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Research Article

Bodies Without Libido: Posthuman Ethics and the Politics of Diagnosis

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Abstract: Contemporary medical and psychological discourses often treat libido as a defining feature of healthy personhood. Within such frameworks, individuals who experience little or no sexual desire are frequently interpreted through diagnostic categories rather than recognized as possessing a valid identity. The figure of the asexual subject challenges this assumption by revealing how norms of sexuality are historically produced, culturally enforced, and institutionally maintained. From a posthuman ethical perspective, bodies are not fixed biological truths but sites shaped by social expectations, biomedical knowledge, and regulatory systems. The classification of non-desire as dysfunction, therefore, raises ethical questions about the authority of diagnostic language and the power structures embedded within it. Labeling low or absent libido as pathology risks reducing diverse forms of embodiment to measurable standards derived from normative models of desire. Such practices may obscure lived experience, silence alternative forms of intimacy, and reinforce narrow definitions of the human. A critical bioethical approach foregrounds the need to distinguish between distress that requires care and difference that warrants recognition. Reconsidering non-desire through posthuman ethics encourages a shift away from essentialist ideas of sexuality towards a more inclusive understanding of personhood. Such a framework supports ethical models that respect bodily variation, question medical authority when necessary, and affirm identities that exist beyond traditional sexual norms.

Keywords: Asexuality; Bioethics; Posthumanism

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Introduction

Modern biomedical discourse frequently presents sexuality as a central indicator of health, maturity, and complete personhood. Within such frameworks, the presence of sexual desire is often treated as a natural and universal human trait. At the same time, its absence is interpreted as a sign of deficiency, immaturity, or disorder. Clinical terminology, diagnostic manuals, and therapeutic interventions have historically reinforced this assumption by positioning libido as a measurable function that can be evaluated, corrected, or restored. Consequently, individuals who experience little or no sexual desire are often understood through categories of dysfunction rather than recognized as embodying a legitimate variation of human experience. This framing reveals how medical knowledge does not merely describe bodies but also assigns value to particular bodily states. The inquiry examines how diagnostic discourses construct non-desire as pathology and questions the ethical assumptions within such classifications. Such scrutiny matters because dominant medical models continue to shape social attitudes, institutional practices, and personal self-understanding in ways that are rarely critically examined.

The emergence of asexual identity challenges these assumptions by questioning the belief that sexual desire is biologically inevitable or necessary for a meaningful life. Asexuality reveals that the absence of sexual attraction does not inherently signal distress, impairment, or pathology. Instead, it exposes the extent to which cultural expectations, institutional authority, and historical patterns of classification shape norms of sexuality. Such recognition complicates the authority traditionally granted to diagnostic systems, since these systems operate within social contexts that influence what counts as normal or abnormal. Diagnostic frameworks, therefore, function not only as clinical tools but also as cultural mechanisms that reinforce dominant understandings of the body. Normative models of desire can thus be understood as regulatory structures that shape social recognition and determine which forms of embodiment are treated as fully human. When sexual desire is positioned as a defining feature of personhood, those who do not conform risk marginalization or medicalization. Examining these assumptions opens space for a broader ethical discussion about the relationship between bodily diversity, medical authority, and the standards used to define human legitimacy.

Sexuality is often presented within scientific and popular discourse as a natural and biologically self-evident aspect of human life, yet historical and cultural analysis demonstrates that ideas about "normal" desire have been shaped over time rather than discovered. What societies interpret as healthy sexuality has been influenced by shifting moral codes, religious teachings, legal regulations, and medical theories. Medical, legal, and psychological institutions have played a central role in defining which expressions of desire are accepted and which are treated as deviant or deficient. These institutions have not merely described sexual behavior but have actively produced standards against which individuals are measured. The concept of libido, for instance, has frequently been treated as though it were a stable and quantifiable biological drive, capable of being assessed, compared, and ranked across individuals. Such a measurement suggests that

desire can be calibrated on a universal scale, thereby reinforcing the belief that there exists a correct level of sexual interest that all healthy individuals should display. "The sodomite had been a temporary aberration; the homosexual was now a species" (Foucault 43). This assumption grants authority to professional expertise while also encouraging individuals to evaluate themselves against institutional norms.

