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Frustration in healthcare: Sex differences in parental perceptions of medical visits for autistic children

Amanda J. Neal[a,*,1,2], Tyler C. McFayden[b,3,4], Jessica E. Goldblum[a,5,6], Stephanie Bristol[a,7,8], Clare Harrop[a,**,9]

[a] *Department of Health Sciences, University of North Carolina at Chapel Hill, USA*
[b] *Carolina Institute for Developmental Disabilities, University of North Carolina at Chapel Hill, USA*

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ABSTRACT

Background: Historical conceptualization of autism as male-dominant has contributed to sex disparities in accessing diagnosis and intervention services for autistic females (McDonnell et al., 2021). These disparities can have a profound impact on parental stress and child outcomes. However, little work has evaluated sex disparities in accessing healthcare. Accordingly, this study sought to evaluate sex differences in frustration accessing healthcare for parents of autistic youth.
Method: Utilizing the National Survey on Children's Health (NSCH) data spanning 2016–2022, this study analyzed a nationally representative sample ($N = 7740$, M_{age}=10.61, 21.4 % female) to determine sex differences in risk of frustration with healthcare services. Ten domains of frustration were evaluated using relative risk ratios comparing parents of autistic females to parents of autistic males. Risk ratios > 1.0 indicated an increase in risk among females, whereas a risk ratio < 1.0 indicated a decrease in risk for females.
Results: Compared to parents of autistic males, parents of autistic females were more likely to endorse frustration in 5 out of 10 domains, including feeling listened to by providers, providers spending enough time with them, feeling like a partner in their child's health-decision making, feeling like the provider was sensitive to their cultural considerations, and having been provided with relevant information.
Discussion: Parents of autistic females were at an elevated risk of experiencing frustration compared to parents of autistic males. Elevated frustration experienced by parents of autistic females has implications for the continued access to healthcare for autistic females across their lifespan.

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* Correspondence to: University of South Alabama, UCOM 1000, 75 South University Blvd., USA.
** Correspondence to: Department of Health Sciences, Bondurant Hall, #3004, 321 S Columbia St, Chapel Hill, NC 27514, USA.
E-mail addresses: ajn2421@jagmail.southalabama.edu (A.J. Neal), clare_harrop@med.unc (C. Harrop).

[1] https://orcid.org/0009–0006-8241–9148

[2] Amanda Neal is now at The University of South Alabama, Mobile, Alabama

[3] https://orcid.org/0000–0001-8942–1562

[4] Author T.C.M. was supported by a training fellowship from NICHD T32HD040127. We have no known conflict of interest to disclose.

[5] https://orcid.org/0000–0003-4769–3935

[6] Jessica E. Goldblum is now at 3 C Institute, Durham, North Carolina.

[7] https://orcid.org/0000–0002-2611–5290

[8] Stephanie Bristol is now at The University of Arizona College of Veterinary Medicine.

[9] https://orcid.org/0000–0003-3381–3473

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Introduction

Autism spectrum disorder (ASD; hereafter autism) has, and continues to be, a historically male-dominant diagnosis, with recent CDC estimates indicating that roughly 3.8 males receive an autism diagnosis for every 1 female (Maenner et al., 2023). Although this sex ratio has reduced over time and across the lifespan (Russell et al., 2022), the majority of autism research is male-centric with fewer studies exploring the experiences of autistic females and their parents (Navot et al., 2017). This historic conceptualization of autism as a "male" phenomenon has contributed to significant sex discrepancies in accessing diagnostic and intervention services for females (McDonnell et al., 2021). Even as recognition of the female phenotype of autism has increased over time, females are still diagnosed around a year later than their male counterparts (Goldblum et al., 2023; Harrop et al., 2024; Kavanaugh et al., 2021; McCormick et al., 2020; McDonnell et al., 2021). Unsurprisingly, autistic females and parents of autistic females often report higher levels of stress related to seeking a diagnosis, with many parents reporting that their concerns were dismissed by both medical professionals and community members (Hamdani et al., 2023; Navot et al., 2017; Wallisch et al., 2021). Of course, numerous factors likely contribute to frustration accessing medical care (e.g., socioeconomic status, rurality, health insurance, bureaucracy, to name a few); importantly, the current study focuses on the role of sex differences in frustration when accessing healthcare services for autistic youth in a nationally-representative dataset spanning six years.

