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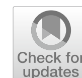


# Asexual-Identified Adults: Interactions with Health-Care Practitioners

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**Abstract**
Historically, people with minority sexual and gender identities (e.g., gay, lesbian, bisexual, transgender) have been pathologized by mental and medical health practitioners. The potential for pathologization of asexuality is particularly salient considering a lack of sexual desire or interest has been studied in relationship to depression, antidepressant medication, and hypothyroidism. To explore this potential pathologization, asexual individuals were asked about their interactions with mental health and medical practitioners. The study included 136 adult participants, primarily from the U.S., who self-identified as asexual. Participants completed an online survey which contained questions about their experiences with mental health and medical practitioners. Results indicated that the majority of participants did not disclose their identity and felt uncomfortable discussing issues related to sexuality with their providers. Participants were more likely to disclose their asexual identity to mental health providers, as compared to medical providers. Participants who had positive experiences were more likely than those who had negative experiences to indicate that their practitioners were familiar with asexuality, accepted the participant's identity completely, and reacted to the disclosure in a positive and affirming manner. Positive experiences included practitioners educating themselves about asexuality, while negative experiences included practitioners disbelieving the existence of asexuality, and between one quarter and one half of participants reported that practitioners attributed their asexuality to a health condition. The findings from this study demonstrate the importance of including information about asexual identities in health education and ongoing diversity training in order to increase the cultural sensitivity of health practitioners.

**Keywords** Asexuality · Health care · Sexual identity · Pathologization · Sexual orientation · Sex education

## Introduction

Health professionals have a long history of pathologizing members of the LGBT+ community (Drescher et al., 2016; Eckhert, 2016; Lev, 2013). This pathologization suggests that other non-normative sexual and gender identity groups may experience pathologization in health-care contexts as well. The potential for pathologization of asexuality is particularly salient considering a lack of sexual desire or interest has been studied in relationship to depression (e.g., Mathew & Weinman, 1982; Phillips & Slaughter, 2000), antidepressant medication (e.g., Kennedy, Dickens, Eisfeld, & Bagby, 1999), and hypothyroidism (e.g., Gunnarsson, Sjoberg, Eriksson, & Nordin, 2001). Pathologization of asexuality is unwarranted given Bogaert's (2006) conclusion that asexuality was best classified as a sexual orientation, as opposed to a sexual desire disorder. Further, more recently, Brotto and Yule (2017) have conducted a literature review and determined "…there is not sufficient evidence to support the categorization of asexuality as a psychiatric condition (or symptom of one) or as a disorder of sexual desire" (p. 619) and concluded "that asexuality is a heterogeneous entity that likely meets conditions for a sexual orientation" (p. 619).

Several additional studies have reaffirmed Bogaert's (2006) and Brotto and Yule's (2017) claims that asexuality is distinct from a sexual desire disorder (e.g., Van Houdenhove, Gijs, T'Sjoen & Enzlin, 2014; Yule, Brotto & Gorzalka, 2015). The main distinction between asexuality and sexual disorders is that asexual people do not experience distress due to their lack of sexual attraction or desire, whereas distress is an important factor in diagnosing a sexual disorder. Further, researchers have explored social issues related to asexuality and have found that asexual individuals experience

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social resistance and rejection of their identities (MacNeela & Murphy, 2014). The existence of bias against asexuals was established by MacInnis and Hodson (2012), who surveyed heterosexual individuals about their attitudes toward people described as asexual, bisexual, homosexual, and heterosexual. These participants evaluated asexuals more negatively compared to the other three sexual orientation groups, saw asexuals as less human than the other groups, and were more likely to avoid contact with an asexual person than a member of the other groups. A scale to measure bias against asexuals was later developed, correlated with other factors such as sexism, social dominance orientation, discomfort hiring or renting to asexuals, and lower intergroup contact with asexuals (Hoffarth, Drolet, Hodson, & Hafer, 2015). Many asexual people have formed online communities, in part to help cope with these social issues, and many find asexuality to be an important part of their identity.

Although no data indicate what proportion of health practitioners are aware of asexuality, some research suggests that when asexual individuals mention their identity to a health practitioner, the practitioner is not aware of the term and does not know what it means (Decker, 2014, 2015; Jones, Hayter, & Jomeen, 2017). Further, asexual individuals tend to expect bias and pathologization from practitioners, anticipate a lack of knowledge or understanding from their health providers, and, as a result, choose not to disclose their identities to providers (Foster & Scherrer, 2014; Jones et al., 2017). Unfortunately, this choice not to disclose their identity means that conversations about asexuality rarely occur in health-care settings, which in turn perpetuates the invisibility of asexuality as a sexual orientation. While a small number of studies have asked asexual individuals about their attitudes and expectations toward health-care providers, the present study is the first to ask about the specific interactions asexual individuals have had with their health practitioners.

## Method

### Participants

A total of 136 participants, 18 years of age or older, identified themselves as asexual ($n = 74$, 54%) (i.e., not experiencing sexual attraction to another person; Miller, 2016), gray asexual ($n = 28$, 21%) (i.e., identifying along a spectrum between completely asexual and completely sexual), demisexual ($n = 27$, 20%) (i.e., not experiencing sexual attraction unless a strong emotional connection is formed), or other identities within the asexual spectrum ($n = 7$, 5%). Forty-two percent of the participants were from Midwestern states (Illinois, Michigan, Minnesota, Ohio, Wisconsin), 17% were from Southern states (Georgia, South Carolina, Texas), 10% were from Canada, 8% were from Western states (California, Oregon, Utah, Washington), 8% were from Northeastern states (Connecticut, Pennsylvania, Vermont), 7% were from Western Europe (England, Germany, Spain), 2% were from the Eastern Europe/Northern Asia region (Czech Republic, Kazakhstan), 1% were from Northern Europe (Finland), and 1% were from Australia. Because asexual people are a small minority population, no demographic information other than sexual identity and location was collected, in order to maximize participants' feelings of anonymity and confidentiality and minimize their fear of being "outed" or identified.

