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Asexual-Identified People's Interactions with Health Care Practitioners

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Project Advisor: Dr. Heather J. Peters
Undergraduate Research Symposium

Asexual-Identified People's Interactions with Health Care Practitioners

Overview

- Introduction
 - Background
 - Previous research
- Objectives
- Hypotheses
- Methods
- Key findings / results
- Limitations
- Conclusion
 - What is already going well?
 - What can be improved upon and how?

Introduction

- Asexuality
 - is a sexual orientation, like “bisexual,” “heterosexual,” and “homosexual”
 - asexuality denotes lack of sexual attraction
 - Subsets
 - Demisexuality
 - Gray-asexuality
 - Does not necessarily mean someone is not or has never been sexually active

Introduction

Previous Research

- Asexuality not pathological or unhealthy, rather a sexual orientation (Bogaert 2006)
- Asexual people have lower arousability, desire for sex, etc. but not lower sexual inhibition (Prause&Graham 2007)
- Major difference between asexuality and SDD- distress, relationships, sexual desire (Van Houdenhove, Gijs, T'Sjoen&Enzlin 2015; Brotto, Yule&Gorzalka 2015)
- Social issues related to asexuality: denial, resistance, invisibility, rejection, due to incompatibility w/heteronormative expectations. Meaningful part of identity for many people, support from online communities. (Macneela&Murphy 2014)

Objectives

- Find out if medical and mental health practice is consistent with research
- Add to the limited research on the topic
- Find out if pathologization or other methods of identity-based discrimination are being perpetrated by practitioners
- Learn how health care practitioners can improve, be more inclusive and affirming

Hypotheses

HYPOTHESIS 1: Participants who disclosed their sexual identity to health practitioners would have more negative health care experiences than participants who did not disclose.

HYPOTHESIS 2: Participants will report that health care practitioners pathologized their identity:

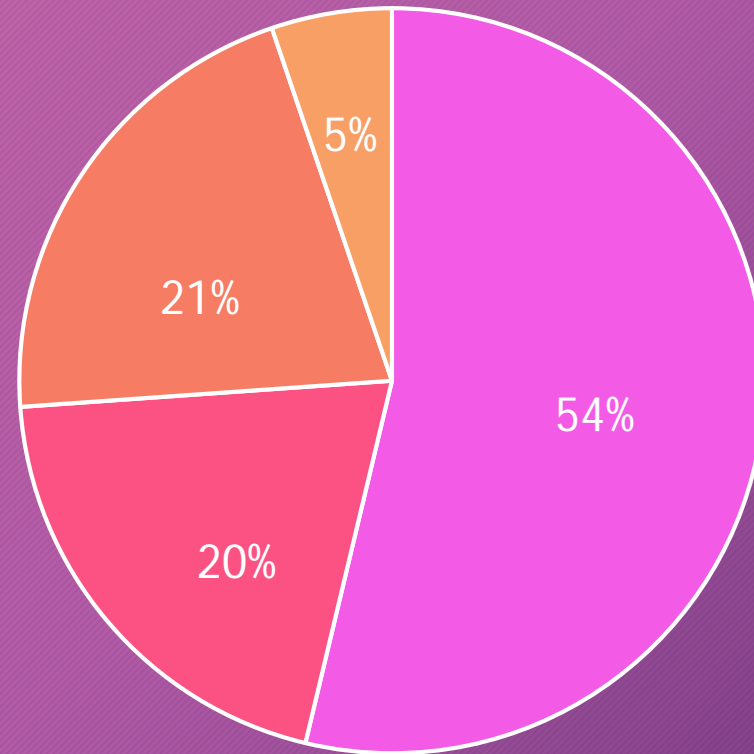
- Diagnosis with mental and/or physical illness because of their identity
- Sexuality attributed to pre-existing diagnoses or conditions

Project Methods

- Formulated survey using Qualtrics
- Recruitment tools:
 - university list serv
 - fliers
 - other universities' LGBT+ Resource Centers
 - Asexuality Visibility and Education Network (AVEN)
- Survey distributed digitally using anonymous link
- Internet survey research
 - Did not experience problems
 - Possible to reach out to more participants
 - Fewer geographical constraints
 - Anonymity- important in work with minority groups