Diagnostic classifications provide clear evidence that sexual norms are historically constructed rather than biologically fixed. Categories such as hypoactive desire disorder illustrate how institutional frameworks define the boundaries between variation and dysfunction. These labels do not emerge in isolation from culture but reflect prevailing expectations about relationships, productivity, gender roles, and emotional fulfillment. What is classified as a disorder in one period may not have been considered problematic in another, demonstrating that definitions of dysfunction change alongside social values. "Definitions of mental disorder are not value-free but are based on social norms" (Horwitz 15). Such shifts indicate that sexual norms are products of discourse shaped by professional authority, social regulation, and cultural belief rather than direct reflections of biological truth. When diagnostic systems present certain patterns of desire as deficient, they often reinforce dominant ideals about what bodies should feel and how they should respond. In this sense, medical language can transform difference into pathology by interpreting diversity through a framework designed to preserve norms. Understanding sexuality as historically produced, therefore, reveals that diagnostic labels frequently reflect cultural expectations as much as, or more than, clinical necessity, and it highlights the importance of examining how institutional power influences definitions of health, normality, and personhood.

Medicalization refers to the process through which human differences are redefined as medical problems requiring diagnosis, explanation, and treatment. It is a process by which "nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad 4). In the context of sexuality, this process often converts variations in desire into signs of pathology. When the absence of sexual desire is framed primarily as a clinical symptom, it becomes interpreted as something that must be corrected rather than understood as a possible form of natural diversity. Such interpretations assume that a consistent level of libido is a universal feature of healthy embodiment. As a result, individuals who do not experience sexual desire may be positioned within diagnostic categories that define their experience as abnormal, even when they do not report distress or impairment. The authority of clinical language plays a significant role in this transformation, because medical terminology carries institutional legitimacy that can outweigh personal accounts of bodily experience. When diagnostic labels are applied, they often reshape how individuals understand themselves, encouraging them to reinterpret their identities through a pathological framework rather than through their own self-descriptions.

The influence of the pharmaceutical and therapeutic industries further reinforces the idea that libido should conform to normative standards. Treatments designed to increase sexual desire implicitly promote the belief that desire is both

necessary and measurable, and that deviations from an expected level require intervention. In this way, diagnostic categories do not merely identify illness but can actively produce patients by defining certain forms of embodiment as problems in need of correction. This process raises ethical concerns about epistemic injustice, since institutional forms of knowledge are frequently granted greater authority than the testimonies of those whose experiences are being classified. When professional expertise is treated as the sole legitimate source of understanding, self-identification may be dismissed as confusion, denial, or misinterpretation. Non-desire is therefore often understood as absence or deficiency rather than as a valid variation within the spectrum of human experience. Recognizing this dynamic highlights how medicalization can shape not only treatment practices but also broader cultural beliefs about normality, health, and the boundaries of acceptable embodiment.

Asexuality presents a significant epistemic challenge to established medical and psychological frameworks because it asserts the legitimacy of an identity that has historically been interpreted as pathology. Rather than understanding the absence of sexual desire as a disorder, asexual self-identification affirms that non-desire can be a stable and meaningful mode of being. This distinction between difference and distress is ethically crucial, since clinical traditions have often assumed that deviation from normative desire must indicate dysfunction. Asexual perspectives demonstrate that lack of sexual attraction does not necessarily produce suffering, impairment, or relational incapacity, and therefore cannot automatically be classified as illness. Such recognition calls attention to the assumptions embedded within diagnostic systems, especially the belief that libido is a universal biological drive that defines healthy subjectivity. "The norm is not the same as a rule, and it is not the same as a law" (Butler 41). When individuals identify as asexual without seeking treatment or cure, they challenge the authority of institutional frameworks that claim to interpret bodily experience more accurately than the individuals themselves. In this way, identity-based recognition operates as a form of resistance to medical authority, not by rejecting medicine as such, but by questioning its exclusive claim to define normality. Asexual communities have also contributed to this challenge by developing alternative vocabularies for describing intimacy, attachment, and relational fulfillment. These linguistic innovations allow experiences to be articulated outside traditional sexual frameworks and demonstrate that emotional connection does not depend on erotic desire. Such discursive practices broaden the conceptual field through which intimacy is understood and undermine the assumption that sexuality is the central organizing principle of human relationships. Recognition of asexuality therefore destabilizes sexual essentialism, the idea that sexual desire is a natural, universal, and defining characteristic of all humans. By existing as a visible and articulated identity, asexuality reveals that what has often been treated as a biological fact may instead be a culturally reinforced expectation. It exposes how psychological classifications frequently rely on unexamined norms that equate desire with vitality, maturity, and completeness. In doing so, non-desire highlights the limits of libido-centered models of human nature and demonstrates that such models cannot adequately account for the diversity of lived experience. The epistemic significance of asexuality lies in its capacity to reveal the