We posted information about the study along with an anonymous link to the survey on our university's all-student email listserv and on the Asexuality Visibility and Education Network (AVEN) website. Additionally, we asked 40 universities' LGBT+ resource centers, located in the U.S., to notify their students about the research project. Individuals from five resource centers indicated that they gave the information to their students.

### Measures and Procedure

The survey assessed aspects of asexual individuals' experiences with mental health and medical practitioners. The digital survey was accessed through an anonymous link. After reviewing the consent form and agreeing to participate, participants reported their sexuality. Each participant's responses to the initial questions determined the follow-up questions they received. Participants were asked "Please indicate which medical health practitioners you have had interactions with" (i.e., general medical practitioner, general nurse, nurse practitioner, medical specialist, other, or none). Next, participants were asked "Please indicate which medical health practitioners you've disclosed your sexual identity to, and indicate the number of each type of practitioner that you've disclosed your sexual identity to." Participants who disclosed their identity to one or more medical practitioner(s) were asked what type of experience(s) they had when disclosing their sexual identity to the medical practitioner(s), with options being positive experiences, negative experiences, or both positive and negative experiences. Participants who had only positive experiences chose one practitioner with whom they had a positive experience and answered all follow-up questions based on that positive experience. The same process occurred for participants who had only negative experiences. Participants who had both positive and negative experiences went through the process twice. Participants then repeated this process for mental health professionals, beginning by selecting the type of mental health practitioners with whom they have had interactions (i.e., psychiatrist, mental health counselor, therapist, other, or none). No category for neutral experiences was included in an attempt to avoid the bias toward middle or neutral responses (Bishop, 1987).

The follow-up questions were based on previous research related to other sexual minorities' experiences with health care (e.g., Kelleher, 2009; Lick, Durso, & Johnson, 2013) and the Foster and Scherrer (2014) study of asexual individuals in clinical settings. Specifically, questions assessed individuals' reasons for disclosing or not disclosing asexual identity to their practitioner (multiple choice with option to fill in reasons not listed); perception of practitioners' familiarity with asexuality on a scale ranging from 0 (*not at all familiar with asexuality*) to 6 (*very familiar with asexuality*); comfort discussing issues related to sexual identity with their health practitioner (yes or no, with option to explain response); practitioner's reaction to disclosure of asexual identity on a scale ranging from 0 (*negative and dismissive*) to 6 (*positive and affirming*); practitioner's acceptance of asexual identity on a scale ranging from 0 (*rejected my identity completely*) to 6 (*accepted and validated my identity completely*); did the practitioner attribute the participant's asexual identity to an existing mental or physical disorder or disability (yes or no) and, if so, what type of diagnosis was discussed (multiple choice, with option to fill in other diagnosis), and did the participant feel this diagnosis was appropriate; and how the practitioner could better support the participant and their asexual identity. Participants were given the option to share any other information about their interactions with their practitioner that they would like to add. All Likert scale questions included an option to explain responses further.

Participants who reported not disclosing their asexual identity to a practitioner answered questions regarding their experiences, such as "Please select all reasons why you did not disclose your sexual identity to this medical practitioner" and "Although you did not disclose your sexual identity to this medical practitioner, did you feel comfortable discussing issues related to sexual identity with them?" Though the survey contained 128 questions, participants only received questions relevant to their experiences with mental health and/or medical practitioners. Participants were able to go back in the survey and revise earlier answers if they wished. Finally, participants were thanked for completing the survey and provided LGBT+ sensitive mental health resources.

## Results

### Participants' Disclosure of Their Asexual Identities

In this sample, 21% of participants identified as gray asexual, 20% as demisexual, and 54% as asexual. Chi-squared analyses compared these three groups in terms of their likelihood to disclose their identity to mental health practitioners, $\chi^2(2) = 4.21$, $p = .12$, and medical practitioners, $\chi^2(2) = .15$, $p = .93$. Results indicate no significant relationship between identity and likelihood of disclosure.

Of participants who saw a mental health practitioner ($n = 76$), 42 (55.3%) disclosed their asexual identity. Of these mental health practitioners, 95.2% were counselors or therapists. Among participants who saw a medical practitioner ($n = 125$), 35 (28.0%) disclosed their sexual identity. Of these medical practitioners, 86.7% were general practitioners or medical specialists. To determine if type of practitioner (i.e., mental health or medical) impacted whether or not the participant disclosed their identity, Pearson's chi-squared test with Yates' continuity correction was conducted. The results indicated that these categories (i.e., likelihood of disclosure and type of practitioner) were not independent of one another, $\chi^2(1) = 5.15$, $p = .02$, suggesting that participants were more likely to disclose their asexual identity to mental health practitioners as compared to medical practitioners.

### Practitioners' Direct Questions about Participants' Sexual Identities

Participants were asked whether their health practitioner asked them a direct question about their sexual identity. Among those who disclosed their identity to a mental health practitioner (1 missing case, $n = 41$) or a medical practitioner (9 missing cases, $n = 26$), 25 (61.0%) and 21 (80.8%), respectively, reported being asked a direct question about their sexual identity. Of those participants who did not disclose their identity to a mental health ($n = 34$) or medical (4 missing cases, $n = 86$) practitioner, 7 (20.6%) and 48 (55.8%), respectively, reported being asked a direct question about their sexual identity. Pearson's chi-squared tests revealed that participants being asked a direct question about sexual identity was not independent of whether or not they disclosed their identity to a mental health, $\chi^2(2) = 10.80$, $p = .001$, or a medical, $\chi^2(1) = 4.25$, $p = .04$, practitioner suggesting that participants were more likely to disclose their sexual identity to a health practitioner when asked a direct question.

### Reasons Why Participants Did Not Disclose Their Asexual Identities

Participants were asked to select reasons why they did not disclose their sexual identity to their practitioner (see Table 1 for the results). Pearson's chi-squared test indicates that participants' reason for not disclosing their asexual identity to a practitioner and type of health practitioner (i.e., mental health or medical) were not independent, $\chi^2(4) = 37.77$, $p < .001$, suggesting that type of practitioner was related to reasons why participants chose not to disclose their asexual identity to their practitioner.