Demographic Statistics

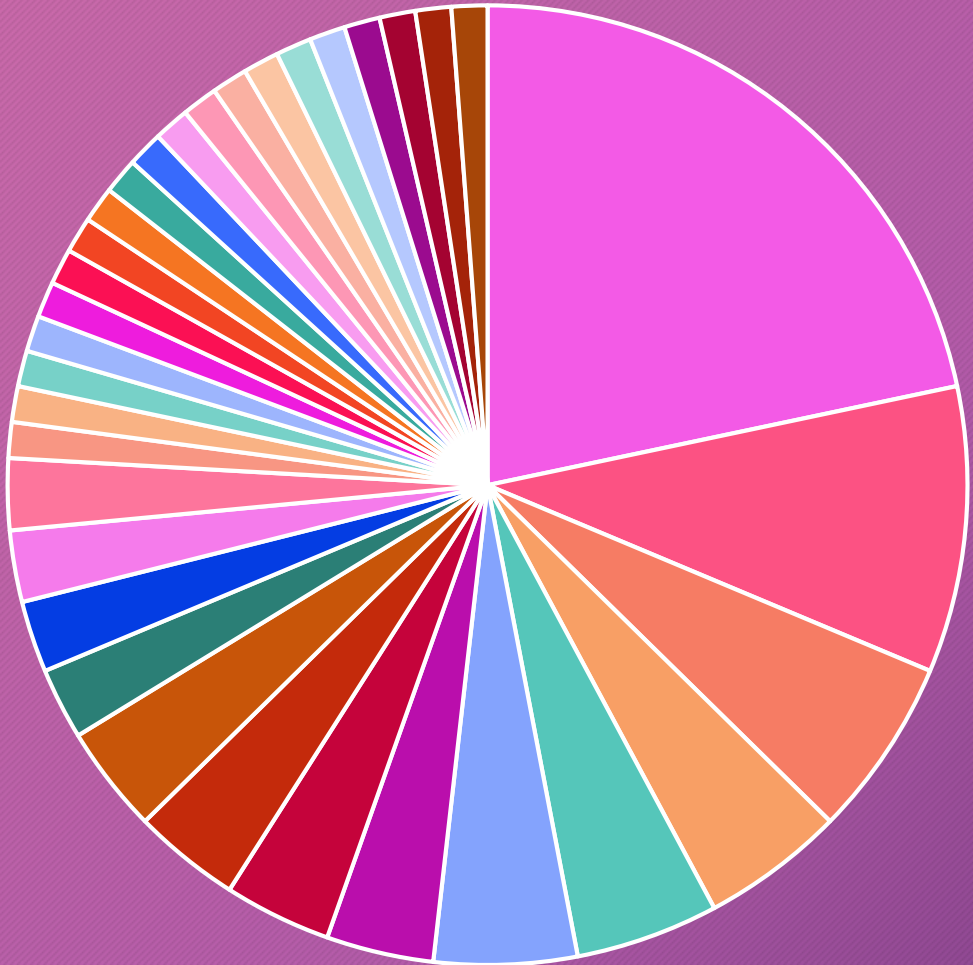
Identity



□ Asexual □ Demisexual □ Graysexual/gray-ace □ Other

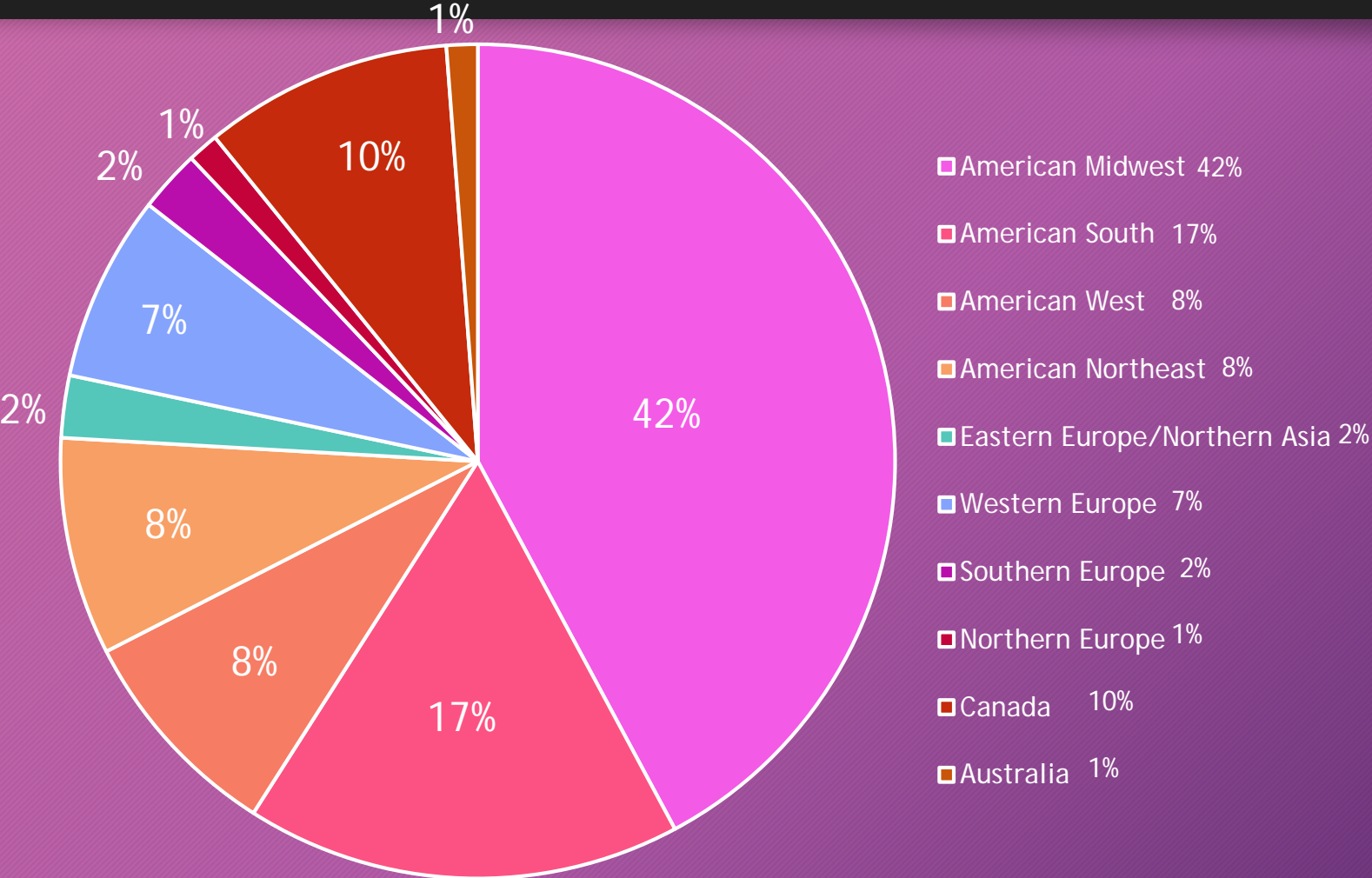
Out of 136 participants

Location



- Minnesota
- New York
- Ohio
- District of Columbia
- South Carolina
- Czech Republic
- Quebec
- Italy
- British Columbia
- Austria
- Washington
- Australia
- Georgia
- Missouri
- California
- Michigan
- Ontario
- Germany
- Kazakhstan
- Finland
- Spain
- Manitoba
- Kansas
- Illinois
- England
- Texas
- Wisconsin
- Oregon
- Pennsylvania
- Vermont
- Connecticut
- New Mexico
- West Virginia
- Utah

