will helped insure balanced groups during analysis.

**Scale Construction**

**Item Pool Development**

According to DeVellis’ (2003) guidelines and Worthington and Whittaker’s (2006) recommendations on scale development, items were created using theory and a well-defined construct. As such, asexual prejudice was defined as:

> Encompassing conscious and unconscious anti-asexual attitudes and beliefs that asexual people are comparatively inadequate that affect both asexual-identified people and potentially asexual people, and is exemplified in discriminatory behaviors, microaggressive statements and actions from others.

During initial review of literature, erasure and social invisibility emerged as major dimensions
that could be further broken down into categories: (1) denial of legitimacy, (2) conflation with LGBTQ experiences, (3) harmful visibility, (4) expectations of sexuality, (5) assumption of pathology, and (6) presumed transience.

First, a pool of items was generated using these dimensions and categories as guides towards creating items assess the types of microaggressions experienced by asexual people—both identified and potential. Items were created using themes and quotes from both theoretical and empirical asexuality research. Archival data from AVEN and other social networking sites were perused for possible item material. The forums on the AVEN websites and discussion from the "wall" of Facebook groups were examined for content regarding discriminatory experiences or unsavory interactions with others. When applicable, this content was then reframed for use as an item. Item structure and content were also pulled from scales of similar structure and/or aim such as the Anti-Bisexual Experiences Scale (ABES; Brewster & Moradi, 2010), Schedule of Racist Events (Landrine & Klonoff, 1996), Schedule of Sexist Events (Klonoff & Landrine, 1995) and modified from related literature regarding stigmatizing experiences among non-heterosexual people (e.g., Nadal, Issa, Leon, Meterko, Wideman, & Wong, 2011).

Next, a 5-point Likert-type scale was determined for use as the response format. Specifically, the response format included two different response scales—one for rating frequency of occurrence (from 0 =  I did not experience this event in the last six months to 4 =  I experienced this event 10 or more times in the past 6 months), and one for perceived impact or level of perceived distress (from 0 =  Did not happen/not applicable to me to 4 =  Bothered me EXTREMELY). Research provides evidence that timeframe may play a role in participant’s endorsement of level of distress (e.g., Nadal, 2011; Wright & Wegner, 2012). For this reason, participants were be asked to respond specifically about occurrences and distress in the last six
months. These methods are consistent with previous measures of sexual orientation
microaggressions (Balsam et al., 2011) and discrimination (Gazzola & Morrison, 2011). The
scale was preceded by the following instructions:

Below are several statements that capture different kinds of experiences. Please rate each item once for the frequency and once more for how much the experience(s) affected you over the PAST SIX (6) MONTHS.

To insure clear endorsement of items based on posited definitions, a brief list of definitions were provided at the start of the scale and interjected at the halfway point as a reminder. These definitions are reproduced below.

Explanation of Terms: The terms below will appear throughout the survey. For the purposes of this research, please keep these terms and their definitions in mind as you answer the questions that follow.

1) Romantic orientation: refers to an individual's pattern of desire to express love towards another, often designated by gender (e.g., homoromantic, heteroromantic, panromantic).
2) Asexuality or asexual-spectrum: refers to an individual’s pattern of sexual attraction towards others (or lack thereof) and includes experiences that are some combination of ‘asexual’ or ‘non-asexual’ (e.g., ace, grey-A, demi-sexual, etc).
3) Sexual attraction: refers to the inclination towards engaging in physically intimate and/or erotic activities with another person OR the ability to be aroused by this attraction.

After solidifying the pool of items and the rating scale, the AMS was subjected to two rounds of expert review to assess for item content validity (DeVellis, 2003; Worthington & Whittaker, 2006) The first round of expert reviewers, identified by their role in asexual communities or knowledge of asexuality, included five individuals who had published on the topic of asexuality in academic journals and/or were prominent figures within asexual communities. Two had published on the topics of asexual prejudice and discrimination. Of the five, three self-identified as asexual while the others had not made this information public. The initial pool of 46 items were assessed for content validity and clarity of the items and the scale as a whole. Reviewers also asked to offer guidance around any issues that may not be being captured by the items provided, length of the scale, and the type of rating scale used to score
each item. Feedback from these reviewers indicated areas that weren’t being assessed and several thoughts about experiences that may be helpful to include. Based on this feedback, the AMS expanded exponentially to 140 items, but was then revised down to 65 items and then sent to three additional expert reviewers for feedback on the revisions. One of these reviewers had experience with scale development for marginalized populations while the remaining two were identified for their contributions to asexuality research. Feedback from this round of expert review helped identify “double barrel” items that ask about more than one idea at a time, clarify the definitions provided, and reduce item redundancy (see Appendix B for complete AMS-41). The number of items decreased to 41 items that were then used subjected to exploratory factor analysis to determine the underlying factor structure as a part of Phase 1. Then, using the other half of the data (N=369), the items retained from Phase 1 were subjected to a CFA to confirm the factor structure in Phase 2.

**Phase 1**

The focus of Phase 1 was to conduct an exploratory factor analysis (EFA) to determine the underlying factor structure and assess construct validity for the AMS.

**Participants**

For Phase 1, data from 369 participants was analyzed (from the randomized split of the total N of 738). Participants ranged in age from 18-59 (M=23.29, Mdn = 22, SD = 5.59), identified on the asexual spectrum (87.5%) and were in the United States (84.3%). Among the remaining 12.5% who identified with aspects of asexuality, 73.91% indicated that they identified as demisexual or gray-A and the specific circumstances under which they might engage in sexual activities or be sexually attracted (i.e., “never been sexually attracted to anyone other than my husband”). In terms of race, 87.3% were White, 8.1% were biracial/multiracial, 7% were
Hispanic or Latin(o/a/x), 6.8% were Asian, 3% were African-American, and 3% were Native American. Fifteen (15) wrote in their ethnicity after indicating as “other”, most identified as Jewish and were coded in to the respective categories. Regarding gender, 53.7% identified as cis-female, 16.3% identified as gender-non-conforming, 12.5% identified as agender, 6.5% identified as cis-male, 3.8% identified as man of trans experience, 1.6% preferred not to disclose their gender, and 1.1% identified as women of trans experience. Five percent (4.6%) of participants chose to write in their gender and included labels such as demigirl, female genderflux, genderfluid, and “human born male.”

Regarding relationship status, 62.9% were single but not dating, 15.7% were in long-term romantic relationships, 8.1% were single and dating, 4.1% were married, in domestic partnership or civil union, and 8.9% indicated other descriptions of their relationship status. Among the 33 written-in responses, aromantic and platonic (i.e., long-term polyqueerplatonic, quasiplatonic) emerged as frequent descriptors. Similarly, 57% of the sample reported being monogamous, 22% were questioning monogamy, 12.5% were not monogamous and 6.8% were not currently but had been monogamous in the past. In reference to romantic and/or sexual orientation, 24.1% identified as aromantic, 17.9% as biromantic, 14.1% as heteroromantic, 12.5% as questioning or curious, 4.6% as homoromantic, and 26.3% provided alternative descriptions such as aromantic bisexual, bi-alterous, autochoriromantic, or indicated that they do not frame romantic attraction in terms of gender.

Regarding disability status, 62.2% had not been diagnosed with a disability, while 27.9 indicated that they had, and 9.8% declined to report. Participants also chose a descriptor of their disability, 17% indicated sensory related disability, 26% mobility or physical related, 20% learning or cognitive, 81% indicated mental health diagnosis, 7% neurodevelopmental diagnosis,
12% provide their own responses which included medical and learning related issues such as ADHD, ulcerative colitis, chronic pain or fatigue and “misophonia.” Though not directly assessed, when given opportunity to specify their disability status, none designated asexuality as a disability.

**Measures**

In addition to the AMS, all 369 participants completed the following measures used to evaluate discriminant and convergent validity of AMS scores.

**Demographic questionnaire.** Participants completed a demographic questionnaire accounting for: geographical location, region (rural, urban, suburban), age, race/ethnicity, relationship status, gender identity (cisgender man, cisgender woman, man of trans experience, woman of trans experience, agender, genderfluid, etc), a/sexual identity (forced choice option and write in option), romantic orientation (panromantic, mostly heterosexual, biromantic, lesbian or gay, aromantic), non-monogamy, and level of participation in asexual and/or LGBT communities. Also, to learn best recruitment strategies, an item asking where they found the study will be included as well.

**Socially desirable responding.** An abbreviated version of the Marlowe-Crowne Social Desirability Scale (MC-C; Reynolds, 1982) was used to assess the extent of social desirability in participant’s responses. This 13-item version is reduced from the original 33-time scale (SDS; Crowne & Marlowe, 1960). For example, participants were asked to rate their level of agreement to statements such as “I never done something to deliberately hurt someone” by selecting true or false. Higher “true” answers indicate participants’ tendency toward social desirability, response acquiescence, and general tendency to agree with statements. The short form of the SDS (MC-C) was found to have better psychometric properties than other short-form versions and other
scales of social desirability (Reynolds, 1982). With a sample of lesbian, gay and bisexual people, the full scale Marlowe-Crowne yielded a coefficient alpha of .94 (Wright & Wegner, 2012). In this study, SDS refers to the short form of the scale and an alpha was .62 and indicates good internal consistency amongst this sample of asexual individuals.

**Stigma consciousness.** Experiences of stigma and awareness of this stigma were assessed using the Stigma Consciousness Questionnaire (SCQ; Pinel, 1999). This is a 10-item scale that assesses the degree to which one expects to be judged on the basis of a stereotype. Items were modified from their original format for people on the asexual/ace spectrum such that “Stereotypes about homosexuals have not affected me personally” became “Stereotypes about asexuals/sexuality have not affected me personally.” Respondents endorsed answers using a 7-point Likert-type scale (1 = strongly disagree to 6 = strongly agree). In the original study with lesbian and gay individuals, the SCQ was deemed a reliable measure (Cronbach’s alpha = .81) and correlated positively with measures of discrimination (Pinel, 1999) with good validity. Among a sample of bisexual participants, the SCQ items yielded a Cronbach’s alpha of .80 (Brewster & Moradi, 2010). Prior to this dissertation, the SCQ had not been used with asexual populations, with this sample the SCQ had an alpha of .79 indicating good reliability for this measure among this sample of asexual individuals.

**Phase 2**

The purpose of Phase 2 was to conduct a confirmatory factor analysis (CFA) to confirm the factor structure of the AMS and further assess its validity.

**Participants.** Data from the remaining 369 participants were collected for Phase 2 to perform the confirmatory factor analysis. These participants were demographically similar those in Phase 1. Participants ranged in age from 18 to 69 (M=23.72, Std=6.69, Mdn=22), were from
the United States (83.7%), and were involved in asexual and/or LGBTQ communities (60.9%).

Eighty-eight percent (87.5%) indicated they identify as asexual where as 12.5% clarified their relationship with asexuality, most of which indicated demisexual or gray-A as best descriptors of their experience. Regarding race, participants were 85.6% White, 9.2% Asian, 6.8% Hispanic or Latino (a/o/x), 5.7% biracial or multiracial, 4.3% African-American/Black, 3.8% Native American or Indigenous, and .8% indicated “other” race or ethnic identity including middle eastern and Ashkenazi Jewish. Regarding gender, 56% identified as cis-female, 14.9% identified as agender, 14.1% were gender non-conforming, 4.9% were cis-male, 1.9% were men of trans experience, .3% were women of trans experience, 4.6% wrote-in their responses, and 3.3% declined to disclose. The 4.6% who chose to provide their own description of gender which included questioning, demigirl, genderflux and “nonbinary but absolutely NOT ‘gender non-conforming’.”

Majority of participants were in single but not dating (66.1%), 16.5% were in long-term romantic relationships, 3.8% were single but not dating, 3.3% were in committed relationships (i.e., married, domestic partnership, civil union) and 10.3% provided text response that included widow/widower, queerplatonic, “polyamorous romantic”, and “single and never dated.” For romantic orientation, 28.5% indicated aromantic status, 15.2% were biromantic, 14.9% were questioning/curious, 12.5% indicated heteroromantic, 4.6% indicated gay-or lesbian-romantic and 24.1% provided personalized descriptions that included androromantic (only men), bi greyromantic, cupioromantic (i.e., aromantic spectrum where you don’t experience romantic attraction but you want to be in a romantic relationship”), demi-romantic, demi-pan romantic, gay (i.e., only romantically attracted to other agender/non-binary trans individuals), polyromantic (i.e, attracted to some but not all genders), quiromatic (i.e., arospectrum but no clear distinction
between platonic and romantic love), and one person felt that “romantic orientation is not useful
to me.” Most participants were monogamous, while 20.9% were questioning, 15.2% were not
monogamous, and 6.9% were not currently but had been in the past.

Most participants, 63.4%, denied having been diagnosed with a disability, 26.3% had
been diagnosed and 10.3% declined to answer. Of those reporting a diagnosis, 73% indicated
that their disability was related to mental health, 24% indicated mobility or physical-related
disability, 33% were neurodevelopmental related, 22% had learning or cognitive difficulties,
14% indicated a sensory related disability, and 15.5% wrote in responses that included chronic
illness or pain, ADD/ADHD, epilepsy, and Lyme disease.

Measures

For Phase 2, in addition to confirming factor structure of AMS, participant responses to
the following measures were used to further evaluate convergent validity AMS scores.

