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Sexual Risk: Contributing Factors to High-Risk Sexual Behaviors in a Transgender/Gender Non-Conforming Population

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Abstract

There are a variety of factors associated with the frequency of risky sexual behaviors. Whereas spirituality is a protective factor for certain populations, depression is correlated with higher rates of sexual risk behaviors. Until now, the relationship between access to healthcare and these risky sexual behaviors has not been studied. This study sought to determine the impact of spirituality, depression, and access to healthcare with risky sexual behaviors for individuals who identify as transgender/gender non-conforming (TGNC). Data was collected from TGNC adults over the age of 18 using an online survey method. This study did not find significant relationships involving depression and spirituality on risky sexual behaviors. However, there was evidence that TGNC individuals who have a primary care provider and were able to access them within the past year engaged in fewer risky sexual behaviors.

Keywords: transgender/gender non-conforming, TGNC, access to healthcare, spirituality, risky sexual behaviors, depression

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Chapter 1

Introduction

Spirituality and lower rates of depression have been associated with decreased sexual risk-taking behaviors (Brown et al., 2006; Storholm et al., 2016; Wutoh et al., 2011), though it is unclear if this is also true for the transgender/gender non-conforming (TGNC) community. Furthermore, there is limited research assessing whether access to healthcare has a significant impact on these risk-taking behaviors. Therefore, the purpose of this study is to determine how spirituality, depression, and access to healthcare are related to high-risk sexual behaviors in a TGNC population.

Sexual Risk Behaviors

TGNC individuals are those who "have a gender identity that is not fully aligned with their sex assigned at birth (Guidelines, 2015). TGNC individuals are more likely to be at risk for a variety of sexual risk behaviors and outcomes. Human immunodeficiency virus (HIV) contraction is a particular risk for TGNC individuals: 35% of male-to-female (MTF) TGNC individuals were diagnosed with HIV, whereas 2% of female-to-male (FTM) participants had been diagnosed with HIV (Clements-Nolle et al., 2001). TGNC individuals are more likely to practice unsafe sexual behaviors when having sex with cisgender men as well (Feldman et al., 2014). HIV risk was higher among MTF TGNC individuals regardless of whether they live in urban or rural areas (Horvath et al. 2014).

Compared to cisgender peers, adolescents identifying as TGNC engaged in sexual risk behaviors, such as substance abuse, unsafe sexual encounters, and suicidal ideation and attempts at significantly higher rates (Eisenberg et al., 2017). Additionally, alcohol use has been found to be a significant predictor of risky sexual behaviors including multiple partners, polysubstance during sex, and unprotected sexual encounters (Garofalo et al., 2006; Reisner et al., 2014; Zimmerman et al., 2015).

MTF TGNC individuals engage in more sexual risk behaviors than FTM counterparts, which elevates their risk of contracting HIV. These behaviors include participating in condomless receptive anal intercourse (CRAI), having more than one sexual partner, and engaging in sex work (Green et al., 2015). Other risks for MTF TGNC individuals include a lower likelihood of using condoms with main sexual partners, as well as a decreased chance of discussing HIV or sexually-transmitted infection status with casual partners (Wilson et al., 2010; Horvath et al, 2014). While MTF TGNC individuals appear more likely to engage in high risk sexual behaviors than their FTM TGNC counterparts, the underlying mechanism for this difference is unclear.

Religion and Spirituality

TGNC individuals have varied experiences and reactions related to their *religious* and *spiritual* encounters. Cragun and Sumerau (2015) found that many lesbian, gay, bisexual, and transgender (LGBT) individuals were leaving religions because religion is considered the "primary opposition to sexual and gender equality in the United States" (p. 830). According to the 2015 U.S. Transgender Survey, 19% of respondents who had ever participated in a faith community had left that community due to rejection, though 42% of those who left those communities eventually located a welcoming and accepting community (James et al., 2016).

While religious institutions can be associated with fear of rejection and oppression, this is not true for all TGNC individuals.

However, LGBT *spiritual* experiences appear to have a more positive impact on their lives. Many LGBT individuals identify as "spiritual" rather than "religious," as this has a less negative connotation, is less structural, and is more relational (Halkitis et al., 2009). In fact, this identification can be a source of strength and self-acceptance, enabling them to encounter prejudice compassionately and develop a deeper meaning and life purpose (Rosenkrantz et al., 2016).

