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„Health in the Context of Outness of People on the Aromantic Spectrum "

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Inhalt

Introduction

The term "aromantic" found its origin in the early 2000s in English-speaking forums and groups around asexuality (*Aromantic History*, 2019; *FAQ*, 2019), yet even as much as 20 years later it is still unknown to many. In recent years the topic has become better known, especially through social media like Twitter and Tumblr. In part because public figures have come out in support of it, like model Yasmin Benout (Pantony, 2021), Youtuber Connie Glynn (Wood, 2018), and musician Moses Sumnay (Cliff, 2019). The community itself is also working on visibility and has found its symbolism.

Figure 1. the aromantic flag. https://lgbta.wikia.org/wiki/Aromantic

Not unlike other LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual/Aromantic, Plus) identities, aromanticism also has a flag (figure 1), with the green stripes representing the aromantic spectrum, the white representing friendship, and the black and gray stripes representing the multitude of sexualities. Lifestyle and other journalistic magazines such as Cosmopolitan (Hsieh, 2018) have also become aware of this orientation and have published articles that have contributed to its visibility. Internationally, aromanticism is gaining attention, both within the LGBTQIA+ community and in the wider mainstream, but publications in the field of psychology are still scarce. Therefore, it is important to first define some terms used by the community and in this further in this thesis.

Attractions

The idea that the variety of attractions people feel for each other do not always relate to the same gender or genders has not just emerged in recent years. One example comes from writer and sexologist Karl Heinrich Urlichs (b. August 28, 1825; †July 14, 1895). In his writings for example he distinguished between two different types of "uranodioning," a term he used for men who felt attraction to both men and women. The differentiation was between "Conjunctive Uranodionings" and "Disjunctive Uranodionings," the former having tender and passionate feelings for men and the latter having only tender feelings for men while still feeling passionate feelings for women (Bristow, 2006; Leck, 2016; Tang, 2016).

With "Love and Limerence: The Experience of Being in Love", Dorothy Tennov (1998) another model to distinguish attractions from each other. In this book, the psychologist describes the results of her research on the topics of attraction and love, which she had conducted in the 1960s. The term "limerence" describes an infatuation or crush that can lead to the formation of a relationship. However, it also recognizes "non-limerant" individuals who do not have these feelings.

Today, the "Split Attraction Model" or SAM is a common term, although its origin is unclear, as it is thought to have originated and gained traction through various discussions in online forums and websites such as Tumblr. The first descriptions of the modern and common distinction are thought to have originated in the Asexuality Visibility and Education Network forums, where primarily asexual individuals shared their experiences with attraction (*Asexuality and Queerness*, 2002; *Relationship Definitions*, 2005; *Split Sexuality?*, 2007). The main distinction here is between romantic and sexual attraction (Doll, 2019; James, 2020; Pochak, 2019).

Romantic attraction is defined here as feelings or emotional responses toward another person that lead to a desire for romantic experiences or a romantic relationship with that person (*Romantic attraction*, 2021). Colloquially, this refers to "being in love," "having a crush," or "butterflies in the stomach." Sexual attraction is defined similarly, as feelings or emotional responses toward another person that lead to a desire to have sexual experiences or a sexual relationship with that person, which can be described colloquially as, for example, "finding someone hot" (*Sexual attraction*, 2017)

These two attractions can exist independently or occur together. For example, one can feel sexual attraction for a person, "finding them hot," and have a desire for a sexual experience without being "in love," that is, without feeling romantic attraction for that person. Further, these two experiences can also refer to the same sex or gender but can also refer to different sexes or genders. Taking Karl Heinrich Urlichs' definitions again and putting them into modern terms, a conjunctive uranodioning by today's description would perhaps be called bisexual biromantic, that is, someone who feels both sexual and romantic feelings for men and women. A disjunctive uranodioning might be described as homoromantic heterosexual according to SAM, that is, a man who feels romantic attraction exclusively for men and sexual attraction exclusively for women.

The SAM in current use also describes other types of attraction that further encompass the spectrum of human experiences. These include, for example, sensual attraction, which refers to the desire to be touched or touch a person, or aesthetic attraction, which refers to being drawn to a person's appearance (Dearborn, 2016; Fader, 2021). However, throughout this thesis, I focus on romantic and sexual attraction in relation to the SAM, as these are the relevant in relation to the research question.

Aromanticism

The term aromanticism is not only etymologically related to asexuality via the common Greek prefix "A," which signifies negation. But it also found its origins in discussions in the forums of the aforementioned AVEN as well as a Yahoo! forum called Haven for the Human Amoeba, which also targeted asexual individuals (*Aromantic History*, 2019; *FAQ*, 2019).

Asexuality is defined as the absence of sexual attraction or the lack of interest in sexual experiences, either completely or in the context of the asexual spectrum to a lesser degree than the assumed societal norm (Bogaert, 2015; Brotto et al., 2010).

Aromanticism is defined similarly, only in parallel with reference to romantic experiences: The absence of romantic attraction or interest in romantic experiences, either completely or in the context of the aromantic spectrum to a lesser extent than the assumed social norm (*Aromantic*, o. J.; *Aromantic*, 2021;

Aromantic Spectrum, o. J.; *Aromantic spectrum*, 2016; Borresen, 2018; Plonski, 2018)

The aromantic and parallel asexual spectrums describe all identities that deviate noticeably from the assumed societal norm precisely in the degree of romantic or sexual attraction for the individual and include several more specific identities. Common terms here are, for example, demiromantic or grayromantic/greyromantic. Demiromantic describes individuals who can only feel romantic attraction under the condition of a pre-existing, deep emotional connection, or in the case of demisexual, sexual attraction (*Demiromantic*, o. J.; *Demiromantic*, 2019). Grayromantic or Greyromantic is a bit less precise in this regard, as it is used by individuals who experience little or conditional romantic attraction, though the extent and conditions may vary from person to person (*Gray-romantic*, 2020; *Greyromantic*, o. J.).

At the other end of the aromantic spectrum is alloromantic, which describes individuals who experience romantic attraction to a degree that meets or exceeds the assumed social norm (*Alloromantic*, o. J.; *Aromantic*, 2021). This can refer to different genders and is used in parallel with common sexuality terms. Heteroromantic, similar to heterosexual, is used as a term for alloromantic individuals who are romantically attracted to the opposite binary gender, i.e., men to women, women to men (*Heteroromantic*, 2017). For homoromantic individuals, it is romantic attraction to one's own gender, biromantic to more than one or both binary genders, panromantic to all genders or regardless of gender, to name a few examples (*Homoromantic*, 2020). Likewise, there is allosexuality contrasted with the asexual spectrum (*Allosexual*, o. J.; *Sexual*, 2013). Though it is important to note there that many people who do not actively use the SAM often include romantic attraction in their concept of sexuality. The term gay can therefore refer purely to sexual attraction to one's own sex, as well as implicitly include homoromantic.

Amatonormativity

The term amatonormativity was first coined by Elizabeth Brake, professor of philosophy. With the concept she describes the social expectations around marriage, romantic relationships and romance in general. What is meant by this is the false belief that everyone seeks the same kind of relationship - a

monogamous, romantic, sexually loving relationship - and that this is what is best for everyone.

Brake sees this norm as marginalizing polyamorous relationship constellations and individuals, that is, people who maintain romantic and or sexual relationships with more than one person at a time, as well as singles, friends, and asexuals. (Brake, 2012; Brake, 2018). Amatonormativity is related to heteronormativity, which describes society's assumption that everyone is heterosexual and how society privileges heterosexuality (Brake, 2017).

As described above, the concept of sexuality, such as homosexual or heterosexual, is also implicitly used by many for romantic attraction, unless the SAM is addressed. Accordingly, heteronormativity has included heteroromanticism in its normative assumptions, whereas amatonormativity presupposes not only allosexuality but also alloromanticism in its normative assumptions.

Since the aromantic individuals fall out of both normative concepts, a certain hostility and alienation of society is to be expected. The term the aromantic community uses for this is "arophobia" or alternatively “aromisia” (*Arophobia*, o. J.; *Basic Aromantic Terms*, o. J.). However, there is as yet no psychological or sociological published research on this.

Pathologizing

One assumption I make in my research is that aromanticism, and thus the (partial) lack of romantic attraction or interest in a romantic relationship, is not in itself pathological. There are thus far no studies on this. However, in the case of asexuality, which represents a similar lack of attraction, there are results that speak against a pathologizing of asexuality.

Brotto et al. (2015) compared asexuality to the DSM-5 sexual appetite disorder Hypoactive Sexual Desire Disorder and found that the results argued against defining asexuality as a disorder. In another study by Brotto and Yule (2017), equally argued against defining asexuality as sexual dysfunction, as a paraphilia or mental disorder favor of defining asexuality as a distinct sexual orientation.

So, on the basis that the lack of a specific attraction, in the case of asexuality sexual attraction, doesn’t seem to be pathological or in need of treatment, I will

assume that the lack of romantic attraction in individuals on the aromantic spectrum should be treated similarly.

Health and Outing

Mental Health

For decades, a wide variety of studies have found LGBTQIA+ individuals to have impaired mental health compared to heterosexual, heteroromantic, and cisgender individuals. In 2015, Plöderl and Tremblay published a systematic review of 199 studies on this topic. Its findings indicated that most of the integrated studies showed increased risks for depression, anxiety disorders, suicide, and suicide attempts for sexual minorities relative to heterosexual control groups. These results were found for both men and women, all age groups, and in different geographic regions. All sexual minorities had these risks, but bisexuals were found to be most affected in most of the studies (Plöderl & Tremblay, 2015).

A study from England found that members of sexual minorities were two to three times more likely to report long-term psychological or emotional problems than the heterosexual control group. Among heterosexual men, 5.2% reported such problems; among homosexual men, 10.9%; and among bisexual men, 15.0%. For women, the pattern was similar, only with higher rates. With 6.0% of heterosexual women, 12.3% of homosexual women, and 18.8% of bisexual women reported these problems (Elliott et al., 2015).

Similarly, an Australian study by Jorm et al. (2002) found that bisexuals showed the highest rates of anxiety, depression, and negative affect, heterosexuals the lowest, and homosexuals were intermediate in rates between heterosexuals and bisexuals. Krueger et al. (2018) also found that members of a sexual minority had more depressive symptoms than the heterosexual comparison group. Jorm (2002) also found that rates for sexual minorities, particularly bisexuals, were higher in psychological distress, anxiety, depression, suicidality, alcoholism abuse, and self-injurious behavior; they were lower in quality of life and emotional well-being. However, a study by Mustanski et al. (2010) of LGBTQIA+ youth between 16 and 20 also found that bisexual youth had lower rates of diagnoses of depression, PTSD, and conduct disorder.

Members of sexual minorities also exhibit higher rates of body dissatisfaction and anorexia and bulimia symptoms (McClain & Peebles, 2016; Siconolfi et al., 2009) with body dissatisfaction being a more dominant predictor than self-esteem (Hospers & Jansen, 2005).

As for the mental health of people on the asexual spectrum, the numbers of studies is still low. A study by Yule et al. (2013) of 282 asexual individuals found that, compared to heterosexual individuals, they were significantly more likely to report the current presence of affective or anxiety disorders, as measured by two items. Whereas women, at 30% of asexual, 34% of otherwise not heterosexual, and 16% of heterosexual, had higher prevalence on average than men, at 24% of asexual, 10% of otherwise not heterosexual, and 15% of heterosexual. Even at follow-up to this, asexual individuals were still more likely than heterosexual individuals to have an affective or anxiety disorder, while there was no significant difference between asexual and otherwise non-heterosexual individuals.