constructed nature of diagnostic knowledge and to encourage more inclusive frameworks that recognize variation without automatically pathologizing it.

Posthuman ethics challenges the assumption that there is a single, fixed definition of what it means to be human. Traditional humanist thought has often treated the human as a stable biological category defined by rationality, productivity, sexuality, and reproductive capacity. In contrast, posthuman perspectives understand bodies as complex assemblages shaped not only by biology but also by culture, technology, language, and social discourse. "The posthuman view thinks of the body as the original prosthesis" (Hayles 3). From this viewpoint, embodiment is not a static essence but an evolving condition produced through multiple influences. Such an approach questions the tendency to measure personhood according to biological functions, especially those connected to sexuality or reproduction. When sexual desire is treated as a defining feature of humanness, individuals who do not conform to this expectation risk being seen as incomplete or deficient. Posthuman ethics exposes this assumption as historically constructed rather than naturally given, showing that standards of normal embodiment emerge from cultural priorities rather than universal biological truths. Within this framework, libido cannot be understood as a universal constant shared equally by all bodies, but rather as a trait that has been culturally privileged and socially reinforced. Normative sexuality functions as a regulatory ideal that shapes how health, maturity, and legitimacy are defined, often without acknowledging the diversity of bodily experience. Ethical reflection grounded in posthuman thought, therefore, calls for frameworks that recognize variation without ranking bodies according to reproductive or sexual norms. Such an approach shifts attention away from conformity to biological standards and towards relational existence, where personhood is understood through connection, interaction, and situated experience rather than through fixed physiological criteria. This perspective supports a more inclusive ethical model that affirms bodily diversity and challenges systems that equate difference with deficiency, thereby expanding the understanding of what counts as human.

Diagnosis is often presented as an objective medical practice based solely on scientific observation, yet social contexts, institutional priorities, and historical conditions deeply shape it. Rather than functioning as a neutral description of bodily or psychological states, diagnostic classification operates within systems of knowledge that reflect prevailing cultural values and power relations. Psychiatric and medical categories are developed through professional consensus, research traditions, and institutional frameworks, all of which are influenced by social norms about behavior, identity, and acceptable forms of embodiment. As a result, what is defined as healthy, normal, or legitimate is not determined only by biological evidence but also by the authority of institutions that possess the power to establish standards. This authority allows professional bodies to define which experiences require treatment and which are considered acceptable variations, thereby shaping both individual self-understanding and public perception. The act of labeling has consequences that extend beyond clinical settings because diagnostic terms can influence how individuals are treated within families, workplaces, and wider society. Labels that mark certain traits as disordered may lead to stigma, marginalization, or exclusion, especially when those traits depart

from dominant expectations. Diagnostic categories can therefore function as disciplinary mechanisms by encouraging individuals to regulate themselves in accordance with institutional norms. "The judges of normality are present everywhere" (Foucault 304). The authority to classify becomes, in effect, the authority to regulate bodies, since classification determines access to treatment, recognition, and social legitimacy. For this reason, ethical evaluation of diagnostic systems must consider not only their clinical usefulness but also their sociopolitical effects. Assessing diagnosis solely in terms of medical accuracy risks overlooking how such classifications may reinforce inequalities, silence alternative forms of experience, or legitimize particular models of normality. A critical perspective recognizes that diagnostic practices are embedded within broader structures of power and that their ethical implications extend to questions of autonomy, identity, and social justice.