Expectations of stigma. A modified version of the Collective Self-Esteem Scale (CSES;
Luhtanen & Crocker, 1992) was used to assess respondents’ awareness of societal attitudes
towards asexual communities and provide a check of convergent validity. On this 4-item scale,
participants rated their level of agreement on a 7-point Likert-type scale (1 = strongly disagree to
7 = strongly agree). Each item was modified to be more applicable for asexual people. For
example, the original item, “In general, others respect the social groups that I am a member of”
was modified to read, “In general, others respect that I am a member of an asexual community.”
Items demonstrating positive feelings toward one’s social group were reverse scored such that
higher scores are related to lower levels of collective self-esteem (increased awareness of
stigma). These items were pulled from the public collective self-esteem subscale of the CSES
which was designed to assess one’s judgments of how other people evaluate one’s social groups.
Luhtanen and Crocker (1992) reported a Cronbach’s alpha for items the CSES of .88 and found comparably consistent reliability with the short form. Thus, evidence supported the reliability and structural validity of the measure. The CSES yielded an alpha of .77 indicating good reliability with this sample of asexual individuals.

**Experiences of discrimination and bias.** The *Heterosexist Harassment, Rejection, and Discrimination Scale* (HHRDS; Szymanski, 2006) was used to explore and quantify experiences of asexual prejudice and discrimination. The original scale consisted of 14 items that examine the frequency that lesbians report having experienced heterosexist harassment, rejection, and discrimination within the past year. The scale was modified to include more applicable experiences of asexual people based on previous research (Gazzola & Morrison, 2011). In Gazzola and Morrison (2011), each HHRDS item was rated on a 6-point Likert-type scale (1 = *the event has never happened to you* to 6 = *event happened most of all the time; more than 70% of the time*). In a sample of asexually-identified people the modified HHRDS items demonstrated good reliability with an alpha coefficient of .84 and were moderately associated with outness ($r(34)=.42, p=.001$; Gazzola & Morrison, 2011). In the current sample of asexual-spectrum identified people, the HHRDS yielded an alpha of .85 which indicates that that measure continues to be reliable even among those who do not purely identify as asexual.

**Asexual identification.** In addition, to measure and assess for level of asexual identity, the *Asexual Identification Scale* (AIS; Brotto, Yule, & Gorzalka, 2014) was used. The AIS is a 12-item questionnaire on which participants rate their level of agreement with statements on a scale from 1 (*completely true*) to 5 (*completely false*) (Brotto, Yule & Gorzalka, 2014). The researchers suggested that the scale is valid due to inverse relations with measures of sexual desire and childhood trauma with reliability of items range from .70 to .94 using Cronbah’s
alpha. The scale allowed researchers to cast a wider net while discriminating between asexual and sexual samples on a spectrum ranging from ‘sexual’ to ‘asexual. The scale was thought to be helpful in capture those who are in the early stages of asexuality identity development (Carrigan, 2011; MacNeela & Murphy, 2014; Scherrer, 2008). The AIS yielded an alpha of .70 which suggests continued reliability with asexual-identified and ‘potentially’ asexual individuals.
CHAPTER 4
Results

Worthington and Whittaker (2006) offer several best practices for scale development in counseling psychology research and were utilized prominently as guidelines. Researchers describe varying rules of thumb to follow based on communalities, factor saturation and factor loading criteria, but generally recommend a 5:1 ratio (10:1 is optimal) of participants to parameters and no less than 100 participants. Given these guidelines, the total 768 participants with 369 in each phase was appropriate for optimizing results of current study. All analysis was conducted using standard statistical software packages (e.g., SPSS version 24 and MPlus version 7.4).

Phase 1: Exploratory factor analysis

In Phase 1, exploratory factor analysis (EFA) was conducted to assess the construct validity of the measure with data from 369 recruited participants. This form of analysis is a set of extraction and rotation techniques used to reveal the latent factor structure of a set of items (i.e., instrument or scale) and reduce the number of items needed for optimal results. EFA also helps determine how many factors are present, which items are related to each factor (i.e., factor loadings), and whether the factors are correlated or uncorrelated (Osborne, 2014; Worthington & Whittaker, 2006)

Using the 41-item AMS (AMS-41), an initial extraction without rotation was conducted using both common factors analysis methods—principal-axis factoring (PAF) and maximum-likelihood factoring. This procedure helped to compare the methods and determine which is most appropriate for the data. The scale was found to be multivariate normal and appropriate for factor analysis based on Kaiser–Meyer–Olkin values above .90 (AMS: .95; Taabachnick & Fidell, 2001) and significant Bartlett’s tests of sphericity AMS: $X^2(820, N = 369) = 8456.12, p <$
.001 (Tabachnick & Fidell, 2001). There were no problems of multicollinearity as evidenced by a determinant score greater than zero (0) (AMS: 4.09E-11; Yong & Pearce, 2013). The correlation matrix and communalities were examined to identify poorly performing items. Items with correlations less than +/- .30 were considered insufficient contributor to item relationships and items with correlations greater than +/- .90 were considered an indication of multicollinearity (Yong & Pearce, 2013). Lastly, regarding communalities, items with extracted communalities less than .20 were removed because they poorly account for the shared variance (Worthington & Whittaker, 2006; Yong & Pearce, 2013). Using these methods, five items were marked for removal—11, 12, 18, 22 and 28\(^5\)—resulting in a 36-item measure. After these changes the factor solution needed to be clarified; and the data was subjected to a series of extractions using both methods to identify patterns in item loadings.

**Extracting factors.** The extracted factor structure was subjected to a oblique rotation method in order to clarify the factor structure by determining factor loadings. Rotations can either be orthogonal or oblique and are determined by whether factors are correlated or uncorrelated (Osborne, 2014; Worthington & Whittacker, 2006). An orthogonal rotation is thought to overestimate loadings for correlated factors and lead to problematic item retention decisions and difficulty with CFA; thus an oblique rotation may be more appropriate for correlated factors (Loehlin, 1998; Osborne, 2014). Worthington and Whittaker (2006) describe the oblique rotation as “good practice” even when the factors are not correlated. The factors of the AMS were assumed to be correlated with one another and thus the oblique rotation, Promax,

\(^5\) Items marked for removal: 11) People have assumed that my asexuality makes me “queer” ; 12) When discussing sexual orientation amongst my social network(s), asexual spectrum identities are not considered; 18) I have been overlooked by institutions (i.e., schools, law, workplace policy); 22) I have been rejected by potential romantic partner because I am asexual; 28) My relationship(s) has/have been considered illegitimate because I am asexual (regardless of my partner’s a/sexual identity).
was applied. Seven (7) factors were initially extracted using eigenvalues greater than one; after
the Promax rotation five factors were extracted.

**Factor retention.** Several methods were used to determine the number of factors to
retain including eigenvalues (Kaiser, 1958), scree plot (Cattell, 1966), and parallel analysis
(Horn, 1965). Eigenvalues indicate the amount of variance accounted for by a given factor, thus,
factors with eigenvalues less than one reflect potential factor instability and will be deleted
(Kaiser, 1958; Osborne, 2014). A scree plot of the factor loadings was used to determine the ‘cut
off’ where the eigenvalues are accounting or significantly less variance (Cattell, 1966). The scree
plot indicated a 5-factor solution (See Figure 1). Using the parallel analysis method or Monte
Carlo Simulation (Horn, 1965; O’Connor, 2000) is based on comparison of differences between
the raw, mean/median, and 95th percentile eigenvalues in which size of the incremental
differences among the parameters lessened as the factors increased, factors with eigenvalues of 1
are also considered most stable in this method, thus three factors were differentiated using this
method. To further clarify the most simple and stable factor structure, Extractions starting from
the largest number of factors, seven (7), down to a two (2) factor solution using both extraction
methods. This process allowed comparison between extraction methods and rotation that best fit
the data.

In the final solution, four factors were extracted using the Maximum Likelihood method
with a Promax rotation. The Promax rotation was more expedient in producing a simplified
structure and appropriately for correlated items (Yong & Pearce, 2013). Despite popularity of
principal axis method, the maximum likelihood method was ultimately more robust as found in
other samples of asexual people (Yule et al., 2013). Researchers suggest that maximum
likelihood method may be more capable with complex data compared to principal axis factoring
Description of factors. Factor 1 was renamed “Expect” to denote that items that loaded on to this factor pertained to the expectation of sexuality (i.e., sexuality should conform to normative social milestones and relationship structures). This factor accounted for 40.87% of variance and included 9 items. Factor 2 is “Denial” which denotes denial of asexuality as legitimate (i.e., questioning one’s ability to identify as asexual, experiences they may have as illegitimate, and/or the very existence of asexuality or asexual people). This factor accounted for 4.11% of the variance and contained 5 items. “Harm” is the abbreviated name for Factor 3 which contained items referring to harmful visibility (i.e., experiences of physical and emotional harm faced by targets due to asexual prejudice). This 5-item factor accounted for 3.40% of the total variance. Lastly, “Cause”, or Factor 4, pertains to instances pertaining to assuming causality in regards to a person’s asexuality status (i.e., assumption that asexuality is pathological or caused by underlying physical or mental health issue or traumatizing event). This factor accounted for 1.98% of the variance with 5 items.
Figure 1
Scree Plot of Eigenvalues by factor in Exploratory Factor Analysis of AMS-41

Note. (Red) Dotted line indicates an eigenvalue of 1.

**Item retention.** Item retention was determined by the magnitude of factor loadings and cross-loadings. While factor loadings less than .50 and cross-loadings less than .15 from highest loading is the suggested cut off for item to be removed (Kahn, 2006; Worthington & Whittaker, 2006). This research found that extending to factor loadings to .40 level allowed for greater understanding of factors and items behavior. Based on the approximate simple structure method, items that have cross-loadings .32 or greater (> .32) on more than one factor were also removed due to significant influence (McDonald, 1985). The overall structure of the AMS is considered somewhat complex due to retention of cross-loading items (i.e., 16, 20, and 27). These items had
a loading of .32 or higher on at least two factors; but were retained because the difference between the highest loading and the next highest was greater than .15 (Worthington & Whittaker, 2006). Of note, one item (“I have been told that being asexual is against human nature.”) was retained for its theoretical importance despite its failure to reach the difference threshold of .15. (actual difference = .12). These methods appear useful in achieving scale structure simplicity and factor stability with the least number of items required (Worthington & Whittaker, 2006). Of the 35 items, 11 were removed using these methods resulting in a 24-item measure. The remaining items are reproduced in Table 1.
Table 1
Factor Loadings for EFA with Promax Rotation of Retained Items of AMS-24

<table>
<thead>
<tr>
<th>Items by Factor</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been told that I am asexual because I haven't met the right person. (38)</td>
<td>0.89</td>
<td>-0.04</td>
<td>-0.20</td>
<td>0.05</td>
</tr>
<tr>
<td>I have been told that asexuality is &quot;just a phase.&quot; (36)</td>
<td>0.83</td>
<td>0.13</td>
<td>-0.30</td>
<td>0.01</td>
</tr>
<tr>
<td>Others have assumed I will miss out on social milestones (i.e., marriage, children) because I am asexual. (26)</td>
<td>0.77</td>
<td>0.21</td>
<td>-0.13</td>
<td>-0.13</td>
</tr>
<tr>
<td>People have assumed that I will live out my life alone because I am asexual. (25)</td>
<td>0.72</td>
<td>0.14</td>
<td>-0.13</td>
<td>0.00</td>
</tr>
<tr>
<td>I have been asked to provide examples of how I know I am asexual. (7)</td>
<td>0.59</td>
<td>-0.02</td>
<td>0.20</td>
<td>0.02</td>
</tr>
<tr>
<td>I have been told that no one will want me as a relationship partner unless I &quot;put out&quot; because I am asexual. (24)</td>
<td>0.53</td>
<td>0.01</td>
<td>0.12</td>
<td>0.09</td>
</tr>
<tr>
<td>People have asked me invasive questions about my sex life (e.g., frequency of sexual encounters, masturbation habits, etc.) as evidence to deny my asexual-spectrum orientation. (2)</td>
<td>0.51</td>
<td>-0.10</td>
<td>0.28</td>
<td>0.09</td>
</tr>
<tr>
<td>Others have assumed that I identify as asexual because I &quot;can't get laid.&quot; (23)</td>
<td>0.49</td>
<td>-0.15</td>
<td>0.22</td>
<td>0.11</td>
</tr>
<tr>
<td>Others have assumed that I choose to be asexual. (40)</td>
<td>0.48</td>
<td>0.13</td>
<td>-0.11</td>
<td>0.24</td>
</tr>
<tr>
<td>Others have told me there is no such thing as asexual discrimination or prejudice. (9)</td>
<td>-0.01</td>
<td>0.79</td>
<td>0.11</td>
<td>-0.12</td>
</tr>
<tr>
<td>Others have objected to asexuality being included under the queer umbrella (10)</td>
<td>-0.04</td>
<td>0.77</td>
<td>-0.03</td>
<td>-0.07</td>
</tr>
<tr>
<td>I have been made to feel inferior by others because I am asexual. (5)</td>
<td>0.06</td>
<td>0.53</td>
<td>-0.09</td>
<td>0.17</td>
</tr>
<tr>
<td>I have been told that being asexual is against human nature. (27)</td>
<td>0.13</td>
<td>0.45</td>
<td>-0.05</td>
<td>0.33</td>
</tr>
<tr>
<td>I have been told that asexuality “isn’t real.” (1)</td>
<td>0.22</td>
<td>0.44</td>
<td>0.12</td>
<td>0.13</td>
</tr>
<tr>
<td>I have been assaulted because I am asexual. (13)</td>
<td>-0.27</td>
<td>0.00</td>
<td>0.75</td>
<td>0.05</td>
</tr>
<tr>
<td>I have been harassed because I am asexual. (14)</td>
<td>-0.10</td>
<td>0.28</td>
<td>0.71</td>
<td>-0.03</td>
</tr>
<tr>
<td>I have been threatened with harm because I am asexual. (16)</td>
<td>-0.31</td>
<td>0.13</td>
<td>0.70</td>
<td>0.12</td>
</tr>
<tr>
<td>I have been propositioned for sex or sex-related activities because I am asexual (e.g. &quot;Let me show you what you are missing.&quot;). (15)</td>
<td>0.17</td>
<td>-0.12</td>
<td>0.65</td>
<td>-0.03</td>
</tr>
<tr>
<td>I have been called derogatory names (e.g., &quot;prude&quot; or &quot;freak&quot;) in relation to my asexuality. (20)</td>
<td>0.32</td>
<td>0.06</td>
<td>0.52</td>
<td>-0.06</td>
</tr>
<tr>
<td>I have been told that I am &quot;not healthy&quot; because I am asexual. (30)</td>
<td>-0.07</td>
<td>0.13</td>
<td>0.01</td>
<td>0.83</td>
</tr>
<tr>
<td>I have been told that asexuality is a form of sexual dysfunction, not a valid way to identify. (29)</td>
<td>-0.01</td>
<td>0.27</td>
<td>-0.08</td>
<td>0.75</td>
</tr>
<tr>
<td>People have asked if sexual trauma is the reason I am asexual. (39)</td>
<td>0.20</td>
<td>-0.20</td>
<td>0.14</td>
<td>0.62</td>
</tr>
<tr>
<td>I have heard non-axexual people speculate about the ‘cause’ of my asexuality. (33)</td>
<td>0.18</td>
<td>-0.11</td>
<td>0.18</td>
<td>0.59</td>
</tr>
<tr>
<td>People assume that I am asexual because of my mental health. (35)</td>
<td>0.09</td>
<td>0.06</td>
<td>0.23</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Note. Factor loadings > .40 are in boldface. Numbers in parentheses identify the original item number.
Reliability

