ACCESSIBILITY OF SEXUAL HEALTHCARE FOR LGBTQ+ AUTISTIC COLLEGE STUDENTS

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by
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ABSTRACT

Accessibility Of Sexual Healthcare For LGBTQ+ Autistic College Students

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Growing evidence has indicated that LGBTQ+ college students and autistic college students experience sexual health disparities (Buhi, Marhefka, & Hoban, 2010; Viswanath & Kreuter, 2007). However, one area that has not been researched is the accessibility of sexual healthcare for autistic LGBTQ+ college students. It is essential to explore this subgroup more due to the heightened risk of multiple stressors because of intersectionality. For this study, I explored autistic LGBTQ+ college students' sexual healthcare interactions with their primary care provider (PCP). To achieve this goal, I completed an online qualitative survey about the participants' experiences with their PCP regarding sexual healthcare—the answers given were analyzed via content analysis to identify common themes in the answers. A literature review was also conducted exploring what previous studies have noted about the dual identity of LGBTQ+ and autism among adults and their experiences with healthcare. Overall, 17 respondents

responded to the survey. Three themes were identified amongst the participants' responses; (1) stigmatization, (2) outed/safety, and (3) No PCP. It is important to note that there are some negative perceptions towards sex from their provider. Participants reported a range of positive and negative experiences when discussing sexual health needs with their PCP. To reduce biases, medical providers working with this subgroup must undergo stigma reduction training. In addition, policy efforts must be made to expand the accessibility of sexual healthcare resources, such as increasing coverage for telehealth services.

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NOMENCLATURE

LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning
PCC	Population, Concept, and Context
PCP	Primary Care Provider
SRH	Sexual and Reproductive Healthcare

INTRODUCTION

The LGBTQ+ (lesbian, gay, bisexual, transgender, questioning, and asexual) community has faced systematic barriers to accessing healthcare resources. According to one qualitative survey, half of the respondents identifying as lesbian, gay, or bisexual reported having experienced discrimination from healthcare professionals (Singh & Laura, 2017). The autism community has also reported similar barriers. These can be exacerbated by coexisting comorbidities such as ADHD, anxiety, or depression, making it harder to find the right health plan to cover the recurring costs that come up with these conditions (Malik-Soni, 2022). However, when exploring the intersectionality of LGBTQ+ autistic individuals to understand potential barriers to accessibility better, very little information explores this topic.

1.1 Sexuality Among Autistic Adults

Autism, as a neurological developmental disorder, was once classified as a rare condition among the general population; however, the diagnostic criteria changed, and the rise of awareness of autism has led researchers to currently estimate that 1-2% of the population is on the spectrum (American Psychiatry Association, 2013; Maenner et al., 2020). In addition, past research has traditionally argued that those on the autistic spectrum were not interested in pursuing romantic or sexual relationships; however, current research has shown that this theory is incorrect and that adults with autism were more likely to identify with non-heterosexuality identities than adults that are not on the spectrum.

R & Stokes (2018) conducted an online study where two groups, one with adults who identified as being diagnosed with autism and one with adults who were not on the spectrum, were surveyed using the Sell Scale of Sexual Orientation to identify the sexual demographics among those who are autistic. As a result, the authors discovered that 70% of their sample with autism reported higher rates of homosexuality, bisexuality, and asexuality than their control sample. This finding supports the author's theory about the likelihood of the rate of non-heterosexual identities in the autistic community. They also found that there were high scores of participants that were reported to identify as asexual, which other studies such as Bejerot & Eriksson (2014) have noted could be due to autistic-specific features influencing sensory issues such as hypersensitivity and a decreased need for sexual intimacy because of a lowered sexual libido and arousal.

It can also be pointed out that social anxiety and the lack of partners can also play a role in the participant's role being celibate; however, the label asexuality should be carefully noted though, as being asexual does not automatically mean no romantic attraction or a desire to be close and intimate with a partner (Attanasio et al., 2022). Even though there is evidence of asexuality in this sample among the participants, it is not fully known if this is due to a lack of access to sexual education or being autistic (ex., Lack of understanding of social cues). It is unclear why autistic people in samples such as this and other studies display high rates of non-heterosexual/cisgender identities compared to their typically developing counterparts.

One theory argues that the link between sexual orientation and autism is due to fetal sex hormone exposure, where varying levels of hormones introduced to the womb, such as prenatal testosterone, can influence sexual orientation in later life in some individuals (Hines, 2011). This theory raises an interesting point as previous studies have shown that autistic people are more likely to develop gender dysphoria, which links to the role of prenatal testosterone in the womb; however, this theory is not thoroughly clear on why this phenomenon exists and whether it is a valid one is still a developing idea that is not fully understood (Miesen et al., 2018).

Another theory could be that autistic people are more likely to reject traditional social norms towards heterosexuality and be more tolerant towards non-heterosexual identities, leading to more experimentation with same-sex relationships. This theory could explain the trend of low rates of traditional self-identification that autistic people demonstrated in the R & Stones study that was previously mentioned, as autistic individuals might find current terms for self-identification of sexuality to be limiting or inappropriate and may seek out other labels that might not fall under the typical labels that exist (Van Der Meisen et al., 2016). In addition, an aspect of forming relationships stems from the individual's preference on whom they are attracted to, whether romantically or sexually, and autistic people might have hindrances in social interaction that can impact their sexual identity, which can help explain the rejection of traditional labels for non-heterosexual identities.

1.2 Healthcare for Young Autistic Queer Adults

Despite the recent research that has explored the intersection of autistic people who identify as LGBTQ+, there is still a limited focus on how this group interacts with healthcare services. Jean P. Hall et al. (2020) explored the barriers to accessing healthcare for autistic people in the LGBTQ+ community. It was noted that LGBTQ+ respondents who were diagnosed with autism reported higher rates of health needs being unmet even when visiting their primary doctor. This is consistent with current research about the healthcare barriers that autistic people face when accessing healthcare due to a lack of knowledge about autism from healthcare providers (Krahn et al. 2015; Bishop-Fitzpatrick & Kind 2017). This can contribute to poor health outcomes and a higher distrust of medical providers, exacerbating preexisting health conditions like poor sleep, immunological disorders, gastrointestinal diseases, epilepsy, OCD, anxiety, depression, and more (Lai et al., 2020; Nicolaidis et al., 2015).

It should be noted that individuals within the LGBTQ+ community are more likely to report poorer health than their heterosexual counterparts due to the stigma connected to their sexuality. While queer minorities face many of the same general health concerns as the general population, each group under this label meets individual health risks, such as gay and bisexual men being more likely to face a higher risk of STIs and make up half of the people who are living with HIV or AIDS in the US (Ranji et al., 2014). This health disparity can impact how an individual is seen through the eyes of a medical professional, where ignorance of the person's HIV status can create a negative experience for that person and develop a sense of distrust towards the medical system. These negative experiences can lead to higher rates of anxiety and depression that can spiral into suicide or substance abuse to cope with mental health concerns (Office of Disease Prevention and Health Promotion, 2000).