Religious and spiritual engagement has also been found to positively impact the rate of high-risk sexual behaviors among TGNC individuals. For example, engaging in formal religious practices (e.g., attending services) may attenuate sexual risk-taking behaviors in young TGNC women (Dowshen et al., 2011). Similarly, religious stress-related growth was negatively correlated with a decreased likelihood of engaging in unprotected sex (Golub et al., 2010). Engagement in spiritual or religious activities therefore appears to be a protective factor for TGNC individuals.

Depression

Minority stress associated with identifying as LGB has been linked to greater rates of depression, anxiety, substance use, and suicidality (Carmel & Erickson-Schroth, 2016; Cochran, 2001; Meyer, 2003). In addition, continued pathologizing of TGNC issues such as accepting and adapting to their gender identity and struggles with depression and anxiety can lead to increased discrimination and minority stress, which in turn impacts anxiety, depression, and suicidality (McCann, 2015). TGNC people experience disproportionately high rates of depression, anxiety, somatization, and overall psychological distress resulting from "enacted and felt stigma,"

compared to non-TGNC individuals (Bockting et al., p. 948, 2013). Experiences of victimization significantly contributed to psychological distress, and this was worse the younger individuals were (Bariola et al., 2015).

While romantic relationships can be a source of close support, these can also be associated with increased depressive symptoms in TGNC individuals. Researchers found that TGNC individuals and their male partners were more likely to experience clinically significant depressive symptoms within the last week (Bockting et al., 2013; Gamarel et al., 2014). However, support from family, friends, and schools have been found to function as protective factors that negate the impact of enacted sigma on mental health symptoms in TGNC individuals (Bockting et al., 2013; Veale et al., 2017).

In addition, TGNC people of color (POC) experience stressors unique to their population, such as racism and gender-related discrimination which is associated with suicidal ideation (Sutter & Perrin, 2016). Aging TGNC POC are also more likely to experience higher rates of mental illness and physical health complaints. As individuals age and move into care homes, they are likely to endure discrimination from staff refusing to care for basic needs, and they often fear fitting in with counterparts who may still hold discriminatory attitudes (Kum, 2017).

The reason for concern regarding these difficulties is that many are related to higher rates of sexual risk-taking behaviors. For example, depressive symptoms correlate with a lack of condom use among adolescents and young adults (Brown et al., 2006). Black men who have sex with men were found to have higher rates of clinically significant depressive symptoms and were at higher risk for HIV infections (Reisner et al., 2009). In addition, TGNC individuals with depression and those who have experienced abuse are more likely to engage in risky sexual behaviors, particularly condomless receptive anal intercourse (CRAI) (Nuttbrock et al., 2013).

While the link between depression and sexual risk-taking behaviors has been demonstrated in other populations, more research is needed regarding the specific risk-taking behaviors among a TGNC population.

Access to Care

TGNC individuals face a variety of barriers to accessing healthcare. Many TGNC individuals report experiencing discrimination, both overt and implicit, from medical providers, or have difficulty finding providers who are competent in the specific healthcare needs of TGNC individuals (Bradford et al., 2013; Ginicola et al., 2017). Though living in larger urban areas increases the chances these individuals will find and see an affirming medical provider, for individuals living in rural areas this can be difficult. This dilemma is intensified for TGNC older adults, whose primary concerns when meeting with providers are fear due to prior negative experiences and anticipated judgment (Fredriksen-Goldsen et al., 2014).

For individuals who do access care, providers may be uneducated and unable to ensure proper and holistic care for patients due to a lack of education or awareness around the specific healthcare needs of TGNC individuals (Alegria, 2011). Knowledge and competency in TGNC healthcare is especially necessary for specific healthcare needs, including hormone replacement therapy and management and higher risk for HIV and other infections (Dickey & Singh, 2017). In addition, TGNC individuals are more likely to not receive necessary cancer screenings. For instance, MTF TGNC individuals still require routine screens for prostate cancer, and FTM TGNC individuals also require routine screens for breast, ovarian, and cervical cancer.

While we know that access to healthcare directly improves the health of TGNC individuals, few studies have examined the relationship between healthcare access and sexual

risk behaviors. It is unclear whether access is correlated with decreases in sexual risk behaviors, such as substance use during sex, number of sexual partners, and contraceptive use.

Purpose of this Study

Spirituality and access to healthcare frequently serve as protective factors decreasing engagement in risky sexual behavior. However, current literature has not explored whether these protective factors extend to the TGNC population. Therefore, this study will examine how access to healthcare, spirituality, and depression impact the rate of high-risk sexual behavior among TGNC individuals.

The hypotheses for this study are as follows:

H1: TGNC individuals who identify as spiritual will engage in fewer risky behaviors than TGNC individuals who do not.

H2: TGNC individuals who endorse accessing healthcare will engage in fewer risky behaviors than individuals who do not.