The importance of timely access to diagnostic, support, and health services cannot be overstated. Early identification and intervention have demonstrated significant improvements in developmental, behavioral and adaptive outcomes for autistic children (Sapiets et al., 2023; van't Hoff et al., 2021) as well as mental health and stress outcomes for parents (Sapiets et al., 2023). Most guidelines recommend a multidisciplinary approach to services and treatment involving many different professionals (Boulton et al., 2023a). In fact, increases in frustration during the diagnostic process may lead to distrust in later interactions with healthcare and an underutilization of healthcare services, suggesting a potentially cascading effect (LaVeist et al., 2009). However, this approach is often made inaccessible through convoluted referral processes and lack of access to specific services within a geographic region (Sapiets et al., 2023), with delays in diagnosis further exasperating this inaccessibility (Boulton et al., 2023b). Difficulty accessing diagnostic and support services has been related to numerous factors, including child and parent factors, availability of local providers, insurance coverage, the larger medical system, and national policies.

Caregivers have also reported challenges accessing services that may directly relate to increased prevalence and awareness of autism without an equivalent increase in related services and resources (Boulton et al., 2023a). These challenges also vary depending on the cognitive ability and sex of the child (McDonnell et al., 2021) and the types and prevalence of autistic traits reported (Kavanaugh et al., 2023; Navot et al., 2017). Further, the socioeconomic status of families, the complexity of the diagnostic and referral process, a potential mismatch between available services and the needs of families, and limited government funding all contribute to challenges and frustration when accessing autism services (Sapiets et al., 2023). The current article focuses on one under-considered area, being assigned female at birth.

Parental frustration with their child's diagnostic journey can have a profound impact on acceptance of an autism diagnosis and, subsequently, child outcomes (Siklos and Kerns, 2007). This frustration appears to be elevated for parents of autistic females (Rabbitte et al., 2017).[10] Although autistic females receive a diagnosis between 12 and 24 months after their male counterparts (Harrop et al., 2021; Harrop et al., 2024; McCormick et al., 2020; Salomone et al., 2016), there is no significant difference in average age of concern between the two groups (Harrop et al., 2021; McDonnell et al., 2021). Parental frustration related to sex biases in diagnosis has been linked to a potential for a mis-, missed, or delayed diagnosis (Rabbitte et al., 2017) and feelings of isolation and guilt (Jackson et al., 2020). Parents of autistic females often report feeling that their experiences with their child vary from those of parents of autistic males and that the male-oriented lens of autism research and related healthcare results in a lack of comparison for their experiences (Lockwood Estrin et al., 2021). Autistic females who seek a diagnosis in adulthood also report many frustrations with the diagnostic process, including being dismissed by medical professionals and lacking the financial resources needed to complete the diagnostic process (Lewis, 2017). Given these well-documented challenges experienced by females seeking an autism diagnosis (Lockwood Estrin et al., 2021), it is likely that frustrations with healthcare and support services do not end at diagnosis. However, there is a paucity of research evaluating frustration with other health-related services, including medical visits, support visits, and other healthcare services (e.g., occupational, speech, physical therapies) for autistic females.

Therefore, the current study seeks to understand parent-reported frustration when accessing healthcare for both diagnostic and support services related to autism, and discrepancies of frustration by child assigned sex at birth. Importantly, by leveraging data from the National Survey on Children's Health NSCH, a nationally representative survey, across six years (2016–2022), we are able to target sex differences across the United States in item-level frustration questions. We hypothesize that parents of autistic females will report greater frustration when interacting with their healthcare providers than parents of autistic males.

