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## Perceptions of Female Sexual Pathology: The Role of Racial Biases in Clinical Decision Making

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Perceptions of Female Sexual Pathology: The Role of Racial Biases in Clinical  
Decision Making

By

Jerusha Sanjeevi

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

In

Clinical Psychology

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Perceptions of Female Sexual Pathology: The Role of Racial Biases in Clinical Decision Making.

Jerusha Sanjeevi

This thesis has been examined and approved by the following members of the student's committee.

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Eric Sprankle, Chairperson

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Moses Langley

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Shannon Miller

## Abstract

Diversity issues such as multicultural competence and sexual health competence have received increased but separate academic attention in recent years. Although empirical support has been found for the presence of racial biases in the diagnoses of mental health disorders, there is no evidence to date regarding the role of racial biases in the diagnoses of female sexual pathology. In the present study, 101 pre-doctoral psychology interns across the United States assessed the symptom severity of a fictional client via online vignettes in which client race was experimentally manipulated. Participants did not report significantly different symptom severity ratings between the vignettes featuring a White client and the vignettes featuring a Black client. Future research should examine service-provider competence among more diverse samples, as well as pedagogical practices within psychology training programs that may be implicated in these results.

*Keywords:* cultural competence, racial biases, sexual health competence, female sexual pathology.

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Perceptions of Female Sexual Pathology: The Role of Racial Biases in Clinical Decision Making.

**Introduction**

Diversity issues such as female sexuality and racial stereotyping have generated increasing academic interest in recent years. Despite heightened interest, there remains a lack of research in the field of psychology addressing the intersection of racial stereotypes and female sexuality in relation to service provision. Perceptions of African American female sexuality, in particular, have not been examined in relation to perceptions of White female sexuality among mental health service providers. Specifically, there is a sparsity of academic knowledge regarding the potential impact of racial biases on clinical decision making of sexual health issues.

Multicultural education appears to have been increasingly valued and reflected in the policies of academic communities in psychology (Sue et al., 2007). In 2002, for example, the American Psychological Association (APA) incorporated guidelines for diversity training into the association's policy. In addition, APA-accredited doctoral psychology programs are currently required to incorporate diversity issues into all domains of their curricula (APA, 2006). However, further study is needed to assess whether current educational standards are effecting successful learning outcomes in trainees required to generalize their skills to applied settings.

Although the APA requires that psychology trainees receive training in both professional competencies and research competencies related to multiculturalism, there are no equivalent requirements for competencies related to sexual health training (APA, 2006). Given the nature of negative historical stereotypes linking sexuality and race

(Collins, 2000), there is need to examine multicultural issues and sexual health issues in a united context.

### **Historical Portrayals**

**Jezebel stereotype.** Historical stereotypes originating in the slavery era may continue to influence modern portrayals of sexuality among African American women in a negative manner (Collins, 2000; Hammonds, 1994). A particularly aspersive sexual stereotype, the Jezebel, refers to an immoral, lascivious, and sexually insatiable Black woman – a stereotype developed to justify sexual violence perpetrated by White slave owners (Collins, 2000; White, D., 1999). The victim-blaming nature of the Jezebel stereotype was also used to justify the physical abuse and lynching of Black female slaves (Hammonds, 1994), and became a tool to elicit subordination (Davis, 1983). Black Feminist scholars have posited that the legacy of the Jezebel stereotype continues to perpetuate not only the hypersexualized images associated with African American women, but also the pathologizing of their sexuality (Collins, 2000; hooks, 1992; White, D., 1999).

**‘Hottentot Venus’.** Other historical portrayals of Black women employed stereotypes about Black female bodies in addition to stereotypes about sexual behaviour. An infamous example involves the life of Sara Baartman, a Khoisan woman sold and exhibited around Europe in the early 1800s under the stage name of the ‘Hottentot Venus’ (Qureshi, 2004). Advertisements for Baartman’s exhibitions described her as an exotic specimen of a savage tribe, while accompanying drawings depicted her with exaggeratedly large buttocks, breasts, and genitalia (Qureshi, 2004).

Sara Baartman later became the subject of scholarly inquiry by historians, sociologists, and cultural critics, and eventually became a symbol of the historical exploitation of Black female sexuality by various White societies (Gilman, 1985; Henderson, 2014). In a seminal essay on the matter, Gilman (1985) noted the substantial influence of the ‘Hottentot Venus’ image on portrayals of Black female sexuality in literature and artwork throughout the rest of the nineteenth century. White artists, writers, and physicians portrayed Black female bodies as having abnormally large genitalia and buttocks, and concluded that Black women were therefore sexually abnormal and aggressive (Gilman, 1985). The buttocks, in particular, were believed to be the source location of these presumed sexual excesses (Gilman, 1985) - a notion containing pronounced parallels with contemporary depictions and emphases on the buttocks of Black women (including the buttocks of the First Lady, Michelle Obama) in popular culture (Collins, 2004; Nash, 2014; Quinlan, Bates, & Webb, 2012; White, T., 2013).

**Impact on research culture.** According to a Black Feminist lens, historical stereotypes have exerted a detrimental influence on modern conceptualizations of sexuality, resulting in current societal perceptions of Black female sexuality as abnormal or deviant (Collins, 2000; Davis, 1983). The historical exoticization of Black female bodies may have also contributed to the relegation of Black female sexuality to the periphery of academic research (Davis, 1983). As such, sexual health research has been impaired by research designs that prioritize the study of White participants at the cost of excluding Black participants. Despite the wealth of research on pornography, for example, Black women have been underrepresented in such research. However, there is

some evidence to suggest that Black performers in general are portrayed as having lower social status than White performers, and that Black female performers receive more acts of physical aggression and engage in more submissive sexual acts in comparison to White female performers (Cowan & Campbell, 1994). Although feminist theories have observed marked similarities between racial biases against Black female performers in modern-era pornography and sexual roles during the slavery era (hooks, 1990), the topic remains under-prioritized in quantitative research.

The underrepresentation of Black participants has been noted to occur in research on other sexual health issues as well. In a noteworthy study, Wiederman, Maynard, and Fretz (1996) reported that out of all the studies (N=1173) published in two prominent journals (*Journal of Sex Research* and *Archives of Sexual Behavior*) between 1971 and 1995, only 137 studies reported including Black participants in study samples. Furthermore, only 47 studies reported including Black ethnicity as a research variable (Wiederman et al., 1996). The authors noted, however, that the visibility of Black participants in sexual health research began to rise, at length, after 1990.