H3: TGNC individuals endorsing depressive symptoms will be more likely to engage in risky sexual practices than individuals who do not.

Chapter 2

Methods

Participants

Only participants self-identifying as TNGC were considered for participation in this study. Demographic information collected included age, gender identity, sexual orientation, spiritual/religious affiliation, race/ethnicity, marital status, highest level of education, annual income, and employment status. Additionally, participants were asked whether they had health care coverage as a method to gauge access to healthcare.

Demographics

Participants had a mean age of 32 (*SD* = 10.029), with ages ranging from 18 to 63. Forty percent of participants identified as a trans woman (MTF, male to female), 18% as non-binary, 12% as trans man (FTM, female to male), 8% as gender non-conforming/gender variant, 2% as transgender, and 2% as trans. 16% identified as other (transfeminine, trans FTM and genderfluid, enby transman (a colloquial term for a non-binary individual), transmasculine and female).

In this sample, 32% identified as agnostic, 24% as atheist, 8% as Christian, 6% as Jewish, and 4% as Wiccan, 21.2% identified as other (pagan, Asatru, Indigenous, Hare Krishna, Discordian, and Satanist), and 2% did not disclose their spiritual or religious affiliation.

Eighty-two percent identified as European Heritage/white, 4% as multiracial, 2% as American Indian or Alaska Native, 2% as biracial, 2% as Latino/Hispanic, and 6% as other (half European/half Syrian, East Asian, and Indigenous).

Sixteen percent of respondents were from other countries, including Argentina, Canada, Sweden, Australia, Brazil, Germany, and the United Kingdom.

Fifty percent of respondents indicated they were employed full-time, 20% as employed part-time, 9.6% as not employed but looking for work, 10% as not employed and not looking for work, 8% as disabled and unable to work, and 1.9% preferred not to answer.

Thirty percent of participants reported an annual income below $19,999, 20% between $20,000-$39,999, 22% between $40,000-$59,000, 6% between $60,000-$79,999, 8% between $80,000-$99,999, and 4% as $100,000 or more. Eight percent preferred not to disclose their annual income.

Eighty-four percent indicated having healthcare coverage of some sort, whereas 12% indicated they did not.

Measures

The Daily Spiritual Experiences Scale (DSES)

The DSES is a 16-item self-report questionnaire measuring daily spiritual experiences (Underwood, 2011). Items are rated on a Likert-type scale from 1 to 6, where 1 is *many times a day* and 6 is *never or almost never*. Internal consistency measured by Cronbach's Alpha was $\alpha =$ 0.86, and reliability as measured by Pearson's correlation was $r = 0.776$ (Loustalot et al., 2006).

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a 9-item self-report measure for depression used in medical settings (Kroenke et al., 2001). Scores for each item range from 0, *not at all* to 3, *nearly every day*, with a total possible score of 27. Internal consistency was measured using a Cronbach's alpha, which scored at $\alpha = 0.89$ in a primary care setting (Kroenke et al., 2001). Test-retest reliability was 0.84 within 48 hours of the initial assessment (Kroenke et al., 2001).

Sexual Risk Behavior Scale

Items regarding sexual behavior were selected from the Youth Risk Behavior Surveillance System (YRBSS) from the Center for Disease Control (CDC) online research database (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018), as no other statistically robust measure was available to measure risky sexual behavior in adults. To develop a sexual risk behavior score, items assessing the number of sexual partners throughout their lifetime, whether they used substances prior to sexual contact, age of first sexual contact, and the use of a prophylactic such as a condom were selected. Age of first sexual contact was coded into two categories as either before or after age 18. Responses to these four items were summed together to create a sexual risk behavior score. The sexual risk behavior score was found to have a mean score of 12.08 (SD = 4.491) with scores ranging from 4 to 20 among this study's participants.

Healthcare Access Scale

Items regarding healthcare access were selected from the Behavioral Risk Factor Surveillance System (BRFSS) survey from the CDC online research database (National Center for Chronic Disease Prevention and Health Promotion, 2019), as no other statistically robust measure was available to measure healthcare access. A healthcare access score was developing using items selected from The Behavioral Risk Factor Surveillance System (BRFSS) survey. These questions were originally used in phone surveys but were adapted for use in this study. Questions regarding healthcare access, including whether individuals have health insurance, and whether individuals had an identified primary care physician were selected. To develop the access scale, these items were summed together to create a composite score. The healthcare

access scale was found to have a mean score of 2.73 (*SD* = .610) with scores ranging from 0 to 4 among this study's participants.