Method

Data source

Data used for this study were aggregated from the 2016–2022 National Survey of Children's Health (NSCH). The NSCH is funded

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[10] For the purposes of this paper, we acknowledge that it is difficult to parse the difference between biological bases of sex and the cultural construct of gender. This paper will henceforth use the terms "sex" and "female" to refer to being assigned female at birth.

and directed by the Health Resources and Services Administration Maternal and Child Health Bureau to provide data across multiple aspects of health at the state and national level for children in the United States (Child and Adolescent Health Measurement Initiative, 2020). Within each year of data sampling, NSCH data is weighted to represent population estimates of all non-institutionalized, national resident children under age 18 in the 50 United States and the District of Columbia. For more information on NSCH data weighting, data collection procedures, or base sampling, see Ghandour et al. (2018). NSCH data collection transitioned from phone- to web- or questionnaire-based systems in 2016 (Ghandour et al., 2018), thus the data used in this study from 2016 through 2022 was collected using the same methodologies.

NSCH data have been used previously in published research evaluating children with autism spectrum disorder diagnoses. Previous research (e.g., Goldblum et al., 2023) has validated the NSCH as a representative dataset of autism prevalence (~2.5 %) and sex ratio (~3.4 male: 1 female; Kogan et al., 2018), replicating other national averages (Maenner et al., 2023). Thus, the aggregate data across six years is largely representative of previously published autistic demographics in the United States.

Participants

The combined 2016–2022 NSCH surveys comprise $N = 7740$ ($n = 1646$ female; 21.4 %) autistic children. The average age of the sample is 10.61 years ($SD = 4.47$) with an average age of diagnosis of 5.06 years ($SD = 3.38$). The sample is predominantly white (65.23 %) and nearly a third of the sample (31.50 %) reported an income 300–400 % over the federal poverty level. Participant demographics are available in Table 1.

Measures

Ten Likert-scale questions and responses related to service frustration over the past twelve months were analyzed for the current study (Supplemental Table 1). Variables included domains asking about frustration in efforts to secure services, feeling like a partner in the child's care, feeling like the provider was sensitive to cultural values, feeling like the provider listened to parental concerns, and overall satisfaction with healthcare. They also included items related to the amount of time the provider spent with the family, and whether the provider asked questions or requested questionnaires in response to parental concerns. Parents were asked to rate their frustration on a scale from 1 (Always) to 4 (Never), while overall satisfaction was rated on a scale 1 (Very Satisfied) to 4 (Very Dissatisfied). For this analysis, responses were dichotomized; broadly, scores were assigned "1" if they indicated the presence of frustration, and a "0" for lack of frustration. Questions, variable numbers, response options, and reassigned codes are available in Supplemental Table 1.

Analytic plan

Data analysis was conducted in SAS Version 9.4 (SAS Institute Inc., 2016). Descriptive statistics were used to estimate group

Table 1
Demographic Characteristics.

	Full Sample ($N = 7740$)	**Autistic Males** ($n = 6094$)	**Autistic Females** ($n = 1646$)	**Chi Square or *t***
Age (*M, SD*)	10.61 (4.47)	10.59 (4.44)	10.69 (4.59)	−0.83
Age of autism diagnosis (*M, SD*)	5.06 (3.38)	4.69 (3.20)	5.24 (3.92)	−6.02 * **
Race (%)				28.09 * **
White	65.23 %	65.92 %	62.80 %	
Black	16.12 %	16.42 %	15.08 %	
Asian	3.16 %	2.96 %	3.87 %	
American Indian/Alaskan Native	0.91 %	0.74 %	1.49 %	
Hawaiian/Pacific Islander	1.64 %	1.60 %	1.79 %	
Other	3.86 %	3.22 %	6.10 %	
Multiracial	9.08 %	9.14 %	8.87 %	
Ethnicity (%)				0.77
Hispanic	12.96 %	28.20 %	28.13 %	
Not Hispanic	87.04 %	71.80 %	71.87 %	
Percent Above Federal Poverty Level (%)				6.26
0 −100	24.54 %	25.75 %	19.99 %	
101 −200	23.84 %	24.41 %	21.69 %	
201 −300	20.12 %	19.89 %	21.21 %	
301 −400	31.50 %	30.00 %	37.11 %	
Parent Education (%)				6.47
Less than High School	9.67 %	9.01 %	12.00 %	
High School	22.61 %	23.05 %	21.07 %	
Some College	25.52 %	25.59 %	26.34 %	
College or Above	42.19 %	42.65 %	40.58 %	
Non-English Home Language (%)	11.21 %	10.86 %	12.43 %	0.17