Notably, African American sexuality has been presented as non-normative in more recent time periods as well. Although the number of sexual health studies including Black participants has increased, many of these studies maintain a problem-focused approach that associates Black ethnicity with negative outcomes such as sexually-transmitted infections (Benda & Corwyn, 1998; McGruder, 2009). Specifically, the majority of research articles published in the *Journal of Sex Research* between 1998 and 2008 were noted to have reported sexual health disparities of Black participants in the absence of “societal context” (McGruder, 2009, p. 256). These findings may highlight a

problematic research approach, given that it may result in the presentation of sexual health disparities as causally related to intrinsic racial and cultural characteristics, as opposed to social and economic factors (McGruder, 2009). These findings may also lend a modern context to the notion that historical sexual stereotypes have impressed not only literature in art or entertainment spaces, but also literature in academic spaces.

### **Modern Portrayals**

**Media images and messages.** Although women and girls across different backgrounds have been sexually objectified in media images and messages (APA, 2007; Ward, 2003), the marginalization of Black women and girls in US society (Collins, 2000) warrants particular examination of racial themes in those messages. However, in comparison to research on portrayals of women in White-oriented media, little research has been conducted on portrayals of women in Black-oriented media (Gordon, 2008; Stephens & Few, 2007; Zhang, Dixon, & Conrad, 2010). This gap accentuates an urgent need for further study, given the potential implications of social learning theory (Bandura, 1977), cultivation theory (Gerber, Gross, Morgan, & Signorielli, 1994), and sexual script theory (Simon & Gagnon, 1984) on the relationships between media messages, sexual attitudes, and behavioural outcomes.

**Theoretical support.** Bandura's (1977) social learning theory, a hallmark of media effects research, posits that an individual will observe behaviours and behavioural consequences of others; and that these observations, in turn, will shape the individual's own behaviours. Cultivation theory, on the other hand, posits that an individual who observes a certain representation of reality (such as music or television) will eventually construct beliefs that accord with that representation of reality (Gerber et al., 1994). As

such, cultivation theory is one of the primary models used to explore the impact of media messages on recipients' attitudes or beliefs (Ward, 2003).

Although media studies have demonstrated support for the presence of cultivation and social learning mechanisms in relation to White female sexuality (APA, 2007; Ward, 2003), a sexual script approach is more commonly supported in research on Black female sexuality (French, 2013; Stephens & Few, 2007; Stephens & Phillips, 2003). According to sexual script theory, an individual will develop sexual practices, attitudes, identity, and relationships based on an interactive script of cultural values and norms, interpersonal experiences, and intrapersonal characteristics (Simon & Gagnon, 1984, 2003). Because sexual norms are often regulated by narratives from dominant cultures, sexual script theory has been explored by Black Feminist researchers in the context of both modern and historical forms of racial and gender inequality (French, 2013; Nash, 2014; Stephens & Phillips, 2003).

***Rap and hip-hop music.*** The little research available on media portrayals of Black women have primarily focused on rap songs and music videos, given that the majority of women featured in rap music videos are Black (Zhang et al., 2010). Although many rap songs and videos have been recognized for conveying penetrative reflections on social issues, political affairs, and cultural identity, other rap songs and videos have been criticized for conveying themes in support of violence against women and sexual objectification of women (Gan, Zillman, & Mitrook, 1997; Oware, 2009; Stephens & Phillips, 2003). While limited, some quantitative reports have addressed the prevalence of sexually objectified and hypersexualized images of Black women in hip-hop music videos. One study, for instance, indicated that 84% of music videos on the Black

Entertainment Television channel contained sexually-objectified images, in which 71% of women featured wore little to no clothing (Ward & Rivadeneyar, 2002). Other researchers have also observed a male-dominated focus of the genre – rap music videos starring male artists have been noted to regularly feature Black female characters in submissive, sexually-objectified roles (Zhang et al., 2010).

*Contradictions in rap music.* Whereas negative sexual stereotypes of Black women were conspicuously present historically, the contemporary visibility of such stereotypes may be impacted by contradictory messages in rap music. Qualitative content analyses of female rap music have suggested that while Black women are often hypersexualized, conflicting messages are also found – often within the same artist’s work (Oware, 2009; Phillips, Reddick-Morgan, & Stephens, 2005; Shelton, 1997). In an extensive analysis of female rap music released between 1976 and 2004, researchers found that female artists conveyed messages in support of both the empowerment and the oppression of Black female sexuality (Phillips et al., 2005). Similarly, another study reported incongruous themes across 44 female rap songs released between 1992 and 2000 (Oware, 2009). The author noted that many of the artists presented self-empowering themes such as braggadocio and female ownership of female sexuality, but also presented themes of self-objectification and male ownership of female sexuality. On the other hand, Chepp (2015) found more frequent themes of female empowerment in an expanded analysis of 259 female rap songs released between 1996 and 2003, arguing that explicit sexual imagery could be interpreted as a means of reclaiming sexual agency. Such contradictions are consistent with observations noting that Black female sexuality has

been both lauded and degraded in US society (Collins, 2000; Oware, 2009). However, the impact of contradictory messages on audiences requires further study.

*Sexual scripts in hip-hop music.* In a notable analysis of sexual content in hip-hop music, Stephens and Phillips (2003) identified parallels between modern sexual scripts and historical sexual stereotypes. For example, they presented similarities between the modern Freak script in hip-hop music and the Jezebel stereotype, noting that both scripts referred to a licentious, sexually aggressive, and sexually insatiable Black woman. The authors cited the music and videos of rappers Lil' Kim and Foxy Brown as perceived examples of this sexual script. The authors also posited that the modern Diva script, which featured a light-skinned, feminine, and seductive Black woman, was a milder, less visible sexual script with roots in the Jezebel stereotype nonetheless (Stephens & Phillips, 2003). The authors asserted that musical artists such as Destiny's Child, Brandy, and Mary J. Blige exemplified this kind of sexual script. Other studies have also suggested parallels between historical images and contemporary portrayals of Black female bodies in hip-hop music (French, 2013; Townsend, Thomas, Neilands, & Jackson, 2010; White, T., 2013). Hip-hop videos by the popular artist Nicki Minaj, for example, have been perceived to prominently emphasize her buttocks after the fashion of the 'Hottentot Venus' image (White, T., 2013).