With the growing number of autistic young adults identifying as part of the LGBTQ+ community, there is little consideration for this subgroup and the healthcare disparities that someone with multiple marginalized identities would face. One aspect of healthcare rarely touched upon when addressing the existing barriers in the healthcare system is sexual healthcare. Sexual healthcare is an essential aspect of an individual's personal life, 99% of sexually active women have utilized a contraceptive method, and at least 1 out of 4 women will use abortion services in their lifetime (Keller et al., 2022).

This service is regularly used in the health care system and has been shown to help women reduce their chances of experiencing poverty and unemployment. However, when it comes to marginalized populations, it can be hard to access these resources, especially for those who have a dual identity. There is inadequate information when it comes to LGBTQ+ people with disabilities trying to access sexual and reproductive resources, as the information presented assumes that the individual is non-disabled and heteronormative, which disregards those who do not meet these criteria and leads to misinformation from providers, especially sexual healthcare providers, on the usage of contraceptives. It is reported that disabled women ``have less contraception knowledge," which can contribute to a low chance of contraception usage compared to nondisabled women (Powell, 2022, pg. 1872-1873). LGBTQ+ disabled individuals, especially those with intellectual disabilities, can be denied opportunities for romantic and sexual exploration due to misconceptions rooted in ableism on the assumption that disabled people are not interested in developing a healthy sexual identity. Transportation also presents an issue as according to a 2018 study, over twenty-seven cities in the United States are considered "abortion deserts," which means that people must travel at least one hundred miles to access these providers, which is an issue for LGBTQ+ disabled people who are suffering poverty and cannot afford to pay for abortion care (Lai & Patel., 2019).

Previous studies have noted that one reason could be a reluctance to seek resources due to previous negative experiences and attitudes connected to the provider (Bruder et al., 2012; Kuhlthau et al., 2014). The lack of information for individuals with combined LGBTQ+ and autism identities is a significant problem for healthcare professionals providing the necessary healthcare care. Growing evidence shows that autistic people are less likely to describe themselves as heterosexual and more likely to categorize themselves as neither heterosexual, homosexual, nor bisexual (Rudolph et al., 2018; Dewinter et al., 2017; Fernandes et al., 2016). As more research is dedicated to this intersected subgroup, it is essential to explore how they interact within the medical system, especially when accessing sexual healthcare resources.

1.3 Limitations from Current Literature

Recent studies have noted that LGBTQ+ adults with autism face significant barriers when accessing sexual healthcare resources (Jean P. Hall et al., 2020; Lewis et al., 2017). In addition, their dual identities can challenge medical providers as they might be unknowledgeable about their condition and instead rely on stigma, which can influence discrimination towards this subgroup and create a higher distrust in the medical system. However, these research efforts to better understand the healthcare barriers faced by groups with multiple marginalized identities, especially when it comes to those who identify as LGBTQ+ and autistic, have a limited scope when trying to identify the areas which lack resources for individuals with dual identities. One group that has not been researched when exploring this intersectionality is the accessibility of sexual healthcare for LGBTQ+ autistic college students. It is essential to highlight this subgroup as approximately 50,000 youth each year with autism enter adulthood, with 35,000 entering postsecondary education within six years of graduating high school (Shattuck et al., 2012).

In a mixed-methods study to explore the experiences of transgender binary and nonbinary university students, Goldberg et al. (2019) noted that an increasing rate of young adults in a college setting has non-binary gender identities, with at least 58% of respondents reported to have at least one mental health diagnosis, with a small percentage reported to have autism as one of the many difficulties that can coexist with their identity. It is also important to note that young adults, especially college students, are more at risk of contracting STDs at a higher rate compared to the general population, as a recent study noted that chlamydial infection among the college student population is more elevated at 4-year campuses and minority-serving institutes than the general population (Habel et al., 2018).

While this may present as a small percentage that can be deemed as insignificant, individuals with multiple minority identities can be vulnerable to intersecting microaggressions when interacting with providers, which can contribute to what is termed as "minority stress" due to being subjected to additional prejudices from being a part of a stigmatized minority group (s). These negative experiences can overall impact the physical and mental health of LGBTQ+ college students who are diagnosed with autism, which can be further exacerbated by coexisting structural and interpersonal stressors that can contribute to an increase in feelings of hopelessness and isolation.

I theorize that we will see similar barriers that LGBTQ+ college students with autism will face when they interact with their primary care provider about sexual healthcare, especially when trying to access it in a rural setting or with limited resources that can make it harder to access help off-campus. Recent studies (Charlton et al., 2020; Lindberg et al., 2020) have investigated the accessibility of sexual healthcare for LGBTQ+ women where they noted that 46% reported delayed or canceled sexual and reproductive services due to the pandemic compared to 31% of straight women who utilize the same resources. This can be detrimental for LGBTQ+ women's mental health, as previous studies have that the LGBTQ+ populations are more likely to experience higher rates of homelessness, and thus the lack of accessible services can be detrimental to one's overall health (Kitts, 2010; McKay, 2011; McBride, 2012).

LGBTQ+ cisgender women enrolled in Medicaid could not rely on insurance to pay out-of-pocket for abortion care due to the United States Supreme Court striking down *Roe v. Wade* (Cohen et al., 2022). There are also similar trends in the autism community, where it is reported that autistic adults reported lower utilization of preventative services such as pap smears due to improper communication or coordination from the primary care provider, which might be attributed to misinformation about the perceived understanding of the sexuality of an autistic adult and thus the procedure might be foregone (Ousseny et al., 2019; Nicolaidis et al., 2013).

To test this theory, I will conduct a literature review and a qualitative survey as both aspects will help complement each other. For the literature review, I will be looking into the existing literature that explores how this intersectional subgroup accesses healthcare systems, which will lay down the foundation for the qualitative survey on what to identify when trying better to understand what possible barriers can occur with accessing sexual health care as an LGBTQ+ college student with autism and also key terms that can assist future researchers on how to expand upon this limited field. The qualitative survey will be used to assess the experiences of the participants who interacted with their primary care provider about sexual healthcare. Content analysis will be used (Hsieh & Shannon, 2005) to identify key themes and words from the answers to help future providers and policymakers create a more inclusive environment.

2. LITERATURE REVIEW METHODS

2.1 Research Aim/Question

Based on the current literature (Goldberg et al., 2019; Rudolph et al., 2018; Dewinter et al., 2017; Fernandes et al., 2016), we understand that young adults diagnosed with autism are more likely to identify as a part of the LGBTQ+ community. However, it is unclear what experiences this subgroup has when interacting with their provider about sexual health. This is especially important when considering different age groups, such as college students. Therefore, my main aim for this study is to explore the experiences autistic LGBTQ+ college students witness when discussing sexual healthcare with their primary care provider (PCP).