Cronbach’s alpha was used as a measure of internal consistency and was calculated for both the frequency and distress scales of the AMS as well as for the validity measures used in Phase 1. For the frequency scale, where participants were asked to select how frequently they had experienced each instance of prejudice. On the distress scale, participants were asked to rate how affected they were by the experience if endorsed. Cronbach’s alpha for the AMS-24 Full Scale was .94 and the alphas for the individual factors ranged from .74 to .90. These are displayed in Table 2.

Validity

Bivariate correlations were calculated to determine discriminant and convergent validity during phase 1. Table 2 displays the correlations among the AMS Full Scale for frequency and distress as well as each factor. It also includes correlations with the SDS and SCQ that were used to assess validity of AMS-24 during phase 1. Pearson’s correlations for the between the AMS-24 subscales and the Full Scale ranged from .77 to .92. Correlations among the AMS distress scale and the subscales ranged from .62 to .82. All correlations with the Social Desirability Scale (SDS; Crowne & Marlowe, 1964) were nonsignificant. This suggests no relationship between the AMS and the tendency to describe one’s self in favorable terms or possible response biases due to social desirability. For the Stigma Consciousness Questionnaire (SCQ; Pinel, 1999), each of the AMS subscales were significant but were low—ranging from .32 to .51 as well as for both the frequency and distress full scale of the AMS. This suggests positive relationship between participants’ awareness of stigma in their environment and the frequency of which they report experiencing prejudice.
Table 2
Bivariate correlations, Cronbach’s alphas, and Descriptive statistics for Phase 1 Measures

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AMSf</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 AMSd</td>
<td>.88**</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Expect</td>
<td>.92**</td>
<td>.82**</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Denial</td>
<td>.84**</td>
<td>.76**</td>
<td>.66**</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Harm</td>
<td>.77**</td>
<td>.62**</td>
<td>.61**</td>
<td>.57**</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Cause</td>
<td>.89**</td>
<td>.76**</td>
<td>.75**</td>
<td>.66**</td>
<td>.68**</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 SDS</td>
<td>-.02</td>
<td>-.05</td>
<td>.00</td>
<td>-.05</td>
<td>.02</td>
<td>-.04</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>8 SCQ</td>
<td>.42**</td>
<td>.51**</td>
<td>.33**</td>
<td>.46**</td>
<td>.32**</td>
<td>.35**</td>
<td>-.10</td>
<td>–</td>
</tr>
<tr>
<td>Mean</td>
<td>46.69</td>
<td>59.49</td>
<td>17.71</td>
<td>12.58</td>
<td>6.72</td>
<td>8.76</td>
<td>6.00</td>
<td>32.42</td>
</tr>
<tr>
<td>SD</td>
<td>17.99</td>
<td>22.21</td>
<td>7.47</td>
<td>5.11</td>
<td>2.72</td>
<td>4.61</td>
<td>2.57</td>
<td>6.18</td>
</tr>
<tr>
<td>Range</td>
<td>0-4</td>
<td>0-4</td>
<td>0-4</td>
<td>0-4</td>
<td>0-4</td>
<td>0-4</td>
<td>0-1</td>
<td>1-5</td>
</tr>
<tr>
<td>α</td>
<td>.94</td>
<td>.92</td>
<td>.87</td>
<td>.83</td>
<td>.74</td>
<td>.89</td>
<td>.62</td>
<td>.79</td>
</tr>
</tbody>
</table>

Note. N=369. SDS = Social Desirability Scale; SCQ = Social Consciousness Questionnaire; AMSf = full scale; AMSd = distress scale.

**p<.01; *p<.05

Phase 2: Confirmatory Factor Analysis

In phase two, confirmatory factor analysis (CFA) was conducted to assess generalizability and replicability of factor structure of the final EFA AMS using new data points from the remaining 369 participants. In general, CFA, as the name suggests, is a way to confirm the initial factor structure and can be conducted using a variety of methods (Osborne, 2014; Worthington & Whittaker, 2006). Structural equation model (SEM) is the most commonly used approach to conduct a CFA and determining the goodness-of-fit for the model captured by the AMS (Worthington & Whittaker, 2006). The CFA and SEM were run using statistical package, Mplus v7.4.

The AMS overall model fit was determined using both absolute and incremental fit indices followed by a chi-square test. Problems related to over-reliance on chi-square tests have been documented in the literature (Bentler & Bonett, 1980; Hu & Bentler, 1995; Worthington & Whittaker, 2006). Thus, absolute model fit will be further assessed using the root mean square
error of approximation (RMSEA) as well as the standardized root mean residual (SRMR) in addition to chi-square tests. Further, incremental model fit will be determined using the comparative fit index (CFI). To determine fit, Weston and Gore (2006) recommends that appropriate fit is indicated by CFI values greater than .90, and RMSEA and SRMR values less than .10. The final model will be confirmed by comparing the model to relevant literature regarding relationships between items and factors (Worthington & Whittaker, 2006).

Initially, the AMS-24 revealed poor fit, CFI = .89, RMSEA = .08 (90% CI [.08, .09]), SRMR = .05, $\chi^2(249) = 913.05$, $p<.001$. However, modification indices (MI), a function of Mplus that helps identify where changes in model can yield better fit. Using this method several “problem variables” or those were negatively impacting the model fit, were identified and either modified or deleted. MI in Mplus are structured by “with” and “by” statements where “with” refers to covariances and “by” indicates factor loadings. Those with higher MI and who had appropriately high estimated parameter change (EPC) were used to improve model fit. In cases where the MI indicated that items be allowed to covary, both items were examined for the standardized parameter estimate (or factor loading), the item that had the lower estimate was deleted. For “by” statements, items were moved to the specified location that yielded the greatest EPC; however, if the model fit did not improve, the item was moved back to its original location or deleted. Examining the estimate as well as the content of each item to assess for issues such as redundancy were helpful in eliminating items and improving fit. Items 2, 10, 13, 23, 25, 26, 35, and 36 were deleted using these methods, resulting in a 16-item measure shown in Table 3.

---

6 Deleted items included: 2) People have asked me invasive questions about my sex life (e.g., frequency of sexual encounters, masturbation habits, etc.) as evidence to deny my asexual-spectrum orientation; 10) Others have objected to asexuality being included under the queer umbrella; 13) I have been assaulted because I am asexual; 23) Others have assumed that I identify as asexual because I “can’t get laid”; 25) People have assumed that I will live my life alone because I am asexual; 26) Others have assumed that I will miss out social milestones (i.e., marriage, children) because I am asexual; 35) People assume that I am asexual because of my mental health; and 36) I have been told that asexuality is “just a phase.”
The AMS-16 was found to have good model fit as indicated by CFI=.95, SRMR=.04, RMSEA=.07 (90% CI [.06, .08]), and \( \chi^2 \) (98)=249.31, p<0.001. Final model with standardized regression loadings, residuals, and standard error are represented in Figure 2.

| Table 3 | Standardized Regression Loadings and Uniqueness for Confirmatory Factor Analysis by Factor |
| --- | --- | --- | --- |
| Items by Factor | Loading | Uniqueness |
| Factor 1: Expectation of sexuality | | |
| I have been told that I am asexual because I haven't met the right person. (38) | .72 | .48 |
| Others have assumed that I choose to be asexual. (40) | .72 | .48 |
| I have been asked to provide examples of how I know I am asexual. (7) | .71 | .49 |
| I have been told that no one will want me as a relationship partner unless I "put out" because I am asexual. (24) | .69 | .53 |
| Factor 2: Denial of asexuality | | |
| I have been told that asexuality “isn’t real.” (1) | .81 | .34 |
| I have been told that being asexual is against human nature. (27) | .79 | .37 |
| Others have told me there is no such thing as asexual discrimination or prejudice. (9) | .67 | .56 |
| I have been made to feel inferior by others because I am asexual. (5) | .61 | .63 |
| Factor 3: Harmful visibility | | |
| I have been harassed because I am asexual. (14) | .79 | .37 |
| I have been called derogatory names (e.g., "prude" or "freak") in relation to my asexuality. (20) | .75 | .44 |
| I have been propositioned for sex or sex-related activities because I am asexual (e.g. "Let me show you what you are missing."). (15) | .63 | .6 |
| I have been threatened with harm because I am asexual. (16) | .60 | .64 |
| Factor 4: Assuming causality | | |
| I have been told that asexuality is a form of sexual dysfunction, not a valid way to identify. (29) | .87 | .24 |
| I have been told that I am "not healthy" because I am asexual. (30) | .84 | .29 |
| I have heard non-asexual people speculate about the 'cause' of my asexuality. (33) | .78 | .39 |
| People have asked me if sexual trauma is the reason I am asexual (39) | .74 | .45 |
Figure 2
Diagram of AMS-16 model with loadings, residuals and standard error

Note. Circles = factors. Squares = items. Straight arrows indicate loadings while curved ones indicate covariance between factors. Numbers in parentheses () are standard error. Numbers at the base of arrows pointing towards items are the residuals.
Reliability

Reliability for the 16-item AMS and its subscales were calculated as well as for the validity scales used in Phase 2. For the subscales, Cronbach’s alphas ranged from .67 to .85. The Full scale AMS revealed an alpha of .88. These levels indicate good internal consistency. See Table 4 for full reliability data by subscale.

Validity

Once again, bivariate correlations were run to further assess for convergent validity (see Table 4). The AMS-16 subscales all correlated significant with each other with Pearson’s r ranging from .67 to .74. Each of the subscales and the full scale of AMS had a statistically significant and negative relationship with the CSES. The Collective Self-esteem Scale (CSES), specifically the public subscale, assessed one’s judgments of how other people evaluate one’s social groups. These findings further illustrate the validity of the AMS. The AIS failed to yield significant correlations for any of the AMS subscales or full scale. This indicates a lack of relationship between the level of one’s identity as asexual and their experience of asexual prejudice. Using the cut-off score of 40 or above out of 60, only a small portion (3%) of sample meets criteria using this scale. Further still, the non-significant relationship with the AMS and the AIS continues even when only run with people who met the criteria for the scale and self-identified as asexual. The HHRDS correlated well with the AMS and its subscales with correlations ranging from .40 to .55. The HHRDS also had a significant negative correlation with the CSES. This further substantiates the scale’s convergent validity.
Table 4

Bivariate correlations, Cronbach's alphas, and Descriptive Statistics for Phase 2 Measures

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AMSf</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 AMSd</td>
<td>.91**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Expect</td>
<td>.89**</td>
<td>.81**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Denial</td>
<td>.86**</td>
<td>.80**</td>
<td>.69**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Harm</td>
<td>.80**</td>
<td>.71**</td>
<td>.63**</td>
<td>.58**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Cause</td>
<td>.89**</td>
<td>.79**</td>
<td>.71**</td>
<td>.67**</td>
<td>.69**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 AIS</td>
<td>.07</td>
<td>.07</td>
<td>.12*</td>
<td>.03</td>
<td>.10</td>
<td>.01</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 CSES</td>
<td>-.42**</td>
<td>-.46**</td>
<td>-.34**</td>
<td>-.46**</td>
<td>-.33**</td>
<td>-.30**</td>
<td>-.06</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>9 HHRDS</td>
<td>.55**</td>
<td>.48**</td>
<td>.50**</td>
<td>.40**</td>
<td>.54**</td>
<td>.49**</td>
<td>.08</td>
<td>-.17**</td>
<td>--</td>
</tr>
</tbody>
</table>

Mean 29.30 37.88 7.83 9.34 5.47 6.65 44.07 14.22 49.03
SD 11.63 15.89 3.69 4.09 2.11 3.35 6.19 4.11 12.16
Range 1-5 1-5 1-5 1-5 1-5 1-5 1-5 1-7 1-7
α .92 .90 .77 .80 .67 .83 .70 .77 .85

Note. N=369. AMSf = frequency scale, AMSd = distress scale, CSES = Collective Self-esteem Scale, HHRDS = Heterosexist Harassment Rejection and Discrimination Scale. AIS = Asexual Identification Scale.