**Impact on attitudes and self-concept.** Although there is a paucity of empirical studies exploring the impact of media messages about Black women and girls, there is some evidence associating exposure with negative outcomes related to sexual attitudes and behaviour. Black adolescents exposed to hip-hop music videos, for example, have reported increased attitudinal tolerance of relationship violence (Johnson, Adam,

Ashburn, & Reed, 1995), as well as endorsements of gender stereotypes (Ward, Hansbrough, & Walker, 2005). Relatedly, Gordon (2008) found that consumption of Black-oriented music, music videos, and television shows among Black girls was positively associated with attitudes regarding the importance of their physical appearance and the physical appearance of other girls. Importantly, these relationships were stronger when the girls identified with the music artist or television character, and were even more pronounced when the artist or character was sexually objectified. Other researchers have also found evidence to suggest that exposure to sexually objectified images of Black women may impact not only attitudes towards physical appearances, but also the self-concepts of Black girls. Specifically, endorsements of stereotypic Jezebel images among Black female adolescents are associated with negative academic self-concept as well as negative perceptions of Black-oriented beauty standards (Townsend et al., 2010).

Notably, exposure to stereotypic media messages about Black women may also impact the attitudes of White individuals. For instance, one study indicated that exposure to sexually explicit rap music negatively influenced White college students' perceptions of Black women, but not of White women (Gan et al., 1997). The authors reported that White students subsequently rated Black women as having increased negative traits such as bad, sleazy, sluttish, crude, indecent, and promiscuous; and that male students reported more severe judgments in comparison to female students.

Racialized sexual stereotypes have also been noted to influence attitudes towards rape survivors – particularly in regards to blame attribution. Media portrayals have been observed to selectively portray rape survivors as White women, with them being more likely to experience sexual assault on fictional television series compared to Black

women (Parrott, S. & Parrott, C., 2015). Such findings may be troubling in light of historical stereotypes portraying Black women as lustful and promiscuous individuals incapable of experiencing rape (Collins, 2000; Donovan 2007). Consistent with this hypothesis, White male college students have reported viewing Black female rape survivors as more promiscuous than White female rape survivors (Donovan, 2007). Specifically, this effect was found when the perpetrator was named as White, a finding that may correspond with the historical usage of the Jezebel stereotype (Donovan, 2007). Racial biases have been found to play a role in the legal system as well, with defendants accused of rape being viewed by White jurors as less guilty when the victim is Black than when the victim is White (Klein & Creech, 1982).

Black women have also been noted to report a greater occurrence of sexual objectification experiences than White women have - experiences that have negatively impacted Black women's perceptions of safety (Watson, Marszalek, Dispenza, & Davids, 2015). Qualitative studies have echoed such reports among Black female adults and adolescents, and also highlighted reports of distress among participants over modern media portrayals that sexually objectify Black women (French, 2013; Stephens & Few, 2007; Watson, Robinson, Dispenza, & Nazari, 2012). One such study observed, in addition, that exposure to stereotypic sexual images in the media influenced the sexual scripts of Black female adolescents, who reported feeling pressure to dress and behave like 'video girls' to attract the sexual desire of male peers (French, 2013). Given the complexity of historical and contemporary contexts influencing the interaction between race and sexuality, it is crucial that mental health professionals address both sexual health and multicultural issues.

### **Sexual Health Training**

**Gaps.** Unfortunately, the issue of sexual health training in the field of psychology has long been characterized by limited access to sexual health education and self-reported trainee and practitioner unpreparedness. In an early study, Nathan (1986) surveyed 113 APA-approved clinical psychology doctoral programs, and found that only 37% of programs offered a sexuality course at the graduate level, while only 13% provided practicum placements in sex therapy. In a more extensive survey of 323 doctoral programs and pre-doctoral internships, Weiderman and Sansone (1999) found that less than 10% of programs offered courses in sexual health assessment and sex therapy, while less than 1% of internship sites did.

Studies within the last decade have not indicated significant improvements – a 2010 study indicated that the majority of North American psychologists surveyed either did not assess or did not frequently assess clients for sexual health issues (Reissing & Giulio, 2010). A 2012 study similarly reported that the majority of North American psychologists surveyed expressed a lack of comfort asking clients about their sexual health (Miller & Byers, 2012). Accordingly, within the last month from the survey date, respondents reported assessing only 40% of their intake clients and 22% of their therapy clients for a sexual health issue (Miller & Byers, 2012).

Training in sexual health has been found to positively relate to willingness to provide sexual health interventions, as well as self-efficacy in providing such interventions (Miller & Byers, 2008, 2009, 2012). In comparison to PhD programs, professional programs in psychology have been noted to more frequently employ faculty with experience teaching or researching sexual health topics (Wiederman & Sansone,

1999). However, trainees in PsyD programs have nonetheless been found to also report low levels of comfort talking about specific sexual health issues with clients (Hanzlik & Gaubatz, 2012). As such, there may not only be need for increased sexual health training, but also need for further research on the utility of different approaches to sexual health training.

**Sex positive education.** The primary approach to sexual health education in the US has been critiqued in recent years on account of its focus on negative aspects of sexuality (Fine & McClellan, 2006). In contrast, sex positive approaches focus on developing positive attitudes towards sexuality based on the tenet that consensual sexual practices should not be shamed or stigmatized (Arakawa, Flanders, Hatfield, & Heck, 2012). Sex positive approaches direct attention towards healthful aspects of sexuality such as sexual satisfaction, pleasure, and empowerment, as well as the destigmatizing of sexual diversity. However, these approaches continue to be underrepresented in modern sexual health research (Arakawa et al., 2012).

In a content analysis of eminent sexual and reproductive health journals (*The Journal of Sex Research*, *Archives of Sexual Behavior*, *The New England Journal of Medicine*, and *Obstetrics and Gynecology*), researchers found that articles published between 1960 and 2012 overwhelmingly reported on negative aspects of sexuality instead of positive aspects (Arakawa et al., 2012). Psychologists receiving continuing education in sexual health have similarly reported that such training has focused on problematic aspects of sexual activity while ignoring healthy aspects of sexual activity (Miller & Byers, 2012). This pattern of attention may have roots in earlier stages of education; despite failing to demonstrate positive outcomes (Bearman & Bruckner, 2001; Bruckner

& Bearman, 2005; Kohler, Manhart, & Lafferty, 2008), abstinence-until-marriage curricula have been the principal form of sex education in the US since the introduction of such education in grade schools (Lamb, Lustig, & Graling, 2013). The advent of evidence-based sex education has more recently resulted in comprehensive sex education (CSE) programs that often promote the inclusion of topics such as sexual desire and pleasure. However, most modern CSE curricula have been observed to associate pleasure and desire with negative events such as unwanted pregnancy, STIs, and sexual regret - in the absence of health-oriented discussions of emotional wellbeing, positive communication, and mutual satisfaction (Lamb et al., 2013).