2.2 Engine Tool/Search Terms

When exploring the existing literature to understand better what barriers existed for LGBTQ+ college students with autism, I utilized various online databases to expand my search results and assess the literature regardless of study design or methodological quality to identify the existing gaps. I wanted to better understand the available research to set up my qualitative survey. While existing literature is limited, it can serve to understand better how accessible sexual healthcare is for autistic LGBTQ+ college students.

Wanting to utilize the databases to look for available information on the accessibility of sexual healthcare for LGBTQ+ college students with autism, I initially searched for the term LGBTQ+, expanded to *bisexual* *gay* *lesbian* *queer* *transgender* *LGBTQ+ college students* and for autism, I expanded the words to include *intellectual disabilities* *autism* *autism spectrum* *autistic adults* *autistic young adults* *autistic college students* as some research articles included autism but either had it under a different name or part of an umbrella of disabilities for clarification.

Finally, for sexual healthcare, it was expanded to include critical terms such as *reproductive health* *abortion services* *sexual health* *HIV testing* *AIDS testing* and *STD testing* as it was essential to break down the term sexual healthcare into key components which people utilize when interacting with this specific kind of healthcare.

2.2.1 Inclusion Criteria

When selecting the studies during the search, I utilized the PCC (Population, Concept, Context) framework to help create my inclusion & exclusion criteria for determining what studies could be included (Peters et al., 2015). While looking at the abstracts, I made sure that the reports included (1) the mentioned population focuses on college students, specifically within the 18-26 age range; (2) focuses on disparities/experiences that occurred within the sexual healthcare system and (3) either identified as LGBTQ+ or autistic. Studies that focused on only the health disparities that impact each group separately were also included, as I wanted to see if there were any overlaps in the experiences that each subgroup faced when encountering their PCP. Studies that include medical providers and caretakers will also be included, as while the main study focuses on the experiences of college students, it is essential to analyze how other third parties view this intersectionality and how that can impact future health decisions.

2.2.2 Exclusion Criteria

Studies that focused on caregivers' or parents' experience with their kids' diagnosis and sexuality were excluded from the review because it was essential to hear from the individuals who had to navigate the healthcare systems themselves rather than hearing it from a third party. In addition, results that focused on young kids and teenagers ages 17 and younger were excluded from the final product as they did not fit with the overall research goal of the study. Finally, it was essential to limit our study to articles from 2010-2022 to ensure that the latest data received is accurate and not based on flawed methodologies that previous studies have used when exploring disparities for this subgroup.

After creating the list of 5 relevant articles that meet the criteria, I extracted theoretically related characteristics, including the sample, the data source, and the main findings using the PPC framework. I pulled data based on the perceived criteria I mentioned above, where I focused on the population, the content, and the study context to determine if the information can be used to help with the direction of the qualitative survey. Applying this framework allowed me to compare existing literature based on the characteristics of the research question for this study, which would be used to identify the themes and gaps in the literature that future medical providers and researchers can utilize to expand on existing knowledge.

3. METHODS QUALITATIVE SURVEY

To test my hypothesis, I created an online survey to assess LGBTQ+ college students with autism and their experiences with accessing sexual healthcare. The survey was made on Qualtrics and distributed through various methods between December 2022 and February 2023 (IRB2022-1482). Participants were recruited through various online means. Social media was used to recruit participants, with graphics posted on Twitter, Instagram, Discord, and Reddit. I also emailed student LGBTQ+ advocacy groups with information about the study and a QR code & link to access the survey, such as Freshman Leading in Acceptance, Kindness, and Equality (FLAKE), LGBTQ+ Aggies, Transcend, and The Queer Grad Group. The total sample size of the survey consisted of 37 respondents by the time the survey closed. See Appendix A for material that was used during recruitment. The questions at the beginning of the study serve as inclusion criteria for the participants to be eligible, requiring (1) giving a "yes" response to the question "are you currently 18 years old?"; (2) currently attending college as an undergraduate; and (3) are you on the autism spectrum? (See Appendix B).

The second portion of the survey asked about participants' recent conversations with their primary care provider (PCP) concerning sexual health and how that can be tied to their sexual orientation. Finally, questions nine to thirteen asked respondents to expand on their experiences so that I could utilize content analysis to thoroughly break down the answers into specific codes that connect to themes that might pop up during the participants' responses (Hsieh, H.-F., & Shannon, S. E. 2005). Respondents were also asked if their PCP knew of their Autism diagnosis and how that might impact their conversation with their PCP. Finally, respondents were asked to list topics related to health issues that can affect someone in the LGBTQ+ community and on the spectrum. This can help address any potential barriers that might not have been mentioned earlier.

These questions were created with the intention of better understanding the accessibility issues which can pop up for a subgroup that previous research has not touched on. The responses from the participants will provide better insight to not only how medical providers can create a more inclusive environment but also into potential policies that can be put into place to reduce possible barriers for this intersectional group. Overall, I analyzed 37 participants, with 17 being included in the content analysis after removing responses that were either incomplete or did not provide enough information for me to investigate.

I used qualitative analysis, specifically content analysis to help extract my data through codes that connect to themes that the participants have reflected on during their conversation with their PCP about their sexual health (Hsieh, H.-F., & Shannon, S. E. 2005). This approach would allow me to immerse myself in the respondents' answers and find new themes by breaking down each word and interpreting it based on current literature about the experiences of dual identity subgroups. Using qualitative content analysis, I organized the responses on google sheets. I categorized them based on several themes that I have made based on the connected ideas shared across the answers. For my codes, I decided to have three principal codes as my overarching themes present throughout the respondents, which include (1) stigmatization, (2) No PCP, and (3) Outed/Safety. For my stigmatization code, I broke it down into three categories of stigmas that were present, which includes sex stigmatization, LGBTQ+ stigma, and disability stigma, as I felt that it was necessary to identify individual stigmas that create a difference in responses amongst the participants. (See Appendix C for the chart).

4. LITERATURE REIVEW RESULTS

4.1 Introduction

When exploring the current literature, the focus for this search was trying to find what present studies noted about the sexual healthcare experiences of autistic LGBTQ+ college students with their PCP. This literature review was created to establish background information on the similarities/differences in sexual healthcare experiences between LGBTQ+ and autistic college students. With the help of the literature review, I can compare my results from the qualitative data of my survey to see if there is a resemblance between experiences noted in the literature and what participants are experiencing in the survey.

With the help of my PCC (Population, Concept, Context) framework, I was able to identify five studies that were able to identify the sexual healthcare experiences of LGBTQ+ autistic college students, which will allow a better understanding of what similarities/differences can occur between the current challenges that autistic LGBTQ+ college students face versus results of the qualitative study. The three main themes that I have identified from the literature review include (1) risky sexual behavior among LGBTQ autistic college students/young adults, (2) sexual health knowledge and information-seeking behaviors among LGBTQ autistic college students/young adults, and finally (3) sexual victimization among LGBTQ autistic college students/young adults.