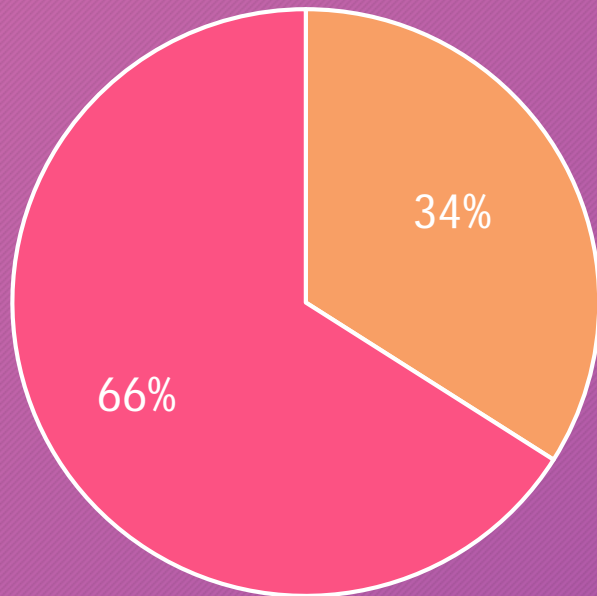
Location



Out of 136 participants

Proportion who disclosed sexual identity

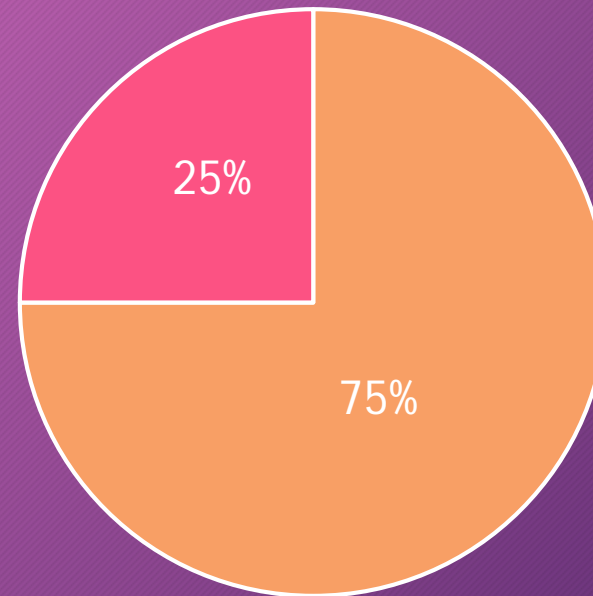
% Disclosed Identity to
Medical Health Practitioner



■ Did Disclose ■ Did Not Disclose

Out of 125 participants

% Disclosed Identity to
Mental Health Practitioners



■ Did Disclose ■ Did Not Disclose

Out of 76 participants

Key findings: Hypothesis 1

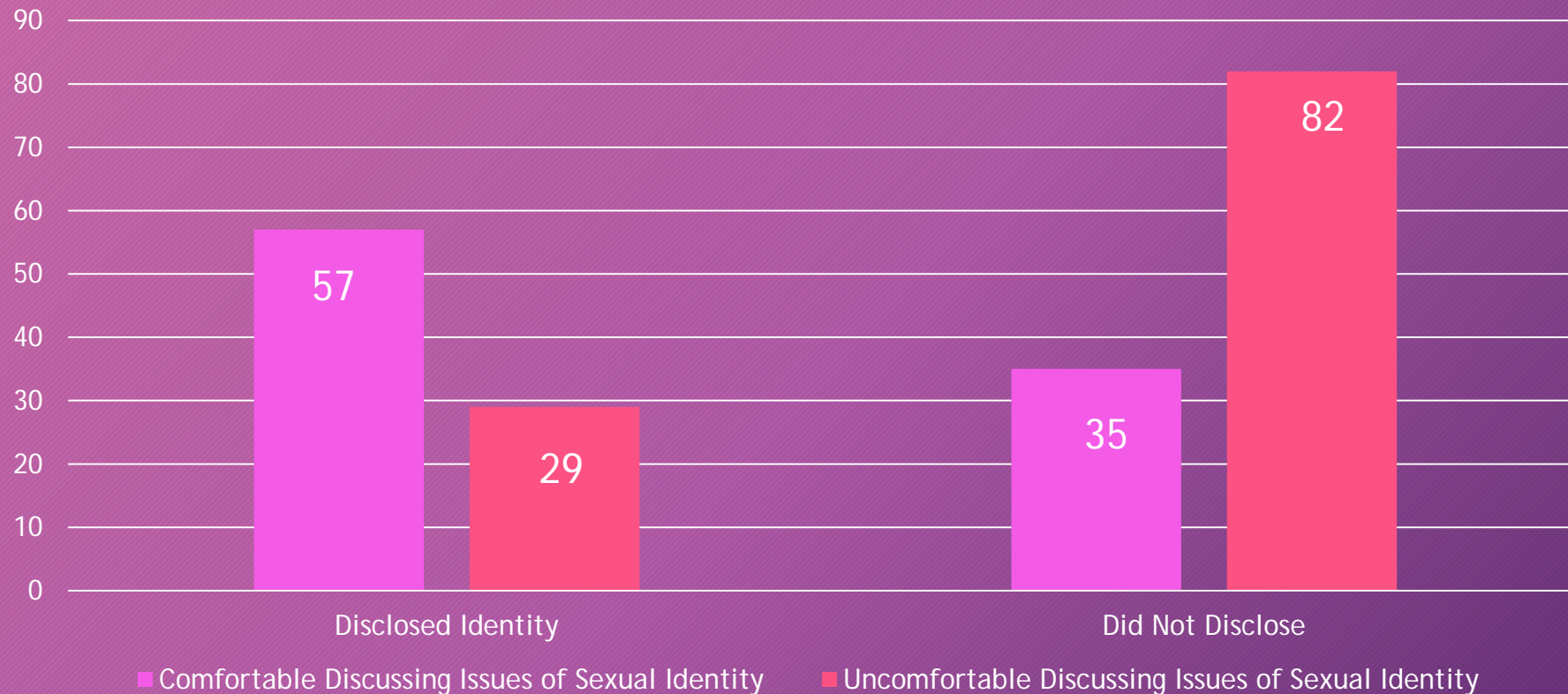
Type of Experiences After Disclosing Identity