### **Cultural Competence Training**

The importance of cultural competence training has also received increased recognition among helping professions in recent years, given the growing number of studies demonstrating the adverse impacts of racism on the health and wellbeing of ethnic minority individuals (Blume, Lovato, Thyken, & Denny, 2012; Horvitz-Lennon, McGuire, Alegria, & Frank, 2009; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014). Issues related to both systemic racism and individual racism from service providers have been implicated in the underutilization of mental health services among ethnic minority individuals (Alegria et al., 2008; Buser, 2009; Kreyenbuhl, Zito, Buchanan, Soeken, & Lehman, 2003). In gradual response, professional organizations within psychology and other human services fields incorporated diversity training into overall training requirements (Sue et al., 2007). However, the availability of outcomes research assessing demonstrated cultural competence of trainees continues to be limited (Cartwright, Daniels, & Zhang, 2008; Seghal et al., 2009).

**Racial microaggressions.** While macro-level forms of racism remain relevant, they have been met with decreasing levels of social acceptance, and have been openly denounced by the ethics codes of human services fields (Nadal et al., 2014). However, researchers studying modern racism have noted that racial microaggressions, or micro-level forms of racism that reflect implicit or automatic bias, are more covert and remain socially accepted relative to overt forms of racism (Sue et al., 2008). More specifically, racial microaggressions are defined as subtle racial insults that may be intentional or unintentional, but nonetheless convey derogatory messages about racial and ethnic minorities (Sue et al., 2007). For example, a racial microaggression frequently reported by African Americans involves assumptions of deviance or criminality on the basis of race. This can be demonstrated by situations such as “when a Black client shares that she was accused of stealing from work, the therapist encourages the client to explore how she might have contributed to her employer’s mistrust of her.” (Sue et al., 2007, p.282). In this case, the therapist’s statement may convey implicit racial biases linking Black ethnicity with criminality (Sue, 2007). It is important to investigate whether stereotypes about deviance may also be present when service providers diagnose sexual health issues, given the pervasiveness of historical sexual stereotypes (Collins, 2000) and reports indicating that Black individuals experience racial microaggressions at a higher rate than members of any other ethnic minority group (Forrest-Bank & Jenson, 2015).

In comparison to overt forms of racism, racial microaggressions might be perceived to be minor acts of discrimination (Sue et al., 2008). However, racial microaggressions have well-documented relationships with psychological functioning among ethnic minority individuals, and are associated with increased somatic symptoms,

binge alcohol use, anxiety, depression, suicidal ideation, negative affect, and psychological distress (Blume et al., 2012; Hwang & Goto, 2009; Nadal et al., 2014; Ong et al., 2013). This is particularly concerning given that ethnic minority individuals not only frequently experience racial microaggressions in daily life, but also during therapy (Ong et al., 2013; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). In fact, one study indicated that 53% of participants reported that their therapists engaged in microaggressive behaviour, and that out of these participants, almost 76% reported that the behaviour was never addressed (Owen et al., 2014). These findings are especially weighty in light of the negative association between client experiences of racial microaggressions and perceptions of therapeutic alliance quality (Constantine, 2007; Owen et al., 2014).

**Racial biases in clinical decision making.** Further disparities are experienced by ethnic minority individuals seeking diagnostic health services (Liang, Matheson, & Douglas, 2016). While some diagnostic differences may be attributed to sociodemographic characteristics besides race or ethnicity, research has shown that cultural conceptualizations of pathology can influence the process of clinical decision making - and that clinician racial bias can play a negative role in the provision of physical and mental health diagnoses and treatments (Dovidio & Fiske, 2012; Liang et al., 2016; Neighbors, Trierweiler, Ford, & Muroff, 2003; Stepanikova, 2012).

**Diagnostic disparities.** Clinical racial bias has been demonstrated to specifically play a role in the mental health diagnoses of African American individuals, even when structured and semi-structured assessment instruments are used (Neighbors et al., 2003; Pavkov, Lewis, & Lyons, 1989). In comparison to White youth, African American youth

are more likely to receive a diagnosis of conduct-related disorders despite controlling for clinical status and sociodemographic variables besides race (Nguyen, 2007). Independent of clinical status, African American individuals are also overwhelmingly more likely to be diagnosed with psychotic disorders instead of mood disorders relative to White individuals (Barnes, 2013; Neighbors et al., 2003; Pavkov et al., 1989). While diagnostic disparities influenced by racial bias have been demonstrated in regards to conduct disorders, mood disorders, and psychotic disorders among African American individuals, there is no research to date examining the role of racial biases in diagnostic disparities related to sexual disorders. When examining diagnostic disparities, it is also particularly important to examine the intersection between racial and gender inequality - stressors that have been identified to impair African American women's physical and mental wellbeing (Perry, Harp, & Oser, 2013).

### **Present Study**

Black female individuals are likely to have experienced a lifetime vulnerability to racialized sexual stereotypes broadcasted through media outlets and broader social outlets (Collins, 2000). Given the negative impact of such stereotypes on perceptions of Black female sexuality, it is imperative that mental health service providers demonstrate both cultural and sexual health competencies. The purpose of this study was to investigate whether client race and participant gender impacted how psychology trainees perceived the severity of symptoms of potential female hypersexuality. It was hypothesized that differences in total ratings of symptom severity would be found between participants rating the symptoms of a fictional African American female client and participants rating the symptoms of a fictional Caucasian female client. Given that gender differences have

been observed among perceptions of sexuality-related issues (Donovan, 2007; Gan et al., 1997), it was also hypothesized that the gender of participants would have an impact on total ratings of symptom severity.

## **Method**

### **Participants**

Participants were pre-doctoral internship students completing their internships at APA-approved internship sites across the United States. Out of the total number of participants ( $N = 169$ ), 68 participants did not complete over 90% of the survey and were excluded from analysis. The final sample consisted of 101 pre-doctoral interns randomly assigned to receive the vignette describing the Caucasian client ( $n = 55$ ), and the vignette describing the African American client ( $n = 46$ ). Descriptive information on the participants' age group, gender, and race are presented in Table 1, while descriptive information on participants' preparedness in training backgrounds, value of religion, and identification on social issues are presented in Table 2. Participants responding to the item requesting information on gender were presented with both multiple choice and open-ended response options; however, no participants submitted open ended responses.