Note. Percentages are a reflection of weighted sampling. M = Mean, SD = Standard Deviation; *** $p < .001$

differences in demographic variables between males and females (Table 1). Risk ratios were estimated for each of the ten binomial frustration measures using SAS PROC GENMOD's log-binomial regression function (Spiegelman & Hertzmark, 2005) with the exposed group being caregivers of children assigned female at birth. The GENMOD procedure fits generalized linear models using generalized estimating equations, which can robustly handle discrete and correlated data, such as the case of multiple responses in the current data set (Spiegelman & Hertzmark, 2005). Risk ratios are used here to estimate relative risk as opposed to odds ratios; in other words, the risk of experiencing the outcome (frustration) in one group (females) compared to another group (males). In the current study, we used sex assigned at birth as the category to evaluate the relative risk of being assigned female at birth. Importantly, risk ratios are more accurate for interpreting relative risk compared to odds ratio given the large, weighted NSCH sample and how representative the current sample is of the larger population of autistic youth in the United States (George et al., 2020). Risk ratios > 1.0 indicated an increase in risk among the exposed group- whereas a risk ratio < 1.0 indicated a decrease in risk for females. Statistical significance is determined by Chi Square and alpha values < .001. Due to the large sample size, it was anticipated that most results would be statistically significant, even at a conservative alpha value of.001. Therefore, clinical significance of risk ratios were determined a priori to be > 1.5 or < 0.5.

Results

Demographic analyses indicated no significant sex differences in child age at time of study, ethnicity, parent education, income, or language spoken at home, *ps* > .01. There were significant sex differences for age of diagnosis, wherein females were diagnosed significantly later than males, $t(7164) = -6.02$, $p < .0001$, a finding that has been established in previous studies with this sample (Goldblum et al., 2023). There were also significant differences in racial distribution between autistic males and autistic females, $X^2 = 28.09, p < .0001$. Autistic females were significantly more likely to identify as Asian, another race alone, and American Indian/Alaskan Native than parents of autistic males. Autistic males were more likely to identify as Black or multiracial compared to autistic females. See Table 1 for all demographic group comparisons.

Risk ratio mean estimates for each variable are available in Table 2 and Fig. 1. Due to the large sample size, all risk ratios were significantly different from 1.0 at a $p < .0001$. Clinically meaningful risk ratios, defined as greater than > 1.5, emerged for five of the ten frustration variables assessed, including parents feeling like providers were sensitive to the family's cultural values (RR = 2.399), parents feeling as though providers listened to their concerns about their child, (RR = 3.395), parental perceptions that providers spent enough time with them (RR = 1.768), parental reports that health care providers gave parents sufficient information related to the health of their child (RR = 2.412), and parental perception of being treated like a partner in the pursuit of care for their child (RR = 2.052). For these values, parents of an autistic female child were 1.8–3.4 times more likely to experience frustration or dissatisfaction in these domains compared to parents of a male autistic child.

Three domains of interest reported risk ratios at or around 1.0, including satisfaction with the amount of time providers spent with families (RR = 0.995), whether providers asked parents about their concerns (RR = 0.975), and whether providers had parents complete a questionnaire about their concerns (RR = 1.094). These risk ratios around 1.0 suggest comparable risk endorsed for autistic females compared to autistic males.

One domain, overall satisfaction, emerged as significantly elevated risk for autistic females compared to autistic males, but did not reach our a priori threshold for clinical significance (RR = 1.267). Parents of autistic females were 1.3 times more likely to report greater dissatisfaction with healthcare services compared to parents of autistic males.