4.2 Risky Sexual Behavior Among College Students

LGBTQ+ college students with autism are more prone to negative attitudes and microaggressions against their identities, including internalized stigma such as internalized homophobia or ableism (Meyer, 2003). They might also encounter horizontal oppression, where they face stigma and prejudice from their communities, where autistic LGBTQ+ students may be treated differently due to their disability, or where members of the autism community might ostracize them for having a sexual or gender identity (Dispenza & DeBlaere, 2017) These experiences can negatively impact their mental health, pushing them to partake in more risky induced activities that can further impact their well-being. Young adults with autism, specifically males, are reported to more likely engage in unsafe sex compared to their neurotypical counterparts (Baines et al., 2018). This can be due to the lack of social networks, where the opportunity to discuss with friends and share information about sexual health would not be there for autistic college students, especially those with more severe symptoms (McCabe, 1999).

4.3 Sexual health knowledge & information-seeking behaviors

Autistic LGBTQ+ college students were more likely to come into college with little to no knowledge or awareness than their peers about sex or romantic relationships, which can leave them more vulnerable to sexual exploitation (Brown-Lavoie et al., 2014). The lack of discussion of sexual health could be attributed to parents underestimating their kid's sexual life due to misconceptions about the role of sexuality being irrelevant to their kids (Dekker et al., 2017).

Even when college students see their primary care provider, sexuality is not often discussed during the conversation other than just to discuss hygiene. This can lead to further frustration for the patient due to the lack of focus on discussing sexual health and can cause a loss of credibility in the patient-provider relationship (Mackin et al., 2016). The individual will have to constantly "shop" around to find a provider to work and support someone with autism, especially if they are also a part of the LGBTQ+ (Zerbo et al., 2019). These challenges can also complicate further comorbidities that exist, as autistic individuals are more at risk of having overlapping health conditions that can affect the person's well-being.

Not only does the lack of a provider cause existing comorbidities to impact the patient abnormally, but it also increases the gap in sexual healthcare knowledge that can easily accommodate the patient's needs. Mehzabin & Stokes (2011) noted that autistic young adults were more likely to seek information about sex from themselves or their peers than to contact their parents or medical professionals. However, due to the nature of autism, individuals diagnosed with more severe symptoms of autism may struggle with communicating information to their peers relating to sex. They may rely on more problematic sources of sexual information (ex., porn). Misinformation from these sources can make it hard for dual identity students to advocate for themselves, as previous studies have noted that disparities in sexual education for autistic young adults have resulted in lower scores in understanding the difference between abusive and safe relationships (Healy et al., 2009; O’Callaghan & Murphy, 2007).

Jahoda and Pownall (2004) have noted that these gaps in sexual health knowledge disproportionately impact women with intellectual disabilities, which makes it harder to make informed decisions about sex. Lack of sex education can also limit someone’s ability to choose contraceptives, especially for autistic college women, who might not be prescribed long-acting reversible contraceptives due to misconceptions about their disability from their provider (Wu et al., 2018a, b). Therefore, we can safely that autistic LGBTQ+ college students are more likely to face adverse sexual experiences due to a lack of inadequate sex education from their younger years, which can increase the chances of sexual assault to occur (Fisher et al., 2016)

4.4 Sexual Victimization

The miscommunication in sexual boundaries relating to consent and appropriate sexual behaviors due to a lack of proper sex education can increase the chances of adverse sexual experiences for young autistic adults. One study noted that the rates for individuals with an intellectual disability were six times more likely to experience sexual victimization compared to neurotypicals, with another study noting that at least 79% of autistic adults have experienced at least one case of sexual victimization (Brow-Lavoie et al. 2014, Nixon et al. 2017). LGBTQ+ students are also at risk of sexual victimization, with a report noting that 86% of queer students have experienced sexual assault due to their identity or sexual orientation (Kosciw et al., 2020). We can infer that autistic LGBTQ+ college students, specifically autistic girls, are more likely to suffer from sexual assault and not resort to it due to embarrassment or lack of resources from their university (Brown & Herman, 2015).

It is, therefore, essential that as autistic LGBTQ+ college students start to move away from their families and head towards a more ambivalent experience free from expectations, the risk of risky sexual experiences can increase for these dual-identity individuals (Brown et al., 2017). In addition, increased attention towards improving sexual education is associated with higher sexual satisfaction (Byers et al., 2013). Increased communication about sexual needs can reduce comorbidities' impact on students with intersecting identities (Jean P Hall et al., 2020; Lewis et al., 2017). Overall, it is vital to focus more on resources dedicated to the intersecting needs presented by marginalized groups, especially when it is LBGTQ+ college students diagnosed with autism.

In the next chapter, I will explore the central themes that appeared through content analysis. I will be discussing the connection of the themes to the accessibility of sexual health and the implication on how that can impact an individual's ability to discuss their health concerns with a health care provider.

5. QUALITATIVE SURVEY RESULTS

The data for this study were analyzed through qualitative analysis, more specifically content analysis, which was used to better understand the findings from the survey through the analysis of the participant's answers to the questions. Seventeen participants were analyzed based on the answers given and the survey completion. When coding, I focused on the responses' commonalities to create codes that identified a specific theme or answer the respondent might have conveyed. For example, if an answer expressed the respondents' fear of being outed to their provider, the response would be coded as "outed" to highlight how this fear might make the patient feel uncomfortable when discussing their sexual health.

Three themes arise from the participants' responses; (1) stigmatization, (2) No PCP, and (3) Outed/Safety. These three themes serve as the main focal points for what could serve as possible barriers to accessibility. For this section, I will walk through each section of code I made and discuss how everyone's experience correlates with the code given and what that would mean on a larger scale.

5.1 Fear of Being Outed/Safety

For this section, the fear of being outed relates to the participants not wanting to disclose themselves due to fear of their loved ones or their providers' discrimination. While this fear is typically associated with stigmatization, I wanted to separate them as it was essential to distinguish the reasons behind this fear due to some responses noting that they didn't want to be outed for their family members to know.

When discussing sexual health, at least 27% of participants worried about revealing their identity among participants when talking about sexual health with their PCP. One participant noted that they did not feel comfortable telling their PCP because they did not “seem to have experience with LGBT patients” and thus may attempt to take on a different identity to be able to “pass” as heteronormative/cisgender.