The participants were interns at university counseling centers, community mental health centers, academic health centers, community health centers, medical schools, private general and psychiatric hospitals, private outpatient clinics, armed forces medical centers, child or adolescent psychiatric hospitals, consortiums, prisons or other correctional facilities, psychology departments, school districts, public hospitals, and veterans affairs medical centers.

### **Procedures**

Training directors of 522 internship sites were contacted with an email containing a link to the survey. The training directors were requested to forward the email if they chose to grant their interns an opportunity to participate in the study. Participants were randomly assigned to receive a survey including either one of two versions of vignettes. The survey consisted of an informed consent form (see Appendix A), a version of the vignettes (see Appendix B), a severity questionnaire (see Appendix C), and a demographics form (see Appendix D). The vignette was divided into two session notes. The participants responded to the severity questionnaire twice (once after reading each session note). At the end of the survey, participants also completed a 3-item questionnaire assessing racial comparisons of symptom severity (see Appendix E).

### **Measures**

**Vignettes.** The vignettes described a 19-year-old, female-identified undergraduate student who was referred to a university counseling center by her doctor, who noted perceived concerns about the client's sexual behaviour. Given that hypersexual disorder is not an official diagnosis in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013)*, the sexual behaviours depicted in the vignettes were based on Kafka's (2010) proposed criteria for defining diagnoses of hypersexual disorder. The definitions are in accordance with the general criteria for disorders in the *DSM-5*, requiring that impaired psychosocial functioning, personal distress, or risk of harm to self or others be present to warrant a diagnosis. The behaviours in the vignettes depicted the Kafka's definition of "recurrent and intense sexual fantasies, sexual urges, and or sexual behaviours" (p.379), but did not meet any of the criteria based on distress, impaired functioning, or risk of

harm. Instead, the client simply reported the frequency, type, and consequences of sexual fantasies and behaviours. The client also reported the lifetime number of partners she had engaged in sexual activity with. Both versions of the vignettes were identical with the exception of the description of client race. In Version A, the client was described as an African American student; whereas in Version B, the client was described as a Caucasian student.

**Severity questionnaire.** The severity questionnaire was adapted from the 11-item Control subscale of the Compulsive Sexual Behavior Inventory (CSBI; Miner, Coleman, Center, Ross, & Rosser, 2007). The measure was restructured from a self-report format into a clinician-report format. The scale was also changed from the original 5-point frequency scale to a 7-point severity rating scale in which 1 indicated ‘absence’ and 7 indicated ‘very severe’ (See Appendix C). Although the psychometric properties of the CSBI are sound and well established (Miner et al., 2007) the psychometric properties of the adaptation used in this study are largely unknown (see limitations section).

**Demographics form.** The demographics form requested information about the participants’ age group, gender, and race. Participants’ value of religion was also assessed on a 4-point scale where 1 = not important and 4 = very important. Perceptions of preparedness in terms of sexual health, diversity, anxiety disorder, psychotic disorder, and mood disorder training were assessed on 4-point scales where 1 = strongly disagree and 4 = strongly agree. Finally, identification on social issues was assessed on a 5-point scale where 1 = very liberal and 5 = very conservative.

**Racial comparison questionnaire.** The 3-item racial comparison questionnaire used the same 7-point rating scale of the severity questionnaire and requested that participants rate their perceptions of the client's symptom severity in comparison to Caucasian, African American, and Latina populations.

## Results

### Assumptions

A Shapiro-Wilk test indicated non-normality in the residuals of both Session Note 1 total severity scores,  $W = .942, p < .001$  and Session Note 2 total severity scores,  $W = .927, p < .001$ . Specifically, the scores were found to be substantially positively skewed ( $z = 2.57; 2.70$ ). Given that the data violated assumptions for ANOVA, logarithm transformations (log base 10) were performed to return the data to normality. It should be noted that for ease of reporting, means and confidence intervals were subsequently back-transformed to fit the original scale. However, calculating ( $10^M$ ) resulted in geometric means, which were lower than the arithmetic means of the original scores. No other assumptions were found to have been violated.

### Client Race and Participant Gender

The results of a 2x2x2 mixed ANOVA indicated no significant main effects. Client race did not impact total severity scores,  $F(1, 89) = .80, p = .38, n^2 = .01$ , with no significant differences found between scores from the Caucasian vignette group and the African American vignette group. Female-identified participants and male-identified participants also did not significantly differ in their ratings of total severity scores,  $F(1, 89) = 3.35, p = .07, n^2 = .04$ . The interaction between client race and participant gender was not significant,  $F(1, 89) = .24, p = .62, n^2 = .003$ , however, the interpretability of this

interaction may be impacted by substantial differences in group size (see limitations).

Within-groups portions of the analyses suggested that participants also did not rate severity scores differently between Session Note 1 and Session Note 2,  $F(1, 89) = .32, p = .57, n^2 = .004$ . This finding was not qualified by interactions between severity scores and client race,  $F(1, 89) = 2.50, p = .12, n^2 = .03$ , severity scores and participant gender,  $F(1, 89) = 1.25, p = .27, n^2 = .01$ , or between all three variables,  $F(1, 89) = 1.77, p = .19, n^2 = .02$ .

### **Additional Analyses**

**Racial comparison questionnaire.** A within-groups analysis of the racial comparison questionnaire demonstrated violations of assumptions of sphericity,  $\chi^2(2) = 15.14, p = .001$ . Participants did not report perceived differences between the symptom severity of the vignette client and that of African American, Caucasian, and Latina populations,  $F(1.74, 165.4) = 2.42, p = .10$  (Greenhouse-Geisser corrected).