**Table 1** Number and percentage of participants' reported reasons for not disclosing asexual identity to mental health and/or medical practitioners

| Reason | Mental health ($n=34$) | Medical ($n=90$) |
|---|---|---|
| Thought asexuality not relevant to care | 18 (52.9%) | 72 (80.0%) |
| Thought health practitioner not familiar with asexuality | 1 (2.9%) | 40 (44.4%) |
| Uncomfortable discussing issues related to sexual identity with this practitioner | 11 (32.4%) | 37 (41.1%) |
| Had negative experiences disclosing identity to practitioners in the past | 9 (26.5%) | 1 (1.1%) |
| Other reason (e.g., "I was not aware I was asexual at the time" and "I thought… they would associate my asexuality… with the fact that I was sexually assaulted") | 3 (8.8%) | 11 (12.2%) |

Participants could select more than one reason for not disclosing their asexual identity

### Reasons Why Participants Disclosed Their Asexual Identity

Participants were asked to select reasons why they disclosed their sexual identity to their practitioner (see Table 2 for the results). Pearson's chi-squared test suggested that type of practitioner was independent from the reasons that participants chose to disclose their identity, $\chi^2(4)=2.67$, $p=.62$. However, relatively small numbers of participants endorsed certain reasons for disclosure, such as positive experiences in the past, so a replication with larger *n* may yield different results.

Of participants who disclosed their identity to a mental health practitioner ($n=42$), 14 (33.3%) felt that they had to disclose their identity and that they did not have a choice in the matter. Most participants who felt a need to disclose their identity reported that their identity was relevant to their therapy. For example, in therapy one participant discussed "the discrimination I was experiencing because of asexuality." One participant reported that "none of my problems nor my personal history makes any sense without understanding I am an asexual person."

Of participants who disclosed their sexual identity to a medical practitioner ($n=35$), 11 (31.4%) felt as though they had to disclose and that they did not have a choice in the matter. The most common reasons participants stated that they felt they had to disclose their asexuality included feeling the need to explain why they were not sexually active, and advocating for their own reproductive healthcare choices. For example, one participant stated "I'm 38 and have never had sex. That's definitely considered weird, so I felt like I had to give her a reason." Another participant stated:

> The first was with a nurse practitioner who was trying to pressure me into a pap smear and expressed concern I hadn't had the HPV vaccine. The other is to a gynecologist; I am currently seeking to permanently stop menstruating, and I had to counter the idea that I might someday change my mind and want a pregnancy with the idea that pregnancy was not ever and will never be in the cards for me.

A younger participant felt they had to disclose their asexuality because the practitioner assumed they were lying about their lack of sexual activity, based on their age and appearance:

> She frowned, insisted that "this is a confidential space, I can only help you as much as you're honest with me. You're pretty, you're in college, have you or have you not partaken in sexual activities?" I told her no, but as she was still glaring at me, hoping for a fuller answer, I elaborated "Well, I suppose I'm asexual–If I don't find anyone attractive, why would I be having sex with them." She nodded and said "Ah, okay then."

**Table 2** Reasons for disclosing asexual identity to mental health and/or medical practitioners

| Reason | Mental health ($n=42$) | Medical ($n=35$) |
|---|---|---|
| Thought asexuality relevant to care | 31 (73.8%) | 19 (54.3%) |
| Felt comfortable disclosing | 26 (61.9%) | 12 (34.3%) |
| Were asked a direct question about sexuality | 12 (28.6%) | 3 (8.6%) |
| Had positive experiences disclosing identity to practitioners in the past | 1 (2.4%) | 1 (2.9%) |
| Other reason (e.g., asexuality was an option for sexual orientation on an intake form, felt the need to explain why not sexually active) | 3 (7.1%) | 3 (8.6%) |

Participants could select more than one reason for disclosing their asexual identity

### Participants Experiences Following Disclosure of Asexual Identity

Chi-squared analyses compared participants who identified as gray asexual, demisexual, and asexual to determine whether they differed in their experiences (i.e., positive, negative, both positive and negative) after disclosing their asexual identity to their mental health, $\chi^2(4) = 2.67$, $p = .61$, and medical, $\chi^2(2) = 2.15$, $p = .71$, practitioners. Results indicate no significant relationship between these different identities and the type of experiences participants had after disclosing their identities.

Among participants who disclosed their identity to mental health practitioners ($n = 42$), 24 (57.1%) reported only positive experiences, 12 (28.6%) reported both positive and negative experiences, and 6 (14.3%) reported only negative experiences following disclosure. Thus, 36 participants (85.7% of those who saw a mental health practitioner) reported a positive experience and 18 participants (42.9%) reported a negative experience with a mental health practitioner. Of participants who disclosed their identity to medical practitioners (2 missing cases, $n = 33$), 17 (51.5%) reported only positive experiences, 10 (30.3%) reported both positive and negative experiences, and 6 (18.2%) reported only negative experiences following disclosure. Thus, 27 participants (81.8% of those who saw a medical practitioner) reported a positive experience and 16 participants (48.5%) reported a negative experience with a medical practitioner. Pearson's chi-squared test suggested that type of health practitioner was independent from participants' experiences (i.e., positive, negative, or both) once they disclosed their sexual identity, $\chi^2(2) = 0.30$, $p = .86$.

#### Experiences with Mental Health and Medical Practitioners

One-way ANOVAs were conducted to determine if participants who had positive experiences differed from those who had negative experiences with their practitioners, in terms of how familiar their practitioners were with asexuality, their mental health or medical practitioners' general reaction to their disclosed sexual identity, and the degree to which practitioners took participants' word about their sexual identity. The results suggested that these three variables did differ between those who had positive versus negative experiences with mental health, $F(5, 142) = 32.84$, $p < .001$, and medical, $F(5, 100) = 28.36$, $p < .001$, practitioners. Follow-up Tukey's honest significant difference (HSD) test results are reported.