Some might not get out themselves due to their environment, as one participant mentioned that since they live in a state known to be not susceptible to the LGBTQ+ population, it “isn’t always safe to come out to people here.” Despite the existence of rights protections and anti-discrimination laws, the surrounding environment where the participant is in might prevent them from being able to discuss their sexual orientation to protect their well-being from any ongoing threats of discrimination. However, by not disclosing their identity to providers, LGBTQ+ patients might receive inappropriate information that does not allow them to seek the appropriate measures for their overall health, especially sexual health. Participant 23 mentioned that they do not disclose their identity because they might not be taken seriously due to their sexual orientation, with evidence being established that most people the respondent has interacted with have told them they “just haven’t met the right person yet.” However, participant 23 later mentioned how they were “pushed into getting a Pap smear” even though they were not sexually active and did not feel comfortable with telling their provider about “coming out as asexual” and thus the PCP assumes that the participant is heterosexual, which further increases discomfort.

Another reason participants might be afraid of disclosing their identity is the fear of significant others or family members being aware of this information, depending on whether the participants are dependents. For example, one participant mentioned that telling their PCP about their LGBTQ+ status would mean “being outed to their family” or another third party, which can result in ridicule or abandonment of support for the patient seeking help and thus limit their ability to seek resources or assistance with their health needs. This can also be extended to being able to disclose autism status, as some patients might not want to share their diagnosis due to fear of being judged or treated differently based on their dual identity.

5.2 Stigmatization

Several codes relating to stigmatization popped up in four of the participants' answers, which accounted for 24% of the respondents that had answered the survey. Regarding LGBTQ+ college students with autism accessing sexual healthcare, PCPs’ reactions to questions connecting to sexual health can impact how patients can comfortably discuss their concerns/questions. For this section, since there are kinds of stigmas during this content analysis, each section will go over a different kind of stigma and the more significant implications that can impact the accessibility for participants.

5.2.1 Sex Stigmatization

For this section, sex stigmatization is defined as the disapproval/discrimination from the provider towards the patient sex life. While there are some instances where this theme is connected to one of the participants’ identities, I wanted to separate them as I feel it’s important to differentiate to understand better where these different stigmas are coming from.

Sex stigmatization popped up when participant 11 mentioned how disappointed they felt when their provider “didn’t seem all too comfortable” discussing hemorrhoids despite the patient being impacted by this condition. While the provider might not have intentionally tried to come off as rude, her body language through non-verbal cues can suggest that there might be a lack of understandable training towards LGBTQ+ health. One code that pops up right away is uncomfortable, which the provider implied through her directed language of anal sex as a “lifestyle,” which further contributes to the patient's stigma and thus makes it harder to diagnose the issue at hand properly. It could also be possible that the provider was not adequately trained to discuss sexual health, especially regarding intersectional health needs for individuals with dual identities. The participant mentioned that their PCP did not seem to have “experience or training with queer people" which can indicate some connection with LGBTQ+ stigma.

This experience has been defined by current literature as a communication casualty, where negative cues from the provider can make the patient in this scenario feel judged based on their sex life (Casanova-Perez et al., 2022). Sex stigmatization, whether it is intentional or not, can cause participants to feel more hopeless or disappointed in their relationship with their provider, as the previous participant mentioned that they were “disappointed” in their first encounter due to the provider not “having basic information on the health issue of hemorrhoids" and thus would have to look elsewhere for another provider that can assist them. Based on these experiences, sex stigma plays a vital role in how sexual healthcare is discussed between the patient and provider, as even nonverbal cues can cause someone to feel like they are being judged for their actions.

5.2.2 LGBTQ+ Stigma

LGBTQ+ stigma refers to specific instances where participants faced conflict after disclosing their sexual orientation. For example, participant 3 discusses how their PCP referred to participant 3 as “biologically female” despite the patient’s awareness of their own body as a transgender man, which can contribute to further gender dysphoria and stress for the individual seeking care. Negative experiences such as this one can cause the individual to seek out or “shop” for a better provider, which can be financially restricted due to socioeconomic status where the patient cannot afford to seek out a trans-friendly provider, especially if the participant is in a rural setting where a provider is hard to access. Participant 3 also mentioned that their first primary care provider as a college student “didn’t want to see” them anymore after the person disclosed their orientation, which can easily create a sense of discomfort within the patient and can make it harder for the participant to reveal their identity without being in fear of discrimination. We also see this in Participant 23, who mentioned how they wished that “doctors were more aware that asexuality exists" because their provider pushed them into getting a pap smear despite the participant claiming they didn’t need it. Incidents like these correlates with current studies pointing out bias against asexual resulting in rejection of their identities and increased minority stressors (MacNeela & Murphy, 2014; MacInnis & Hodson, 2012). Being unable to bring up the topic of asexuality to a PCP due to fear of stigma can lead to the continuous perpetuation of asexuality not being deemed valid (Jones et al., 2017). Based on these experiences, LGBTQ+ stigma can play a role in how the participants can comfortably disclose their identity. Negative assumptions based on stereotypes around the community can harm an individual’s ability to advocate for themselves.

5.2.3 Disability Stigma

Disability stigma can be defined as discrimination or negative attitudes towards a participant’s action due to their autism. Participant 23 said that when they brought their parents to help with communicating health needs to the provider, she felt that the provider wasn’t taking the participant “seriously” due to the misconception of the provider assuming that based on the patients' age, they should be able to advocate for themselves. This kind of stigma can make it harder for the participant to seek further help or choose to advocate for themselves, which depending on the person’s social deficits, can make communication of sexual health needs complex or incomprehensible to the PCP, and would lead to further stress and anxiety about future health visits. Stereotyping can make the participants feel they cannot care for themselves or advocate when visiting their provider. This can also further contribute to the internalization of helplessness connected to the participants' disabilities.

5.3 No PCP

I've focused on the lack of PCP that five participants had included in their responses, which accounts for 29% of the respondents in the survey. This theme focuses on the lack of a reliable medical provider that these participants. It was noted that they filled out the first few questions but stopped at the question about going to a PCP. As previously mentioned, as young adults transition into college and gain greater autonomy over their health, students are more likely to engage in various risky behaviors that can impact their overall health status. This can be due to the lack of emotional maturity, where young adults may believe they are "invincible" from any consequences of their actions, even if they know how sexual diseases are transmitted. This factor could explain why these participants do not have a PCP, as they might believe that they are ultimately in good shape, and thus there is no need to access sexual health resources since everything is online. However, most college students are more likely to have multiple partners throughout college, which can contribute to spreading STDs amongst the general student population.

5.4 Health Topics/Issues

For this section, I had two questions on the survey that explored the health topics and health issues they thought were essential to autistic LGBTQ+ college students to provide insight into future research efforts. 82% of the eligible participants have responded to question 20, with the majority selecting all the responses provided (See Appendix B.2). This is consistent with current literature about the shared comorbidities that impact someone with multiple intersecting identities (Jean P Hall et al., 2020; Lewis et al., 2017). However, one participant noted that another factor that could impact someone with dual identities is systematic queerphobia and ableism in the healthcare system—growing evidence has noted the importance of these two themes intertwining based on the high levels of social exclusion from healthcare services due to the normalization of stigmatizing attitudes (Waling et al., 2019; Frawley et al., 2015; Leonard et al., 2012). Services that are dedicated to LGBTQ+ communities often fail to provide services that are accessible for those with disabilities, especially those with autism, and vice versa (O'Shea et al., 2020). Therefore, future researchers must focus on the intersecting problems for this subgroup when navigating the medical system.