**Relationships with demographic variables.** Social conservatism was moderately linked by a Spearman's Rho correlation with higher ratings of symptom severity for Session Note 2,  $\rho = .30, p = .003$ , and weakly linked with higher ratings of symptom severity for Session Note 1,  $\rho = .22, p = .04$ . Likewise, there was a moderate relationship linking value of religion and Session Note 2 scores;  $\rho = .30, p = .007$ , and a weak relationship linking value of religion and Session Note 1 scores;  $\rho = .22, p = .04$ . However, the value of religion was not a significant covariate in the mixed ANOVA model. Social conservatism was a significant covariate,  $F(1, 84) = 4.33, p = .04$ , but did not impact the model. Preparedness in terms of sexual health training was not significantly linked to perceptions of symptom severity for Session Note 2,  $\rho = .06, p =$

.57, or Session Note 1,  $\rho = .07, p = .49$ . Similarly, preparedness in terms of diversity training was not significantly linked to perceptions of symptom severity for either Session Note 2,  $\rho = -.09, p = .37$ , or Session Note 1,  $\rho = -.11, p = .29$ . However, mood disorder preparedness was significantly related to sexual health preparedness,  $\rho = .20, p = .045$ , and diversity preparedness,  $\rho = .25, p = .02$ . Sexual health preparedness was also related to diversity preparedness,  $\rho = .30, p = .01$ .

### **Measure Properties**

Although the measure used in this study was adapted from a single subscale of the CSBI (Miner et al., 2007), the simple structure of the adapted measure consisted of two components (based on initial Eigenvalues). Bartlett's Test of Sphericity was significant,  $\chi^2(55) = 881.75, p < .001$ , indicating the appropriateness of principal component analysis, while the Kaiser-Meyer-Olkin index was .88, indicating adequate sampling. An oblique rotation was justified by the component correlation coefficient (.48), which exceeded Tabachnik and Fidell's (2007) recommended minimum criterion of .32. With an oblique rotation, the two components accounted for 73% of the total variance. Three items: "trouble controlling sexual urges", "trouble controlling sexual behaviour", and "trouble controlling sexual feelings", loaded onto the second component that explained only 14.8% of the variance, suggesting that the scale may include items that measure slightly different concepts. Nevertheless, the 11-item measure as a whole demonstrated good scale consistency ( $\alpha = .916$ ) that did not improve significantly when the 3 items were removed ( $\alpha = .921$ ).

## **Discussion**

### **Summary**

The results of the study did not provide support for the main hypotheses - neither client race nor participant gender significantly impacted overall ratings of symptom severity. The ratings of participants who received the vignette featuring the African American client were not significantly higher or lower than the ratings of participants who received the vignette featuring the Caucasian client. Consistent with these between-groups results, a within-groups analysis also indicated no significant differences within participant ratings on the racial comparisons questionnaire. Participants did not rate symptom severity differently within their ratings of the first and second session notes as well. Importantly, this did not change at different levels of the between-groups conditions, providing further support for the main null hypotheses. This suggests that participants did not make clinical decisions chiefly based on client race, a finding that differs from existing literature on diagnostic disparities related to racial biases against African Americans (Barnes, 2013; Neighbors et al., 2003; Pavkov et al., 1989). Given that studies to date have not explored the role of racial biases in clinical decision making of female sexual pathology, these findings may provide important new information about the connection between the two variables. Furthermore, participants in both groups rated the total symptom severity of the client to be mild. These ratings are consistent with DSM-5 criteria requiring that distress, risk of harm, or psychosocial impairment be present to warrant diagnosis of a disorder (American Psychiatric Association, 2013). As such, these findings imply that participants may have relied on diagnostic information other than client race to make their decisions.

Notably, participants reported feeling well prepared in terms of their background training in anxiety disorders and mood disorders (see Table 2) – both of which are

generally diagnosed according to DSM-5 criteria (American Psychiatric Association, 2013). Mood disorder preparedness, in particular, was significantly correlated with sexual health preparedness and diversity preparedness. While there were no significant relationships between symptom severity scores and these three variables respectively, it is possible that skills related to mood disorder diagnosis may generalize to skills related to both sexual disorder diagnosis and culturally-informed diagnosis. These skills may then relate to clinical decisions through pathways that are indirect.

Certain demographic characteristics were implicated in participants' perceptions of symptoms – reports of viewing religion as more important, as well as reports of identifying with social conservatism, had small to moderate associations with higher ratings of symptom severity. In contrast to predictions of previous research (Donovan, 2007; Gan et al., 1997), gender did not significantly impact perceptions of symptom severity. However, the effects of gender are particularly inconclusive due to the study's limitations.

### **Limitations**

**Unbalanced sample sizes.** A primary concern that may impact the interpretability of the results involves the 11:3 gender ratio among the participants. Although the data did demonstrate homoscedasticity, the sample size of male-identified participants is unlikely to represent the population, and may confound the interpretation of other pieces of information derived from the mixed ANOVA. This concern becomes more pronounced specifically during interpretations of interaction effects – cross-tabulations indicated that 31 female-identified and 15 male-identified participants received the vignettes featuring the African American client, while 46 female-identified

and only 6 male-identified participants received the vignettes featuring the Caucasian client. Because substantial imbalances were demonstrated between group sizes, the main effects of both variables may have been confounded by the interaction. This may occur because an ANOVA (using Type III sums of squares) adjusts calculations according to main effects and interactions, as opposed to main effects alone (Hecter, von Felten, & Schmid, 2010). While main effects are often more meaningful when interpreted in the context of their interactions, in cases of severely unequal sample sizes, an ANOVA may be less effective at identifying the effects of each variable independently (Shaw & Mitchell-Olds, 1993). As such, it can introduce a shortcoming by way of reducing power to detect true differences (Hector et al., 2010; Shaw & Mitchell-Olds, 1993).

**Design.** Another limitation of the study stems from the lack of a control group. Although a control group was excluded from the design due to concerns about recruiting enough participants, the exclusion impacts the validity of the study. A related concern is associated with the nature of the vignettes and their relationship to the measure – which assessed the severity of the client’s struggles with various behaviours, even though the vignettes did not reflect such struggles. While the vignettes were designed to avoid portraying distress, risk of harm, or psychosocial impairment (to better assess potential biases towards less-mainstream sexual practices), this deficiency may have resulted in low ratings of symptoms in general and reduced variability in scores, regardless of client race. Therefore, to better assess racial biases, it may have been more useful to include some behaviours that met general DSM-5 criteria for disordered behaviour.

Finally, the validity and reliability of the symptom severity measure remains largely unknown. Although the items demonstrated good internal consistency and

relevance to the scale, there is no information on other forms of reliability and validity.

Importantly, the CSBI has not been validated with a female-identified population (Miner et al., 2007), which may have impacted findings given that 79% of the sample in the current study identified as female.