**p<.01; *p<.05

Supplemental Analysis

Results of the EFA and CFA gave evidence for use of the AMS as a multidimensional instrument with 4 factors. Of note, when comparing the correlations of the full scale and the subscales to other measures, the relationships were strongest when the full scale AMS remained intact. However, these analyses alone do not provide support for use of the total score of the AMS. For the purpose of this dissertation, using both the total and factor scores of the AMS were of interest. Thus, using the complete dataset (N=738), the four-factor structure of the AMS was further examined using a bifactor model.

Bifactor analysis provides helpful information when confronted with issues of scale dimensionality (Hammer & Toland, 2016). Bifactor analysis has been found to be a useful tool in making sense of the internal structure of measurement tools and has been recommended for use alongside other factor analysis methods (Reise et al., 2007). The bifactor model demonstrates
how the items are directly affected by a general factor while simultaneously testing whether the items have unique variances in the specific factors that go beyond the general factor (Reise, Moore, & Haviland, 2010). To do so, the model assumes that the general and specific factors are independent of each other. That is, the method compares a unidimensional model to a multi-factor model to determine which one accounts for more of the model variance in an effort to verify a scale’s utility as multidimensional and if the total score is reliable-enough measure of the latent construct or general factor.

First, to provide a comparison for the general factor, another CFA was run with all items loading on to a single factor in order to test model fit of a unidimensional model. The unidimensional model demonstrated poor fit as demonstrated by fit indices: RMSEA=.08, p<.05 [90% CI=.07, .09], CFI=.89, SRMR=.06, $X^2(104)=349.11$, p<.001.

Second, the bifactor model was run using variables as categorical because likert-type scales are not technically continuous. As a result, instead of SRMR, a different measure weighted root-mean-square residual (WRMR) was used as an indicator of fit. WRMR has been found to identify model fit across sample sizes up to 1000 using cut-offs close to 1.0 when used in conjunction with other indices of fit (Yu, 2002). The AMS-16 showed good fit with a RMSEA of .05 [90% CI=.04, .06], CFI = .96, WRMR = .74, $X^2(88)= 191.09$, p<.001. Based on these, the bifactor model showed comparable fit as the correlated factors model (see Table 5 for summary).
Finally, the bifactor model has additional ancillary analyses that help clarify the dimensionality of the instrument and/or model-based reliability of the total and subscale scores (Hammer & Toland, 2016; Rodriguez, Reise, & Haviland, 2016a).

Determining dimensionality. There are several ancillary bifactor measures that help understand dimensionality.

Based on the findings from these bifactor ancillary measures, the AMS-16 is best conceptualized as a primarily unidimensional instrument where the total score (with no subscales) is most useful despite the presence of some multidimensionality. Despite the poor fit of the initial unidimensional CFA model, there would be minimal measurement bias created by treating the AMS as a general factor. However, of note, when bifactor analyses were run using variables as continuous, the model had also had adequate fit RMSEA = .05 [90% CI 0.039, 0.061], CFI = .96, SRMR = .04, and $\chi^2(120)=2290.22$, p<.001. In regards to the ancillary measures that determine dimensionality, ECV = .78, PUC = 80%, and ARPB = 3%. Comparing the standardized loadings for the general factor against the specific factors showed that items expect38, cause39, expect9, and harm14 were closest to their loadings on the general factor. When comparing the IECVs, all except harm16 were above .5 (.46) and four were .9 and above.

Table 5
CFA results from each model

<table>
<thead>
<tr>
<th>Model</th>
<th>$\chi^2$</th>
<th>df</th>
<th>RMSEA</th>
<th>CFI</th>
<th>SRMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unidimensional</td>
<td>349.11</td>
<td>104</td>
<td>.08</td>
<td>.89</td>
<td>.06</td>
</tr>
<tr>
<td>Correlated Factors</td>
<td>249.31</td>
<td>98</td>
<td>.07</td>
<td>.95</td>
<td>.04</td>
</tr>
<tr>
<td>Bifactor (continuous)</td>
<td>169.76</td>
<td>88</td>
<td>.05</td>
<td>.96</td>
<td>.04</td>
</tr>
<tr>
<td>Bifactor (categorical)</td>
<td>191.09</td>
<td>88</td>
<td>.06</td>
<td>.99</td>
<td>.74*</td>
</tr>
</tbody>
</table>

*Weighted root mean square residual (WRMR) is the estimator given that variables were categorical.
Thus, even when the using the variables as continuous rather than categorical, the AMS remains useful as a general factor (i.e., “total score”) measure.

Table 6

Standardized Factor loadings for general factor for Unidimensional and Bifactor Models

<table>
<thead>
<tr>
<th>Items</th>
<th>Unidimensional</th>
<th>Bifactor (cat.)</th>
<th>Bifactor (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been asked to provide examples of how I know I am asexual. (7)</td>
<td>.67</td>
<td>.72</td>
<td>.67</td>
</tr>
<tr>
<td>I have been told that no one will want me as a relationship partner unless I &quot;put out&quot; because I am asexual. (24)</td>
<td>.62</td>
<td>.66</td>
<td>.61</td>
</tr>
<tr>
<td>I have been told that I am asexual because I haven't met the right person. (38)</td>
<td>.63</td>
<td>.65</td>
<td>.61</td>
</tr>
<tr>
<td>Others have assumed that I choose to be asexual. (40)</td>
<td>.66</td>
<td>.69</td>
<td>.66</td>
</tr>
<tr>
<td>I have been told that asexuality “isn’t real.” (1)</td>
<td>.75</td>
<td>.78</td>
<td>.74</td>
</tr>
<tr>
<td>I have been made to feel inferior by others because I am asexual. (5)</td>
<td>.55</td>
<td>.57</td>
<td>.54</td>
</tr>
<tr>
<td>Others have told me there is no such thing as asexual discrimination or prejudice. (9)</td>
<td>.59</td>
<td>.64</td>
<td>.57</td>
</tr>
<tr>
<td>I have been told that being asexual is against human nature. (27)</td>
<td>.74</td>
<td>.79</td>
<td>.75</td>
</tr>
<tr>
<td>have been harassed because I am asexual. (14)</td>
<td>.66</td>
<td>.75</td>
<td>.63</td>
</tr>
<tr>
<td>I have been propositioned for sex or sex-related activities because I am asexual (e.g. &quot;Let me show you what you are missing.&quot;). (15)</td>
<td>.55</td>
<td>.68</td>
<td>.53</td>
</tr>
<tr>
<td>I have been threatened with harm because I am asexual. (16)</td>
<td>.48</td>
<td>.77</td>
<td>.44</td>
</tr>
<tr>
<td>I have been called derogatory names (e.g., &quot;prude&quot; or &quot;freak&quot;) in relation to my asexuality. (20)</td>
<td>.67</td>
<td>.74</td>
<td>.65</td>
</tr>
<tr>
<td>I have been told that asexuality is a form of sexual dysfunction, not a valid way to identify. (29)</td>
<td>.84</td>
<td>.87</td>
<td>.84</td>
</tr>
<tr>
<td>I have been told that I am &quot;not healthy&quot; because I am asexual. (30)</td>
<td>.81</td>
<td>.83</td>
<td>.79</td>
</tr>
<tr>
<td>I have heard non-asexual people speculate about the 'cause' of my asexuality. (33)</td>
<td>.76</td>
<td>.78</td>
<td>.73</td>
</tr>
<tr>
<td>People have asked me if sexual trauma is the reason I am asexual (39)</td>
<td>.71</td>
<td>.75</td>
<td>.66</td>
</tr>
</tbody>
</table>

Model-based reliability. In addition to examining the dimensionality of the measure, bifactor ancillary measures also look at model-based reliability which provide evidence that the total scale and subscale scores are truly representative of the target construct of interest (Hammer & Toland, 2016). There are several of these measures including omega, omega hierarchical for both total scale and subscales, and percentage of reliable variance.
Omega (ω) was used to indicate how much of the total score variance is due to both the general and the specific factors (common factors) and demonstrates the reliability of the multidimensional composite total score (Hammer & Toland, 2016). The AMS had an ω- score .96 indicating 96% of the total score variance is due to all common factors. The subscales had scores of .83, .90, .89, .90 which indicate that 83% to 90% of subscale score variance is due to general plus that specific factor. Omega Hierarchical (ωH) is the total score variance that can be attributed to the general factor after accounting for all specific factors (Hammer & Toland, 2016). It is the degree to which the total score reflects the general factor. Between .5 and .75 are preferable cut-offs for this measure (Reise et al, 2012). The ωH for AMS-16 is .92 or 92% which means that the total score reflects the single general factor, permitting the use of the total score as sufficiently reliable measure of the general factor. However, the ωHS for subscales fell very below the .5 cutoff ranging from .11 to .17 and indicating that the subscale scores do not reliably measure the intended specific factor or construct (e.g, Harm). Thus, there is a lack of evidence for using the subscales as measures of specific dimensions, independent of the general factor or total score.

The percentage of reliable variance (PRV) is more definitive than omega and omegaH because it accounts for omega and is seen as a prerequisite for using the total score (Hammer & Toland, 2016; Rodriguez et al, 2016a). There are no empirically-derived guidelines exist for the total score PRV; however, Reise and colleagues (2012) recommend using .75 as a preferred cut off with .5 as a minimum to indicate how strongly the factor is accounted for by its items. AMS had a PRV total score of .95 indicating 95% of reliable variable is due to the general factor which is further evidence of using total score. The PRVs for each subscale were .12, .18, .18, and .21 which correspond to 12-21% of reliable variance due to the specific factor independent of the
general factor. This suggests that the AMS-16 is useful when used as a general measure of asexual prejudice but the subscales cannot stand alone because they are not accounting for unique dimensions independent of the general factor.

These measures of model-based reliability were calculated using in the continuous variable bifactor model: $\omega = .94$ (subscale $\omega = .80, .91, .69,$ and $.87$), $\omega H=.88$ (subscales $\omega H = 11, .17, .18,$ and $.21$), and PRV of $.94$ (subscales PRV $= .22, .20, .31,$ and $.13$). Once more, providing evidence for using the AMS total-score but not for use of the subscales independently.

Taken together, these supplementary analyses illustrate the use of AMS as a “general factor” scale where the total-score is represented of the overall construct, asexual prejudice, and that the subscales do not necessarily provide substantive value beyond the general factor. However, when compared to the fit and strength of loadings compared to the original correlated factors model, the subscales are useful in that they do characterize thematic differences in the manifestation of asexual prejudice.
Table 7

*Bivariate correlations, alphas and descriptive statistics for AMS total scores*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AMSf</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>AMSd</td>
<td>.89**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Expect</td>
<td>.89**</td>
<td>.79**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Denial</td>
<td>.88**</td>
<td>.81**</td>
<td>.69**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Harm</td>
<td>.80**</td>
<td>.68**</td>
<td>.62**</td>
<td>.61**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Cause</td>
<td>.89**</td>
<td>.77**</td>
<td>.72**</td>
<td>.69**</td>
<td>.68**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>CSES</td>
<td>-.39**</td>
<td>-.43**</td>
<td>-.28**</td>
<td>-.45**</td>
<td>-.32**</td>
<td>-.30**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>AIS</td>
<td>.10**</td>
<td>.12**</td>
<td>.11**</td>
<td>.10**</td>
<td>.09'</td>
<td>.06</td>
<td>-.11**</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>SCQ</td>
<td>.45**</td>
<td>.51**</td>
<td>.45**</td>
<td>.49**</td>
<td>.35**</td>
<td>.36**</td>
<td>-.61**</td>
<td>.17**</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>SDS</td>
<td>.03</td>
<td>.01</td>
<td>.05</td>
<td>.01</td>
<td>.03</td>
<td>.01</td>
<td>.09'</td>
<td>-.01</td>
<td>-.09'</td>
<td>--</td>
</tr>
<tr>
<td>11</td>
<td>HHRDS</td>
<td>.52**</td>
<td>.43**</td>
<td>.45**</td>
<td>.41**</td>
<td>.53**</td>
<td>.45**</td>
<td>-.15**</td>
<td>.02</td>
<td>.20**</td>
<td>.02</td>
</tr>
<tr>
<td>Mean</td>
<td>29.94</td>
<td>38.87</td>
<td>7.99</td>
<td>9.53</td>
<td>5.57</td>
<td>6.86</td>
<td>14.17</td>
<td>43.95</td>
<td>32.21</td>
<td>5.99</td>
<td>48.91</td>
</tr>
<tr>
<td>SD</td>
<td>12.04</td>
<td>15.78</td>
<td>3.78</td>
<td>4.1</td>
<td>2.34</td>
<td>3.60</td>
<td>4.00</td>
<td>6.17</td>
<td>6.38</td>
<td>2.50</td>
<td>12.88</td>
</tr>
<tr>
<td>Range</td>
<td>1-5</td>
<td>1-5</td>
<td>1-5</td>
<td>1-5</td>
<td>1-5</td>
<td>1-5</td>
<td>1-5</td>
<td>1-7</td>
<td>1-7</td>
<td>0-1</td>
<td>1-7</td>
</tr>
<tr>
<td>(\alpha)</td>
<td>.92</td>
<td>.90</td>
<td>.79</td>
<td>.80</td>
<td>.73</td>
<td>.86</td>
<td>.77</td>
<td>.70</td>
<td>.80</td>
<td>.60</td>
<td>.87</td>
</tr>
</tbody>
</table>

*Note. N=738. AMSf = frequency scale. AMSd = distress scale. CSES = Collective Self-esteem Scale. HHRDS = Heterosexist Harassment Rejection and Discrimination Scale. AIS = Asexual Identification Scale. SDS = Social Desirability Scale. SCQ = Stigma Consciousness Questionnaire.*

**p<.01; *p<.05
Mean Comparisons by Demographics

Table 8 displays frequency data for demographic variables for complete sample were run then compared to the Asexuality Community 2016 Census and US population data to assess representativeness of the data. The current sample aligns with ace census data on age, gender, educational level, and race.