Lastly, we had question sixteen, which asked about sexual topics participants would like their PCPs to discuss—only 6% of the participants answered this question, indicating that most participants were satisfied with their conversation with their provider or could find answers elsewhere. One participant said they wished their provider would discuss vaginismus and endometriosis when the topic of sexual healthcare popped up. Vaginismus is the body's reaction to the fear of vaginal penetration (Binik, 2010). Despite this condition being a joint female sexual dysfunction, there is a lack of education on the topic in medical school, which can result in the inability to diagnose and treat the condition effectively (Pacik, 2014). The lack of education can increase the stigmatization of this condition for the patient. The provider might incorrectly judge the individual for not trying hard enough or to "just relax." (Huber et al., 2010)—acts of stigmatization can increase anxiety among patients and can lead some women to avoid seeking reproductive health care, which can increase their risk for gynecological problems (Hilden et al., 2003).

We also see similar trends of stigmatization when it comes to endometriosis. Latina women with endometriosis were more likely to be labeled as excessive whiners or changas by their healthcare providers, family members, etc. (Matias-Gonzalez et al., 2020). Participants in this study reported their healthcare providers laughing at their pain symptoms and invalidating their experiences, which can further increase poor health outcomes due to denied healthcare. Individuals with endometriosis are also reported to more likely mask their pain due to negative experiences, which can translate to reluctance of reporting chronic pelvic pain symptoms to health care providers (Seear, 2009). Young adults, more specifically bisexual young women, are more likely to anticipate stigma more than older adults due to structures within society that systematically impacts marginalized groups. (Gupta et al., 2021). It is therefore important that there is an assessment of the rising prevalence of stigma towards vaginismus & endometriosis, as there is a small handful of qualitative studies that have focused on the impact of stigma. By conducting more research studies, we can examine the stigma and give a voice to those who have these conditions, especially when it impacts LGBTQ+ college students.

6. DISCUSSION

The main goal of this study was to explore the accessibility of sexual healthcare for LGBTQ+ autistic college students. Current literature has noted the sexual disparities for LGBTQ+ college students. This marginalized subgroup is more likely to have a higher rate of STDs due to the high number of partners compared to heterosexuals (Oswalt & Wyatt, 2013). Despite the high rate of STDs due to lower condom usage, LGBTQ+ subgroups such as lesbians are less likely to undergo sexual health screenings (i.e., Pap smears) and physical checkups (Charlton et al., 2011; Luk, Gilman, Haynie, & Simons-Morton, 2018).

We also see an overlap of information when looking at autistic college students, where condom usage among autistic young men is low compared to their neurotypical counterparts (Baines et al., 2018). This can be attributed to lower levels of friendship and participation in social groups which can ultimately leave out autistic young men from learning about sex through discussions (Jahoda & Pownall, 2014). Autistic young adults are also less likely to receive sexual and reproductive health services (SRH) than their peers, especially regarding routine pelvic exams (Ames et al., 2021). Therefore, we can conclude that autistic LGBTQ+ college students are also at risk due to the increased rate of minority stressors due to this intersected identity (Jean P. Hall et al., 2020).

However, there is still a limited scope on the experiences of LGBTQ+ autistic college students when discussing sexual healthcare with their PCP due to the lack of an intersectional focus. Therefore, I completed an online qualitative survey about the participants' experiences with their PCP regarding sexual healthcare—the answers given were analyzed via content analysis to identify common themes in the answers. A literature review was also conducted exploring what previous studies have noted about the dual identity of LGBTQ+ and autism among young adults and their experiences with healthcare.

The literature review and the qualitative study have noted variation in responses for the participants, with some mentioning the varying degrees of the stigma that has negatively impacted their experience with their provider. In contrast, others fear outing themselves due to their environment or provider. This is consistent with most studies that have noted the fear of discrimination from providers based on being a part of marginalized identities, especially if it has been a recurring issue based on previous experiences (Krahn et al. 2015; Bishop-Fitzpatrick & Kind 2017; Jean P. Hall et al.,2020). However, overall, three main themes were identified during the study; (1) stigmatization, (2) outed/safety, and (3) No PCP.

We found that the first prominent theme in the respondents' answers was stigmatization, which 24% of participants reported in the survey. Some participants noted that it was very short when answering questions about birth control and contraceptives. However, one participant noted the trend in how healthcare providers “don't view sex as an essential part of life” or even something which can be detrimental to one’s being. This is consistent with current literature about PCPs’ views of sexual healthcare. One study noted that PCPs had varying opinions on whether it was their job to initiate and discuss sexual healthcare resources. Some PCPs might not initiate preconception counseling because they do not prioritize it or might be uncertain about their role (Chuang et al., 2012; McCall-Hosenfeld & Weisman, 2011). However, the PCP’s uncertainty about their role might come off as being negative or not caring about their patient’s concerns. These negative perceptions can make it more complicated for participants to fully seek help about their concerns, especially when considering the likelihood of multiple stressors/comorbidities impacting LGBTQ+ autistic college students across behavioral, emotional, physical, and mental health. These findings suggest inadequate training regarding PCPs' conversations about sexual healthcare for LGBTQ+ autistic college students. Medical providers must make more of an effort toward a more inclusive environment that can be made by giving more freedom to the patient and allowing them to communicate in the way that they are most comfortable, whether through written communication or a device (Zerbo et al., 2019). It is also essential for clinicians to be aware that autistic individuals are more likely to identify as LGBTQ+ and the challenges that can come from being a part of this subgroup. Workshops should be implemented during their time in residency that can teach about implicit bias through written or verbal communication for marginalized populations. Research has noted that teaching intentional strategies through workshops or classes during medical school can reduce biased behaviors in medical providers (FitzGerald et al., 2019). Therefore, PCPs must ensure that they are not stigmatizing their patients and be aware of the shared comorbidities that LGBTQ+ autistic young adults may have.

Our results demonstrate that 47% of participants have reported fear of being outed and not wanting to disclose their identity with their provider out of safety. This theme is consistent with the primary literature about marginalized populations’ experiences with their provider. According to Meyer’s minority stress theory (2003), one proximal stressor discussed was the sexual identity concealment, which includes hiding one’s LGBTQ+ identity as a form of protection from stigmatization. This component is demonstrated through one participant who mentioned how it “isn’t always safe to come out to people here,” indicating that the environment they live in is unsafe for those that fall under the LGBTQ+ community. Another factor that could contribute to this fear is family members finding out about the participant’s status through using sexual healthcare. Zapata et al. (2022) noted that when LGBTQ+ young adults moved back with their families during the quarantine, there was a decrease in using prevention services due to concerns of disapproval or outing themselves accidentally to their family. However, by not regularly meeting with a provider or disclosing information, existing comorbidities will continue to negatively impact the individual, especially if minority stress plays a role in those comorbidities due to the multiple stressors that come with a dual identity.