### **Conclusions**

**Implications.** The results of this study may indicate that current pre-doctoral psychology interns demonstrate sexual health and multicultural competence in the context of diagnosing female sexual pathology. The interpretations of these findings carry cautious but notable implications for the current body of knowledge on psychology trainee competence. Although previous research has generally indicated service provider unpreparedness in relation to sexual health issues (Hanzlik & Gaubatz, 2012; Miller & Byers, 2008, 2009, 2012) and cultural competence issues (Neighbors et al., 2003; Nguyen, 2007; Owen et al., 2014), the results of this study suggest otherwise. Further research is needed to assess and validate these outcomes among larger and more diverse samples, and to examine the utility of specific pedagogical practices in graduate training programs that may hold agency in such outcomes.

The lack of a significant association between severity scores and perceptions of preparedness in sexual health and diversity issues warrants further investigation as well. It is possible that some of the learning processes implicated in such competencies exist outside of, or in addition to, educational training experiences. However, it is also plausible that participants may have reported on their self-efficacy in regards to their preparedness, as opposed to their actual preparedness.

Despite the limitations, the study has nonetheless contributed to the existing body of literature through examination of a topic that had not been previously examined in the field of psychology. The design of the study also adds to the knowledge base by measuring observed cultural competence in addition to self-reported cultural competence, thereby reducing risks of socially desirable reporting. Designs that solely measure self-reported competence continue to be the most commonly employed designs in outcomes research on cultural competence (Cartwright et al., 2008). However, questionnaires that directly assess self-perceived cultural competence do not always coincide with reports of observed competence (Worthington, Mobley, Franks, & Tan, 2000) and can result in ratings higher than that of observed competence (Cartwright et al., 2008).

Future research should continue to investigate competency outcomes through both observation and self-report. It may also be useful to investigate the possible link between social conservatism, religion, and perceptions of female sexual pathology. Given the strong literature support for the occurrence of racial discrimination – and its detrimental impact on the wellbeing of ethnic minority individuals – continued efforts should be made to research and address training needs related to multicultural competence among mental health care providers. Specifically, thoughtful attention should be directed towards the invisibility of discourse in the field of psychology on the intersection of racialized sexual stereotypes and gender inequality. To this end, it is recommended that further study aim to identify specific mechanisms underlying competence in multiculturalism, sexual health, and intersectionality; such that trainees may ably generalize these skills from theory to praxis.

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Table 1

*Participant Race, Gender, and Age Group*

Variable		Frequency	Valid Percent
Race	African American	7	7.2
	Hispanic	4	4.1
	Caucasian	78	80.4
	Asian/Pacific Islander	8	8.2
	Missing	72	
Gender	Female-identified	77	78.6
	Male-identified	21	21.4
	Missing	71	
Age Group	18-25	2	2.0
	26-30	58	59.2
	31-40	36	36.7
	41-50	2	2.0
	Missing	71	

Table 2

*Participant Training Background, Value of Religion, and Identification on Social Issues*

Variable	Mean	SD	Range
Sexual Health Training	2.57	.81	3
Diversity Training	3.49	.58	2
Anxiety Disorder Training	3.59	.51	2
Psychotic Disorder Training	2.85	.77	3
Mood Disorder Training	3.54	.54	2
Value of Religion	1.84	1.08	3
Identification on Social Issues	1.8	.92	4

## APPENDIX A

**Informed Consent**  
**IRB ID: 841981**

You are invited to participate in a research study that will examine diagnostic opinions among doctoral students. Dr. Eric Sprankle, a clinical psychologist and assistant professor at Minnesota State University, Mankato, and Jerusha Sanjeevi, a clinical psychology graduate student are conducting this study.

**Background Information**

The purpose of this research is to better understand the diagnostic opinions of pre-doctoral internship students in clinical settings. This information may be useful for future research in developing training programs for doctoral students in psychology and other health service providers. All data collected will be used solely for the purpose of this study.

**Procedures**

If you consent to participate you will be asked to read two brief vignettes that each describe a session note from intake sessions at a university counseling center. Following reading each vignette, you will be asked to complete a questionnaire inquiring about your ratings of symptoms presented in the vignettes. Finally, you will be asked to complete a demographics form. It is estimated to take 10-15 minutes to complete both questionnaires and the demographics form.

**Risks and Benefits of Being in the Study**

Despite the sexually explicit nature of the vignettes in this study, there is minimal risk for participating. If you do feel any negative emotions, such as embarrassment, discomfort, or distress, your participation is voluntary, and you have the right to withdraw from this study at any time without negative consequences. You may also be concerned about disclosing personal information, but only non-identifying demographic data will be collected, and all of this will be kept completely anonymous with no way for the researchers to identify specific participants. There are no direct benefits associated with participation in this study.

**Confidentiality**

The surveys are anonymous and participant responses cannot be traced to any identifying information. Only Dr. Eric Sprankle and his research assistants will have secured access to the raw data. The surveys will be stored on a hard drive in Dr. Sprankle's office for 7 years, after which it will be destroyed. If you have additional questions about the security of this information, please contact the information security manager at MNSU at 507-389-6654, [ITSecurity@MNSU.edu](mailto:ITSecurity@MNSU.edu)

**Voluntary Nature of the Study**

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relationships with Minnesota State University, Mankato. If you decide to participate, you are free to withdraw at any time by not completing the questionnaire.

### **Contacts and Questions**

If you have any questions, or would like to obtain a copy of the consent form, you are encouraged to contact Dr. Eric Sprankle (the principal investigator) at Minnesota State University, Armstrong Hall 23, 507-389-5825, or by email at [eric.sprankle@mnsu.edu](mailto:eric.sprankle@mnsu.edu).

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, or if you have questions/concerns about the treatment of human subjects, you are encouraged to contact the Dean of Graduate Studies and Research at Minnesota State University, Mankato, Dr. Barry Ries at 507-389-1242 via phone or at [barry.ries@mnsu.edu](mailto:barry.ries@mnsu.edu) via email.

### **Consent**

By continuing on to the survey, you affirm that you are at least 18 years of age, have read and understood the above information, and consent to participate.

## APPENDIX B

**Vignette A**

Client ID: 00145764

Birthdate: 9/22/1996

Expected Graduation Date: 5/2018

**Reason for referral:** The client was referred to the university counseling center by her primary care physician, who noted concerns about the client's sexual behaviour. The physician ruled out mood disorders, including manic episodes.