For anxiety disorders, it was 23% for asexual men and women, 20% of otherwise non-heterosexual men and women, and 8% of heterosexual men and 15% of heterosexual women, respectively. With regard to suicidality, 26% of all asexual persons reported experiencing feelings of suicidality in the past two weeks, as did 24% of all otherwise nonheterosexual persons and 12% of all heterosexual persons. For thoughts of death or dying, 36% of all asexuals, 33% of all otherwise non-heterosexuals, and 23% of all heterosexuals reported having experienced this in the past two weeks. There were no significant differences between genders in this regard.

Physical health

Compared to studies on mental health, the topic area of physical health LGBTQIA+ individuals is less explored. A study found a higher prevalence of disability in LGB+ individuals compared to heterosexual individuals (Fredriksen-Goldsen et al., 2011). Prevalence rates in the dash sample were 36% of homosexual and bisexual women and 25% of heterosexual women and 26% of homosexual men, 40% of bisexual men, and 22% of heterosexual men. The

homosexual and bisexual individuals reporting disability were also younger on average than the heterosexual comparison group.

Fredriksen-Goldsen et al. (2013) had similar findings. Homosexual and bisexual individuals are at higher risk of disability or chronic disease, with homosexual and bisexual women reporting cardiovascular disease significantly more often than heterosexual women. Homosexual and bisexual men are especially at increased risk for poor physical health. (Conron et al., 2010) also found an increased risk of chronic illnesses for sexual minorities in their study. Sexual minorities reported activity limitations and asthma, and bisexual individuals and homosexual women reported cardiovascular disease.

In another study by Dilley et al. (2010) found that homosexual and bisexual women report poor physical health and bisexual women also report diabetes more often compared to heterosexual women. Homosexual and bisexual men were significantly more likely than heterosexual men to report poor health and limited activities. Similar to the mental health studies described above, bisexual individuals again seem to have the highest rates and the greatest differences from heterosexual individuals.

To my knowledge there hasn't been a publication tackling the prevalence of chronic illnesses and disabilities and the state of their general physical health that explicitly included people on the asexual spectrum.

Coming Out and Outness

Coming Out in the context of a LGBTQIA+ Identity means making your identity known to both yourself and the people around you. It generally is not a one time event but this disclosure happens multiple times throughout one's life with different people. Even after coming out to everyone in your life, it continues on when meeting new people as for most heteronormative and cisnormative (the assumption that everyone is the gender they were assigned at birth, not transgender) assumptions lead them to be assumed to be straight and cisgender. Therefor the level of outness, so being out to the people around you varies. Some might be out to their friends and family, but not at work, or only out to their fellow LGBTQIA+ friends but still "in the closet" to their assumed to be straight friends.

Research also suggests that different LGBTQIA+ identities have varying average levels of outness. Bisexuals, asexuals and other non-monosexual individuals are less likely to be out at work, to their family, healthcare providers and even to their LGBTQIA+ peers for example (Balsam & Mohr, 2007; Dyar et al., 2015; Pew Research Center, 2013; Rothblum et al., 2020).

One study showed that bisexual feel additional stigma when coming out within the LGBTQIA+ community, especially while having an opposite-gender partner with the fear of erasure by being seen as straight (Brotman et al., 2002).

In regards to asexual individuals and coming out, (Robbins et al., 2016) took a qualitative look at their experiences. They found that different themes in the reaction to and fears of coming out, like being met with skepticism, dismissal and disbelief, a lack of understanding and acceptance, selective disclosure often to their partners only or non-disclosure, as well as a fear of being pitied or being labeled “crazy.” However, they also found positive themes, like the relief of finding the community and the role the internet play in that, feelings of validation, acceptance and liberation after coming out as well as little to know regret after coming out regardless of the reaction they received.

Overall, there seem to be potential downsides to coming out there for example LGBTQIA+ discrimination at the work place, a stop in career progression and wage inequality (Ozeren, 2014). Generally, the decision on coming out is a weighing of costs, like the risk of social avoidance and disproval, self-consciousness and a threat to physical health and safety, and the benefits, like the potential of higher well being, and increased self esteem (Corrigan & Matthews, 2003).

Another study by (Brotman et al., 2002) took a qualitative look at the coming out experiences of gay, lesbian, bisexual and two-spirit Canadians in the context of health and health care, with two-spirit being an identity specific to native American cultures that deviates from heteronormative and cisnormative views of the colonized society. In it they found that coming out was a central construct in regards to health care access. In addition, the participants named the stress of being in the closet as one of the strongest impacts on health and described being closeted as “not a good state of health”.

Tabaac et al. (2015) looked into Outness to family specifically which they found to correlate positively with social support and wellness behavior. Wellness behavior in return correlated negatively with depression and social support by family and friends correlated positively with good mental health. In parallel, Bybee et al. (2009) found feeling shame in regards to the queer identity in bisexual and gay men was linked to a lowered likelihood of being out, as well as higher likelihood of suicidality, drug and alcohol abuse, and depression. A study looking at bisexual and lesbian women also found that outness was linked to lower psychological distress and through that to lower suicidality (Morris et al., 2001). Generally speaking, Outness seems to be connected with better well being, better mental health and lower depression (Kosciw et al., 2015; Lewis et al., 2002).

Present Study

Over all, studies suggest that the mental and physical health of all LGBTQIA+ identity groups on average seems to be compromised compared to their straight counterparts and that outness overall seems to have a positive effect on the well being and health of LGBTQIA+ people. However, to my knowledge, as of writing this thesis there hasn't been any study that considered people on the aromantic spectrum or the notion of a differing romantic attraction from the sexual attraction at all. So the aim of this thesis is a first exploration of people on the aromantic spectrum, their physical and mental health, their outness and the connection between outness and health.

If we take on the view point of heteronormativity and amatonormativity, aromanticism deviates from the expected norms similarly to other LGBTQIA+ identities by not adhering to heterosexual standards of attraction which include alloromanticism. It can be considered a non-monosexual or in this case non-monoromantic attraction like bisexuality and especially asexuality which might come with additional stigmas even within LGBTQIA+ spaces, as explored above.

Considering all these factors brings me to the following hypothesis:

1. The mental health of aromantic individuals on average is compromised compared to alloromantic individuals.

2. The physical health of aromantic individuals on average is compromised compared to alloromantic individuals.

3. Aromantic individuals will score lower on Outness compared to their own sexual orientation.

4. Aromantic individuals will score lower on Outness compared to alloromantic people.

5. Outness is positively correlated to better mental and physical health in aromantic individuals.

Methods

Participants

The study was open for all adults over the age of 18 residing in Europe, regardless of sexual and romantic orientation or gender. No other exclusion or inclusion criteria applied. Recruitment was done online via post on several social media platforms like Twitter, Reddit, Tumblr, and Facebook to reach an international audience.

Materials

Demographics

Participants were asked about their gender, with the option's "male", "female" and "nonbinary / other", their age as an open text field, their country of residence both with a drop down menu including all European Countries. Additionally, participants will also be asked which term describes their sexual orientation the closest, given eight options: "Heterosexual", "Lesbian/Homosexual", "Gay/Homosexual", "Bisexual/Pansexual/Other Multiple gender sexuality", "Asexual Spectrum", "Queer", "Other" with an additional optional text field, and "I don't know/prefer not to answer".

Aromantic Spectrum Identity

All participants were asked if they identify with the aromantic spectrum and were given seven options: “Yes, as aromantic”, “Yes, as demiromantic”, “Yes, as gray/greyromantic”, “Yes, as on the aromantic spectrum”, “Yes, as …” followed by a text field, “No”, and “I don’t know/prefer not to answer”.

Health

For information on participants health, two approaches were taken. For mental health, participants were asked two questions, “Are you currently diagnosed with a mental or developmental disorder” and “Have you in the past ever been diagnosed with a mental or developmental disorder”. Both questions have the following twelve answer possibilities of which multiple can be chosen: “Yes, a mood disorder (depression, bipolar..)”, “Yes, an anxiety disorder”, “Yes, PTSD or C-PTSD”, “Yes, an Obsessive-compulsive Disorder”, “Yes, a Feeding or Eating Disorder”, “Yes, a Personality Disorder”, “Yes, Schizophrenia or other primary psychotic disorder”, “Yes, Autism Spectrum Disorder”, “Yes, ADHD”, “Yes, other…” including a text field, “No”, and “I don’t know/prefer not to answer”.

The other approach is through the Patient Health Questionnaire (PHQ) (Spitzer et al., 1999, 2000). The PHQ is a self assessment screener covering areas of depressive, anxiety, somatoform, alcohol, and eating disorders for clinical and subclinical groups with up to 59 items, depending on previously given answers. For example, a participant will only be shown the 14 questions about anxiety attacks if they answered “yes” to “In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?”, similarly to the subscales of anxiety, alcohol and eating related questions.

Somatic symptoms cover 13 items, depressive symptoms 9 items, Anxiety up to 22 items – 15 for anxiety attacks and 7 for generalized anxiety -, eating related questions up to 8 and alcohol related questions up to 6 items.

Depending on the items, the questions are concerned with the previous two or four weeks and answers are either dichotomous or on a Likert scale (appendix 1) Higher points indicate more severe symptomology.

Outness

To measure outness I used the Outness Inventory (OI) by Mohr & Fassinger, (2000) in two modified variations. The OI is a scale to measure the degree in which lesbian, gay and bisexual individuals are out to eleven different roles, “mother”, “father”, “siblings (sisters, brothers)”, “extended family”, “my new straight friends”, “my work peers”, “my work supervisor(s)”, “members of my religious community”, “leaders of my religious community”, “strangers, new acquaintances”, and “my old heterosexual friends.” The 11-Items in the original version can be split up into three domains and scored in them individually, “out to family” (Items 1, 2,3 and 4), “out to world” (items 5, 6, 7 and 10) and “out to religion” (items 8 and 9) by taking averages of corresponding items. It also results in an overall outness score, which averages the scores of the subscales instead of individual items to weigh in the different domains. Item 11 is not counted for any of the subscales. A higher score indicates a higher degree of outness.

The scores result from the answer system ranging from 0 to 7, 0 being not applicable in this case. 1 standing for “person definitely does not know about your sexual orientation status”, 2 for “person might know about your sexual orientation status, but it is never talked about”, 3 for “person probably knows about your sexual orientation status, but it is never talked about”, 4 for “person probably knows about your sexual orientation status, but it is rarely talked about”, 5 for “person definitely knows about your sexual orientation status, but it is rarely talked about”, 6 for “person definitely knows about your sexual orientation status, and it is sometimes talked about”, and 7 for “person definitely knows about your sexual orientation status, and it is openly talked about”.

The first modified version for sexual orientation includes the following people and groups as items: “Mother/Parental Guardian”, “Father/Parental Guardian”, “Siblings”, “Extended Family”, “Straight Friends”, “LGBTQIA+ Friends”, “Work/University Peers”, “Supervisors/Teachers”, and “strangers/new acquaintances”.

In the second modified version for the aromantic spectrum identity the inventory includes “Mother/Parental Guardian”, “Father/Parental Guardian”, “Siblings”, “Extended Family”, “Straight Friends”, “LGBTQIA+ Friends”, “Friends on the

Aromantic Spectrum", "Work/University Peers", "Supervisors", and "strangers/new acquaintances" as roles (appendix 1).

Changes were made to be more inclusive to complex family settings and occupational settings and the inclusion of "LGBTQIA+ friends" and "Friends on the Aromantic Spectrum" was made to include the potential struggle of bisexual and potentially other non-monosexual identities to come out to the LGBTQIA+ community (Brotman et al., 2002), replacing the religious roles, keeping the amount of roles the same. These two new items will be counted into the domain of "out to the world".