Sexual Health in Recovery

To measure substance use, questions were selected from the Sexual Health in Recovery questionnaire (Braun-Harvey, 2011). Items were rated on a five-point Likert scale, which were then summed to create a composite score. The substance use scale was found to have a range from nine to 32, with a mean score of 11.39 (*SD* = 4.847) among this study's participants.

Procedure

Participants were selected through a snowball sampling method (SSM) utilizing an online social media platform (Cohen & Arieli, 2011). Participants accessed an online survey link on Facebook that was shared by other members who had previously completed the study. Prior to the survey, participants read the informed consent and were required to answer whether they agreed to the informed consent and whether they were age 18 or older. Only participants older than 18 were eligible to complete the survey. Participants then completed the online survey, including a set of demographic questions, which took an average of nine minutes.

Chapter 3

Results

Spirituality and Sexual Behaviors

Correlation coefficients were computed between spirituality as measured by the DSES (m = 60.83, SD = 12.107) and sexual risk behavior scores. No significant relationship was found between these variables (r (46) = -.070, p = .637).

Healthcare Access and Sexual Behaviors

Chi-square tests were conducted to explore the relationship between healthcare coverage and sexual risk behaviors. Healthcare coverage was unrelated to engaging in sexual risk behavior frequency (X^2(12, N = 48) = 11.429, p = .493) however, individuals who had a personal doctor engaged in fewer sexual (or sexual risk) behaviors (X^2(36, N = 49) = 52.860, p = .035).

Access to a doctor when needed in the past twelve months was not found to be related to sexual risk behavior frequency (X^2(12, N = 48) = 9.017, p = .701). However, individuals who saw a doctor within the past year engaged in fewer risky sexual behaviors than those who had gone longer without seeing a medical provider (X^2(48, N = 49) = 78.993, p = .003).

Depression and Sexual Behaviors

The mean score for PHQ-9 symptoms was 10.43 (SD = 7.220), with scores ranging from 0 to 24 among study participants. Correlation coefficients to determine whether there was a relationship between depression symptoms and high-risk sexual behaviors failed to find a significant relationship between these two (r (47) = .091, p = .534).

Substance Use

As substance use during sex is a contributing factor to sexual risk behaviors, this was analyzed in relation to other factors listed above. The access to healthcare items were then tested regarding substance use. Participants who had healthcare coverage reported engaging in fewer substance use behaviors ($X^2(11, N = 48) = 23.409$, $p = .015$). However, substance use was not related to having someone they identified as their personal doctor ($X^2(33, N = 49) = 23.261$, $p = .896$), being able to access a doctor within the past 12 months ($X^2(11, N = 48) = 12.442$, $p = .331$), or when they last saw a doctor ($X^2(44, N = 49) = 56.908$, $p = .092$).

Contributing Factors for Sexual Risk Behaviors

A multiple regression analysis was conducted to evaluate how well depression, spirituality, access to healthcare, and substance use predicted sexual risk behaviors. The combination of these measures did not significantly contribute to increased numbers of sexual risk behaviors ($F(4, 41) = .606$, $p = .660$). The sample multiple correlation coefficient was .236, indicating that approximately 6% of the variance in the sample can be accounted for by the linear combination of these measures.

Chapter 4

Discussion

This study sought to determine what factors were related to sexual risk behaviors among TGNC adults. Though spirituality has been found to be a protective factor in previous research, this study did not find any relationship between spirituality and sexual risk behaviors among TGNC individuals. This may be due to the fact the majority of participants in the sample indicated spirituality was not a significant part of their lives. Over half of participants identified as either agnostic or atheist. Though this identification does not preclude a spiritual experience, a lack of spiritual identity may make establishing a link between these factors difficult.

Similarly, among the sample for this study there was no significant relationship between depression and sexual risk behaviors. This contradicted prior research (Brown et al., 2006; Nuttbrock et al., 2013) that reported a significant relationship between depression and sexual risk behaviors such as a lack of contraception. Average scores on the depression measure fell within the *moderate* range, indicating most participants may be experiencing significant symptoms that inhibit their interactions with others. Individuals taking antidepressant medication may experience reduced or absent libido, which is a common side effect (Schweitzer et al., 2009). This side effect could explain why this study did not replicate the same relationship as prior research between depression and sexual risk behaviors.

Individuals who identified having a personal doctor and who were able to visit a doctor within the past 12 months also engaged in significantly fewer risky behaviors than those who did

not identify having a personal doctor or those who had last seen a doctor longer than one year ago. As TGNC individuals are at a higher risk for sexually transmitted infections (STIs) like HIV (Clements-Nolle et al., 2001), it is recommended that doctors ask if the patient has been tested for that and other STIs (Eckstrand & Ehrenfeld, 2016). Additionally, it is recommended that doctors speak to their patients about using pre-exposure prophylaxis (PrEP) and other prophylactic interventions. These conversations could lead to increased awareness around preventing and treating these STIs in this population.