**Mental Health and Medical Practitioners' Familiarity with Asexuality** Participants rated how familiar their health practitioners were with asexuality or the asexual spectrum on a 7-point Likert scale ranging from 0 (*not at all familiar with asexuality*) to 6 (*very familiar with asexuality*). Participants who reported positive experiences with their mental health (2 missing cases, $n = 34$, $M = 4.12$, SD= 0.43), or medical (3 missing cases, $n = 22$, $M = 3.36$, SD = 0.37), practitioners were compared to individuals who reported negative experiences with their mental health (3 missing cases, $n = 15$, $M = 2.33$, SD= 0.31), or medical (3 missing cases, $n = 13$, $M = 1.62$, SD= 0.29), practitioners, respectively. Tukey's HSD tests showed significant differences between individuals who had positive versus negative experiences with both mental health, $t(34) = 1.78$, $p = .001$, 95% CI [0.52, 3.05], and medical, $t(30) = 1.75$, $p = .002$, 95% CI [0.45, 3.05], practitioners. The results suggest that participants who had positive experiences with mental health or medical practitioners rated their practitioners as more familiar with asexuality than participants who had negative experiences.

Some participants who had positive experiences after disclosing provided a range of illustrations. For example, one participant said their practitioner "seemed to not know 'asexual' or 'demisexual' as a term, but she seemed to be familiar with the concept and was able to listen effectively," and another participant said "[my practitioner] may not have been familiar with the word 'asexual,' but she didn't seem too surprised by the general idea." Several participants reported that their practitioners did research about asexuality following their disclosure of their sexual identity. For example, one participant reported that their practitioner "told me later that she had done some basic internet research on the subject" and another participant stated "I'm pretty sure she went away and read about it before our next session."

Some participants who had negative experiences after disclosing reported that their practitioner had little to no knowledge about asexuality, stating that "they didn't seem to know it exists and assumed I was making it up," "they completely ignored it and didn't act as though they had any working knowledge of it," or they guessed "based on the look she gave me" that the practitioner "wasn't at all familiar with asexuality." One participant stated:

> I did eventually bring out a handout to her that I found online. But in the end she compared my husband and my relationship to me suddenly deciding I was a lesbian and expecting my husband to stay married to me- that seemed an awful ignorant comparison.

Another participant reported:

> I don't know whether she was familiar with the concept of asexuality but based on her dismissive behavior it was pretty evident that she didn't think anyone could actually be asexual and that those who don't want to have sex are broken and must be fixed.

**Mental Health and Medical Practitioners' Reactions to Participants' Identity Disclosure** Participants rated their prac-

titioners' reaction when they disclosed their identity on a 7-point Likert scale ranging from 0 (*negative and dismissive*) to 6 (*positive and affirming*). Participants who reported positive experiences with their mental health (1 missing case, $n = 35$, $M = 5.71$, SD= 0.44), or medical (4 missing cases, $n = 23$, $M = 4.96$, SD = 0.37), practitioners were compared to individuals who reported negative experiences with their mental health (3 missing cases, $n = 15$, $M = 2.67$, SD = 0.31), or medical (3 missing cases, $n = 13$, $M = 2.23$, SD= 0.29), practitioners, respectively. Tukey's HSD tests showed significant differences between individuals who had positive versus negative experiences with both mental health, $t(25) = 3.05$, $p < .001$, 95% CI [1.79, 4.30], and medical, $t(31) = 2.73$, $p < .001$, 95% CI [1.44, 4.02], practitioners. These results indicated that participants who had positive experiences with mental health and medical practitioners rated their practitioners' reaction as more positive and affirming than participants who reported negative experiences.

Many participants who had positive experiences after disclosing stated that their practitioners' reaction was positive because they were accepting, supportive, and aware of asexuality. For example, participants mentioned that their practitioners were "well versed in the subject," "knew what it was and was very positive," and had "done research and affirms my experience as much as they can." One participant stated:

> I was treated as if what I was saying was normal and understandable; in my world, to be treated like there's not much different from me compared to others is the greatest dignity I can be given, so I was appreciative.

Some participants stated that their practitioners' reactions were positive because they did not say or do anything actively negative or stigmatizing, stating that they "didn't feel judged" or that the practitioner "didn't make a negative issue out of it, and supported" their identity. Some participants said their practitioners' reactions were positive, but they still had to explain asexuality, or their practitioners still had misunderstandings about it, such as not understanding "the relationship between identity and actions (e.g., asexual people can still have sex, etc.)."

Some participants who had negative experiences after disclosing stated that their practitioner's reaction was negative because the practitioner didn't believe them or was dismissive about their identity, such as doubting "that I could be telling the truth and insisting on giving me advice on if (read:when) I had sex with women" or deciding "to mark me down as equally likely to have sex with both men and women" or assuming "I'd 'meet the right person' at some point." Another participant reported their therapist, due to being unaware of the asexual community, doubted its existence:

> This was a marriage therapist. She said, "Well, I've never heard of it, and I consider myself up on the LGBT community." The conversation went downhill from there. She implied that I was making up the asexuality community.

**Mental Health and Medical Practitioners Taking Participants at Their Word About Their Identity** Participants rated the degree to which their health practitioners took them at their word that their identities were what they said they were on a 7-point Likert scale ranging from 0 (*rejected my identity completely*) to 6 (*accepted and validated my identity completely*). Participants who reported positive experiences with their mental health (2 missing cases, $n = 34$, $M = 5.88$, SD= 0.43), or medical (1 missing case, $n = 22$, $M = 5.55$, SD = 0.37), practitioners were compared to individuals who reported negative experiences with their mental health (3 missing cases, $n = 15$, $M = 2.73$, SD = 0.31), or medical (3 missing cases, $n = 13$, $M = 2.08$, SD= 0.29), practitioners, respectively. Tukey's HSD tests showed significant differences between individuals who had positive experiences versus those who had negative experiences with both mental health, $t(20) = 3.50$, $p < .001$, 95% CI [2.24, 4.76], and medical, $t(33) = 3.47$, $p < .001$, 95% CI [2.17, 4.77], practitioners. The results suggest that participants who had positive experiences with their mental health or medical practitioners after disclosing their sexual identity rated their practitioners as more accepting and validating of their identity as compared to participants who had negative experiences.