Procedure

Participants were reached through posts on different social media sites like Facebook, Tumblr, Reddit, Twitter, and Discord which included the link to the survey on soscisurvey. They were informed about the general themes of the survey in the post and on the first page of the survey. The first page also served as consent form, including information on anonymity and voluntariness as well as contact information. They then were presented with the questions, starting with the demographics, followed by the current and former diagnosis, the PHQ and the OI for sexual orientation and aromantic spectrum identity (appendix 1).

Results

Participants

First, looking at romantic identities, out of 549 valid responses 55.6% (305) of them were somewhere on the aromantic spectrum (aromantic spectrum group), 38.6% (212) were not on the Spectrum (alloromantic group) and 5.8% (32) didn't know or preferred not to answer. Of the 305 in the aromantic spectrum group, half of the participants described themselves as aromantic (153), experiencing no romantic attraction or interest in romantic relationships forming the aromantic group. The other half (152) are in the spectrum group, including all aromantic spectrum identities that are not fully aromantic, so people that experience some romantic or interest but less than the expected norm, less than the alloromantic group or only situational. Those in the spectrum group most likely identified as "on the aromantic Spectrum" (64) without specifying a microlabel, followed by

“demiromantic” (46) and gray/greyromantic (31). Eleven participants choose the option to fill in their own identity (appendix 2).

For gender there was an underrepresentation of men in every group. For the alloromantic group, 62.7% (133) were female, 21.7% (46) nonbinary/other and 15,6% (33) were male. Within the aromantic spectrum group 49.2% (150) female, nonbinary/other made up 41.3% (126) and only 9.5% (29) were male. Looking at the aromantic group 48.2% (74) female, nonbinary/other made up 44.4% (68) and 7.2% (11) were male, whereas in the spectrum group it was 50.0% (76) female, 38.2% (58) were nonbinary other and 11.8% (18) were male.

The average age of the aromantic spectrum group (*M* = 24.5, *SD* = 5.6) was about the same as that of the alloromantic group (*M* = 25.7, *SD* = 6.0). Similarly, looking at the aromantic (*M* = 24.2, *SD* = 5.3) and the spectrum group (*M* = 24.8, *SD* = 5.9), were also similar in average age.

	Aromantic		Spectrum		Alloromantic	
	%	N	%	N	%	N
Hetero	3.3	5	2.0	3	10.4	22
Lesbian	1.3	2	6.6	10	15.6	33
Gay	1.3	2	0	0	2.4	5
Bisexual/ Pansexual	9.8	15	17.1	26	34.0	72
Asexual Spectrum	68.6	105	56.6	86	23.6	50
Queer	6.5	10	11.2	17	9.9	21
Other	7.2	11	6.6	10	3.3	7
No answer	2.0	3	0	0	0.9	2

table 1 Sexual Orientation by Romantic Identity Group

For sexual orientations, in all three groups, gay/homosexual man were the minority. Heterosexuals were the second largest minorities, followed by queer participants and lesbian/homosexual women (table 1). Asexual Spectrum and Bisexual/Pansexual always make up the two biggest groups, however within the participants in the aromantic and the spectrum group over half of them were also on the asexual spectrum. Additionally, 29 people choose to fill in their own label (appendix 3), eight could be grouped into “Non-SAM aromantic spectrum”, people on the aromantic spectrum that didn’t use the SAM or didn’t identified with any sexual orientation.

Most of the participants had finished school, only 2.0% (3) of the aromantic group, 3.3% (5) of the spectrum group and 2.8% (5) of the alloromantic group did not graduate school. The biggest percentage in all three groups had a college/university of a bachelor's degree/equivalent or higher, with 44.4% (68) of the aromantic group, 52.0% (79) of the spectrum group and 59,9% (127) of the alloromantic group. In the aromantic group 13.2% (20), 7.2% (11) of the spectrum group and 8.0% (17) of the alloromantic group had finished trade, technical or vocational training, and 36.1% (110) of the aromantic Spectrum group and 27.4% (58) of the alloromantic group were school graduates with no other formal degree (appendix 4).

For income, all three groups had a similar pattern with the lowest income (under 1000€ a month) being the most common one getting less common with higher income with the highest income (3500€ or more) being the least common one. Within the aromantic group 43.8% (67) stated their income as lower than 1000€ a month, 13.1% (20) 1000-1500€, 10.5% (16) 1501-2500€, 3.3% (5) 2501-3500€ and only one person or 0.7% stated an income over 3500€, the rest (28.8% or 44 people) didn't give an answer. For the spectrum group 49.8% (75) stated their income as lower than 1000€ a month, 7.2% (11) 1000-1500€, 13.2% (20) 1501-2500€, 3.9% (6) 2501-3500€ and only one person or 0.7% stated an income over 3500€, the rest (25.7% or 39 people) didn't give an answer. And within the alloromantic group 45.3% (96) stated their income as lower than 1000€ a month, 12.3% (26) 1000-1500€, 16.0% (34) 1501-2500€, 4.2% (9) 2501-3500€ and 4.2% (9) stated an income over 3500€, the rest (17.9% or 38 people) didn't give an answer.

About half of all participants were students, with 48.4% (74) of the aromantic group, 48.7% (74) of the spectrum group and 42.9%% (91) of the alloromantic group. A little more than one third was working, with 31.4% (48) of the aromantic group, 35.5% (54) of the spectrum group and 43.4% (92) of the alloromantic group, either employed for wages or self employed. Of the aromantic group 16,3% were unemployed or unable to work, in the spectrum group it was 14.2% (22) and for the alloromantic group 8.0% (17). Only 2 participants were retired, both in the alloromantic group (appendix 5).

First Hypothesis

To compare the mental health of aromantic individuals to that of alloromantic individuals, three things were taken into consideration: The PHQ mental health subscales combined into one mental health subscale measurement (Depression, Anxiety Attacks, Generalized Anxiety, Eating Disorders and Alcohol Use), current diagnosis and former diagnosis.

PHQ

To examine the potential difference in the average score of the PHQ mental health subscale of the aromantic group, spectrum group and alloromantic group a One-way ANOVA was conducted. A Levene test found that the assumption of homogeneity of variance was met. There were a statistically significant difference between group means as determined by one-way ANOVA ($F(2,514) = 3.54$, $p = .030$).

In a second step a One-way ANCOVA was conducted to determine potential differences between the aromantic group, spectrum group and alloromantic group on mental health scale of the PHQ, controlling for sexuality, gender, age, income, education and employment. Levene's test and normality checks were carried out and the assumptions were met. There was no statistically significant difference between group means ($F(2,380) = 2.24$, $p = .108$). The covariates with significant effects were gender ($F(2,380) = 6.36$, $p = .012$), sexual orientation ($F(2,360) = 7.65$, $p = .006$), highest education ($F(2,360) = 6.62$, $p = .010$) and monthly income ($F(2,360) = 4.25$, $p = .040$). Comparing the estimated marginal means showed that the highest average points on the mental health scale was in the spectrum group (M=19.7, SE = 1.0) compared to the aromantic group (M=16.7, SE = 1.1) and the alloromantic group (M=18.8, SE = 0.9).

	Mean	SD
Aromantic	18.3	9.7
Spectrum	20.8	11.7
Alloromantic	17.9	11.1

table 2 Average PHQ mental health subscale by romantic orientation

Looking at the mean directly, the alloromantic group has the lowest average PHQ mental health score and the aromantic spectrum group as the highest (table 2).

Taking a look at the covariates with significant influence, for gender it showed that nonbinary participants had the highest average score on the mental health subscale of the PHQ (*M* = 22.2, *SD* = 10.5), compared to female (*M* = 17.3, *SD* = 10.8) and male participants (*M* = 16.7, *SD* = 10.9).

For income, a Pearson Correlation was conducted, showing a significant negative correlation between income and the mental health subscale ($r(396) = -.0{,}20$ $p < .001$). The higher the income the lower the score was, showing in the lowest income group of less than 1000€ a month having the highest score (*M* = 20.3, *SD* = 11.2) and the highest income group with over 3500 having the lowest score (*M* = 12.9, *SD* = 13.4).

	Mean	SD
Heterosexual	11.5	7.5
Lesbian	20.2	12.3
Gay	16.6	10.0
Bisexual/ Pansexual	19.8	11.6
Asexual Spectrum	18.1	10.4
Queer	22.5	10.6
Other	21.7	10.9

table 3 Average PHQ mental health subscale by sexual orientation

When considering sexual orientation, heterosexual had the lowest score, followed by gay men, while queer participants and participants other, not listed sexual orientations had the highest (table 3).

Lastly, for highest level of education, those with university degrees, bachelor's degree (*M* = 16.1, *SD* = 10.3) or equivalent, master's degree (*M* = 16.6, *SD* = 11.3) and doctorate (*M* = 11.9, *SD* = 9.2), had on average lower scores than participants that had finished trade/technical/vocational training (*M* = 21.8, *SD* = 11.1), had a school diploma (*M* = 21.7, *SD* = 10.5) or had no diploma at all. (*M* = 23.1, *SD* = 11.6). A Pearsons's Correlation was conducted, showing a significant negative correlation between education level and the PHQ mental health subscale ($r(396) = -.0{,}24$ $p < .001$).

PHQ Subscales

Additionally, I looked at each of the specific subscales by conducting one-way ANOVAs. Levene's tests were carried out and the assumptions were met.

There were a statistically significant differences on the Depression Scale between group means as determined by one-way ANOVA ($F(1,514) = 5.40$, $p = .021$), but when controlling for sexuality, gender, age, income, education and employment with a One-wa ANCOVA, there no longer was a significant effect ($F(1,380) = 1.91$, $p = .150$) . For both the Anxiety Attack ($F(2,224) = 1.36$, $p = .259$) and Generalized Anxiety ($F(2,451) = 1.87$, $p = .155$) scale there were no significant differences, neither were Eating Disorders ($F(2,59) = 1.25$, $p = .295$) and Alcohol Use ($F(2,299) = 0.65$, $p = .526$).

Current Diagnosis

To examine the potential difference in the average amount of current diagnosis of the aromantic group, spectrum group and alloromantic group a one-way ANOVA was conducted. A Levene test found that the assumption of homogeneity of variance was met. There was no statistically significant difference between group means as determined by one-way ANOVA ($F(2,514) = 2.55$, $p = .079$).

In a second step a One-way ANCOVA was conducted to determine potential differences between the aromantic group, spectrum group and alloromantic group the average amount current diagnosis controlling for sexuality, gender, age, income, education and employment. Levene's test and normality checks were carried out and the assumptions were met. There was no statistically significant difference between group means ($F(2,380) = 1.93$, $p = .146$). The covariates with significant effects were gender ($F(2,380) = 10.43$, $p = .001$), highest education ($F(2,380) = 4.98$, $p = .026$) and level of employment ($F(2,380) = 3.97$, $p = .047$). Comparing the estimated marginal means showed that the highest average amount of current diagnosis was in the spectrum group (M=1.13) compared to the aromantic group (M=0.79) and the alloromantic group (M=0.96).

Taking a look at the covariates with significant influence, for gender it showed that nonbinary participant had the highest average amount of current diagnosis (M = 1.3, SD = 1.4), compared to male (M = 1.0, SD = 1.7) and female participants (M = 0.7, SD = 1.1).

	Mean	SD
Employed for wages	0.8	1.2
Self-employed	0.9	1.1
Unemployed	1.2	1.0
Student	0.9	1.3
Retired	0.0	0.0
Unable to work	2.6	1.8

table 4 Average amount of current diagnosis by employment level

Considering employment level, participants unable to work had the highest average amount, followed by those that were unemployed (table 4). Of the participants that were retired none reported a current diagnosis, though there were only two participants in that group.