This includes 33 responses about medical practitioners and 43 responses about mental health practitioners
From 59 participants, 16 responded only about mental health, 26 only about medical, and 17 about both

Key findings: Hypothesis 1

Comfort Discussing Issues of Sexual Identity



Out of 86 Participants

Out of 117 Participants

- Significant difference between
- Comfort with practitioner when disclosed identity
 - Comfort with practitioner when did not disclose identity
 - $t=-5.46$
 - $p\text{-value}=0.00$

Key Findings: Hypothesis 1

- What made clients feel comfortable discussing sexual identity:
 - Supportive environment
 - Practitioner acts empathetic and kind in general
 - Practitioner indicates support or understanding of LGBTQIA2S+ community in general
- What made clients feel uncomfortable discussing sexual identity:
 - Asexuality not an option for sexual orientation on intake form
 - Practitioner different gender from the participant
- "I am afraid that if I talk about my sexuality with them, it will become a negative experience."

Key Findings: Hypothesis 2

- 9 out of 40 (22.5%) respondents reported that their practitioner either diagnosed or discussed diagnosing them with a new mental or physical condition due to their asexual identity
 - 8 of the diagnoses were discussed by a medical practitioner, 1 by a mental health practitioner
- 14 out of 40 (35%) respondents reported that their asexual identity was attributed to an existing mental or physical condition
 - 12 of the diagnoses were discussed by a medical practitioner 2 by a mental health practitioner