Intimacy is frequently assumed to be inseparable from sexual expression, particularly within cultural narratives that portray romantic and erotic attachment as the highest form of human connection. Such assumptions position sexuality as the central measure of relational depth, often overlooking other forms of closeness that do not involve sexual desire. Emotional support, intellectual companionship, shared values, and communal belonging all demonstrate that intimacy can exist independently of sexual activity. "Love is as love does" (hooks 5). These modes of connection challenge the belief that sexuality is the primary foundation of meaningful relationships and suggest that relational fulfillment can take multiple forms. Asexual relational models make this diversity especially visible by showing that individuals can build profound and lasting bonds without erotic attraction. These models broaden the conceptual understanding of intimacy by highlighting forms of attachment grounded in care, trust, and mutual recognition rather than in sexual expectation. Cultural narratives, however, often marginalize or erase such non-sexual forms of intimacy by presenting them as incomplete, immature, or secondary. Popular media, social conventions, and institutional assumptions frequently reinforce the idea that relationships gain legitimacy only when they conform to romantic or sexual norms. This tendency can obscure the richness of non-sexual bonds and create the impression that intimacy without desire is lacking or deficient. Positioning sexuality as the sole marker of relational fulfillment, therefore, risks narrowing the scope of what counts as meaningful connection. Acknowledging diverse forms of intimacy fosters a more ethically inclusive perspective that affirms different relational experiences without ranking them by a single standard. Nonsexual relationality exposes biases in prevailing cultural narratives and prompts a reevaluation of definitions of connection, belonging, and closeness. Such a perspective frames relational variation as a standard feature of social life rather than a deviation from an implicit norm.

Ethical medical practice depends on the ability to distinguish clearly between illness and variation, since not every deviation from a statistical or cultural norm constitutes a disorder. "The normal is not a statistical concept but a normative concept" (Canguilhem). When differences in bodily experience are automatically interpreted as symptoms, clinical judgment risks confusing diversity with pathology. The distinction is especially important in matters related to desire, where expectations about what is

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normal are often shaped by social beliefs rather than by demonstrable harm. Respect for patient autonomy requires acknowledging individuals' right to describe and interpret their own experiences, including how they understand their desires or lack of desire. When individuals identify their condition as a natural aspect of themselves rather than as a problem requiring correction, ethical practice calls for careful consideration rather than immediate intervention. Pathologization without clear evidence of distress or impairment can lead to coercive forms of treatment, whether through medication, therapy, or social pressure, thereby raising concerns about consent and the proper limits of clinical authority. An inclusive approach to bioethics, therefore, places significant value on lived experience as a source of knowledge alongside professional expertise. Such an approach recognizes that diagnostic systems, while useful, are shaped by historical assumptions and cultural expectations that may not apply equally to all individuals. Diagnostic restraint becomes ethically necessary when a difference does not produce harm, because unnecessary classification can create stigma, alter self-perception, and legitimize interventions that are neither desired nor beneficial. Respect for bodily diversity should guide clinical practice by encouraging attentiveness to variation rather than presuming uniformity. The perspective also requires bioethics to examine its own underlying assumptions, particularly those that privilege certain forms of embodiment as more natural, healthy, or complete than others. By critically reflecting on its conceptual foundations, bioethics can move towards a more responsive and equitable model of care that affirms diversity, protects autonomy, and resists the tendency to translate difference into disorder.

Contemporary medical practice requires a shift away from correction-centered models of care towards approaches grounded in recognition and respect. Correction-oriented medicine often presumes that departures from established norms must be modified or treated, thereby privileging conformity over individual experience. By contrast, recognition-based care begins from the understanding that variation is a natural aspect of human embodiment rather than a problem to be resolved. Such an approach foregrounds dignity instead of uniformity and affirms that ethical legitimacy in clinical practice rests on acknowledging difference rather than eliminating it. When medical systems validate diverse bodily experiences, they create conditions in which individuals are regarded as informed participants in their own care rather than as passive subjects of institutional authority. Integrating patient narratives into diagnostic processes forms a crucial part of this approach. Personal accounts provide insight into how individuals experience their bodies, relationships, and identities, offering forms of knowledge that cannot be captured through measurement alone. “The illness narrative is a story the patient tells, and significant therapeutic work takes place through the telling of that story” (Kleinman 49). When clinical assessment incorporates these perspectives, diagnosis becomes more responsive and context-sensitive, reducing the likelihood that differences will be mistaken for disorder. Recognition also has practical consequences for wellbeing, since individuals who feel understood and respected are less likely to experience stigma, alienation, or mistrust of medical institutions. Shifting from rigid libido norms to pluralistic models of embodiment bolsters this approach by recognizing wide variation in desire, independent of health, maturity, or relational