For highest level of education, those with university degrees, bachelor's degree or equivalent (M = 0.8, SD = 1.2), master's degree or equivalent (M = 0.7, SD = 0.8) and doctorate (M = .8, SD = 0.9), had less than one diagnosis on average. Whereas participants that had finished trade/technical/vocational training (M = 1.4, SD = 1.6), had a school diploma (M = 1.1, SD = 1.5) or had no diploma at all (M = 1.9, SD = 1.2) on average had more than one. A Pearsons's Correlation was conducted, showing a significant negative correlation between education level and the average amount of diagnosis ($r(396) = -.18$ $p < .001$).

	Aromantic		Spectrum		Alloromantic	
	%	N	%	N	%	N
Mood Disorders	23.5	36	32.2	49	27.8	59
Anxiety Disorders	26.1	40	32.9	50	25.0	53
PTSD/ C-PTSD	2.0	3	6.6	10	5.2	11
OCD	2.0	3	3.9	6	1.4	3
Eating/Feeding Disorders	4.6	7	6.6	10	2.8	6
Personality Disorders	2.6	4	3.9	6	4.2	9
Primarly Psychotic	1.3	2	0.7	1	0.5	1
ASD	11.1	17	16.4	25	6.6	14
ADHD	15.7	24	11.2	17	10.9	28

table 5 Current diagnosis by romantic identity groups

Looking at the diagnosis separately (table 5), the biggest difference seems to lay in the neurodevelopmental conditions of ASD and ADHD. For ASD, especially the

spectrum group has a higher percentage than both other groups, but also the aromantic group compared to the alloromantic group. For ADHD as well, the aromantic group has a higher percentage than both the spectrum and the alloromantic group. Generally speaking, mood disorders and anxiety disorders were the most common ones, the spectrum group having the highest percentages in both.

Former Diagnosis

To examine the potential difference in the average amount current diagnosis of the aromantic group, spectrum group and alloromantic group a One-way ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There were no statistically significant differences between group means as determined by one-way ANOVA ($F(2,514) = 3.72$, $p = .090$).

In a second step a One-way ANCOVA was conducted to determine potential differences between the aromantic group, spectrum group and alloromantic group the average amount former diagnosis controlling for sexuality, gender, age, income, education and employment. Levene's test and normality checks were carried out and the assumptions were met. There was no statistically significant differences between group means ($F(2,380) = 2.42$, $p = .091$). The covariates with significant effects were gender ($F(2,380) = 11.99$, $p = .001$), and age ($F(2,380) = 5.03$, $p = .026$). Comparing the estimated marginal means showed that the highest average amount of former diagnosis was in the spectrum group (M=1.1) compared to the aromantic group (M=0.8) and the alloromantic group (M=0.8).

Taking a look at the covariates with significant influence, for gender it showed a that nonbinary participant had the highest average amount of former diagnosis ($M = 1.2$, $SD = 1.4$), compared to male ($M = 0.9$, $SD = 1.3$) and female participants ($M = 0.7$, $SD = 1.1$).

For age, a Pearsons's Correlation was conducted, showing no significant correlation between education level and the average amount of diagnosis ($r(517) = -.04$, $p = .339$).

	Aromantic		Spectrum		Alloromantic	
	%	N	%	N	%	N
Mood Discorders	22.9	35	37.5	57	29.2	62
Anxiety Disorders	26.1	40	29.6	45	22.2	47
PTSD/ C-PTSD	3.9	6	5.9	9	6.1	13
OCD	3.3	5	3.3	5	1.4	3
Eating/Feeding Disorders	3.9	6	7.2	11	6.1	13
Personality Disorders	2.0	3	3.3	5	4.2	9
Primarly Psychotic	0.7	1	0.7	1	0	0
ASD	9.8	15	13.8	21	2.4	5
ADHD	7.2	11	5.9	9	6.6	14

table 6 Former diagnosis by romantic identity groups

Looking at the diagnosis separately (table 6), similarly to the current diagnosis, ASD diagnoses were more common within the spectrum and the aromantic group compared to the alloromantic group. Also generally speaking, mood disorders and anxiety disorders were the most common ones again, the spectrum group having the highest percentages in both.

Second Hypothesis

Somatic Subscale

To examine the potential difference in the average physical health of the aromantic group, spectrum group and alloromantic group a One-way ANOVA was conducted, looking at the somatic scale of the PHQ. A Levene's test found that the assumption of homogeneity of variance was met. There were a statistically significant differences between group means as determined by one-way ANOVA ($F(2,514) = 4.59$, $p = .011$).

In a second step a One-way ANCOVA was conducted to determine a potential difference between the aromantic group, spectrum group and alloromantic group on somatic scale of the PHQ controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between group means ($F(2,380) = 3.89$, $p = .021$). Post hoc tests showed there

was a significant difference between the aromantic group and the spectrum group (p = .004). Only one covariate had an significant effects with sexual orientation (F(2,380) = 5.02, p = .026). Comparing the estimated marginal means showed that the highest average points on the somatic scales was in the spectrum group (M=7.5) compared to the alloromantic group (M=6.9) and the aromantic group (M=6.1).

	Mean	SD
Aromantic	6.4	3.8
Spectrum	7.7	4.4
Alloromantic	6.9	3.7

table 7 Average PHQ somatic subscale by romantic orientation

Looking at the mean directly, the alloromantic group has the lowest average PHQ mental health score and the aromantic spectrum group as the highest (table 7).

	Mean	SD
Heterosexual	4.1	2.8
Lesbian	7.7	4.2
Gay	7.2	4.5
Bisexual/ Pansexual	7.5	4.4
Asexual Spectrum	6.7	3.4
Queer	6.8	5.2
Other	6.0	4.4

table 8 Average score on the PHQ somatic subscale by sexual orientation

When looking at sexual orientation separately, heterosexual had the lowest score, with the next closes being other not listed sexual orientations. Bisexual/pansexual participants and lesbian participants having the highest score (table 8).

Third Hypothesis

Outness Inventory Overall Score

Looking at the outness of people on the aromantic spectrum, to compare their outness on their aromantic spectrum identity and their own sexual orientation, a repeated measures ANOVA was conducted. A Levene test found that the assumption of homogeneity of variance was met. There was a statistically significant difference between means on the outness scale as determined by repeated measures ANOVA (F(1,298) = 38.38, p < .001).

In a second step a repeated measure ANCOVA was conducted to determine potential differences between the aromantic spectrum identity and their sexual orientation the average score on the OI controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between means ($F(1,204) = 7.17$, $p = .008$). No other within-subject effect or contrast was significant. Comparing the means showed that the lowest average outness score was in the aromantic spectrum identity (M=3.0) compared to the sexual orientation (M=3.4).

Family Subscale

Focusing on the outness of people on the aromantic spectrum to their family, comparing their outness on their aromantic spectrum identity and their own sexual orientation, a repeated measures ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There was a statistically significant difference between means on the OI family subscale as determined by repeated measures ANOVA ($F(1,298) = 62,81$, $p < .001$).

In a second step a repeated measure ANCOVA was conducted to determine a statistically significant difference between the aromantic spectrum identity and their sexual orientation the average score on the OI controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between means ($F(1,204) = 7.65$, $p = .006$). No other within-subject effect or contrast was significant. Comparing the means showed that the lowest average outness score was in the aromantic spectrum identity (M=2.7) compared to the sexual orientation (M=3.1).

World Subscale

Focusing on the outness of people on the aromantic spectrum to the world, comparing their outness on their aromantic spectrum identity and their own sexual orientation, a repeated measures ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There was a statistically

significant difference between means on the OI world subscale as determined by repeated measures ANOVA ($F(1,296) = 8.82$, $p = .003$).

In a second step a repeated measure ANCOVA was conducted to determine a statistically significant difference between the aromantic spectrum identity and their sexual orientation the average score on the OI controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between means ($F(1,204) = 1.90$, $p = .006$). No other within-subject effect or contrast was significant. Comparing the means showed that the lowest average outness score was in the aromantic spectrum identity (M=3.4) compared to the sexual orientation (M=3.6).

Roles

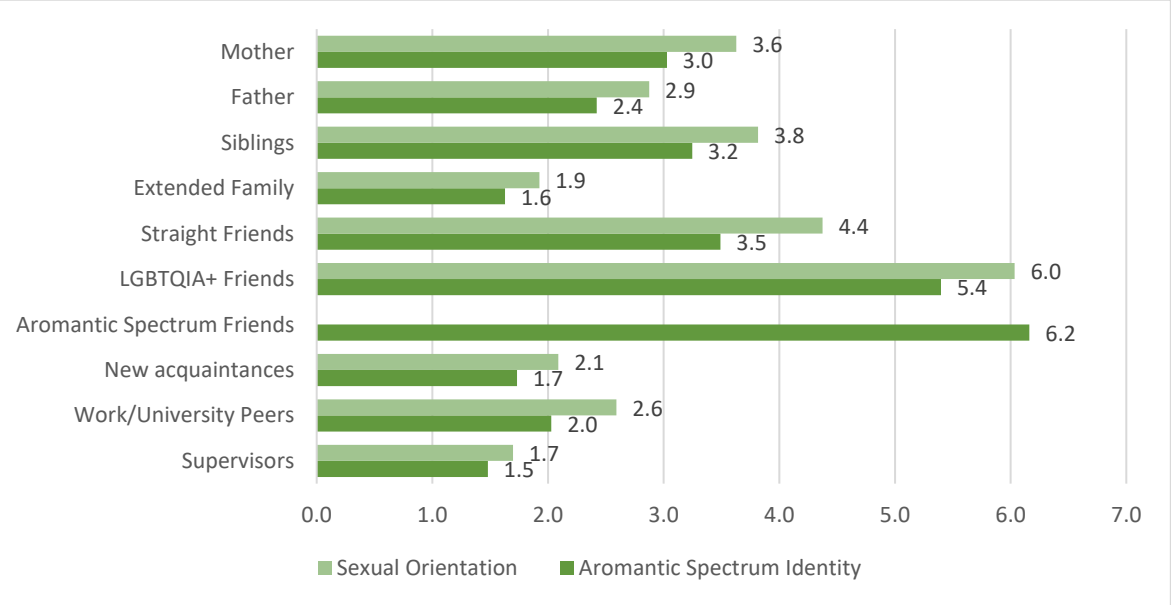

Figure 2 Average OI Outness Score by Role for the Aromantic Spectrum Group on their Sexual Orientation and on their Aromantic Spectrum Identity

Looking at each role separately (figure 2), participants were more likely to be out about their sexual orientations than their aromantic spectrum identity to all roles where a comparison was made. Overall, the most open to about any orientation was their outness on their aromantic spectrum identity to friends that are also on the aromantic spectrum, closely followed by their outness about their sexual orientation to LGBTQIA+ friends. Their outness about their aromantic spectrum identity to LGBTQIA+ friends was also still higher than to any non-friend or straight

role on either part of their orientation, though straight friends were next highest for both sexual orientation and aromantic spectrum identity. For both, close family members (siblings, mother, father) followed the friend roles, work/ university peers and supervisors as well as extended family and new acquaintances being the roles they were the least out to.

Spectrum Identity

Focusing on the outness of participants of the aromantic and spectrum groups separately, comparing their outness on their aromantic spectrum identity and their own sexual orientation, repeated measures ANCOVAs were conducted.

First, focusing on the aromantic group, a Levene's test found that the assumption of homogeneity of variance was met. There was a statistically significant difference between group means on the OI outness score as determined by repeated measures ANOVA ($F(1,150) = 5.75$, $p = .018$).

In a next step a repeated measures ANCOVA was conducted, controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between means ($F(1,93) = 6.26$, $p = .014$). No other within-subject effect or contrast was significant. Comparing the means showed that the lowest average outness score was in the aromantic identity (M=3.2) compared to the sexual orientation (M=3.3).