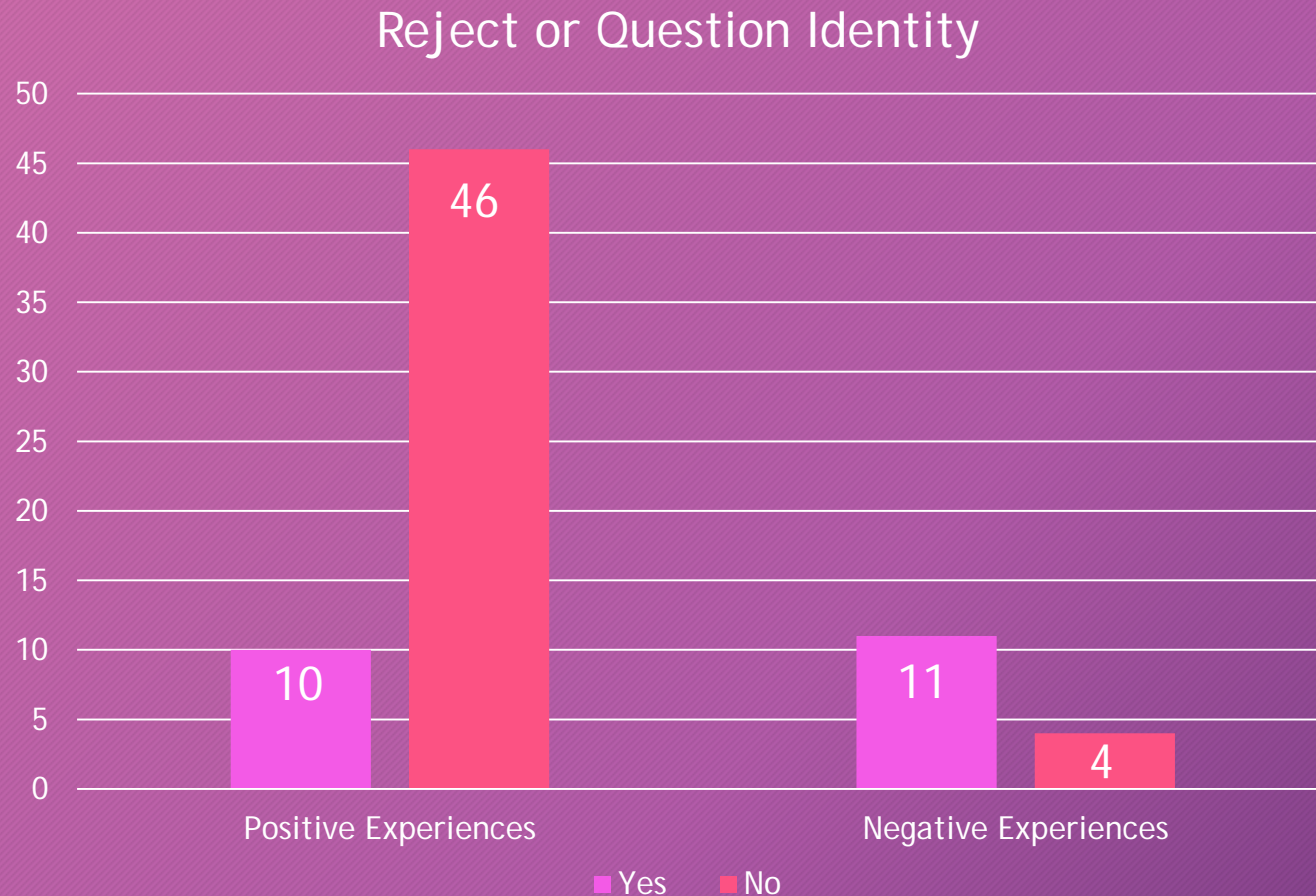
Key findings: Hypothesis 2

- Diagnoses discussed:
 - Depression 14
 - Anxiety 6
 - Female Sexual Interest/Arousal Disorder 2
 - Hypoactive Sexual Desire Disorder 2
 - Specified Sexual Dysfunction 1
 - Unspecified Sexual Dysfunction 1
 - Sexual Aversion Disorder 1
 - Autism 1
 - Other 5

Key Findings: Factors associated with positive and negative health care experiences

Factors with significant differences	What was the difference?	t	p-value
Reaction to your identity mostly positive or negative?	Those who had positive experiences reported that the practitioners' reaction was more positive	11.13	0.00
Taking you at your word that your identity is what you say it is	Those who had positive experiences on average reported that the practitioners took them at their word	11.55	0.00