Finally, the last theme noticed among the participants was the lack of a primary care provider. In this scenario, five participants filled out the first few questions but stopped at the question about going to a PCP. While the survey did not ask about providing a reason for not having a provider, I hypothesized that autistic LGBTQ+ college students might struggle with finding a reliable PCP that can understand their concerns. Previous literature has noted the role that minority stressors play in marginalized populations, where the constant stream of harassment, discrimination, and violence negatively impacts well-being and health (Kelleher, 2009; Meyer, 1995; Toomey, Ryan, Diaz & Russell, 2018).

This is especially true for LGBTQ+ autistic college students, who might encounter negative attitudes from stigma directed at their intersecting identities (Drummond & Brotman, 2014). One factor that could lead to not having a reliable PCP would be the fear of stigmatization from providers due to intersecting identities. Previous studies have discussed how providers' biases can impact their patient's health outcomes, and both explicit and implicit biases can lead to discriminatory treatment of dual-identity patients (Staats et al., 2017; Fallin-Bennett, 2015; Levine & Ambady, 2013). Repeated incidences of biases can cause existing minority stressors to worsen due to negative communication, leading to lower utilization of services due to LGBTQ+ individuals avoiding or delaying services (Buchmueller & Carpenter, 2010; Krehely, 2009).

Geographic location can also impact one's ability to access services. While most college campuses offer sexual health services for their students, specific services, such as STI testing, may not be readily available due to high deductibles and copays (Habel et al., 2018). This can push students to seek services elsewhere to find the care they need, which might be problematic if they're in a rural community with limited access to these services.

Policymakers must also try to raise awareness for the accessibility of sexual healthcare resources for marginalized populations. There has been an increased attempt from states to restrict reproductive healthcare resources since the passing of the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* that has made abortion illegal in over twenty-six states (Elizabeth & Nash, 2021). According to Guttmacher Institute, eighty-nine percent of counties are reported to have no abortion provider, which can leave autistic LGBTQ+ college students at adverse risk if they have no adequate transportation (Jones RK et al., 2022). Federal and state governments need to create laws and policies that address social determinants of health, such as poverty and transportation, which can expand access to sexual healthcare services and information.

One method that can help alleviate the inaccessibility is increasing the use of Telehealth, which can provide sexual and reproductive healthcare information for college students that cannot afford to meet a provider in-person (Gabriel Weigel, 2019; Kathryn Wager, 2017). These efforts are essential for autistic LGBTQ+ college students, as the study that I have conducted has noted that at least 29% of the participants have pointed out no primary care provider, which can be due to financial constraints or transportation problems that can make it difficult to see a medical provider. Cheng et al. (2021) have noted that most young people and those with disabilities utilized remote services during the pandemic and reported positive experiences due to the accessibility of telehealth. Therefore, we must work on expanding not only accessible healthcare but also affordable opportunities for marginalized populations that may not have access to an in-person healthcare clinic.

This study had several limitations, especially regarding the number of participants. While the answers from the respondents were in-depth to allow me to do qualitative analysis, future studies need to conduct research on a larger scale, including a bigger sampling size. Participants in this study were recruited online, whether through social media or email. However, we end up missing out on participants who might have more to contribute but do not have access to online sources to be able to share their stories, so more effort must be attributed to gathering respondents through word of mouth or other methods that make it easier for everyone to access. Future research should be dedicated to other factors, such as race or income, as these two variables can help expand the focus on how intersectional groups interact with the healthcare system.

In conclusion, while this study has shown the potential challenges that LGBTQ+ autistic college students face when it comes to accessing sexual healthcare, this only serves as the first steppingstone into creating more research efforts for establishing an inclusive environment for everyone. We must continue to expand our research focus while implementing changes in the health system infrastructure so that health equity can help reduce the barriers and stigma that stand in the way of better health outcomes.

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APPENDIX A: RECRUITMENT MATERIAL

Survey for College Students

- Are you a current college student?
- Are you on the Autism Spectrum?

Then you are eligible for this survey! You will complete a 20-minute survey to answer questions about your experiences accessing sexual healthcare.

If interested or have any questions, please contact:

James Lifton

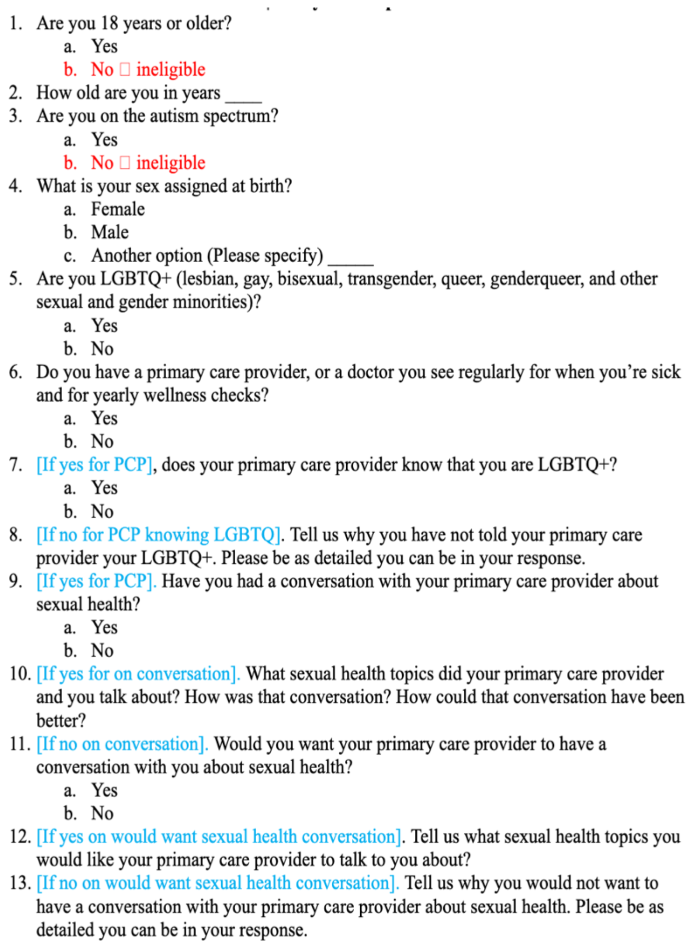
jameslifton97@tamu.edu

Call or text: 512-791-3827

QR Code

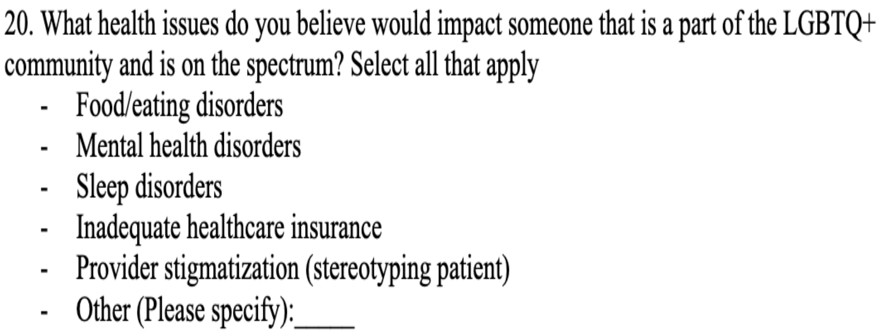
Figure A.1: Poster for Reddit, Instagram, and Twitter