Lastly, one domain scored a risk ratio below 1.0: overall frustration with health care in the past twelve months (RR = 0.878), suggesting parents of autistic females were 0.88 times as likely to express general frustration compared to parents of autistic males, indicating *less* overall frustration. To summarize, across 10 domains of frustration, parents of autistic females were 1.3–3.4 times more likely to report frustration in 6 domains, were as likely to report frustration in 3 domains, and less likely to report frustration in 2 domains when compared to parents of autistic males.

Table 2
Risk Ratios for Measures of Frustration.

Variable	Mean Risk Estimate	95 % Confidence Interval	Chi Square	*P* value
Feeling Overall Frustrated	0.878	0.875 –0.881	4383.4	< .0001
Providers Were Sensitive	2.399	2.359 –2.440	10276	< .0001
Providers Listened	3.395	3.332 –3.459	16497	< .0001
Providers Spent Time	1.768	1.741 –1.795	5341.7	< .0001
Providers Provided Info	2.412	2.373 –2.452	11278	< .0001
Felt Like a Partner	2.052	2.012 –2.085	8011.4	< .0001
Feeling Overall Satisfied	1.267	1.254 –1.279	2253.4	< .0001
Duration Spent with Provider	0.995	0.994 –0.997	36.68	< .0001
Provider Asked About Concerns	0.975	0.961 –0.990	11.29	< .0001
Provider Gave Questionnaire	1.094	1.080 –1.108	193.60	< .0001

Note. Full variable questions are available in Supplemental Information. Risk Estimates > 1.0 indicate females are at elevated risk. Risk Estimates < 1.0 indicate females are at a lower risk. For the purposes of the current study, clinically significant risk ratios were determined as Mean Risk Estimates > 1.5.