Now, focusing on the spectrum group, a Levene test found that the assumption of homogeneity of variance was met. There was a statistically significant difference between group means on the OI outness score as determined by repeated measures ANOVA ($F(1,147) = 38.85$, $p < .001$).

In a next step a repeated measures ANCOVA was conducted, controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between means ($F(1,103) = 1.28$, $p = .026$). No other within-subject effect or contrast was significant. Comparing the means showed that the lowest average outness score was in the aromantic spectrum identity (M=2.6) compared to the sexual orientation (M=3.1).

Fourth Hypothesis

Outness Scale

To compare the outness of alloromantic participants on their sexuality and participants on the aromantic spectrum on their aromantic spectrum identity, a ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There was statistically significant difference between group means on their OI overall score as determined by One-way ANOVA ($F(1,508) = 21.06$, $p < .001$).

In a second step a One-way ANCOVA was conducted to determine potential differences between the aromantic group, spectrum group and alloromantic group on their outness score measured by the OI, controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between group means ($F(2,380) = 9.66$, $p < .001$). The only significant covariate was sexual orientation ($F(2,380) = 32.27$, $p < .001$). Post hoc tests showed there was a significant difference between the alloromantic group and the spectrum group ($p < .001$). Comparing the estimated marginal means showed that the lowest average outness score was in the spectrum group ($M = 3.0$), followed by the aromantic group ($M = 3.3$) and the alloromantic group ($M = 3.8$) with a maximum of seven.

Family Subscale

To compare the outness to their family of alloromantic participants on their sexuality and participants on the aromantic spectrum on their aromantic spectrum identity, One-way ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There was statistically significant difference between group means on their OI family scale as determined by one-way ANOVA ($F(1,508) = 20.36$, $p < .001$).

In a second step a One-way ANCOVA was conducted to determine potential differences between the aromantic group, spectrum group and alloromantic group on the family subscale measured by the OI, controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were

carried out and the assumptions were met. There was a statistically significant difference between group means ($F(2,380) = 8.31$, $p < .001$). Sexual orientation was the only significant covariate ($F(1,380) = 30.52$, $p < .001$). Post hoc tests showed there was a significant difference between the alloromantic group and the spectrum group ($p < .001$). Comparing the estimated marginal means showed that the lowest average outness score was in the spectrum group (M=2.6), followed by the aromantic group (M=3.1) and the alloromantic group (M=3.5).

World Subscale

To compare the outness to the world of alloromantic participants on their sexuality and participants on the aromantic spectrum on their aromantic spectrum identity, a One-way ANOVA was conducted. A Levene's test found that the assumption of homogeneity of variance was met. There was statistically significant difference between group means on their OI overall score as determined by one-way ANOVA ($F(1,505) = 11.52$, $p < .001$).

In a second step a One-way ANCOVA was conducted to determine a statistically significant difference between the aromantic group, spectrum group and alloromantic group on their world subscale measured by the OI, controlling for sexuality, gender, age, income, education, and employment. Levene's test and normality checks were carried out and the assumptions were met. There was a statistically significant difference between group means ($F(2,379) = 6.65$, $p = .001$). Sexual orientation was the only significant covariate ($F(1,379) = 19.06$, $p < .001$). Post hoc tests showed there was a significant difference between the alloromantic group and the spectrum group ($p = .001$). Comparing the estimated marginal means showed that the lowest average outness score was in the spectrum group (M=3.4), followed by the aromantic group (M=3.6) and the alloromantic group (M=4.1).

Roles

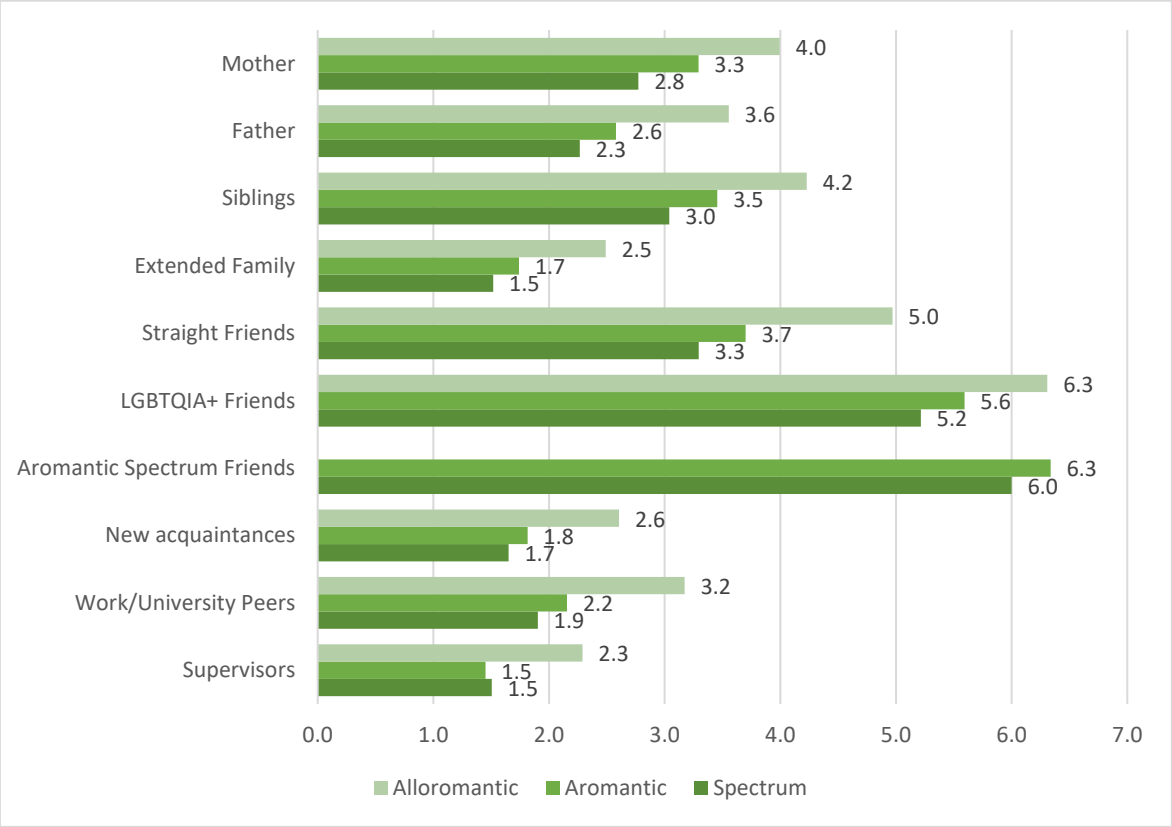

Figure 3 Average OI Outness Score by Role for the Aromantic and Spectrum Group on their Aromantic Spectrum Identity and the Alloromantic Group on their sexual orientation

Looking at each role separately (figure 3), alloromantic participants on average were more open about their sexual orientations than both the aromantic and spectrum group on their aromantic spectrum orientation to all roles where a comparison was made. Participants in the aromantic group were more open about their aromantic spectrum identity than the spectrum group on all roles besides supervisors. Overall, the most open to about any orientation was the outness on their aromantic spectrum identity by the aromantic group to friends that are also on the aromantic spectrum, closely followed by the alloromantic group outness about their sexual orientation to LGBTQIA+ friends and the spectrum group to Aromantic Spectrum friends. The outness about their aromantic spectrum identity to LGBTQIA+ friends was also still higher than to any non-friend or straight role for both the aromantic group and the spectrum group. The average scores have a similar pattern for all of them, with straight friends and then close family (siblings, mother, father) being the roles they are most open to, work/ university peers and supervisors as well as extended family and new acquaintances being the roles they were the least out to.

By Orientation

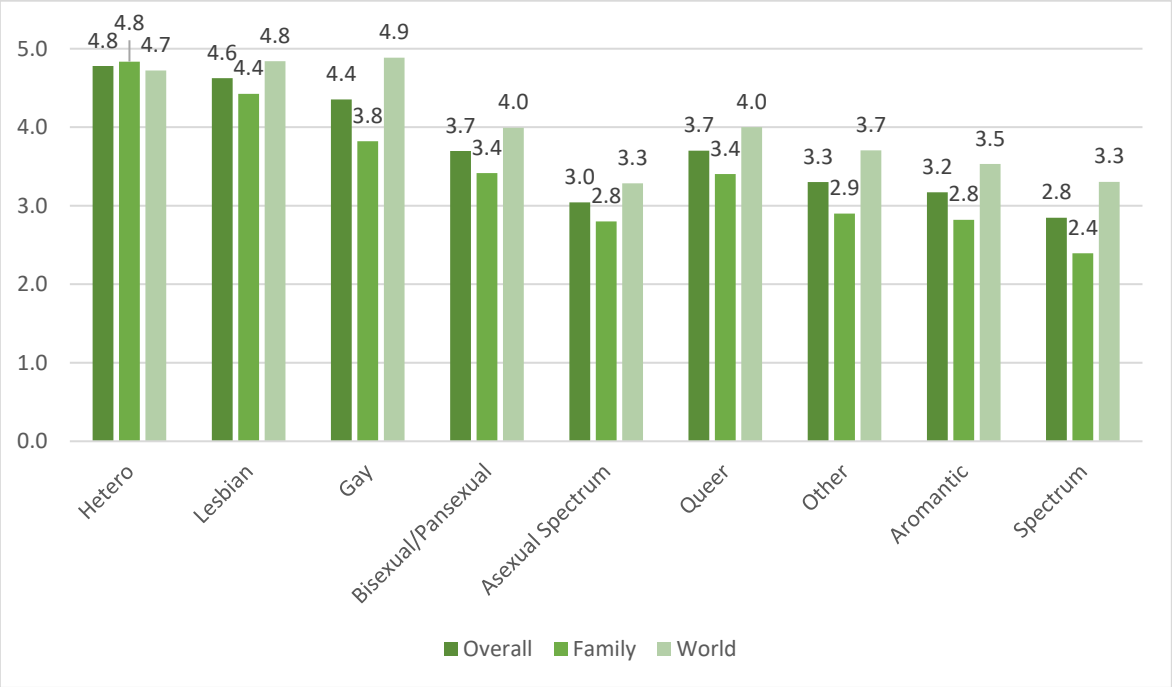

Figure 4 Average OI Over Outness Score, Family Subscale and World Subscale for Alloromantic Groups Sexual Orientations and Aromantic and Spectrums Groups Aromantic Spectrum Identities

When comparing the OI outness score by sexual orientation for alloromantic participants and aromantic spectrum identities for the aromantic and spectrum group, for all but heterosexual participants, the world subscale is higher than the family subscale (figure 4). For the overall score, heterosexual, lesbian and gay participants all had a score over 4 while none of the non-monosexual orientations reached that. Participants on the asexual spectrum as well as those on the aromantic spectrum, so the aromantic and spectrum group, had the lowest outness scores for all three measures.

Fifth Hypothesis

To check if outness is positively correlated to better mental and physical health in aromantic individuals as well as sexual orientation, I correlated the different health measures (current diagnosis, former diagnosis, PHQ mental health subscale and PHQ somatic health subscale) with the OI score and the OI family and world subscales.