Participants who had positive experiences with practitioners taking them at their word reported that their "identity and orientation was not questioned, merely accepted" or that their mental health practitioner "never doubted that I was asexual, that it was my orientation and not a byproduct of some mental affliction, or that asexuality was real" or "never once tried to deny me my identity, and supported me for identifying as asexual." Another participant reported that their medical practitioner "did not question anything about my identity, and made a note of it in the chart so that she would make sure to remember" and another stated that their practitioner "made some suggestions about how I could meet other asexuals."

Several participants who had negative experiences after disclosing stated that the practitioner rejected their identity by dismissing, not believing, and even mocking their identity, or assuming that their identity was something that would change in the future. Participants reported that their practitioner "decided I was having sex and just didn't want to tell them who with" or "thought I had deluded myself from internalized homophobia." Participants reported being told that "things change" or that they would "meet the right one," implying that their asexuality was temporary. One participant reported that their practitioner considered their asexuality to be a mental health problem:

> I told her that I didn't want to have sex with people "it's not my thing." I didn't use the word "asexual" because I knew better than to use this word when talking to a therapist. Then she was like "so you wouldn't want to sleep with a guy or a girl?"and I said "no…." She responded by saying some random crap about my not having the ability to feel enough to have sex with people being a major problem and that the issue had to be fixed asap. For the record, I'm a pretty empathetic person. I can relate to lots of people and situations, but no, I don't want to have sex with anyone! Not wanting to have sex doesn't mean not having the ability to relate to people.

### Participants' Comfort Discussing Issues Related to Sexual Identity with Their Practitioner

Among participants who reported positive experiences after disclosing to a mental health (1 missing case, $n=35$), or medical (4 missing cases, $n=23$), practitioner, 33 (94.3%) and 19 (82.6%), respectively, reported they felt comfortable discussing sexual identity with the practitioner. In comparison, among participants who reported negative experiences after disclosing to a mental health (3 missing cases, $n=15$), or medical (3 missing cases, $n=13$), practitioner, four (26.7%) and one (7.7%), respectively, said they felt comfortable discussing sexual identity with the practitioner. Pearson's chi-squared tests with Yates' continuity correction indicated that participants comfort discussing issues of sexuality with their practitioners was not independent of whether they had positive or negative experiences with their mental health, $\chi^2(1)=21.56$, $p<.001$, or medical, $\chi^2(1)=15.97$, $p<.001$, practitioner. These results indicate that participants who had positive experiences after disclosing their sexual identity to either their mental health or medical practitioner were more likely to report being comfortable talking to their practitioner about sexual identity than those who had negative experiences.

Most participants who had positive experiences said they were comfortable discussing sexual identity with the practitioner because the practitioner had a generally accepting attitude, made it clear early on that they would be nonjudgmental and/or accepting of different identities, and in some cases created space for non-normative sexual identity, by placing "rainbow stickers on the doors of therapists." For example, participants stated that the practitioner had "created a safe space already" and "definitely seems culturally competent" or that the practitioner's office was "a safe environment, with no judgement." Some participants stated that their practitioner was "well-educated on what asexuality was and very accepting of it" or "committed to representing asexuality as a valid identity." Another participant stated:

> I knew that he was highly recommended by a friend of mine who identities as a lesbian but is currently dating a man (and who knows about asexuality herself) so I assumed he was okay not just with LGBTQ clients but also beyond the usual boxes of identity and behavior. Also I had been seeing him for several months and trusted him.

One participant also stated that the level of trust required for them to have an effective relationship with their therapist made them comfortable discussing sexual identity:

> Because I'm talking with my therapist about my mental health, which is another vulnerable aspect of my identity, I feel comfortable talking about this as well when it intersects, because that degree of trust and confidentiality is already in place.

Finally, some participants reported being comfortable discussing these issues because the medical health practitioner was respectful when these issues were brought up, despite not having a prior understanding of asexuality. For example, participants stated that their identity was not "treated as any kind of issue, nor denied in any way" or that although "they didn't really understand what asexuality was, they were very respectful and listened well and made no assumptions or dismissive comments."

Participants who had negative experiences generally felt uncomfortable because of the practitioner's attitude toward different identities and their negative and dismissive comments. For example, participants indicated that the practitioner "was generally dismissive of much of what I had to say regardless of whether it related to sexual identity or not," "didn't believe me and became dismissive," or "voiced disapproval before I could elaborate, saying I would grow out of it." Other participants wrote "[I] did not feel that this provider took me seriously or that she believed I was being truthful" and "[I felt] discriminated against by [the practitioner's] rudeness and pure lack of empathy."

### Practitioners' Pathologization of Participants' Asexual Identities

Among participants who did not disclose their identity to a mental health ($n=8$) or medical ($n=33$) practitioner and answered the survey question regarding diagnosis, three (37.5%) and eight (24.2%), respectively, reported that their practitioner discussed diagnosing them with a mental, physical, or sexual disorder due to factors related to their sexual identity, such as lack of sexual desire, activity, or drive, or attributed these factors to an existing diagnosis. Among participants who disclosed their identity to a mental health ($n=41$) or medical ($n=28$) practitioner and answered the survey question regarding diagnosis,

13 (31.7%) and 14 (50.0%), respectively, indicated that their practitioner pathologized their identity. Pearson's chi-squared tests with Yates' continuity correction suggested that pathologization of asexuality by a practitioner was independent of whether the participant disclosed their identity to their mental health, $\chi^2(1) < 1$, or medical, $\chi^2(1) = 3.31$, $p = .07$, practitioner. However, given the tendency of Yates' continuity correction to overcorrect (Sokal & Rohlf, 1981), the relationship between pathologization of asexuality by a medical practitioner and whether the participant disclosed their identity to that medical practitioner can be said to have approached significance, and replication with a larger sample may yield a significant result.

Among those who received a diagnosis, either from a mental health or medical practitioner, as a result of their asexuality and responded to the survey question asking if they believed the diagnosis they received was appropriate, ($n = 19$), 15 (78.9%) reported that they did not feel the diagnosis was appropriate.