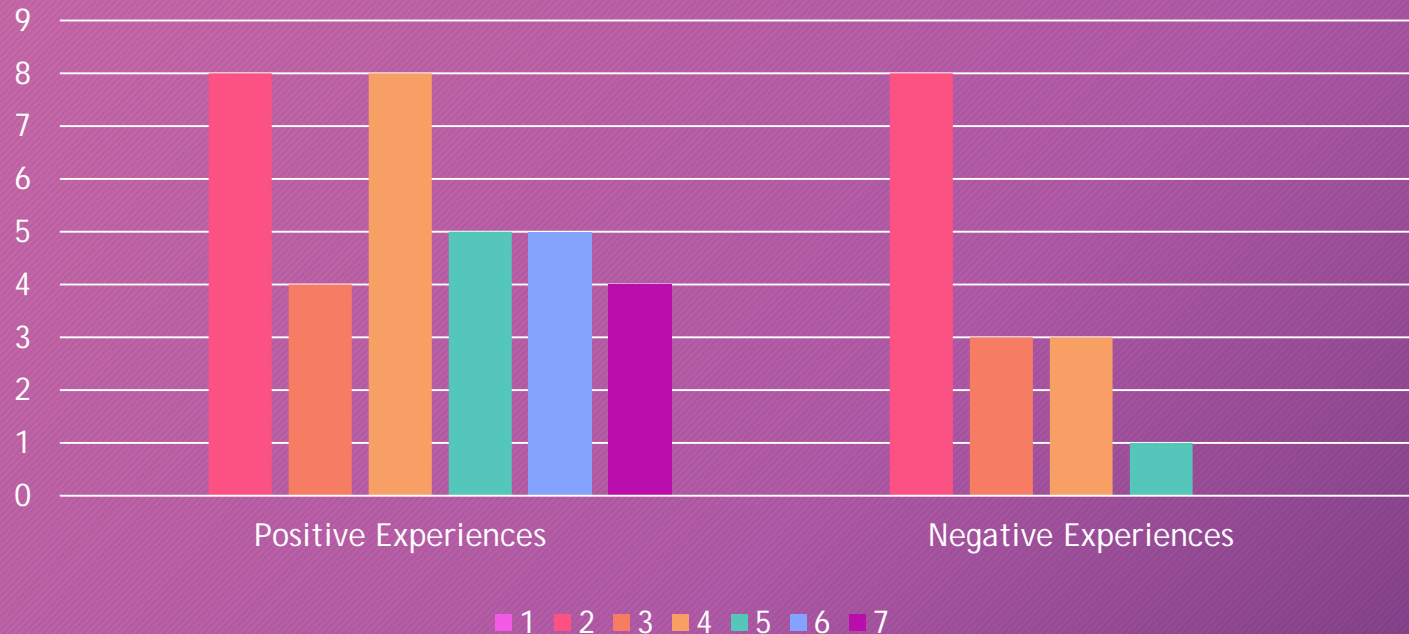
Key Findings: Factors associated with positive and negative health care experiences



chi-squared=6.16
p-value=0.01

Key Findings: Factors associated with positive and negative health care experiences

Familiarity with Asexuality



$t=3.65$

$p\text{-value}=0.00$

Mean of familiarity score
among positive experiences:
4.12

Mean of familiarity score
among negative experiences:
2.33

Example of a Negative Experience

- The participant never explicitly disclosed their identity, but did state that they weren't interested in having sex
- Therapist was "very condescending"
- Client felt "accused" after disclosing lack of sexual desire
- Therapist stated the client lacked empathy and/or emotion due to lack of sexual desire
- Implied that "those who don't want to have sex are broken and must be fixed"

Example of a Positive Experience

- Started by asking preferred pronouns, indicating LGBTQIA2S+-affirming practice
- “Seems culturally competent”
- Identity was “readily and easily accepted”

Limitations

- Important to protect anonymity by not requesting too much personal information- however, this means limited knowledge of other identities of participants, which could contribute to health care experiences as well

Conclusion

- Hypothesis 1: not supported
 - More positive experiences associated with disclosing
 - Related to self-protecting- only disclosing when feeling comfortable doing so
- Hypothesis 2: supported
 - Above 30% of participants who responded to the question about diagnosis had their identity attributed to a new or existing diagnosis

Conclusion

- What are practitioners doing that is helpful?
 - According to participants:
 - Having “asexual” as a sexual orientation option on intake forms
 - Responding in an affirmative way to statements about identity, even when they don’t understand, i.e. “okay, tell me about that” versus “what? What’s that?”
 - Listening and believing clients
- What can practitioners do to improve?
 - According to participants:
 - Understand asexuality better
 - Create a more supportive and accepting environment

Questions & Discussion