Aromantic Spectrum

		Overall	Family	World
PHQ Somatic	Pearson Correlation	0.00	-0.01	0.02
	Sig. (2-tailed)	0.971	0.831	0.785
PHQ Mental Health	Pearson Correlation	-0.09	**-1.35**	-0.01
	Sig. (2-tailed)	0.130	**0.020**	0.815
Current Diagnosis	Pearson Correlation	0.03	0.0	0.06
	Sig. (2-tailed)	0.562	0.980	0.318
Former Diagnosis	Pearson Correlation	.03	.01	.03
	Sig. (2-tailed)	0.642	0.832	0.567

table 9 Correlation of OI Outness Scores, family subscale and world subscale of aromantic spectrum identity with health measures PHQ somatic subscale, PHQ mental health subscale, average amount of current diagnosis and average amount of former diagnosis

To determine a potential link between health and outness a series of Pearson correlations were conducted. The overall outness score, family subscale and determined by the OI for aromantic spectrum identity were each correlated with the PHQ scores for somatic and mental health as well as the average amount of former and current diagnosis. The only significant correlation was a negative link between the PHQ mental health score and the family subscale (table 9).

Aromantic Group

		Overall	Family	World
PHQ Somatic	Pearson Correlation	0.08	0.01	0.13
	Sig. (2-tailed)	.344	.921	.109
PHQ Mental Health	Pearson Correlation	-.08	**-0.19**	0.08
	Sig. (2-tailed)	.352	**.023**	.324
Current Diagnosis	Pearson Correlation	-0.04	-0.10	0.01
	Sig. (2-tailed)	.639	.418	.923
Former Diagnosis	Pearson Correlation	0.01	0.01	0.01
	Sig. (2-tailed)	.873	.872	.910

table 10 Correlation of OI Outness Scores, family subscale and world subscale of aromantic spectrum identity fort he aromantic group with health measures PHQ somatic subscale, PHQ mental health subscale, average amount of current diagnosis and average amount of former diagnosis

Looking at the aromantic group separately to determine a potential link between health and outness a series of Pearson correlations were conducted. The overall outness score, family subscale and determined by the OI for aromantic spectrum identity were each correlated with the PHQ scores for somatic and mental health as well as the average amount of former and current diagnosis. The only

significant correlation was a negative link between the PHQ mental health score and the family subscale, similar to the aromantic spectrum group overall (table 10).

Spectrum Group

		Overall	Family	World
PHQ Somatic	Pearson Correlation	-0.03	0.01	-0.06
	Sig. (2-tailed)	.762	.875	.481
PHQ Mental Health	Pearson Correlation	-0.07	-0.06	-0.07
	Sig. (2-tailed)	.383	.475	.370
Current Diagnosis	Pearson Correlation	0.12	0.10	0.12
	Sig. (2-tailed)	.131	.219	.154
Former Diagnosis	Pearson Correlation	0.07	0.04	**0.81**
	Sig. (2-tailed)	.421	.608	**.000**

table 11 Correlation of OI Outness Scores, family subscale and world subscale of aromantic spectrum identity for the spectrum group with health measures PHQ somatic subscale, PHQ mental health subscale, average amount of current diagnosis and average amount of former diagnosis

Looking at the spectrum group separately to determine a potential link between health and outness a series of Pearson correlations were conducted. The overall outness score, family subscale and determined by the OI for aromantic spectrum identity were each correlated with the PHQ scores for somatic and mental health as well as the average amount of former and current diagnosis. The only significant correlation was a positive link between the average amount of former diagnosis and the world subscale (table 11).

Sexual Orientation

		Overall	Family	World
PHQ Somatic	Pearson Correlation	-0.01	-0.03	0.02
	Sig. (2-tailed)	.821	.428	.642
PHQ Mental Health	Pearson Correlation	-0.08	**-0.14**	0.00
	Sig. (2-tailed)	.056	**.002**	.955
Current Diagnosis	Pearson Correlation	0.06	0.00	**0.10**
	Sig. (2-tailed)	.157	.661	**.030**
Former Diagnosis	Pearson Correlation	0.08	0.04	0.10
	Sig. (2-tailed)	.063	.331	.018

table 12 Correlation of OI Outness Scores, family subscale and world subscale of sexual with health measures PHQ somatic subscale, PHQ mental health subscale, average amount of current diagnosis and average amount of former diagnosis

To determine a potential link between health and outness of sexual orientation a series of Pearson correlations were conducted. The overall outness score, family subscale and determined by the OI for sexual orientation were each correlated

with the PHQ scores for somatic and mental health as well as the average amount of former and current diagnosis. Two significant correlation occurred, one being a positive correlation between the average amount of current diagnosis and the OI world subscale and the other one being a negative correlation between the PHQ mental health subscale and the OI family subscale (table 12).

Discussion

Health

To observe a potential difference in health for alloromantic people and people on the aromantic spectrum, I looked at both mental health and physical health. Regarding mental health, three aspects were considered: The average score on the PHQ subscale for mental health, the average amount of current mental and developmental diagnosis and former mental and developmental diagnosis. There was a significant difference for the PHQ mental health subscale and specifically the depression subscale measured by the ANOVA. However, there were no significant differences in group means on all measures between the fully aromantic, the spectrum and the alloromantic group when controlling for sexual orientation, gender, age, income, education and employment. For all mental health measurements, the estimated marginal means followed the same pattern, with the spectrum group having the highest, followed by the alloromantic group and the aromantic group having the lowest score or amount.

Looking at the influential covariates, gender was significant for all three measurements, with the nonbinary group having the highest score for all measurements, which aligns with the current research showing that nonbinary and transgender individuals suffer from more mental health problems than their cisgender counterparts (Jones et al., 2019; Price-Feeney et al., 2020; Rimes et al., 2019; Thorne et al., 2019). The spectrum group also had the highest amount of nonbinary people with 44.4%, compared to 38.2% in the aromantic and 21.7% in the alloromantic group. Considering the high amount of trans nonbinary people, it is possible that the amount of binary transgender people, meaning trans men and women, is also higher in the spectrum group. Considering the above finding, that might have had an influence on the scores. However, I didn’t differentiate between

trans and cis men and trans and cis women and it also doesn't explain why the aromantic group has the lowest score as their part of trans nonbinary individuals is also higher than that of the alloromantic group.

For both current symptoms measured by the PHQ and current diagnosis, the highest education level was a significant influence. There was a notable split between people holding a university or college degree having lower scores and a lower amount of diagnosis compared to those that did not hold a higher educational degree. Interestingly, however, the aromantic group was the only group comprised of less than half of the participants with a university or college degree. Considering they are the youngest group, with nearly half of them still being students, it might be that they simply have not finished their first degree yet. Otherwise, there might be underlying interactions between education level and other factors that need to be further explored in this context.

Income was only significant for current mental health symptoms. A negative correlation was found, which fits the current state of research linking lower income to worse mental health (Gresenz et al., 2000; Jenkins et al., 2008). Age was found to be significant for former diagnosis and correlated positively with it. This result might be easily explained by reasoning that the older a person is, the more likely they already have received a diagnosis and might have experienced remission.

For employment there was a split between those currently either working or studying having less than one diagnosis, while people that were unemployed and especially those unable to work had more. The aromantic group was comprised of the largest amount of people unable to work with 7.2%, which is nearly double the amount of the spectrum group (3.9%), and over seven times that of the alloromantic group (0.9%). The overall percentage of the group is low, though the influence might not be as big. However, it is something worth considering and further exploring if it was just within my sample or if it reflects a general issue within the aromantic group.

When looking at the individual diagnosis, it is noteworthy that there might be a difference between participants on the aromantic spectrum and alloromantic participants, especially in regards to developmental disorders or neurodivergences like Autism Spectrum Disorder. For ASD, the aromantic group had double the amount of current and triple the amount of former diagnosis as the alloromantic

group, for the spectrum group it was triple for current and five times for former diagnosis. Other research has shown that people on the autism spectrum are more likely to be LGBTQIA+ in general (Dewinter et al., 2017; George & Stokes, 2018, 2018; Pecora et al., 2016; Strang et al., 2014). Explanations for this vary. One explanation might be that because they struggle to conform to and are more likely to question social norms, that this struggling and questioning of norm applies to amatonormativity and heteronormativity as well, which means they are either more likely to be on the aromantic spectrum or simply more likely to realize that they are on the aromantic spectrum, or similarly any other non-heterosexual orientation.

There was a significant difference between group means even after controlling for all covariates in physical health between group means as measured by the PHQ somatic subscale. Specifically, the pairwise comparison showed a difference between the aromantic and spectrum group, the means showing the same pattern of the spectrum group having the highest and with that the worst score, followed by the alloromantic group and the aromantic group having the lowest score.

For current symptoms, for both the somatic subscale as well as the mental health subscale of the PHQ, sexual orientation was a significant covariate. For both of those measurements, heterosexual participants had by far the lowest scores. For the other sexual orientations there was no pattern within or between those scores, no direct differences between monosexual and non-monosexual orientations could be found. However, the scores of both the aromantic and the spectrum group were closer to the non-heterosexual orientations than to the heterosexuals. This could be an indicator that people on the aromantic spectrum, regardless of sexual orientation, are similarly compromised in their health as other LGBTQIA+ groups. So it could be argued that the influence of heteronormativity and amatonormativity might have similar effects on people on the aromantic spectrum as it does to other marginalized orientations. However, due to the low number of heterosexual participants, it should be investigated further.

Why is it that over all measurements the spectrum group seemed to show the worst health, while the aromantic group had the best scores? A lot of the challenges they face, like invisibility, dismissal within the LGBTQIA+ community, amatonormativity and heteronormativity, are faced by both groups. Maybe there is

stress connected to feeling some romantic attraction, engaging with and managing potential and ongoing romantic relationships, that a fully aromantic person doesn't face as they might be able to just not engage with it at all. It is possible that fully aromantic people have internally resolved themselves of amatonormative expectations because fulfilling these is not an option for a lot of them, while those on the spectrum have them more internalized or maybe also more pushed onto them from the outside. For future research, measuring internalized and external amatonormative pressure and expectations regarding aromantic spectrum identities is something to consider.

It would also be interesting to explore the thoughts and wants of aromantic people regarding romantic love and stable relationships akin to that of a romantic one and how that might influence their health. Within the aromantic spectrum group, but also beyond that, the term queerplatonic relationship or quasiplatonic relationship (QPR) has appeared, describing a committed relationship that wanders the line between romantic and platonic, though not fulfilling the traditional ideas of either (*Queerplatonic Relationship*, o. J.-a; *Queerplatonic Relationship*, o. J.-b; „Queerplatonic Relationship“, 2021). Do people on the spectrum have a bigger want for a committed relationship overall or just for romantic relationships? Does the possibility of a QPR help or worsen the experience of amatonormative expectations of monogamy? All of these questions should be considered further.

Overall, it would be important to research the differences in experience regarding relationships, amatonormativity and heteronormativity between people that are fully aromantic and people that are on the aromantic spectrum, while still experiencing some romantic attraction and/or interest in romantic relationships.

Outness

At first, the outness of participants on the aromantic spectrum to their own sexual orientation were compared. The hypothesis that people on the aromantic spectrum are more out about their sexual orientation than their romantic orientation, was supported by the data after factoring in sexual orientation, gender, age, income, education and employment, of which nothing influenced the result significantly. This significant difference was also true when looking at participants that are fully aromantic and participants that are on the spectrum separately. The difference

was also significant when looking at the family and world subscales and for every role individually.

In a second step the outness of participants on the aromantic and the spectrum group on their aromantic identity and the alloromantic group on their sexual orientation were compared. The results support the hypothesis that alloromantic people are more out about their sexual orientation than people on the aromantic spectrum are out about their aromantic spectrum identity, even after controlling for sexual orientation, gender, age, income, education and employment, specifically between the alloromantic and spectrum group. The outness of the alloromantic group was the highest followed by the aromantic group, the spectrum group being the lowest. This pattern was the same when looking at the family and world subscales as well. For the overall outness as well as the family and world subscales, sexual orientation was the only significant covariate.