APPENDIX B: SURVEY



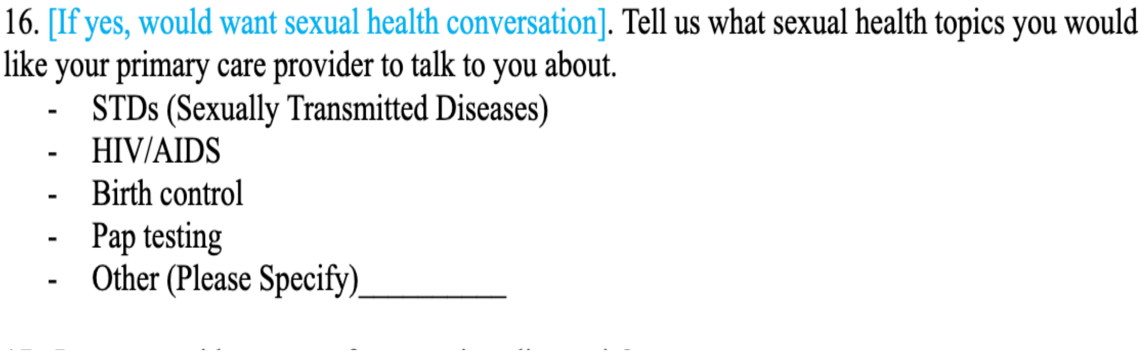
1. Are you 18 years or older?
    a. Yes
    b. No □ ineligible
2. How old are you in years ____
3. Are you on the autism spectrum?
    a. Yes
    b. No □ ineligible
4. What is your sex assigned at birth?
    a. Female
    b. Male
    c. Another option (Please specify) _____
5. Are you LGBTQ+ (lesbian, gay, bisexual, transgender, queer, genderqueer, and other sexual and gender minorities)?
    a. Yes
    b. No
6. Do you have a primary care provider, or a doctor you see regularly for when you're sick and for yearly wellness checks?
    a. Yes
    b. No
7. [If yes for PCP], does your primary care provider know that you are LGBTQ+?
    a. Yes
    b. No
8. [If no for PCP knowing LGBTQ]. Tell us why you have not told your primary care provider your LGBTQ+. Please be as detailed you can be in your response.
9. [If yes for PCP]. Have you had a conversation with your primary care provider about sexual health?
    a. Yes
    b. No
10. [If yes for on conversation]. What sexual health topics did your primary care provider and you talk about? How was that conversation? How could that conversation have been better?
11. [If no on conversation]. Would you want your primary care provider to have a conversation with you about sexual health?
    a. Yes
    b. No
12. [If yes on would want sexual health conversation]. Tell us what sexual health topics you would like your primary care provider to talk to you about?
13. [If no on would want sexual health conversation]. Tell us why you would not want to have a conversation with your primary care provider about sexual health. Please be as detailed you can be in your response.

Figure B.1: Qualitative Survey



20. What health issues do you believe would impact someone that is a part of the LGBTQ+ community and is on the spectrum? Select all that apply
    - Food/eating disorders
    - Mental health disorders
    - Sleep disorders
    - Inadequate healthcare insurance
    - Provider stigmatization (stereotyping patient)
    - Other (Please specify):_____

Figure B.2: Health issues



16. [If yes, would want sexual health conversation]. Tell us what sexual health topics you would like your primary care provider to talk to you about.

- STDs (Sexually Transmitted Diseases)
- HIV/AIDS
- Birth control
- Pap testing
- Other (Please Specify)__________

Figure B.3: Sexual health topics

APPENDIX C: CHART

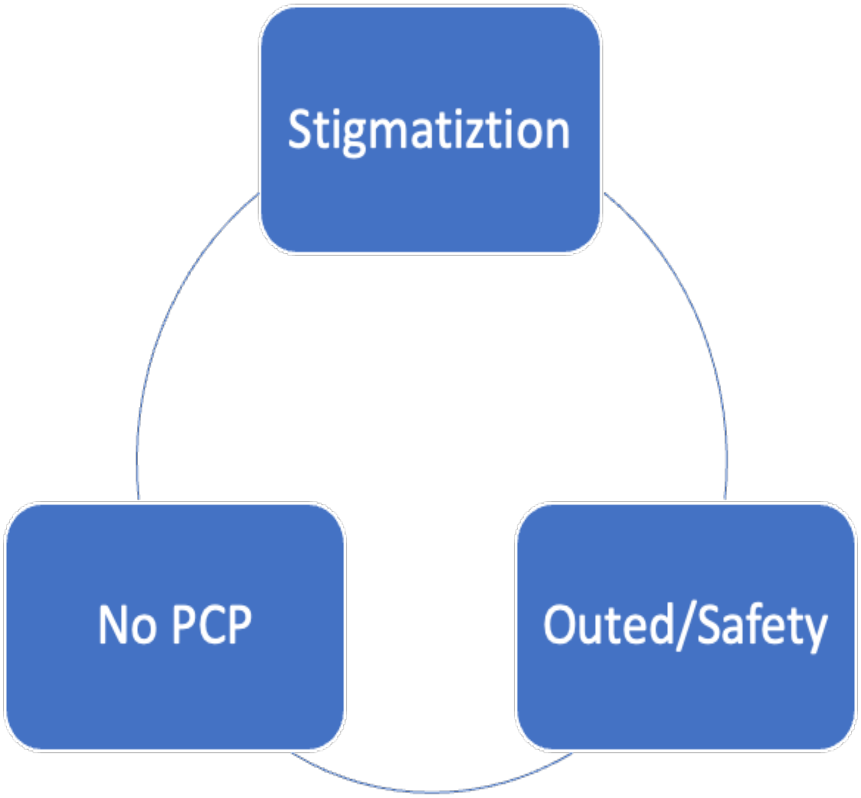


Figure C.1: Chart of the three main themes; (1) Stigmatization, (2) No PCP & (3) Outed/Safety