## Participants' Recommendations for Practitioners

Among participants who had positive experiences after disclosing to mental health and medical practitioners, 65.7% and 70.6%, respectively, made suggestions for how their practitioner could change in order to better support them and their sexual identity. Many participants reported that their practitioners needed to be more knowledgeable about asexuality. For example, "orientation does not equal actions" or "it just comes back to education–if you are doing couples counseling, I think therapists have a responsibility to learn, somehow, about sexual orientations, and that includes asexuality." Another participant commented:

> I think all therapists/psychologists need to be educated, or educate themselves, in asexuality. Some therapists list in profiles online or in bios they work with LGBT–but it's rare to find someone who lists LGBTA.

On the other hand, one participant reported that their practitioner should stop assuming that she knows more about asexuality than her asexual client:

> She even tried to tell me something about her google research on asexuality as though I might not know it, even though I have told her repeatedly that I am deeply involved in the asexual community, especially on the theory side.

One participant also noted that they wanted their practitioner to stop focusing on whether or not asexuality was their "natural/birth orientation," or due to trauma they had experienced, and instead to "view things at the practical/functional level":

> It doesn't seem to matter how the current state of events originated, because it is now how I consistently function. Their view has been that if it was not, in fact, the "natural/birth" orientation and was induced by stress, it can be reversed/fixed. Even if this were true, I think it's pointless to focus on it because (1) purely cultural factors are what dictate their belief that "fixing" it is the best/most useful course of action and (2) I think the critical period for that has already passed anyway (I'm nearly 25 years old).

Other participants noted that they would prefer asexuality to be taken more into account in terms of their health care. For example, one participant stated:

> I would like to not need pelvic exams to get my birth control pills. Given that I've not had sex and have had the HPV vaccines, I'm in the very low risk group for cervical cancer. I'd rather not get poked or touched when I don't need it.

Another participant stated:

> I wish it were better indicated on my chart so I don't have to come out to the nurses every time they're questioning me before my appointment. The doctor knows, but I'm not as comfortable telling every nurse that I have no sexual history because I'm asexual.

All of the participants who had negative experiences after disclosing to mental health and medical practitioners made suggestions for how their practitioner could change in order to better support them and their sexual identity. For example, they would like their practitioners to be more knowledgeable about asexuality: "She wasn't very up to date about sexual orientations and other nonstandard identities and lifestyles." One participant recommended that "safe space training should not be considered complete if asexuality is not discussed." They also stated that they would like their practitioners to have less discriminatory and pathologizing attitudes and assumptions about asexuality, and listen to what their clients say about their own identities. For example, one participant expressed:

> Don't give strange looks to patients who disclose details about their sexual identity or sexual life. That's very immature. Also be open minded; if you never heard of something doesn't mean it doesn't exist. Do some researche [sic], educate yourself; use that opportunity to learn something instead of casting judgment on someone just because they are different.

Other participants stated that practitioners should "not try to pathologize asexuality" and to "stop [attributing] people's lack of sexual/romantic interest to be mental illness." One participant stated:

> He could have tried to listening to me, instead of arguing with me that it was all due to my depression. It was one of my first experiences with telling someone about my identity and it still worries me that anyone I tell will act in the same way.

Participants who did not disclose their asexual identity, to their mental health or medical practitioner, made suggestions for how their practitioner could change in order to better support them and their sexual identity. Specifically, many want their practitioners to be more knowledgeable about asexuality, by "educat[ing] themselves on what the ace spectrum is" and seeking information about "the full spectrum of sexuality, including asexuality and its facets." Others wanted sexual inclusivity and recognition of different identities to be an apparent part of their health-care environments, such as "a poster on her door/in the office that said she and the other doctors supported LGBTQIA people, and especially if it explicitly mentions asexuality."

For example, "on the intake form, a simple optional question about orientation (are you hetero, homo, asexual, etc.)-would be nice-then they could follow up with that." Another participant wrote:

> When first meeting me, asking me questions about myself to build stronger rapport. Ask me what my pronouns are, because they are they/them, my sexual orientation or my current relationship status (if relevant).

Participants also expressed wishing their practitioners would not make assumptions about sexuality and sexual behavior in general, such as "assuming people are sexually active once they reach a certain age," that "lack of libido or attraction is not by itself a problem unless the patient perceives it as a problem or unless there's an underlying problem causing it," or that "a strongly negative response [to being touched] doesn't always mean that a patient was abused." One participant also commented that they "would like a system where heterosexuality isn't the assumed orientation."

## Discussion

The participants provided valuable information that mental health and medical practitioners can use to improve the experience asexual clients have in health-care settings. Our results revealed that a large proportion of participants chose not to disclose their identity and felt uncomfortable discussing issues related to sexual identity with their health practitioner. These findings suggest that many of our participants withheld their asexual identity in an attempt to avoid anticipated negative interactions. This conclusion is supported by previous researchers who found that participants are cautious about disclosing their asexual identity because they expect a lack of knowledge or understanding (Jones et al., 2017) and negative attitudes toward and dismissal of their asexual identity from health practitioners (Foster & Scherrer, 2014).

Participants were more likely to disclose their asexual identity to mental health as compared to medical practitioners. Understanding why participants chose not to disclose their asexual identity provides some insight into this discrepancy. Specifically, more participants cited perception that practitioners were unfamiliar with asexuality and irrelevance of asexuality to their care as reasons for not disclosing to medical as compared to mental health practitioners. Thus, a real or perceived lack of familiarity with asexuality among medical practitioners provides one explanation for the difference in disclosure. In addition, participants may view their identity as more relevant to their mental health care than their medical care due to different roles and job responsibilities of mental health and medical practitioners. For example, mental health practitioners often talk to clients about their relationships with others, and it would be difficult to do this work effectively without understanding that a client is asexual and what this identity means for them. Further, more participants reported disclosing their identity to mental health, as compared to medical, practitioners because they were asked a direct question about their identity. Thus, some of this discrepancy may be explained by a higher likelihood of mental health practitioners inquiring directly about sexual orientation.