Table 8
*Demographic Percentages in Population across US Census, Asexuality Census, and Current Sample*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>US Census(^a)</th>
<th>Asexual Census(^b)</th>
<th>Current Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>11.18%</td>
<td>66.94%</td>
<td>76.56%</td>
</tr>
<tr>
<td>26-45</td>
<td>26.25%</td>
<td>29.58%</td>
<td>22.09%</td>
</tr>
<tr>
<td>46-69</td>
<td>29.79%</td>
<td>2.06%</td>
<td>1.36%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisgender-female (non-trans female)</td>
<td>50.77%</td>
<td>60.86%</td>
<td>54.74%</td>
</tr>
<tr>
<td>Cisgender-male (non-trans male)</td>
<td>49.23%</td>
<td>7.08%</td>
<td>5.69%</td>
</tr>
<tr>
<td>Woman w/ trans experience</td>
<td>3.22%</td>
<td>0.68%</td>
<td></td>
</tr>
<tr>
<td>Man w/ trans experience</td>
<td>3.45%</td>
<td>2.85%</td>
<td></td>
</tr>
<tr>
<td>Agender</td>
<td>6.72%</td>
<td>13.69%</td>
<td></td>
</tr>
<tr>
<td>Gender-non-conforming</td>
<td>18.68%</td>
<td>15.18%</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>13.48%</td>
<td>4.47%</td>
<td>5.56%</td>
</tr>
<tr>
<td>High School Graduate/GED</td>
<td>28.02%</td>
<td>8.81%</td>
<td>9.21%</td>
</tr>
<tr>
<td>Some College</td>
<td>31.30%</td>
<td>45.64%</td>
<td>45.53%</td>
</tr>
<tr>
<td>College Degree (e.g., BA or BS, Assoc.)</td>
<td>27.19%</td>
<td>32.76%</td>
<td>31.17%</td>
</tr>
<tr>
<td>Professional Degree (e.g., MBA, MS, Ph.D., M.D.)</td>
<td>8.32%</td>
<td>8.54%</td>
<td></td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $25,000</td>
<td>22.10%</td>
<td>22.36%</td>
<td></td>
</tr>
<tr>
<td>$25,000 to $34,999</td>
<td>10.00%</td>
<td>10.57%</td>
<td></td>
</tr>
<tr>
<td>$35,000 to $49,999</td>
<td>12.70%</td>
<td>11.65%</td>
<td></td>
</tr>
<tr>
<td>$50,000 to $74,999</td>
<td>16.70%</td>
<td>11.25%</td>
<td></td>
</tr>
<tr>
<td>$75,000 to $99,999</td>
<td>12.10%</td>
<td>7.86%</td>
<td></td>
</tr>
<tr>
<td>$100,000 to $149,999</td>
<td>14.10%</td>
<td>6.91%</td>
<td></td>
</tr>
<tr>
<td>$150,000 or more</td>
<td>12.30%</td>
<td>6.10%</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single but not dating</td>
<td>71.06%</td>
<td>64.50%</td>
<td></td>
</tr>
<tr>
<td>Single and dating</td>
<td>22.20%</td>
<td>5.96%</td>
<td></td>
</tr>
</tbody>
</table>
Long-term romantic relationship 16.12%
Married/Domestic Partnership/Civil Union 6.75% 3.66%
Other (including divorce) 9.62%

Sexual Orientation:

<table>
<thead>
<tr>
<th>Sexual Orientation (i.e., lesbian- or gay-romantic)</th>
<th>1.60%</th>
<th>2.96%</th>
<th>4.61%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heteroromantic</td>
<td>97.70%</td>
<td>6.14%</td>
<td>13.28%</td>
</tr>
<tr>
<td>Biromantic</td>
<td>0.70%</td>
<td>4.22%</td>
<td>16.53%</td>
</tr>
<tr>
<td>Aromantic</td>
<td>73.00%</td>
<td>0.00%</td>
<td>26.29%</td>
</tr>
<tr>
<td>Questioning/Curious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (including panromantic)</td>
<td>13.67%</td>
<td></td>
<td>25.20%</td>
</tr>
</tbody>
</table>

Race:

<table>
<thead>
<tr>
<th>Race</th>
<th>12.30%</th>
<th>4%</th>
<th>3.66%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American/Black</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian American-Pacific Islander</td>
<td>5.30%</td>
<td>7.57%</td>
<td>7.99%</td>
</tr>
<tr>
<td>Native American/Indigenous</td>
<td>0.70%</td>
<td>4.3%</td>
<td>3.39%</td>
</tr>
<tr>
<td>Hispanic/Latino/a/x</td>
<td>17.60%</td>
<td>9.85%</td>
<td>6.91%</td>
</tr>
<tr>
<td>Biracial/Multi-racial</td>
<td>2.20%</td>
<td>8%</td>
<td>6.91%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>62.30%</td>
<td>82.4%</td>
<td>86.45%</td>
</tr>
</tbody>
</table>

Disability:

<table>
<thead>
<tr>
<th>Disability</th>
<th>NOT diagnosed with a disability, under age 65 years, percent, 2011-2015</th>
<th>91.40%</th>
<th>85.88%</th>
<th>62.74%</th>
</tr>
</thead>
<tbody>
<tr>
<td>With a disability, under age 65 years, percent, 2011-2015</td>
<td></td>
<td>8.60%</td>
<td>14.12%</td>
<td>27.10%</td>
</tr>
</tbody>
</table>

Note. Spaces with no data indicate lack of data to be found on this demographic for the given population.

*a Data pulled from Center for Disease and Control Prevention

*b US data pulled from Asexual Community Census 2016, N=4965

*c For US Census, ‘sexual categories’ were used in lieu of romantic orientation information.

To examine the performance of the AMS amongst different demographic groups, analysis of means was conducted using SPSS 24. Specifically, age, gender, and race were demographics used in comparisons of endorsement of asexual prejudice measured by the AMS. Each of the variables in the comparisons were found to be non-normally distributed with skewness values moderate deviations from normality (Tabachnick & Fidell, 2007; West, Finch, Curran, 1995). Though age and race were found to have equal variances amongst groups based on Levene’s statistics, gender did not meet this assumption.
**Age.** Age data were categorized into three groups based on adult developmental literature. 18-25 were the emerging adulthood group (n=565; Arnett, 2000, 2007), 26-45-year olds were designated as the young adulthood group (n=149; Erikson, 1998, 1980), and 46-69 year olds were specified as the middle adulthood group (n=24; Kail & Cavanaugh, 2012). Age was non-normally distributed with skewness of 1.76 (SE = .09) and kurtosis of 2.25 (SE = .18). At the .05 level, the Levene’s statistic was nonsignificant, indicating equal variance amongst the (W(2,735)=.43, p = .65). One-way ANOVA was run using the AMS as dependent variable and age variable as predictors. There was a significant effect of age group on the AMS, F (2,735) = 5.44, p<.05. Post hoc tests using Tukey’s HSD test indicated that the mean score on the AMS for the emerging adult group (M =1.92, SD =.75) were significantly different and higher than the middle adult group (M =1.51, SD = .69). Comparisons between the young and emerging, and emerging and middle adult groups were not significantly different.

**Race.** Participant race data were re-categorized into three groups reflecting three large categories of racial identities: person of color (n = 72), multiracial (n = 90), and predominantly White individuals (n = 571). Multiracial people were kept separate from the POC group initially because it was not clear how people were responding; whether the participant identified as a person of interracial parentage or their race and ethnic group (such as White Latina) because participants were given the option to choose more than one response. Race was also non-normally distributed with skewness of -1.72 (SE = .09) and kurtosis of 1.31 (SE = .18), but groups were found to have equal variances based on nonsignificant Levene’s test (W (2,730)=1.13, p = .32). There were no statistically significant differences amongst groups as evidenced by one-way ANOVA (F (2, 730) =1.70, p = .18). Because this variable violated the
assumptions of equality of means, Welch’s F was calculated and revealed nonsignificant differences among the groups on their scores on the AMS ($F(2, 132.62) = 1.77, p = .175$).

**Gender.** Participants self-selected into 1 of 8 categories: cis-gender man/male, cis-gender woman/female, woman of trans experience, man of trans experience, agender, gender-non-conforming, personal terms (“not listed”), and those that preferred not to say. Though the variable had evidence of skewness of .85 ($SE = .09$) and kurtosis of -.83 ($SE = .18$) these were not found to be substantial (West et al., 1995). However, the gender variable violated the assumption of equality of means with significant Levene’s statistic ($W (7,729) = 2.32, p = .02$).

There were statistically significant differences between gender group means as tested by one-way ANOVA ($F (7, 729) = 2.74, p = .008$). Because the variable did not have equal means amongst groups, Welch’s F was calculated to account for this problem. Gender group means had still statistically significant differences on this test ($F (7, 50.48) = 2.31, p = .04$). Post hoc tests using Tukey’= HSD test indicated that the mean score on the AMS for cisgender women ($M =1.79, SD = .68$) was significantly different and lower than the gender-non-conforming group ($M=2.0, SD = .83$). Comparisons between the remaining gender groups were not significantly different.
Chapter 5

DISCUSSION

The purpose of this study was to create a psychometrically sound measure of asexual prejudice that can be used to document the unique experiences of asexual people and asexuality. To date, few studies investigate the experience of discrimination and bias against asexual people. Of the two studies that have empirically examined this phenomenon, only one of them targeted self-identified asexual people but was limited by a small sample and use of modified measures. Thus, the development of the Asexual Microaggressions Scale (AMS) is a necessary step towards addressing these gaps in the literature. This study also serves as one of the first to document the lived experiences of asexual prejudice and constitutes the largest study of self-identified asexual people. Using the recommendations of Worthington and Whittaker (2006) to guide the scale’s development, the AMS was found to be a reliable and valid measure of asexual prejudice.

Phase 1 Exploratory Factor Analysis

The purpose of the first phase of this dissertation was to explore the factor structure of the measure and test the scale’s validity. From the literature review, two overall dimensions—social invisibility and erasure—represented the major themes that best characterized asexual prejudice and its links with sexual normativity. Subsumed under these theme-based dimensions were several categories that clarify and specify experiences within each dimension: (1) denial of legitimacy, (2) conflation with LGBTQ experience, (3) harmful visibility, (4) expectations of sexuality, (5) assumption of pathology, and (6) presumed transience. Items for the AMS were derived partially using these themes. As such it was hypothesized that there would at least two factors reflecting microaggressive experiences. The EFA revealed a correlated four-factor
structure for measuring asexual prejudice: Factor1 – Expectations of sexuality, Factor2—Denial of asexuality as legitimate, Factor3—Harmful visibility, and Factor4—Assuming causality. Each factor represents a manifestation of asexual prejudice which supports findings from the literature review that identified asexual prejudice as multidimensional.