Looking at the individual roles, the pattern was the same besides for supervisors, for which the spectrum group was marginally higher in outness. Additionally, all three groups had the same order regarding to how open they were about orientations to each role, with aromantic spectrum friends and LGBTQIA+ friends being the highest and supervisors being the lowest. This was true for the sexual orientation of people on the aromantic spectrum as well. The most outness was always towards people that were similar in orientation, so for people on the aromantic spectrum it was friends on the aromantic spectrum and for sexual orientation, both alloromantic participants and participants on the aromantic spectrum, it was LGBTQIA+ friends. The fear of rejection within these groups is probably way lower and a lot of LGBTQIA+ people actively seek out friends that are part of the community as well in specific spaces for them, so it is unsurprising that the openness within these friendships is the highest of all of them. Straight friends are for all groups the next highest in terms of outness over family members and work/school related roles, which can be explained by a lot of factors for example, a lot of people are more likely to discuss private matter with their friends, since friends are people you choose and those former friends that turned out to be unsupportive might have been already dropped.

However, people on the aromantic spectrum being less out to LGBTQIA+ friends about their spectrum identity than about their own sexual orientation and than alloromantic people, shows that there might be prejudices towards and a lack of knowledge about aromantic spectrum identities within the community.

Following friends are roles could be grouped as close family, with siblings being the role participants were the most out to, followed by mothers/parental guardians and fathers/parental guardians. Considering the aspect of closeness, close family should be about as high as friends. However, the risk of coming out to a non-accepting family member compared to a friend is way higher as the consequences are potentially bigger. As a lot of the participants were in their 20s and still students, coming out to non-accepting parents might mean the loss of financial support. Siblings being rated higher could be explained by the fact that younger people tend to be more accepting (Anand, 2016; Bowman, 1979; Cheng et al., 2016; Poushter & Kent, 2020), and mothers as the next highest could be because women on average are more accepting than men (Barringer et al., 2013; Poushter & Kent, 2020). New acquaintances and extended family are the third and second to last each, which could be explained by a lack of closeness which means private matters are less likely to be discussed as well as an unsureness about the other person’s stand on LGBTQIA+ related topics. Work/School related roles being the lowest is probably explained by a lack of closeness and in addition potential consequences of outness. These potential issues of outness, however, seem to be stronger for people on the aromantic spectrum - or there are additional issues people on the aromantic spectrum face that other LGBTQIA+ identities do not.

To further examine that possibility, it is worth it to look at the orientations separately. Heterosexual participants were the most open, followed by the other monosexual orientations, namely lesbian and gay participants. Following that were non-monosexual orientations, with bisexual/pansexual and queer participants as well as other, not listed sexual orientations following. The orientations defined by a lack, so the asexual and the aromantic spectrum orientations, were the lowest, with participants in the aromantic group being the most out overall between the three, followed by asexual spectrum, the spectrum group being the least out

overall. Here it would be interesting to differentiate between fully asexual people and people that are on the asexual spectrum while not fully asexual.

The fact that the outness of heterosexual participants on their sexual orientation is fairly close to the outness of lesbian and gay participants, is curious and might point more to a lack of communication about the love and sex life especially within the work place/school or to extended family than a lack of willingness to disclose heterosexuality as this is often assumed instead of having to be disclosed in the first place. It also might indicate a rise of acceptance towards other orientations, especially homosexuality.

However, people with non-monosexual orientations still seem to face obstacles in coming out that people with monosexual orientations do not, especially those on the asexual and aromantic spectrum. Research on that so far is low. There is one theory that within LGBTQIA+ spaces, bisexuals face further stigma and a fear of erasure by being perceived as straight, especially when they have a opposite gender partner (Brotman et al., 2002). Something similar might apply to people lacking attraction, as they might have a opposite gender partner in a romantic relationship or a QPR as well as a lack of attraction towards the same gender might leave them being read or treated as straight. With marriage equality having been or still being a major focus point in queer activism, paroles like “love is love” being common and media representation often focusing on romantic love as a story arch for their queer characters, people lacking attraction might not find a welcoming place. In online spaces especially but not exclusively, there has been a discussion on whether or not people on the asexual and aromantic spectrum should even be included in the LGBTQIA+ community.

Generally speaking, of 360 regular and recurring LGBTQIA+ characters in film and TV in 2020, only 99 were bisexual and none were on the asexual or aromantic spectrum (Townsend & Deerwater, 2021), contributing to the lack of knowledge about these identities not just within LGBTQIA+ spaces but beyond that as well (Calzo & Ward, 2009). A lack of knowledge might be a big factor in keeping people on the aromantic and asexual spectrum closeted as it might mean they have to explain or even defend their orientation or have to face prejudices and dismissal stemming from ignorance.

Another factor that could play into it is the discussion around pathologizing the lack of attraction, leading people on the asexual and aromantic spectrum to fear being labeled as mentally ill or in need of healing – something happening to all LGBTQIA+ identities in the form of conversion therapy (Ashley, 2020; Flores et al., 2020; Higbee et al., 2020), a process slowly getting banned (Fitzsimons, 2020; Savage, 2020). The WHO also has taken stances against the pathologizing of attraction to the same gender by removing homosexuality from the list of mental illnesses in 1973 and for trans and nonbinary identities by focusing the diagnosis on gender dysphoria and not the identity itself with the ICD-11. However, if the lack of attraction gets mislabeled as Hypoactive Sexual Desire Disorder (HSDD) or a paraphilia for example (Brotto et al., 2015; Brotto & Yule, 2017), a ban on conversion therapy might not work as means of protection. The lack of knowledge on these orientations might also be prevalent in health care providers, increasing the chances of getting mislabeled.

Another possibility might be that due to amatonormativity and the assumption that a romantic relationship is needed for happiness in every adult's life, could lead not just to adverse experiences for not being straight but pity and shame for being on the aromantic spectrum specifically. Pity might stem from apparently missing out on an experience viewed as important for happiness, the shame might result from feeling or being perceived as not being able to fulfill this step of adulthood, at least not in the same way as alloromantic people can. This might also lead to them being labeled as "late-bloomers" instead of their actual identity, as amatonormativity assumes everyone will and wants to experience alloromantic attraction.

However, as of now there is no research on the effects of heteronormativity and amatonormativity on people on the aromantic spectrum and their likelihood of being open about their orientation. Neither is there for people on the asexual spectrum or other non-monosexual orientations, so it can only be theorized.

Another question that so far has no research to lead to answer is why people on the aromantic spectrum that are not fully aromantic are less out than those that are fully aromantic. It might be that there is even less knowledge in broader society or even within LGBTQIA+ or aromantic spectrum spaces on them than about full aromanticism. It might also be because the communities, at least according to my

sample, are smaller, leading to less people modeling outness and spreading awareness. A third point might be that because they experience some romantic attraction – more than fully aromantic people, but less than alloromantic people – that there is a lack of belonging or an unsureness of where they belong. That would explain why they are also less likely to be out to aromantic spectrum friends compared to fully aromantic people. Further research is needed.

The connection of health and outness

To discover whether outness and health influence each other, the measurements of health (PHQ mental health scale, PHQ physical health scale, average amount of current diagnosis and average amount of former diagnosis) were correlated with measurements of outness (OI overall scale, family scale and world scale) for the aromantic spectrum group, aromantic group, spectrum group and sexual orientation of all participants. Most correlations were not significant.

The family subscale correlated negatively with the PHQ mental health scale for the aromantic spectrum group, the aromantic group and for sexual orientation. Meaning the more out to their family they were, the less current mental health symptoms they reported. The world subscale correlated positively with the amount of former diagnosis in the spectrum group and positively with the amount of current diagnosis, so the more out these participants were to their friends and workplace/school/university the more likely they had received a diagnosis.

Looking at these results, overall it seems as if especially outness to one's family influenced the current mental health status. Part of that might be that an accepting household is good for mental health as the likelihood of discussing these matters is probably higher than in unaccepting households – not just the amount of discussion itself. However, no other influence that relates to outness and minority stress was measured. For now, the results just suggest that the lack of open communication within one's family about one's orientation has negative influence on current mental health symptoms.

However, being open about one's orientation to the world seemed to lead to more diagnoses. This could mean that outness might lead to negative experiences within friendships, school and workplaces. Another possibility is that openness to the world leads to a higher likelihood of going to a mental health care provider and

getting diagnosed. Outness to health care providers was not part of the outness scale, neither were measurements of experiences with discrimination, so these might be additions for future research.

Overall the correlations were sparce and inconclusive, which reflects the ambiguous results of former research, showing both positive and negative effects of outness on health (Brotman et al., 2002; Corrigan & Matthews, 2003; Kosciw et al., 2015; Lewis et al., 2002; Ozeren, 2014; Tabaac et al., 2015). Further research on what aspects have positive and negative effects is needed, especially ones that differentiate between monosexual and non-monosexual orientation and include both people on the asexual and aromantic spectrum.

Limitations

One limitation lies within the sample: A lack of men, an overrepresentation of people on the asexual spectrum and an underrepresentation of heterosexual and heteroromantic people. This was probably in part due to recruitment in online spaces designated for both people on the aromantic and asexual spectrum, as these communities tend to share spaces and experiences and seem to have a low amount of men as well. A more balanced sample might lead to different results and would make it possible to compare people on the aromantic spectrum to heteroromantic and heterosexual people.

Another part is the design being quantitative. That fact, together with very little no other research having been done on this or similar topics, left a lot up to speculation and as topic for future research since there is little basis to theorize on why the results showed the differences they did. Also, certain additional measurements like trans and intersex status of the participants, outness to health care providers and other measurements of minority stress, among others, should be included in future research on these issues.

Conclusion

While the mental and physical health of aromantic people does not seem to be worse than that of alloromantic people, it seems similarly compromised to other LGBTQI+ groups compared to heterosexual participants. People on the aromantic spectrum are, however, less out about their aromantic spectrum identity than their own sexual orientation and alloromantic people on their orientation. For both

health and outness, people that are on the aromantic spectrum were doing less well than the fully aromantic participants. Correlations between health and outness were sparce and mainly a negative link between outness to family and current mental health symptoms and a positive link between outness to the world and diagnosis. Overall, the results point towards a need for more research as the aromantic spectrum has been largely ignored while facing the similar issues as other LGBTQIA+ identities and potentially other issues unique to people either fully or partially lacking romantic attraction or interest.

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Appendix

1. Age

2. Gender

- ○ Female
- ○ Male
- ○ Nonbinary / Other

3. Country of Residence

[Please choose]

4. Highest level of eduction

- ○ Some school, no diploma
- ○ School graduate
- ○ Trade/technical/vocational training
- ○ Bachelor's degree/Undergraduate education
- ○ Master's degree/postgraduate education
- ○ Doctorate degree
- ○ Prefer not to answer

5. Current employment status

- ○ Employed for wages
- ○ Self-employed
- ○ Unemployed
- ○ Student
- ○ Retired
- ○ Unable to work
- ○ Prefer not to answer

6. Average monthly income

- ○ <1000€
- ○ 1000-1500€
- ○ 1501- 2500€
- ○ 2501-3500€
- ○ >3500€
- ○ I dont know/prefer not to answer

7. Sexual Orientation

Which term(s) describes your sexual orientation the closest?