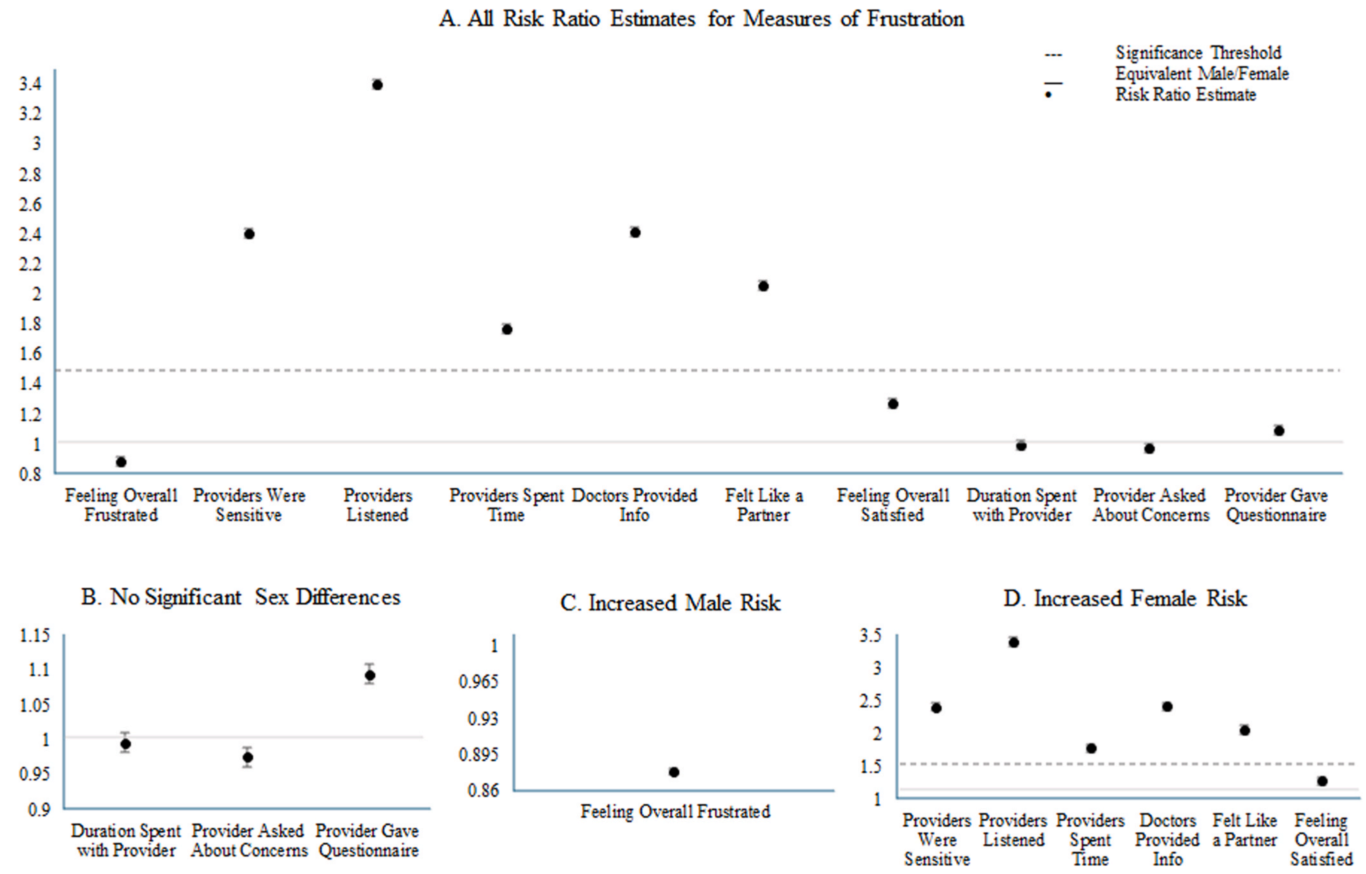

Fig. 1. Risk Ratio Estimates for Measures of Frustration.

Discussion

The current study evaluated the relative risk of experiencing medical frustration due to being an autistic female, compared to autistic males. Using a nationally representative dataset of over seven thousand parents of autistic youth in the United States spanning six years, we found that parents of autistic females were at an elevated risk of experiencing frustration when engaging with healthcare providers for five out of the ten assessed domains, largely supporting our hypotheses. Relative risk ratios suggested parents of autistic females were 1.8–3.4x more likely to experience frustration related to being heard, feeling as though providers were sensitive to their cultural values, feeling providers spent enough time with the family, were provided information, and were viewed as partners in their child's care. The largest risk ratio ($RR = 3.395$) emerged in the domain of feeling listened to by providers, with parents of autistic females 3.4x more likely to endorse not being heard by medical providers compared to parents of autistic males. The results partially mirror those found in both a qualitative study of autistic women's experiences with service providers (Tint & Weiss, 2018) and a qualitative study of the experiences of late diagnosed autistic women (Leedham et al., 2020) where feeling heard and understood by service providers was reported as a major barrier to care.

Three domains of frustration, although statistically significant, were approximately equivalent to a value of 1.0, suggesting no clinically elevated relative risk for autistic females compared to autistic males. These three domains included the amount of time spent with providers, whether providers asked about concerns, and whether providers had parents complete a questionnaire about their concerns. The lack of clinically significant differences could potentially be due to the more objective nature of these three domains compared to the others, which are more based on perception and more subjective in nature. If, indeed, providers are treating patients in an equitable and standard fashion regardless of child assigned sex, it is likely that they are spending equivocal amounts of time with each family, asking parents' their concerns, and providing patients with questionnaires to complete.