Expectations that an asexual person will adhere to specific social norms pertaining to sexuality and relations were captured in the first factor. Microaggressions of this domain suggest that asexually identified people are expected to be having sex or identify with sexuality. This is consistent with qualitative findings highlighting sex as the “most important thing” in the context of relationships (Pryzbylo, 2014). Participants endorsed items that indicated microaggressive statements about choosing to be asexual that the consequences of this choice is to miss out on important social milestones including romantic relationships. Further still, the items capture by this factor indicate that it becomes necessary to defend one’s personal experiences (or lack thereof) when confronted with these expectations. The items reflect that being alone or loneliness is the consequence of not meeting these expectations or that one would only have to do something in order to be compliant or be fixed. Similar reflections on one solution to the asexual problem highlight the need to engage in purposeful sexual activity (Chasin, 2013). Conveyed through these items is the idea that being asexual is a willful choice to not adhere to sexuality scripts. This factor represents the crux of sexual normativity’s influence in society and supports previous assertions that asexual prejudice and microaggressions may also stem from an endorsement of sexual normative culture and beliefs. In doing so, this factor mirrors the endorsement of heteronormative or gender normative culture themes included as one of the eight themes Nadal and colleagues (2010) indicated in their taxonomy of sexual minority microaggressions.
Similarly, the second factor captures microaggressive experiences where asexuality is denied its legitimacy as an identity or lived experience. The items reflect the direct, yet subtle, messages about asexuality’s inferiority to sexuality and sexuality as the preferable human characteristic (Carrigan 2012; Chasin, 2011; Flore, 2014; Gupta, 2013). Denial of legitimacy included denying claims to articulate one’s experiences of discrimination as an asexual person and to claims to occupy specific spaces with other sexual minority groups. Microaggressions in this domain invalidate and dehumanize very existence of asexuality. In doing so, they help create an environment in which it may be difficult to disclose an asexual identity and thus curtail opportunities to link with others who have shared experiences or identify similarly. Prior research has linked ‘closeted’ asexuality and concealed asexual identities to feelings of isolation and alienation (Murphy & MacNeela, 2014). Further still, it has been found that negative self-assessments are based on the lack of social acknowledgement of asexuality as a legitimate orientation (Carrigan, 2011), rather than being made on a purely intrapersonal level (Scherrer, 2008). Thus this factor highlights the ubiquitous nature and unconscious perpetuation of asexual people.

Physical and emotional harm experienced by targets of asexual prejudice were captured by the third factor, Harmful visibility. More specifically this domain captures microassaults, or explicitly derogatory statements deliberately used to demean a person (Sue et al., 2007; Nadal, Issa, et al., 2011). Harm took the form of being harassed, threatened, propositions for sex and being referred to by derogatory names due to their identification with asexuality. This factor also represents an aspect of how normative sexuality is imbedded in or can be entangled with erroneous beliefs about “correcting” deviations from a norm (Chasin, 2013, Decker, 2014). Representation of asexuality often stems from stereotypes about what people think asexuality is,
perpetuating harmful visibility for asexual people overall (Decker, 2014; Foster & Scherrer, 2014; Gazzola & Morrison, 2011; Scherrer, 2008). This illustrates how gains in visibility—individually or systemically—may have links with increased vulnerability a spectrum of aggressive, invalidating, or violent acts.

The final factor, assuming causality, accounts for assumptions made about whether asexuality is pathological or caused by an underlying physical condition, mental health issue, or traumatizing event. These microaggressions pertained to ways that targets were communicated that their asexuality is a problem. Being told that asexuality is “not healthy,” and simply overhearing others speculate about the cause of asexuality were microaggressive experiences captured by these items. Views of asexuality as a biological dysfunction or psychological problem is well-documented in the literature (Foster & Scherrer, 2014; Prause & Graham, 2007; MacNeela & Murphy, 2014). In fact, assumptions of causality can be linked to expectations of sexuality when asexuality is conceptualized as regressed, pre-sexual, traumatized, or sexually immature (Barounis, 2014; Bogeart, 2004; Ceranowski & Milks, 2010; Decker, 2014; Milks, 2014; Prause & Graham, 2007). These terms reflect intolerance for deviation from a presumed sexual trajectory and promote the view of asexuality as a state of becoming, transience, or not fully formed. Inherent in labeling something as a problem, is that it requires a solution. The solutions to the asexual problem are a variety of methods including hormonal treatment, psychotherapy, and/or violent methods. Thus, these items are also invalidations of asexual experiences and undermine the possibility of asexuality as valid or legitimate.

Results from Phase 1 indicated good construct, discriminant, and convergent validity as hypothesized. Construct validity of the AMS-24 was supported in relation to measures of social desirability and stigma consciousness. Discriminant validity was supported through
nonsignificant and low correlations with socially desirable responding (Marlowe & Crowne, 1960; Reynolds, 1982). AMS-24 had modest but significant relationships with stigma consciousness (Pinel, 1999). Stigma consciousness, or the degree to which participants expected to be judged based on a stereotype about asexuality, increased as the frequency of asexual prejudice increased. This is consistent with previous literature documenting this relationship amongst lesbian, gay and bisexual individuals (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Brewster & Moradi, 2010; Herek, 2007, 2009, Lewis, Derlega, Griffin, & Krowinski, 2003, Pinel, 1999). Interestingly, stigma consciousness was strongly correlated with the distress scale, which indicates that greater awareness of stigma is also related to greater distress. These findings are also consistent with those in prior studies documenting other sexual minority experiences (Brewster & Moradi, 2010).

All four subscales, both full scales and the validity measures were subject to correlations to examine their relationships. The subscales were all highly correlated with each other suggesting that the factors are related but distinct aspects of asexual prejudice experiences. The subscales were unrelated to socially desirable responding which confirms discriminate validity for the subscales (Marlowe & Crowne, 1960; Reynolds; 1982). In regards to stigma consciousness, the Denial subscale had the strongest positive relationship out of all four subscales with the measure of expectation of stigma (Pinel, 1999). This finding suggests that the frequency of asexual prejudice experiences pertaining to denial of the legitimacy of asexuality increased as expectations of stigma increased. Differences in means for each of the subscales describe the differences in how often each of the subscales was endorsed. When viewed this way, Expectations of sexuality were the most frequently reported, followed by Denial of legitimacy, then Assumption of causality and finally harmful visibility. Though participants were
more frequently microaggressed by being expected to conform to normative sexuality; these were not as strongly related to expectations of stigma as they were to Denial of legitimacy. One possible reason for this is that both measures are assessing expectations albeit either explicitly or implicitly. Each of the subscales had strong positive correlations with both total AMS scales as expected. Overall, the Expect factor had the strongest relationships with both the frequency and distress scales indicating that these microaggressions occur the most frequently and are linked to greater distress. However, additional analysis is required to determine if these differences are statistically significant.

**Phase 2 Confirmatory Factor Analysis**

Phase 2 of this dissertation focused on confirming the factor structure of the AMS and further assessing its validity and internal consistency. The CFA solidified the utility of the AMS as a four-factor measure, and supplemental bifactor analysis supported the use of the total score. Although a strictly unidimensional model did not fit the data well, the bifactor model demonstrated better support for the general factor—whether factors were allowed to correlate or not. Conversely, the bifactor follow-up analysis did not provide support for the use of subscales as independent scores. As such, the AMS may be best used as a total score, representing a general factor of asexual prejudice, but its four subscales can also be used to provide thematic guidance in how these microaggressions manifest. Allowing these hypothesized categories to remain a part of the AMS honors the conceptualization of asexual prejudice as multidimensional.

The validity of the AMS-16 was demonstrated as expected with measures of social attitudes towards asexuality (CSES; Luhtanen & Crocker, 1992), level of asexual identity (AIS; Brotto, Yule, & Gorzalka, 2014), and measure of discrimination and bias (HHRDS; Szymanski, 2006). Moderately strong correlations with heterosexist discrimination, harassment and rejection
indicated good convergent validity asexual prejudice microaggressions are conceptually similarly with heterosexist experiences impacting asexual people. Similar correlation coefficients between this measure and the Harm subscale also support convergent validity as this is the factor that more closely relates to direct experiences of discrimination and harassment. Asexual prejudice had an inverse relationship with judgements of how other people evaluate asexual groups, the more participants indicated experiencing microaggressions, the lower sense of collective self-esteem they felt. This was a surprising finding and contrary to hypothesis; however, this finding is consistent with prior research that has shown this scale to have a negative correlation with one’s beliefs in discrimination such that the higher the public sense of their group’s acceptance in larger society indicated lower beliefs in discrimination (Crocker & Major, 1989; Luhtanen & Crocker, 1992). Further still, collective self-esteem was similarly related to heterosexist discrimination as compared to the AMS. Lastly, the AMS was unrelated to asexual identity which suggests that one’s identity as asexual does not inform endorsement of asexual prejudice microaggressions. Scholars of group identification and bias research, have identified a buffering or positive effect of group identification of perceived discrimination (Branscombe, Ellemers, Spears, & Doosje, 1999; Jetten, Branscombe, Schmitt, Spears, 2001; Luhtanen & Crocker, 1992). Discrimination is a threat to one’s group identity because it implies that the culture as a whole devalues the group membership; thus research indicates that people tend to have increased group identification when faced with discrimination (Branscombe, Ellemers, Spears, & Doosje, 1999; Tajfel & Turner, 1979). Further still, the CSES was originally constructed to assess individual differences in collective self-esteem (Luthanen & Crocker, 1992). Combined with results from this study, it maybe that higher collective self-esteem is related to greater group identification which then mediates the relationship with perceived
discrimination as asexual. This effect has been found amongst various marginalized groups such as people with tattoos (Jetten, Branscombe, Schmitt, Spears, 2001). This is an interesting finding due to the idea that asexual people do no report a collective identity per se, but are collectively organized around the experience (Carrigan, 2011). This sense of collectiveness could also be an artifact of the samples’ recruitment from social-networking sites where people are already identified with a group (albeit in varying degrees). Both scale and factor scores indicated strong internal consistency as demonstrated by above threshold alpha and omega Hierarchical levels (Ponterotto & Ruckdeschel, 2007; Reise et al, 2012).

Each of the subscales was correlated with the AMS total score for frequency and distress as well as the validity measures. On the measure of asexual identity, the Expect subscale was the only significant correlation while the other three were nonsignificant (r=.12, <.05). Yet the relationship was minimal. This slight but statistically significant relationship suggest that level of identity as asexual is marginally related microaggressions pertaining to expectations of sexuality—such that some asexual identities may be more sensitive to these types of microaggressions than others. As with the total scale, each of the subscales had moderate strength relationship with public collective self-esteem. Harm subscale had the strongest link amongst the subscales and matched the full scales in strength. This suggests that harmful visibility is related to lower public self-esteem which is consistent and conceptually meaningful because the harm subscale captures experiences where being seen as asexual brings negative consequences, visibility is one aspects of public collective self-esteem in that it requires one to consider how others see asexual people. Such that, belief that there are negative views of asexual people were linked to greater incidence of more direct, and overt expressions of asexual prejudice. Lastly, each of the subscales had positive and strong relationships with the
heterosexist harassment, discrimination and rejection; particularly the Harm subscale as this one is the most closely aligned with the constructs of this scale.

Item content and distress level were compared and revealed the item reading, “I have been told that asexuality “isn’t real”, had the highest level of distress overall \( (m=3.24) \). This item was followed by “I have been made to feel inferior by others because I am asexual” \( (m=3.18) \) and “Others have told me there is no such thing as asexual discrimination or prejudice” \( (m=3.17) \). This is consistent with posited belief that asexual microaggressions relate to insults and invalidations as opposed to other forms of prejudice (Gazzola & Morrison, 2012). All three of these items are pulled from the Denial of Legitimacy subscale. Even still, the experiences captured by the Harm subscale validate the occurrence of such egregious acts made towards asexual people and supports their inclusion in the larger narrative of asexual prejudice as evidence of the ways in which sexual normativity is maintained.

Mean comparisons by demographic variables were conducted to explore possible differences in endorsement of asexual prejudice across salient demographic categories. These were completed using age, gender and race as these are factors most easily accessed for comparison to larger populations or census data (See Table 8 for comparison of current sample, asexuality census and US census and department of labor percentages). These analyses revealed an effect of age such that the emerging adulthood group reported higher frequency of microaggressions. There were no significant differences found among groups regarding race; however, this finding does not suggest that asexual microaggressions occur regardless of race. However, this may be due to unequal group sizes and overrepresentation of White women in the data set. Regarding gender, the gender-non-conforming group reported more occurrences of these microaggressions compared to the cisgender-female group. These differences indicate that
the AMS is also sensitive to demographic group differences and may be used with a wide variety of samples.

**Limitations**

The findings of this dissertation must be contextualized in light of study limitations. First the majority of participants were White women from the United States. Studies of Internet use, indicate that these individuals are more likely to be female, young, well educated, and urban (Ekman, Dickman, Klint, Weider-pass, & Litton, 2006; Ross et al., 2005). Similar participant demographics have been observed and problematized in previous research (Foster & Scherrer, 2014; Yule, Brotto, Gorzalka, 2013). Comparisons of this study’s sample with Asexuality Census 2016 demonstrates similar proportions of people according to race, gender, and age when analyzed for specifically United States respondents (Asexual Census, 2016; see Table 8). However the sample is not representative of the larger United States population. As such, it may be helpful to further validate this measure with racially and ethnically diverse individuals, as well as men, in order to further explore the external generalizability of this scale.

Second, the Internet survey have may posed unique challenge to external reliability due to overemphasis of those most active on internet (Scherrer, 2008). As highlighted previously, internet recruitment is both advantageous and problematic for the study of asexuality as well as other marginalized identities (Turkle, 1995; McKenna & Bargh, 1998). The Internet has been a primary site of communal dialogue and education and is particularly integral to the identity development process for many asexual identified people. As such, social networking sites such as Tumblr and Facebook with other forums designed for information exchange are key to recruitment in the study of asexuality (Pacho, 2013; Renninger, 2014). Indeed, this notion was corroborated by recruitment sites in this study as indicated by the majority of participants being
recruited from Tumblr. This suggests that the data may be skewed towards people who have found an online community of people who think or feel similarly and have access to more information about asexual community issues.