The majority of participants who chose to disclose their identity reported having at least one positive experience following disclosure. This finding may have occurred because many practitioners, who participants chose to disclose their identities to, were either knowledgeable about and sensitive toward asexuality or were able to apply their cultural sensitivity and general knowledge about sexual minority identities to their asexual clients in effective ways. This interpretation is supported by the large number of participants' qualitative statements which demonstrated either their practitioners' understanding of asexuality and respect of asexual identities or how, despite a lack of knowledge of asexuality, practitioners were accepting, nonjudgmental, and willing to educate themselves about asexuality. Another possible explanation for the large proportion of positive experiences after disclosing asexuality may be that participants had low expectations for what they would consider a positive experience. As shown in participants' responses, many considered their experiences positive simply because practitioners were not overtly hostile or rejecting toward their identities. This information suggests that participants may have expected a level of pathologization, confusion, or rejection from practitioners, the absence of which was interpreted as positive. This conclusion is supported by the fact that practitioners' lack of knowledge was pointed out by participants who had both positive and negative experiences following disclosure. For

many, the practitioners' reactions to encountering new information (e.g., nonjudgmental and accepting, as opposed to inaccurate assumptions and dismissal) are what determined whether participants had positive or negative experiences. Taken together, these results highlight the importance of health practitioner's developing cultural sensitivity because it allows them to value their clients' and patients' identities that differ from their own and respond to those differences, regardless of their level of familiarity or knowledge, with acceptance, caring, and a desire to learn.

Almost all participants who had positive experiences following disclosure of their identity to their health practitioner reported being comfortable discussing sexual identity with their practitioner, whereas this was not the case for participants who reported negative experiences. Participants' ratings of their health practitioners help us understand some factors associated with their level of comfort in discussing their asexual identity. Specifically, regardless of type of health practitioner, participants who had positive experiences after disclosing their asexual identity were more likely to indicate that their health practitioners were familiar with asexuality, accepted the participant's identity completely, and reacted to the disclosure in a positive and affirming manner, whereas participants who had negative experiences were more likely to indicate that their practitioners were not familiar with asexuality, rejected the participant's identity completely, and reacted to the disclosure in a negative and dismissive manner. These results do not allow for conclusions about the directionality of the association between positive and negative experiences following disclosure and feelings of comfort in discussing sexual identity, but they show an association between these factors. Future research may explore whether participants disclosed their identities because they felt comfortable discussing their asexual identity with their practitioner, or whether participants became comfortable talking about their identity with their practitioner because they disclosed and had a positive experience.

The previous results suggest that continued efforts to increase health practitioners' familiarity with and knowledge about LGBT+ individuals by including information about these communities in health curriculum and diversity trainings are warranted (e.g., Hardacker, Rubinstein, Hotton, & Houlberg, 2013; Moll et al., 2014; Snowdon, 2010; Yingling, Cotler, & Hughes, 2016). Unfortunately, recent findings suggest that health-care education often overlooks sexual minority identities and, as a result, likely contains very little or no information on asexuality (Dean, Victor, & Guidry-Grimes, 2016). Diversity trainings that increase general knowledge about LGBT+ communities, but ignore communities such as asexual or intersex individuals, may negatively impact asexual individuals' experiences in health-care settings. For example, providers who believe they have sufficient knowledge about LGBT communities and hold equitable beliefs may be less likely to evaluate or change their own behavior toward asexual individuals. This error is exemplified by a participant who described how her practitioner's self-perceived competence about the LGBT community led the practitioner to conclude that her client was "making up asexuality." To be effective, diversity trainings should include information about asexuality and aim to help providers understand and challenge their own biases.

Between one quarter and one half of participants reported that they were diagnosed with a mental, physical, or sexual disorder due to factors related to their sexual identity, such as lack of sexual desire, activity, or drive or had these factors attributed to an existing diagnosis. The majority of these participants reported that they did not feel the diagnosis was appropriate. These findings support asexual individuals' concerns about pathologization from health practitioners (Foster & Scherrer, 2014; Gupta, 2017). Further, this pathologization is not supported by research over the past decade, which has determined that asexuality is not a health problem, but a sexual orientation (e.g., Bogaert, 2006; Brotto & Yule, 2017; Van Houdenhove et al., 2014; Yule et al., 2015).

Some participants reported that because practitioners pathologized lack of sexual desire, activity, or drive, they felt forced to disclose their asexual identity in an attempt to explain their feelings and behavior. These results demonstrate that some health providers believe that not being "sexually active" is abnormal and needs to be explained in order for it to be believed and that "being asexual" functions as an adequate explanation for why someone might not want to have sex. This assumption is dangerous because it assumes that every non-asexual adult should want to have sex and disregards the fact that some asexual people have sex. This finding has implications for health providers with respect to challenging their assumptions, beliefs, and values. Specifically, health practitioners should know that asexuality exists, that it should not be pathologized, and that some people, asexual or otherwise, do not want to have sex and do not have sex. Additionally, it is important to understand that asexual individuals have a range of experiences and wishes with respect to having or not having sexual contact in their lives. This point is especially important since many of the participants who were diagnosed with a disorder related to their asexuality had not disclosed their asexuality. Clients and patients should not have to disclose their asexuality to avoid being pathologized.

Our results suggest participants were more likely to report their asexuality if they were asked a direct question, and participants recommend inclusive intake forms that ask questions regarding their asexuality. However, the results also reveal preliminary evidence that medical practitioners are more likely to pathologize participants' lack of sexual desire, activity, or drive if participants disclosed their asexuality. Thus, there is evidence both for and against health

practitioners asking about a client's or patient's asexuality. These conflicting results provide more evidence for the importance of health practitioners developing their cultural sensitivity. If health practitioners are accepting, validating, and seek out accurate information about asexuality, then the risk of pathologizing a patient's asexuality is diminished and the benefits of asking about a client's or patient's asexuality, in an inclusive way and when appropriate, will materialize.