Findings warranting further investigation

There were a number of findings that warrant further investigation. For example, the two general domains of overall frustration and overall satisfaction produced nebulous results. Parents of autistic females were.88x more likely than parents of autistic males to report general frustration with health care providers in the past 12 months, suggesting they were *less* likely to report frustration than parents of autistic males. This result is counter to our hypothesis, wherein we predicted autistic females would be at an elevated risk of experiencing frustration relative to their male counterparts. This result is also contradicted by the aforementioned results, as parents of autistic females reported being at an elevated risk of frustration in 5/10 domains, and equivalent frustration in 3/10 domains. Taken together, it was hypothesized that given these observed risk ratios, overall frustration would follow in the same pattern. It is possible that appreciation of receiving services for parents of autistic females, who frequently experience diagnostic delays and overshadowing, overrides any frustration. In other words, parents of autistic males may have higher expectations of medical interactions given that demographic is the exemplar in autism research. A recent interpretative phenomenological investigation into the experience of pursuing an autism diagnosis for daughters reported parents of autistic females felt excitement or neutral curiosity when first receiving a diagnosis for their child (Freeman & Paradis, 2022). In fact, one of the top three themes was "just getting it done and dusted", indicating that visit completion may have been more rewarding for parents of autistic females, thus decreasing their overall frustration once the interaction was complete.

The second domain of overall satisfaction was statistically different from 1.0 ($RR = 1.267$), suggesting a significant risk ratio observed wherein parents of autistic females are 1.27x more likely to report lower satisfaction compared to parents of autistic males. This value is in alignment with our predicted hypotheses; however, it did not reach our subjective a priori determination for a clinically meaningful relative risk. Given the large sample of the current study, a decision was made in advance to interpret clinically relevant RR values > 1.5; however, it does not mean this risk ratio is not to be considered or interpreted. Considering the elevated levels of risk for five of the aforementioned variables (RRs range from 1.8–3.4), it remains surprising that the overall risk ratio for general satisfaction was not higher. As with frustration, appreciation of receiving services may impact overall satisfaction with services provided, especially if the parents had a previous negative expectation of how the interaction would go (Freeman & Paradis, 2022).

Implications for healthcare access and future research

The lack of clinically meaningful risk ratios in the two overall domains of frustration and satisfaction does not replicate previous research suggesting autistic females experience higher levels of frustration accessing healthcare (Tint & Weiss, 2018). This discrepancy could be due to the type of healthcare being accessed, as many previous studies evaluated frustration with diagnostic services specifically (Lockwood Estrin et al., 2021; Freeman & Paradis, 2023; Leedham et al., 2020; Siklos & Kerns, 2007), not healthcare services broadly speaking. However, when looking at item-specific responses, our results support previous research suggesting sex differences in experiences of healthcare (Freeman & Paradis, 2023; Huang et al., 2024). These results have serious implications for autistic females in their pursuit of healthcare across the lifespan, with research highlighting continued frustration in adulthood when accessing medical services related to reproductive services, indicative of a pervasive issue with access and support (Karavidas & De Visser, 2022). Indeed, if accessing healthcare is an overly cumbersome process (Sapiets et al., 2023), which is exacerbated by being female (Tint & Weiss, 2018), it stands to reason that these experiences reduce the likelihood of pursuing additional healthcare in the future. Importantly, the observed risk ratios for frustration in autistic females were relative to *autistic* males; in other words, it does not consider the amount of frustration or dissatisfaction observed relative to *nonautistic* males and females. If identifying as autistic adds layers of frustration, as reported in previous research (Jackson et al., 2020), it is likely that the intersectionality of being autistic and female conveys exacerbated risk. Considering the well-established rates of co-occurring medical (Kassee et al., 2020) and psychiatric (Martini et al., 2022) challenges experienced by autistic females across the lifespan, continued access to affirming and supportive healthcare without frustration is crucial.

Our results cannot speak to whether these differences truly exist in medical biases, or whether these are differences in parental perceptions. Previous qualitative work suggests that the male-oriented past of autism may create an environment where autistic females are told they cannot be autistic due to their sex assigned at birth, leading to autistic females feeling unheard and dismissed (Leedham et al., 2020). We cannot, however, prove that this is a universal experience for all autistic females or that it happens at every healthcare visit or with every provider. As LaVeist et al. (2009) found, it is possible that one negative experience with a healthcare provider may increase frustration with all following healthcare visits regardless of the established provider-client relationship. Regardless, -although the current data may be driven by two different causal pathways (e.g., parents perceiving higher frustration versus medical professionals treating females and males differently), the impact of these results remains. Parental perception of the diagnostic process has previously been linked to parental perception of a child's diagnosis (Siklos & Kerns, 2007) and stress and uncertainty related to future directions and healthcare (Keenan et al., 2020). As such, reducing frustration, regardless of where the frustration originates, should be given strong consideration in future research.