Another limitation is that this study relied on using scales for validity that were modified for use with asexual people for the first time in this study. The measures of socially desirable responding, stigma consciousness and collective self-esteem were all modified for use with this sample. As emphasized in the aims and purpose of this dissertation, this limits the ability for this study to fully illustrate the kinds of experiences unique to asexual people (Chasin, 2015; Morrison, Bishop, Morrison & Parker-Taneo, 2016). Because of their use in this present study, the HHRDS for asexual people and the AIS gained additional support for their use. Similarly, while this is the first use of the SDS, SCQ and CSES for these purposes it need not be the last given good ratings of internal consistency with these measures with the current sample which suggests the need for greater exploration of the utility of these measures with asexual populations.

**Future Directions**

With a prevalence of approximately 1-5% of the population, asexual people constitute a sexual minority group who are negatively impacted by normative ideas about sex and sexuality. From this sex normative stance, asexual prejudice is a counterargument that undermines the legitimacy and possibility of an asexual reality. Though narratives of asexual prejudice emerge amongst communities and advocacy efforts, academic research lags with systematic ways of identifying and quantifying these instances. One barrier to this work is the lack of ways to quantify and identify these experiences for asexual people. Given that asexual microaggressions
stem from systemic enforcement and sex normativity, it is important to contextualize these findings to identify ways that this tool is best used.

As awareness of and knowledge about asexuality increases, the importance of recognizing the issues impacting this community also grows. Because this scale is a first step towards examining the experiences of asexual people and asexual prejudice. Further study of the impact of these microaggressions and other macroaggressive experiences would be another area of next steps. Prior research has indicated the asexual people may experience more psychological distress compared to other sexual minorities (Lucassen, 2011; Nurius, 1983). Coupled with findings that asexual college students seek help at lower rates despite endorsement of significant distress (McAleavey, Castonguay & Locke, 2011). Distress has been discussed as a function of timing—that there may be differences between those who have yet to acknowledge to themselves and/or others that they are asexual. Researchers have reported that people identifying as asexual, but who have yet to find community may feel more distress due to isolation and confusion compared to those who have reached an integrated asexual identity (Brotto & Yule, 2009; Yule et al., 2013). Taken together, those still questioning or seeking community, may be just as aware of stigmas facing asexual people but are less equipped to manage them without a sufficient network. Thus additional work examining the links of microaggression and prejudice, distress and timing would be helpful in clarifying the impact of microaggressions and determining ways to address the consequences (Sue et al., 2009).

With a measure of stigma, investigation in to how minority stress model or minority stress theory (MST) may apply to the lives of asexually-identified people is possible (Meyer, 2003). Several of the measures used in the present study have been used in prior research in minority stress (Morrison, Bishop, Morrison & Parker-Taneo, 2016). As it stands, none of the
research with minority stress have included asexual people in their samples. However, minority stress becomes a useful framework to understand asexuality-specific stigma experiences due to its flexibility and incorporation of intrapsychic (internalized oppression), interpersonal (prejudice harassment and discrimination), institutional (social institutions such as family, marriage, medicine) and ideological (heterosexism, racism, homophobia) levels of threat. Much of the work in expanding MST to asexuality is laid by the creation of the AMS scale. Further exploration into the nature of distress and the context in which these experiences is more possible; particularly in the context of an academic field and society were normative ideas regarding sexuality are also imbedded in each aspect of the research designed to support its narratives (Flore, 2013; Hanson, 2014). In addition, when framed in the context of MST, the AMS could also be used in clinical settings as a tool to initiate discussion about an asexual identity and maybe be helpful in clarifying experiences that maybe a source of clinical concern.

The findings suggest that it is important to for clinicians to keep an open mind as to the ways in which experiences become traumatic and then, potentially, become implicated in the person’s asexual identity. The reported distress may be due to the identity as opposed to causing it. It also points out that clinicians may need to increase their knowledge of asexuality as to not unintentionally invalidate an asexual person’s experience (Foster & Scherrer 2014). Either in research or clinical work, exploring the nature of distress that is associated with an asexual identity would be helpful when conducted from the standpoint of potentially ameliorating the effects of minority stress.

Lastly, given the broad ways that people identified themselves, and the large numbers of asexual people who also carry marginalized or oppressed identities as people of color, as LGBTQ, or as having a disability, another important step would be to further assess how asexual
prejudice manifests and mixes with other identities and the discrimination associated with them. As noted in the limitations, the sample was majority young White women. Overrepresentation of this group suggests that this population is (or is allowed to) engage in their sexuality in a way that other ethnic groups and genders are not permitted. This may be due to the unique intersections of marginalized and privileged identities that supports this group’s agency in defining their sexuality for themselves. Here, there are links to radical feminist efforts to identify as asexual as an act of rebellion from the patriarchy and compulsory heterosexuality (Fahs, 2013). Recognizing the unique issues affecting this population both directly and indirectly related to their asexual identities is also implicated in further research of the intersections of race and gender (Aiken et al., 2013). Further still with evidence that religion plays a role in how an asexual identity becomes determined (Aiken et al., 2013; Bogeart, 2004; Foster, Eklund, Walker, Brewster, & Candon, in preparation). When examined through these lenses, asexual prejudice and microaggressions may shift in salience, intensity and/or frequency, thus further research will help contextualize and extend the findings of this dissertation.
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APPENDIX A

Glossary of Terms

ace: shorthand term for person who identifies as asexual or along the asexual spectrum
aromantic: lack of romantic attraction; sometimes referred to as “aro” for short
asexophobia: has been used to refer to the irrational fear of asexuality
asexual prejudice: anti-asexual attitudes and beliefs
asexual spectrum: term used to encompass diversity within asexual communities; includes those reporting lack of or limited a/sexual attraction
asexuality: an umbrella term that captures the attraction, experiences, and fantasies that privilege emotion and non-sexual intimacy in the context of infrequent or no sexual attraction
biromantic: romantic attraction towards both genders; also can be bisexual
demisexuality: orientation in which sexual attraction is develop almost exclusively in the context of romantic relationships
gray-asexuality: (also known as gray-As) those individuals who identify in the gray area between asexuality and sexuality.
heteroromantic: romantic attraction towards another gender different from oneself; also can be heterosexual.
homoromantic: same-gender romantic attraction; also can be gay or lesbian
intimacy: close familiarity or friendship; closeness but not explicitly sexual or erotic
nonsexuality: instances in which sexual desire, attraction, or behavior is absent but an asexual identity is not present
panromantic: romantic attraction towards others regardless of gender; also can be pansexual
romantic attraction: is an emotional response that most people often feel that results in a desire for a romantic relationship with the person that the attraction is felt towards. M
romantic orientation: refers to an individual's pattern of desire to express love towards another, often designated by gender.
romantic: conducive to or characterized by the expression of love in a non-familial context.
sexual attraction: refers to the inclination towards engaging in physically intimate and/or erotic activities with with another person OR the ability to be aroused by this attraction.
sexuals: refers to those who are sexually attracted towards other people; sometimes referred to as allosexual
APPENDIX B

Asexual Microaggressions Scale (AMS)

INSTRUCTIONS: Below are several statements that capture different kinds of experiences. Please rate each item once for the frequency and once more for how much the experience(s) affected you over the PAST SIX (6) MONTHS.

Explanation of Terms: The terms below will appear throughout the survey. For the purposes of this research, please keep these terms and their definitions in mind as you answer the questions that follow.

1) Romantic orientation: refers to an individual’s pattern of desire to express love towards another, often designated by gender (e.g., homoromantic, heteroromantic, panromantic).
2) Asexuality or asexual-spectrum: refers to an individual’s pattern of sexual attraction towards others (or lack thereof) and includes experiences that are some combination of ‘asexual’ or ‘non-asexual’ (e.g., ace, grey-A, demi-sexual, etc).
3) Sexual attraction: refers to the inclination towards engaging in physically intimate and/or erotic activities with another person OR the ability to be aroused by this attraction.

Frequency
1 = I did not experience this in the past 6 months
2 = I experienced this event ONCE IN A WHILE/RARELY (1–3 times) in the past 6 months
3 = I experienced this event SOMETIMES (4–6 times) in the past 6 months
4 = I experienced this event A LOT/OFTEN (7–9 times) in the past 6 months
5 = I experienced this event ALMOST ALL OF THE TIME (10 or more times) in the past 6 months

Distress
1 = Did not happen/not applicable to me
2 = It bothered me NOT AT ALL
3 = It bothered me A LITTLE BIT
4 = It bothered me QUITE A BIT
5 = It happened, and it bothered me EXTREMELY

Expectation of sexuality
1. I have been told that I am asexual because I haven't met the right person.
2. Others have assumed that I choose to be asexual.
3. I have been asked to provide examples of how I know I am asexual.
4. I have been told that no one will want me as a relationship partner unless I "put out" because I am asexual.

Denial of asexuality
5. I have been told that asexuality "isn't real."
6. I have been told that being asexual is against human nature.
7. Others have told me there is no such thing as asexual discrimination or prejudice.
8. I have been made to feel inferior by others because I am asexual.

Harmful visibility
9. I have been harassed because I am asexual.
10. I have been called derogatory names (e.g., "prude" or "freak") in relation to my asexuality.
11. I have been propositioned for sex or sex-related activities because I am asexual (e.g., "Let me show you what you are missing.").
12. I have been threatened with harm because I am asexual.

Assuming causality
13. I have been told that asexuality is a form of sexual dysfunction, not a valid way to identify.
14. I have been told that I am "not healthy" because I am asexual.
15. I have heard non-aseual people speculate about the 'cause' of my asexuality.
16. People have asked me if sexual trauma is the reason I am asexual.

Scoring:
AMSf Total Score = mean of all frequency items
AMSD Total Score = mean of distress level for each item
APPENDIX C

Marlowe-Crowne Social Desirability Scale Short Form
(MC-C; Reynolds, 1982; MCSD*; Crowne & Marlowe, 1960)

INSTRUCTIONS: Please indicate if the statement is true or false for you.

1. It is sometimes hard for me to go on with my work if I am not encouraged.
2. I sometimes feel resentful when I don’t get my way.
3. On a few occasions, I have given up doing something because I thought too little of my ability.
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. No matter who I’m talking to, I’m always a good listener.
6. There have been occasions when I took advantage of someone.
7. I’m always willing to admit it when I make a mistake.
8. I sometimes try to get even rather than forgive and forget.
9. I am always courteous, even to people who are disagreeable.
10. I have never been irked when people expressed ideas very different from my own.
11. There have been times when I was quite jealous of the good fortune of others.
12. I am sometimes irritated by people who ask favors of me.
13. I have never deliberately said something that hurt someone’s feelings.

Item number(s): 3, 6, 10, 12, 13, 15, 16, 19, 21, 26, 28, 30, 33 of original 33-item scale*
APPENDIX D

Stigma Consciousness Questionnaire
(SCQ; Pinel, 1999)

INSTRUCTIONS: Please indicate the extent to which you agree or disagree with the following statements using the scale below.

(1) Strong Disagree ======Neither Agree or Disagree====== Strongly Agree (6)

<table>
<thead>
<tr>
<th>Original</th>
<th>Modified</th>
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<tbody>
<tr>
<td>1. Stereotypes about homosexuals have not affected me personally.</td>
<td>1. Stereotypes about asexual people have not affected me personally.</td>
</tr>
<tr>
<td>2. I never worry that my behaviors will be viewed as stereotypical of homosexuals.</td>
<td>2. I never worry that my behaviors will be viewed as stereotypical of asexual people.</td>
</tr>
<tr>
<td>3. When interacting with heterosexuals who know of my sexual preference, I feel like they interpret all my behaviors in terms of the fact that I am a homosexual.</td>
<td>3. When interacting with non-asexual people who know of my asexuality I feel like they interpret all my behaviors in terms of the fact that I am asexual.</td>
</tr>
<tr>
<td>4. Most heterosexuals do not judge homosexuals on the basis of their sexual preference.</td>
<td>4. Most non-asexual people do not judge homosexuals on the basis of their lack of sexual preference.</td>
</tr>
<tr>
<td>5. My being homosexual does not influence how homosexuals act with me.</td>
<td>5. My being asexual does not influence how asexuals act with me.</td>
</tr>
<tr>
<td>6. I almost never think about the fact that I am homosexual when I interact with heterosexuals.</td>
<td>6. I almost never think about the fact that I am asexual when I interact with non-asexual people.</td>
</tr>
<tr>
<td>7. My being homosexual does not influence how people act with me.</td>
<td>7. My being asexual does not influence how people act with me.</td>
</tr>
<tr>
<td>8. Most heterosexuals have a lot more homophobic thoughts than they actually express.</td>
<td>8. Most non-asexual people have a lot more anti-asexual thoughts than they actually express.</td>
</tr>
<tr>
<td>9. I often think that heterosexuals are unfairly accused of being homophobic.</td>
<td>9. I often think that non-asexuals are unfairly accused of being anti-asexual.</td>
</tr>
<tr>
<td>10. Most heterosexuals have a problem viewing homosexuals as equals.</td>
<td>10. Most non-asexuals have a problem viewing asexuals as equals.</td>
</tr>
</tbody>
</table>
APPENDIX E

Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992)

INSTRUCTIONS: We are all members of different social groups or social categories. Some of such social groups or categories pertain to gender, race, religion, nationality, ethnicity, and socioeconomic class. We would like you to consider your memberships as an asexual person OR questioning or potentially asexual person, and respond to the following statements on the basis of how you feel about those groups and your memberships in them. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions. Please read each statement carefully, and respond by using the following scale from 1 to 7:

1 (Strongly Disagree)-----------------------------7 (Strongly Agree)

1. Overall, asexual people are considered good by others.

2. Most people consider asexual people, on the average, to be more ineffective than other social groups.

3. In general, others respect asexual people.

4. In general, others think that asexual people are unworthy.
INSTRUCTIONS: Please think carefully about your life as you answer the questions below. Read each question and then circle the number that best describes events in the PAST YEAR, using these rules. Circle 1—If the event has NEVER happened to you; Circle 2—If the event happened ONCE IN A WHILE (less than 10% of the time); Circle 3—If the event happened SOMETIMES (10–25% of the time); Circle 4—If the event happened A LOT (26–49% of the time); Circle 5—If the event happened MOST OF THE TIME (50–70% of the time); Circle 6—If the event happened ALMOST ALL OF THE TIME (more than 70% of the time).