Some participants' statements were consistent with Bogaert's (2006) assertion that how a sexual orientation originated does not make it a pathology or any less of a valid orientation. For example, one participant wrote about how whether asexuality was their "natural/birth" orientation is not relevant because it is how they currently function and not something that needs to be "fixed." Statements like these provide additional support for the understanding that asexuality is a sexual orientation, and how someone comes to identify as asexual does not discount their identity.

The majority of the participants who had positive experiences and all participants who had negative experiences following identity disclosure made suggestions for how their health practitioner could change in order to better support them and their sexual identity. Common participant recommendations suggest that mental health and medical practitioners should: believe their client after disclosure of asexuality and respond in a positive and affirming way; create inclusive intake forms that ask about sexual orientation; educate themselves about asexuality and view it as a sexual orientation, not as a pathology or medical problem; understand how asexuality might change "typical" health-care protocols; and provide recognition and inclusion of sexual and gender minority identities in health-care settings. These suggestions are in line with Foster and Scherrer's (2014) recommendations for how practitioners can support their asexual clients. For example, Foster and Scherrer recommend that practitioners should gain knowledge about asexuality, signal to clients via language on forms, questions in session, and educational pamphlets that they affirm and accept LGBT+ identities, and view asexuality as a healthy and viable sexual identity. Additionally, the suggestions made by participants in the current study are similar to recommendations that have previously been given related to other sexual minority identities (e.g., Cook, Gunter, & Lopez, 2017; Fuzzell, Fedesco, Alexander, Fortenberry, & Shields, 2016; Kano, Silva-Banuelos, Sturm, & Willging, 2015). For example, gay, lesbian, bisexual, and pansexual participants indicated that inclusivity of health-care spaces (e.g., language use on paperwork and LGBT+ inclusive messages in office environments) played an important role in their feelings of comfort in these spaces. The similarities between the recommendations of previous studies and those made by participants in this study give an indication of how asexual individuals may be best supported. Of course, how exactly an individual practitioner applies these findings with an individual client will depend on the client's situation as well as the type of practice and level of knowledge of the practitioner.

As with other sexual minority identities, practitioners must consider whether asexual identity may be relevant to a particular health concern or situation, such as issues related to discrimination or relationship difficulties, rather than assuming asexuality is or is not always relevant (Fuzzell et al., 2016; Kano et al., 2015). Another similar element to working with other sexual minorities is the balance health practitioners must find between having a basic understanding of asexuality and not making assumptions about what an asexual identity may mean for a particular client or patient (e.g., whether a client has sex or does not).

Many of the results from the present study are similar to St. Pierre's (2012) review of the experiences of lesbians following disclosure of their sexual orientation to health-care providers. Similarities include choosing practitioners based on referrals from other sexual minorities, disclosing their sexual identities when they believed it was relevant to their health care, and being more likely to disclose their sexual identity if the health-care environment seemed to be a safe space for sexual minorities. These similarities, taken together with the parallel recommendations provided by participants in the current study and those made by previous sexual minorities (e.g., Cook et al., 2017; Fuzzell et al., 2016; Kano et al., 2015), provide further evidence for Bogaert's (2006) assertion that asexuality is not a health problem but a sexual orientation and supports our call for health practitioners to stop pathologizing asexuality.

## Future Research and Limitations

Although the body of literature about asexuality is growing, it still remains limited. Additional research is needed so researchers and practitioners alike can become more knowledgeable about this population and its needs. The current study attempted to add to this growing body of literature; however, as with all research, this study had limitations. Although the analyses were sufficiently powerful to yield significant results, the dichotomous nature of many of the variables of the data limited the type of statistical analyses that could be done with these data. Because this study employed a self-report-based design, the subjective perspectives of asexual participants were examined. Thus, perceptions of health practitioners were viewed through the worldviews of the asexual client and not that of the practitioner. Considering the pathologization of participants' asexual identities, future researchers should explore mental health and medical practitioners' attitudes and practices with respect to asexual individuals. Further, although our results indicated that disclosure or lack of disclosure did not significantly influence mental health and medical

practitioners likelihood of pathologization, the finding related to medical practitioners approached significance, $p = .07$, and might be an artifact of a small $n$ (i.e., 33 did not disclose and 28 disclosed); thus, more research with a larger sample is needed. Future research could also explore how health practitioners' pathologization of asexual identity, as shown in the present study and other studies (e.g., Foster & Scherrer, 2014; Gupta, 2017), influences the health disparities experienced by this population.

Another limitation of the study was that, in an attempt to protect the identity of our sexual minority participants who experience marginalization, no demographic information was collected other than sexual identity and geographic location. Upon reflection, this precaution was not necessary. Additionally, the choice not to collect these data prevented the analysis of other potentially relevant variables that may have impacted the participants' experiences with their health practitioners, such as race, gender identity, or age. Several participants, in their written remarks, reported that their age, gender, or identity as trans or nonbinary was a relevant factor in their practitioners' responses to their asexuality. These interactions may be an important avenue for future research.

A final limitation is that we did not examine how romantic orientation may have influenced our results. Although asexual individuals typically lack sexual attraction, they may still desire and have romantic relationships with others. Whether these individuals have romantic relationships that are perceived as straight or gay/lesbian may impact the practitioner's perception of the individual's sexual identity. Individuals who identify as aromantic as well as asexual, and are thus not interested in pursuing romantic relationships, may be perceived as more pathological by practitioners than those who are interested in romantic relationships, since they may be seen as more abnormal. Future studies may want to examine factors like level of sexual activity, romantic orientation, etc. to narrow down the specific target of pathologization of asexual identity.

In conclusion, many participants who had positive experiences after disclosing their identity reported that their health practitioners were familiar with asexuality, accepted the participant's identity completely, and reacted to the disclosure in a positive and affirming manner. These results demonstrate the importance of including information about asexual identities in health education and ongoing diversity training in order to increase the cultural sensitivity of health practitioners. We hope that the results of this study and the recommendations provided by participants give mental health and medical practitioners information that facilitate better relationships with their asexual clients and eliminate pathologization of asexuality, thus enabling more effective health care.

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## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflict of interest.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed Consent** Informed consent was obtained from all individual participants in the study.

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