Strengths and limitations

Our study has numerous strengths, including the nationally-representative dataset spanning several years and sufficient samples of autistic males and females. As noted in a recent systematic review detailing barriers and difficulties accessing an autism diagnosis by race and ethnicity, samples are often too small to adequately evaluate sex and gender effects (Fisher et al., 2023). Furthermore, the two groups of autistic youth (males and females) were well-matched on the majority of demographic variables assessed. However, our results should be interpreted in light of limitations. Several variables that are known to impact health care frustration were not assessed or included here, including medical co-occurring conditions, distance to healthcare, health insurance, type of healthcare accessed (medical visits, therapy services, obtaining necessary accommodations, etc.), and cultural perceptions of healthcare informed by other facets of identity. One variable of interest to the authors was the interaction between rurality and frustration risk. This was not possible due to missingness of data. Variables were also evaluated through closed questions. More information gathered in an open-ended, qualitative format may have helped elucidate the reason for the disparity in frustration risk in narrow and broader contexts and also shed light on unexpected findings such as the discrepancy between individual metrics of frustration (higher risk for females) and more general sentiments of overall frustration (higher risk for males).

This study also did not evaluate the role of intersectionality of race, ethnicity, and assigned sex at birth that has been shown in previous research to be related to diagnostic outcomes (Goldblum et al., 2023). A recent systematic review (Fisher et al., 2023) found that parents of color reported many barriers and difficulties associated with the diagnostic process. Across 15 studies, parents reported challenges with systemic and financial barriers, provider barriers similar to the ones identified in this study (e.g., spending time with families, asking about concerns), and personal barriers (such as education and advocacy skills). Additionally, another study found that Black participants had significantly higher levels of medical mistrust than white participants (Arnett et al., 2016). As the racial distribution between the two groups analyzed in this study was significantly different, our results may also be influenced by the different racial distribution between autistic males and females; the NSCH autistic sample included in our analyses significantly differed in relation to the proportion of Asian males/females, Black males/females, and those who identified their racial group as "other". Therefore, it is difficult to estimate how the risk ratios may have been impacted by sex, race and ethnicity, representing a key future direction.

When considering intersectionality, it is also important to address the overlap between neurodiversity and gender diversity (Strang et al., 2023). The current study only evaluated youth grouped by assigned sex at birth as opposed to gender. Future work may consider the role of gender identity and sex assigned at birth in accessing neurodiversity- and gender diversity-affirming care.

Conclusion

Using a nationally-representative dataset spanning six years, parents of autistic females were at an elevated risk of experiencing frustration with medical services in 5 out of 10 domains and an equivalent risk in 3 out of 10 when compared to parents of autistic males. Despite parents of autistic females being at a significantly higher risk (1.8–3.4x) of reporting frustration with being heard, feeling like a partner, and having cultural values taken seriously by medical providers, parents of autistic females reported lower *overall* frustration and higher satisfaction than parents of autistic males. These results have important implications for considering how and when autistic females access healthcare, barriers to healthcare adherence, and sex differences in how youth and parents are treated in the medical field.

CRediT authorship contribution statement

Neal Amanda J: Writing – review & editing, Writing – original draft, Validation, Project administration, Investigation. **McFayden Tyler C:** Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Methodology, Investigation, Formal analysis. **Goldblum Jessica E:** Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Bristol Stephanie:** Writing – review & editing, Methodology, Investigation, Conceptualization. **Harrop Clare:** Writing – review & editing, Supervision, Resources, Project administration, Funding acquisition, Conceptualization.

Declaration of Competing Interest

None.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.reia.2025.202576.

Data availability

The National Survey of Children's Health Data is available from the Health Resources and Services Administration Maternal and Child Health Bureau.

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