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<thead>
<tr>
<th>Original</th>
<th>Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 1 Harassment and rejection</strong></td>
<td><strong>Harassment and rejection</strong></td>
</tr>
<tr>
<td>12 How many times have you been rejected by friends because you are a LESBIAN?</td>
<td>12 How many times have you been rejected by friends because you are ASEXUAL?</td>
</tr>
<tr>
<td>14 How many times have you been verbally insulted because you are a LESBIAN?</td>
<td>14 How many times have you been verbally insulted because you are ASEXUAL?</td>
</tr>
<tr>
<td>10 How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are a LESBIAN?</td>
<td>10 How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are ASEXUAL?</td>
</tr>
<tr>
<td>13 How many times have you heard ANTI-LESBIAN/ANTI-GAY remarks from family members?</td>
<td>13 How many times have you heard ANTI-ASEXUAL remarks from family members?</td>
</tr>
<tr>
<td>11 How many times have you been rejected by family members because you are a LESBIAN?</td>
<td>11 How many times have you been rejected by family members because you are ASEXUAL?</td>
</tr>
<tr>
<td>9 How many times have you been called a HETEROSEXIST name like dyke, lezzie, or other names?</td>
<td>9 How many times have you been called a HETEROSEXIST name like dyke, lezzie, or other names?</td>
</tr>
<tr>
<td>8 How many times have you been treated unfairly by your family because you are a LESBIAN?</td>
<td>8 How many times have you been treated unfairly by your family because you are ASEXUAL?</td>
</tr>
<tr>
<td><strong>Factor 2 Workplace and school discrimination</strong></td>
<td><strong>Workplace and school discrimination</strong></td>
</tr>
<tr>
<td>2 How many times have you been treated unfairly by your employer, boss, or supervisors because you are a LESBIAN?</td>
<td>2 How many times have you been treated unfairly by your employer, boss, or supervisors because you are ASEXUAL?</td>
</tr>
<tr>
<td>7 How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are a LESBIAN?</td>
<td>7 How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are ASEXUAL?</td>
</tr>
</tbody>
</table>
1. Verbally insulted
2. Called an insulting name that referred to asexual identity/appearance
3. Heard anti-asexual remarks from family members
4. Treated unfairly by parents
5. Treated unfairly by fellow students
6. Treated unfairly by extended family
7. Treated unfairly by strangers
8. Rejected by female friends
9. Treated unfairly by romantic partner
10. Rejected by a romantic partner
11. Treated unfairly by people in a medical profession
12. Rejected by parents
13. Treated unfairly by co-workers
14. Rejected by male friends
15. Rejected by siblings
16. Treated unfairly by siblings
17. Treated unfairly by people in service jobs
18. Treated unfairly by teachers or professors
19. Denied something at work not mentioned above that you deserved
20. Treated unfairly by employers or supervisors
21. Denied a raise that you deserved
22. Denied a promotion that you deserved
23. Denied a job that you deserved
24. Rejected by extended family

HHRDS-A (modified version of HHRDS for asexuals; Gazzola & Morrison, 2012) exchanged asexual or lesbian. Several items were added to capture unique asexual experiences resulting in 24 items instead of 20. Items were rating on a scale from 0-6 where: (0) Not applicable, (1) Never, (2) 1-2 times, (3) 3-4 times (4) 5-7 times, (5) 8-10 times, (6) more than 10 times.
Asexuality Identification Scale
(AIS; Yule, M. A., Brotto, L. A. & Gorzalka, B. B., 2014)

What is your sexual orientation? _____________________

1. I experience sexual attraction toward other people
2. I lack interest in sexual activity
3. I don’t feel that I fit the conventional categories of sexual orientation such as heterosexual, homosexual (gay or lesbian), or bisexual.
4. The thought of sexual activity repulses me.
5. I find myself experiencing sexual attraction toward another person
6. I am confused by how much interest and time other people put into sexual relationships
7. The term “nonsexual” would be an accurate description of my sexuality
8. I would be content if I never had sex again
9. I would be relieved if I was told that I never had to engage in any sort of sexual activity again
10. I go to great lengths to avoid situations where sex might be expected of me
11. My ideal relationship would not involve sexual activity
12. Sex has no place in my life
13. Which of the following best describes you?
   [Heterosexual, Bisexual, Homosexual (Lesbian or Gay); Asexual]
APPENDIX H

DEMOGRAPHIC ITEMS

1. Romantic Orientation
   a. Homoromantic
   b. Heteroromantic
   c. Biromantic
   d. Personal Term: _____________

2. Partnership Status (check all that apply currently)
   a. Married
   b. Single never married
   c. Dating
   d. Divorced
   e. More complicated? Please specify __________

3. Poly (amorous or polyfidelity)

4. Gender
   a. Woman of trans* experience (e.g., male-assigned-at-birth)
   b. Ciswoman
   c. Man of trans* experience (e.g., female-assigned-at-birth)
   d. Cisman
   e. Nonbinary (e.g., neutrois, genderfluid, boi, agender). Please specify: __________

5. Race and Ethnicity
   a. Black
      i. African-American
      ii. Latino@/Hispanic
      iii. West Indian (e.g., Jamaica, Barbados, Trinidadian, etc)
   b. White or Caucasian
      i. European or Anglo
      ii. Jewish
   c. Asian
      i. East Asian (e.g., Chinese, Japanese)
      ii. South Asian (e.g., Bengali, Nepalese, Indian)
   d. Latin@ (no race specified)
   e. Middle Eastern
   f. Multi/biracial or Multiethnic? Please specify: __________
   g. Indigenous or Native. Please specify Region: __________

6. Age
   a. 18-24
   b. 25-35
   c. 36-45
   d. 46-65
   e. 65+

7. Education (best the describes your current situation)
   a. Currently pursuing college or university. Specify year:  1  2  3  4 (5 or 6)
   b. Completed high school or equivalent
   c. Graduated with Associates
d. Graduated with Bachelors or Bachelorette  
e. Enrolled in post-graduate work (e.g., MA, MS, PhD, MD, etc)  
f. Graduated with post-graduate degree

8. SES  
  a. Poverty or Homeless  
  b. Low Income or Working Class  
  c. Middle class  
  d. Upper middle class or income  
  e. Upper class

9. Geographic  
  a. Urban  
  b. Suburban  
  c. Rural

10. How did you hear about this study?  
  a. AVEN  
  b. CraigsList  
  c. Facebook  
  d. Tumblr  
  e. Personal Contact  
  f. Other: ____________

11. Ever been diagnosed with psychological or physical condition? (yes no)  
  a. If yes, describe diagnosis (if known) and age. Does this have any bearing on your view of asexuality?
### APPENDIX I

**ALL LOADINGS FOR ALL ITEMS**

<table>
<thead>
<tr>
<th>Items by Factor</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been told that I am asexual because I haven't met the right person.</td>
<td>0.888</td>
<td>-0.039</td>
<td>-0.202</td>
<td>0.054</td>
</tr>
<tr>
<td>(38F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been told that asexuality is &quot;just a phase.&quot; (36F)</td>
<td>0.831</td>
<td>0.126</td>
<td>-0.301</td>
<td>0.006</td>
</tr>
<tr>
<td>Others have assumed I will miss out on social milestones (i.e., marriage,</td>
<td>0.769</td>
<td>0.209</td>
<td>-0.125</td>
<td>-0.133</td>
</tr>
<tr>
<td>children) because I am asexual. (26F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People have assumed that I will live out my life alone because I am asexual.</td>
<td>0.715</td>
<td>0.141</td>
<td>-0.132</td>
<td>-0.003</td>
</tr>
<tr>
<td>(25F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been asked to provide examples of how I know I am asexual. (7F)</td>
<td>0.593</td>
<td>-0.015</td>
<td>0.197</td>
<td>0.016</td>
</tr>
<tr>
<td>I have been told that no one will want me as a relationship partner unless I</td>
<td>0.529</td>
<td>0.01</td>
<td>0.124</td>
<td>0.09</td>
</tr>
<tr>
<td>&quot;put out&quot; because I am asexual. (24F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People have asked me invasive questions about my sex life (e.g., frequency</td>
<td>0.508</td>
<td>-0.103</td>
<td>0.278</td>
<td>0.085</td>
</tr>
<tr>
<td>of sexual encounters, masturbation habits, etc.) as evidence to deny my</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>asexual-spectrum orientation. (2F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others have assumed that I identify as asexual because I &quot;can't get laid.&quot;</td>
<td>0.491</td>
<td>-0.146</td>
<td>0.219</td>
<td>0.112</td>
</tr>
<tr>
<td>(23F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others have assumed that I choose to be asexual. (40F)</td>
<td>0.477</td>
<td>0.13</td>
<td>-0.108</td>
<td>0.238</td>
</tr>
<tr>
<td>I have been pressured to be sexually active because I am asexual. (17F)</td>
<td>0.431</td>
<td>-0.187</td>
<td>0.404</td>
<td>0.05</td>
</tr>
<tr>
<td>Others have told me there is no such thing as asexual discrimination or</td>
<td>-0.01</td>
<td>0.792</td>
<td>0.111</td>
<td>-0.117</td>
</tr>
<tr>
<td>prejudice. (9F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others have objected to asexuality being included under the queer umbrella</td>
<td>-0.04</td>
<td>0.773</td>
<td>-0.034</td>
<td>-0.073</td>
</tr>
<tr>
<td>(10F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been made to feel inferior by others because I am asexual. (5F)</td>
<td>0.064</td>
<td>0.53</td>
<td>-0.094</td>
<td>0.165</td>
</tr>
<tr>
<td>I have been told that being asexual is against human nature. (27F)</td>
<td>0.129</td>
<td>0.449</td>
<td>-0.05</td>
<td>0.326</td>
</tr>
<tr>
<td>I have been told that asexuality “isn’t real.” (1F)</td>
<td>0.218</td>
<td>0.436</td>
<td>0.121</td>
<td>0.131</td>
</tr>
<tr>
<td>I have been assaulted because I am asexual. (13F)</td>
<td>-0.266</td>
<td>0.002</td>
<td>0.753</td>
<td>0.048</td>
</tr>
<tr>
<td>I have been harassed because I am asexual. (14F)</td>
<td>-0.098</td>
<td>0.284</td>
<td>0.711</td>
<td>-0.027</td>
</tr>
<tr>
<td>I have been threatened with harm because I am asexual. (16F)</td>
<td>-0.307</td>
<td>0.128</td>
<td>0.698</td>
<td>0.118</td>
</tr>
<tr>
<td>I have been propositioned for sex or sex-related activities because I am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>asexual (e.g. &quot;Let me show you what you are missing.&quot;). (15F)</td>
<td>0.173</td>
<td>-0.12</td>
<td>0.646</td>
<td>-0.027</td>
</tr>
<tr>
<td>I have been called derogatory names (e.g., &quot;prude&quot; or &quot;freak&quot;) in relation to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>my asexuality. (20F)</td>
<td>0.317</td>
<td>0.058</td>
<td>0.517</td>
<td>-0.057</td>
</tr>
<tr>
<td>I have been told that I am &quot;not healthy&quot; because I am asexual. (30F)</td>
<td>-0.069</td>
<td>0.131</td>
<td>0.005</td>
<td>0.827</td>
</tr>
<tr>
<td>I have been told that asexuality is a form of sexual dysfunction, not a valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>way to identify. (29F)</td>
<td>-0.008</td>
<td>0.265</td>
<td>-0.078</td>
<td>0.753</td>
</tr>
<tr>
<td>People have asked if sexual trauma is the reason I am asexual. (39F)</td>
<td>0.198</td>
<td>-0.197</td>
<td>0.142</td>
<td>0.623</td>
</tr>
<tr>
<td>I have heard non-aseual people speculate about the 'cause' of my asexuality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(33F)</td>
<td>0.184</td>
<td>-0.108</td>
<td>0.176</td>
<td>0.591</td>
</tr>
<tr>
<td>Despite what I tell them, others have assumed that my experience(s) with sex</td>
<td>0.356</td>
<td>-0.159</td>
<td>0.092</td>
<td>0.454</td>
</tr>
<tr>
<td>(e.g., whether I have had sex) indicate whether or not I can be asexual. (41F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People assume that I am asexual because of my mental health. (35F)</td>
<td>0.09</td>
<td>0.056</td>
<td>0.226</td>
<td>0.4</td>
</tr>
</tbody>
</table>