- ○ Heterosexual
- ○ Lesbian/Homosexual
- ○ Gay/Homosexual
- ○ Bisexual/Pansexual
- ○ Asexual Spectrum
- ○ Queer
- ○ Other
- ○ I don't know/prefer not to answer

8. Do you identify as on the Aromantic Spectrum?

- ○ Yes, as aromantic
- ○ Yes, as demiromantic
- ○ Yes, as gray/greyromantic
- ○ Yes, as on the Aromantic Spectrum
- ○ Yes, as
- ○ No
- ○ I don't know/prefer not to answer

9. Are you currently diagnosed with a mental or developmental disorder?

- ☐ Yes, a mood disorder (depression, bipolar..)
- ☐ Yes, an anxiety disorder
- ☐ Yes, Post Traumatic Stress Disorder (PTSD) or Complex Post Traumatic Stress Disorder (C-PTSD)
- ☐ Yes, an Obsessive-compulsive Disorder (OCD)
- ☐ Yes, a Feeding or Eating Disorder
- ☐ Yes, a Personality Disorder
- ☐ Yes, Schizophrenia or other primary psychotic disorder
- ☐ Yes, Autism Spectrum Disorder
- ☐ Yes, Attention Defizit Hyperactivity Disorder (ADHD)
- ☐ Yes,
- ☐ No
- ☐ I don't know/prefer not to answer

10. Have you in the past ever been diagnosed with a mental or developmental disorder?

- ☐ Yes, a mood disorder (depression, bipolar..)
- ☐ Yes, an anxiety disorder
- ☐ Yes, PTSD or C-PTSD
- ☐ Yes, an Obsessive-compulsive Disorder
- ☐ Yes, a Feeding or Eating Disorder
- ☐ Yes, a Personality Disorder
- ☐ Yes, Schizophrenia or other primary psychotic disorder
- ☐ Yes, Autism Spectrum Disorder
- ☐ Yes, ADHD
- ☐ Yes,
- ☐ No
- ☐ I don't know/prefer not to answer

11. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
Stomach pain	○	○	○
Back pain	○	○	○
Pain in your arms, legs, or joints (knees, hips, etc.)	○	○	○
Menstrual cramps or other problems with your periods	○	○	○
Pain or problems during sexual intercourse	○	○	○
Headaches	○	○	○
Chest pain	○	○	○
Dizziness	○	○	○
Fainting spells	○	○	○
Feeling your heart pound or race	○	○	○
Shortness of breath	○	○	○
Constipation, loose bowels, or diarrhea	○	○	○
Nausea, gas, or indigestion	○	○	○

12. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

13. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?

○ No
○ Yes

14. Questions about anxiety attacks

	No	Yes
Has this ever happened before?	○	○
Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	○	○
Do these attacks bother you a lot or are you worried about having another attack?	○	○

15. Think about your last bad anxiety attack.

	No	Yes
Were you short of breath?	○	○
Did your heart race, pound, or skip?	○	○
Did you have chest pain or pressure?	○	○
Did you sweat?	○	○
Did you feel as if you were choking?	○	○
Did you have hot flashes or chills?	○	○
Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	○	○
Did you feel dizzy, unsteady, or faint?	○	○
Did you have tingling or numbness in parts of your body?	○	○
Did you tremble or shake?	○	○
Were you afraid you were dying?	○	○

16. Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
Feeling nervous, anxious, on edge, or worrying a lot about different things	○	○	○

17. Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
Feeling restless so that it is hard to sit still.	○	○	○
Getting tired very easily.	○	○	○
Muscle tension, aches, or soreness.	○	○	○
Trouble falling asleep or staying asleep.	○	○	○
Trouble concentrating on things, such as reading a book or watching TV.	○	○	○
Becoming easily annoyed or irritable.	○	○	○

18. Questions about eating.

	No	Yes
Do you often feel that you can't control what or how much you eat?	○	○
Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	○	○

19. If you checked "YES" to any of these questions about eating, has this been as often, on average, as twice a week for the last 3 months?

- ○ No
- ○ Yes

20. In the last 3 months have you often done any of the following in order to avoid gaining weight?

	No	Yes
Made yourself vomit?	○	○
Took more than twice the recommended dose of laxatives?	○	○
Fasted — not eaten anything at all for at least 24 hours?	○	○
Exercised for more than an hour specifically to avoid gaining weight after binge eating?	○	○

21. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?

- ○ No
- ○ Yes

22. Do you ever drink alcohol (including beer or wine)?

- ○ No
- ○ Yes

23. Have any of the following happened to you more than once in the last 6 months?

	No	Yes
You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	○	○
You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	○	○
You missed or were late for work, school, or other activities because you were drinking or hung over.	○	○
You had a problem getting along with other people while you were drinking.	○	○
You drove a car after having several drinks or after drinking too much.	○	○

24. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

25. Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you. If an item refers to a group of people (e.g., work peers), then indicate how out you generally are to that group.

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

	1	2	3	4	5	6	7	0
Mother/Parental Guardian	○	○	○	○	○	○	○	○
Father/Parental Guardian	○	○	○	○	○	○	○	○
Siblings	○	○	○	○	○	○	○	○
Extended Family	○	○	○	○	○	○	○	○
Straight Friends	○	○	○	○	○	○	○	○
LGBTQIA+ Friends	○	○	○	○	○	○	○	○
Work/University Peers	○	○	○	○	○	○	○	○
Supervisors	○	○	○	○	○	○	○	○
New acquaintances	○	○	○	○	○	○	○	○

26. Use the following rating scale to indicate how open you are about your romantic orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you. If an item refers to a group of people (e.g., work peers), then indicate how out you generally are to that group.

1 = person definitely does NOT know about your sexual orientation status

2 = person might know about your romantic orientation status, but it is NEVER talked about

3 = person probably knows about your romantic orientation status, but it is NEVER talked about

4 = person probably knows about your romantic orientation status, but it is RARELY talked about

5 = person definitely knows about your romantic orientation status, but it is RARELY talked about

6 = person definitely knows about your romantic orientation status, and it is SOMETIMES talked about

7 = person definitely knows about your romantic orientation status, and it is OPENLY talked about

0 = not applicable to your situation; there is no such person or group of people in your life

	1	2	3	4	5	6	7	0
Mother/Parental Guardian	○	○	○	○	○	○	○	○
Father/Parental Guardian	○	○	○	○	○	○	○	○
Siblings	○	○	○	○	○	○	○	○
Extended Family	○	○	○	○	○	○	○	○
Straight Friends	○	○	○	○	○	○	○	○
LGBTQIA+ Friends	○	○	○	○	○	○	○	○
Aromantic Spectrum Friends	○	○	○	○	○	○	○	○
Work/University Peers	○	○	○	○	○	○	○	○
Supervisors	○	○	○	○	○	○	○	○
New acquaintances	○	○	○	○	○	○	○	○

Appendix 1 The entire possible questionnaire as seen by the participants.

Label(s)	N
Cupioromantic	2
demiromantic but make it pan	1
I don't know for sure what I identify with	1
lithromantic	1
On the demiromantic spectrum	1
Oriented aroace	1
questioning	1
quoiromantic	3

Appendix 2 Other aromantic spectrum identities filled in by the participants.

Label(s)	N
Ace Lesbian	1
Aroace	1
Aromantic	1
Aromantic - I do not use the split attraction model.	1
Asexual Spectrum Lesbian	1
bi gray-ace	1
Bisexual or asexual	1
Demi Ace	1
Demisexual	2
Demisexual lesbian	1
Demisexual with stronger preference for women	1
either bisexual or asexual	1
heteroflexible	1
I don't identify with any sexual orientation	2
N/A	1
Non-SAM	2
None	1
panromantic and demisexual/asexual	1
Pansexual/Demi-Sexual	1
Probably asexual but I'm kind of in a questioning phase atm	1
Queer, aromantic, pansexual, polyamorous	1
queer, asexual	4

Appendix 3 Other sexual orientations filled in by the participants.

	Aromantic		Spectrum		Alloromantic	
	%	N	%2	N3	%4	N5
Some school, no diploma	2.0	3	3.3	5	2.8	6
School graduate	36.6	56	35.5	54	27.4	58
Trade/technical/ vocational training	13.1	20	7.2	11	8.0	17
Bachelor's degree/ Undergraduate education	32.7	50	33.6	51	35.4	75
Master's degree/ postgraduate education	10.5	16	17.1	26	21.7	46
Doctorate degree	1.3	2	1.3	2	2.8	6
Prefer not to answer	3.9	6	2.0	3	1.9	4

Appendix 4 Highest level of education by romantic identity group.

	Aromantic		Spectrum		Alloromantic	
	%	N	%	N	%	N
Employed for wages	27.5	42	30.3	46	35.8	76
Self-employed	3.9	6	5.3	8	7.5	16
Unemployed	9.2	14	10.5	16	7.1	15
Student	48.4	74	48.7	74	42.9	91
Unable to work	7.2	11	3.9	6	0.9	2
Prefer not to answer	3.9	6	1.3	2	5.7	12

Appendix 5 Level of employment by romantic identity group.

Abstracts

English

People fully or partially lacking romantic attraction are on the aromantic spectrum – a group of identities within the LGBTQIA+ community that so far has received little attention in research. In this study I hypothesised that people on the aromantic spectrum, similarly to other LGBTQIA+ identities, have compromised mental and physical health compared to alloromantic people. Like other non-monosexual orientations, they are less likely to be out about their aromantic spectrum identity as they are about their own sexual orientation and as alloromantic people. Lastly, I hypothesised that the is a link between being more out about ones orientation and heaving better mental and physical health. The hypotheses about health were not supported by the data, however the participants on the aromantic spectrum seem to have similarly compromised mental and physical health as other LGBTQIA+ participants compared to the heterosexual ones. For outness, both hypotheses were supported. The link between outness and health was only sparce, showing a negative correlation between outness to family and current mental health symptoms for aromantic spectrum identities and sexual orientation and a positive correlation between outness to the world and current mental health diagnoses for sexual orientation and former mental health diagnoses for people on the aromantic spectrum. Overall there seems to be a need for more research for this group as their health might be similarly compromised as other LGBTQIA+ people and potentially additional struggles connected to being open about ones aromantic spectrum identity.

German

Menschen, denen es ganz oder teilweise an romantischer Anziehung fehlt, befinden sich auf dem aromantischen Spektrum - eine Gruppe von Identitäten innerhalb der LGBTQIA+-Community, die bisher in der Forschung wenig Beachtung gefunden hat. In dieser Studie habe ich die Hypothese aufgestellt, dass Menschen auf dem aromantischen Spektrum, ähnlich wie andere LGBTQIA+ Identitäten, im Vergleich zu alloromantischen Menschen eine beeinträchtigte psychische und physische Gesundheit haben. Wie bei anderen nicht-

monosexuellen Orientierungen ist es weniger wahrscheinlich, dass sie sich zu ihrer aromantischen Spektrum-Identität bekennen als zu ihrer eigenen sexuellen Orientierung und als alloromantische Menschen. Schließlich stellte ich die Hypothese auf, dass es einen Zusammenhang zwischen der Offenheit über die eigene Orientierung und einer besseren psychischen und physischen Gesundheit gibt. Die Hypothesen zur Gesundheit wurden von den Daten nicht unterstützt, allerdings scheinen die Teilnehmer aus dem aromantischen Spektrum eine ähnlich beeinträchtigte Gesundheit zu haben wie andere LGBTQIA+ Teilnehmer im Vergleich zu den heterosexuellen. Für Outness wurden beide Hypothesen unterstützt. Der Zusammenhang zwischen Outness und Gesundheit war nur spärlich und zeigte eine negative Korrelation zwischen Outness zur Familie und aktuellen psychischen Gesundheitssymptomen für aromantische Spektrum-Identitäten und sexuelle Orientierung und eine positive Korrelation zwischen Outness zur Welt und aktuellen psychischen Gesundheitsdiagnosen für sexuelle Orientierung und frühere psychische Gesundheitsdiagnosen für Personen auf dem aromantischen Spektrum. Insgesamt scheint es einen Bedarf an Forschung für diese Gruppe zu geben, da ihre Gesundheit ähnlich gefährdet sein könnte wie die anderer LGBTQIA+ Menschen und möglicherweise zusätzliche Probleme, die spezifisch die Offenheit über aromantischen Spektrums Identitäten betreffen.