**Summary:** The information was gathered through semi-structured interviews across two 50-minute intake sessions.

**Session Notes:**

Date: 12/2/2015

The client is a 19-year-old, African-American, female-identified undergraduate student. The client reported beginning to experience an increase in sexual activity during her junior year of high school without any known environmental trigger to explain the change in behavior. During that year, she reported that after 3 months of dating her boyfriend, she began to have recurrent fantasies about other classmates and then proceeded to engage in sexual intercourse with them. She stated that she would use condoms with all of her partners. The client reported ending the relationship with her boyfriend 2 months after beginning sexual relationships with other classmates. Also during this time period, she reported occasionally having sexual intercourse with other students in exchange for money or gifts, and reported enjoying the experience. The client reported that by the time she had graduated high school, she had engaged in sexual activity with 21 people.

Date: 12/22/2015

The client returned to the clinic for the second portion of the intake assessment. The client reported that after her first boyfriend, all of her partnered sexual activity had occurred in the context of casual encounters, as she felt that her emotional needs were satisfied through interacting with family and friends. She endorsed experiencing an

increase in sexual fantasies and urges since beginning college, in which she attributed to being around “new and exciting people.” Among the varied sexual outlets she reported, the client stated she masturbates three times a day on average. She also reported masturbating in front of a camera for a live web audience during her free time for extra money, and endorsed feeling highly aroused by the experience. The client also stated she enjoyed engaging in group sex, and that she particularly enjoyed engaging in anal intercourse and oral-anal contact in those settings. The client reported experiencing strong arousal from watching pornography with masochistic themes, including choking and bondage, and stated she desires to try these behaviors with a partner. Lastly, the client reported consistent condom use, and estimated engaging in partnered sexual activity about 11 times a week (on average), and that she had engaged in sexual activity with 44 partners by the end of her sophomore year of college.

### **Vignette B**

Client ID: 00145764

Birthdate: 9/22/1996

Expected Graduation Date: 5/2018

**Reason for referral:** The client was referred to the university counseling center by her primary care physician, who noted concerns about the client’s sexual behaviour. The physician ruled out mood disorders, including manic episodes.

**Summary:** The information was gathered through semi-structured interviews across two 50-minute intake sessions.

#### **Session Notes:**

Date: 12/2/2015

The client is a 19-year-old, Caucasian, female-identified undergraduate student. The client reported beginning to experience an increase in sexual activity during her junior year of high school without any known environmental trigger to explain the change in behavior. During that year, she reported that after 3 months of dating her boyfriend, she began to have recurrent fantasies about other classmates and then proceeded to engage in sexual intercourse with them. She stated that she would use condoms with all of her partners. The client reported ending the relationship with her boyfriend 2 months after

beginning sexual relationships with other classmates. Also during this time period, she reported occasionally having sexual intercourse with other students in exchange for money or gifts, and reported enjoying the experience. The client reported that by the time she had graduated high school, she had engaged in sexual activity with 21 people.

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The client returned to the clinic for the second portion of the intake assessment. The client reported that after her first boyfriend, all of her partnered sexual activity had occurred in the context of casual encounters, as she felt that her emotional needs were satisfied through interacting with family and friends. She endorsed experiencing an increase in sexual fantasies and urges since beginning college, in which she attributed to being around “new and exciting people.” Among the varied sexual outlets she reported, the client stated she masturbates three times a day on average. She also reported masturbating in front of a camera for a live web audience during her free time for extra money, and endorsed feeling highly aroused by the experience. The client also stated she enjoyed engaging in group sex, and that she particularly enjoyed engaging in anal intercourse and oral-anal contact in those settings. The client reported experiencing strong arousal from watching pornography with masochistic themes, including choking and bondage, and stated she desires to try these behaviors with a partner. Lastly, the client reported consistent condom use, and estimated engaging in partnered sexual activity about 11 times a week (on average), and that she had engaged in sexual activity with 44 partners by the end of her sophomore year of college.

## APPENDIX C

**Symptom Severity Questionnaire**

Please assess the severity of the client's symptoms in the vignette according to a rating scale where 1 = absent, 4= moderately severe and 7 = very severe.

1. Trouble controlling sexual urges  
1 2 3 4 5 6 7
2. Trouble controlling sexual behaviour  
1 2 3 4 5 6 7
3. Struggling with guilt or shame about aspects of sexual behaviour  
1 2 3 4 5 6 7
4. Struggling with concealing or hiding sexual behaviour from others  
1 2 3 4 5 6 7
5. Trouble controlling sexual feelings  
1 2 3 4 5 6 7
6. Struggling with sexual thoughts or behaviors interfering with formation of friendships  
1 2 3 4 5 6 7
7. Struggling with developing excuses and reasons to justify sexual behaviour  
1 2 3 4 5 6 7
8. Struggling with missing opportunities for productive and enhancing activities because of sexual activity  
1 2 3 4 5 6 7
9. Struggling with sexual activities causing financial problems  
1 2 3 4 5 6 7
10. Struggling with being emotionally distant when engaging in sex with others  
1 2 3 4 5 6 7
11. Struggling with having sex or masturbating more than she wants to  
1 2 3 4 5 6 7

## APPENDIX D

**Demographics Form****General Demographics**

1. What is your age group?

a. 18 – 25

b. 25 – 30

c. 30 – 40

d. 40 – 50

e. Over 50

2. How do you identify your gender?

a. Female

b. Male

c. Other \_\_\_\_\_

3. How do you identify your race?

a. African American

b. Hispanic

c. Caucasian

d. Asian/Pacific Islander

e. Native American/Alaska Native

**Training demographics**

Please indicate the degree to which you agree with the following statements

5. I am well prepared in terms of my training in mood disorders

1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

6. I am well prepared in terms of my training in sexual health

1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

7. I am well prepared in terms of training in psychotic disorders

1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

8. I am well prepared in terms of my diversity training

1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

9. I am well prepared in terms of my training in anxiety disorders

1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

### **Social Demographics**

11. How important is religion to you?

1 = not important, 2 = somewhat important, 3 = important, 4 = very important

12. How do you identify on social issues?

1 = very liberal, 2 = liberal, 3 = center, 4 = conservative, 5 = very conservative

## APPENDIX E

**Racial Comparison Questionnaire**

**According to a rating scale where 1 = absent, 4 = moderately severe, and 7 = very severe:**

1. In comparison to the African American population, how does this client rate in terms of severity of symptoms?

1 2 3 4 5 6 7

2. In comparison to the Caucasian population, how does this client rate in terms of severity of symptoms?

1 2 3 4 5 6 7

3. In comparison to the Latina population, how does this client rate in terms of severity of symptoms?

1 2 3 4 5 6 7