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capacity. This pluralism yields more precise clinical insights, grounded in diverse lived experiences rather than restrictive assumptions about bodily function. Inclusive ethical frameworks thus advance both moral and clinical practice, showing that honoring variation serves justice while enabling more reliable, humane care.

Non-desire invites a reconsideration of long-standing assumptions about sexuality and personhood that have often been treated as self-evident truths. When sexual desire is positioned as a universal and necessary feature of human life, those who do not experience it are easily interpreted as lacking something essential. Recognizing non-desire as a legitimate form of embodiment challenges this belief and reveals how strongly cultural expectations shape definitions of normality. Such recognition encourages closer examination of diagnostic frameworks that classify variations in desire as disorders, since these systems do not arise in isolation from social values. "The sodomite had been a temporary aberration; the homosexual was now a species" (Foucault 43). Critical attention to diagnosis shows that medical classifications can reflect historical assumptions about what bodies should feel rather than objective measures of wellbeing. Questioning these assumptions does not reject medical knowledge but instead calls for a more reflective understanding of how it is produced and applied.

Asexuality makes visible the limits of libido-centered models of the human by demonstrating that meaningful lives, relationships, and identities do not depend on sexual desire. It reveals that definitions of health and completeness grounded in libido norms exclude forms of existence that do not conform to these expectations. Posthuman ethical perspectives offer a constructive way forward by proposing that humans should be understood as diverse, relational, and shaped by multiple influences rather than defined by a fixed set of biological traits. Within such a framework, ethical medical practice is oriented towards recognizing variation rather than correcting it. Reframing non-desire as a natural variation rather than a deficit, therefore, has implications beyond questions of sexuality alone. It reshapes bioethical thinking by encouraging respect for bodily diversity and transforms broader understandings of the human by decentring sexuality as the primary measure of personhood. Taken together, these reflections emphasize that questions surrounding desire, diagnosis, and embodiment are not only clinical matters but also ethical and philosophical concerns that shape how humanity itself is understood. Recognizing non-desire as a legitimate variation rather than a deviation calls for sustained critical engagement with the assumptions that structure medical knowledge and social expectations. Such engagement encourages approaches to care that prioritize dignity, attentiveness, and respect for difference, thereby aligning clinical practice with principles of justice and inclusivity. A framework grounded in these values does more than reconsider a single category of experience; it reorients the understanding of health, normality, and personhood towards a model that affirms diversity as intrinsic to human life.

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Works cited

Butler, Judith. *Undoing Gender.* Routledge, 2004.

Canguilhem, Georges. *The Normal and the Pathological.* Translated by Carolyn R. Fawcett and Robert S. Cohen, Zone Books, 1991.

Conrad, Peter. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.* Johns Hopkins UP, 2007.

Hayles, N. Katherine. *How We Became Posthuman: Virtual Bodies in Cybernetics, Literature, and Informatics.* University of Chicago Press, 1999.

Hooks, bell. *All About Love: New Visions.* William Morrow, 2000.

Foucault, Michel. *Discipline and Punish: The Birth of the Prison.* Translated by Alan Sheridan, Vintage Books, 1995.

Foucault, Michel. *The History of Sexuality, Volume 1: An Introduction.* Translated by Robert Hurley, Vintage Books, 1978.

Horwitz, Allan V. *Creating Mental Illness.* University of Chicago Press, 2002.

Kleinman, Arthur. *The Illness Narratives: Suffering, Healing, and the Human Condition.* Basic Books, 1988.