Limitations

This study had a small sample size, participants were not randomly selected, and some of the measures used have not been psychometrically validated. Thus, the results of this study may not be generalizable. For example, participants were recruited using a social media page, which automatically excludes anyone not currently active on that social media site. Additionally, there is no way to verify self-identification as TGNC, which makes it difficult to ensure that others non-members of that population are not skewing the results. Additionally, the healthcare access scale may not accurately measure all the factors contributing to access to healthcare (e.g., an individual's ability to get to and from appointments). No psychometrically sound sexual risk behavior measure could be found and the sexual risk behavior questionnaire constructed for this research has not been psychometrically validated, and so it may not accurately measure the contributing factors. Though participants were asked whether they had used alcohol or other substances prior to their last sexual encounter, they were not asked about how frequently they have had sex while under the influence. Not accounting for the frequency for prior encounters may provide incomplete information regarding substance use and sexual risk behaviors. Additionally, the spirituality questionnaire used the word "God" in the instructions and in

prompts throughout. Though there were instructions for participants to substitute this with a word that better fit their spiritual worldview, feedback was received indicating this was upsetting for one participant and was incongruent with their own theology. Additionally, as many TGNC individuals have had negative experiences in Christian churches, this word choice may also bring up prior painful experiences. Scores may be lower on this measure due to the perceived incongruence with their beliefs and nomenclature.

Future Research

There are multiple areas for future research to consider following this study. First, since having a personal doctor was related to lower sexual risk behaviors, it is important to determine what specific factors of having a personal doctor are responsible for this relationship. Teasing apart whether individuals have an established relationship, feel validated and appreciated, and trust the competency of their medical provider are some of the possible factors to assess. This information could then be integrated into trainings to be disseminated among primary care medical providers who work with TGNC individuals. Though research and clinical material is becoming increasingly available, it is unclear whether medical providers have access to appropriate training to provide appropriate medical care to TGNC individuals.

Assessing the frequency and consistency in the past of whether individuals had engaged in sexual risk behaviors while under the influence of substances would also be beneficial. Though this study asked whether participants had been under the influence during their most recent encounter, this provided only a singular snapshot that does not take into consideration all of their prior experiences.

Other areas of future research could focus on developing an empirically validated measure to assess sexual risk behaviors. This would not only help standardize future research but

could also prove to be a useful clinical tool to assist medical and mental health providers in understanding and speaking with patients about their sexual health.

Finally, further research could look into spiritual beliefs and attitudes, as well as perception of other faith systems. Understanding the spiritual and religious experiences of TGNC individuals will continue to provide insight into how this impact individuals on an individual and systemic level. This information will also be useful in expanding future research possibilities, as there may be different spiritual beliefs layered with prior spiritual experiences and perceptions of other faith systems. Understanding the nuances of spirituality will be helpful in providing more sensitive and competent care for these individuals.

Conclusion

This study sought to determine how depression, spirituality, and access to healthcare are related to sexual risk behaviors. Our study found no significant relationship between depression or spirituality and sexual risk behaviors. However, having a primary care provider was associated with fewer sexual risk behaviors suggesting individuals who have a primary care provider may be less likely to take risks or may have greater health literacy. As a result, training medical and behavioral health practitioners to provide competent and affirming healthcare practices, and medical assistants and front office staff in affirming practices that create a safe and welcoming environment for TGNC patients, may help decrease high-risk sexual behaviors.

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Appendix A

Consent

This survey will be used for Jo Crowl's doctoral dissertation. The goal is to learn about health care access, spirituality, mental health, and sexual behaviors among transgender/gender non-conforming (TGNC) individuals.

All data will be kept confidential. Data will be analyzed as a whole. Individual data will not be shared from the survey. Participation is voluntary. Participants may stop any time before the data is analyzed.

The survey takes about 10 minutes. You are not expected to experience any discomfort. However, should this happen you may call the following resources if needed:

Trans Lifeline at 877-565-8860
National Suicide Prevention Hotline at 800-273-TALK (8255)

Findings from this study may be shared to improve access to healthcare and mental health services for TGNC individuals. If you have questions, you may contact Jo Crowl at jcrowl16@georgefox.edu, or the faculty adviser, Dr. William Buhrow, at bbuhrow@georgefox.edu.

Appendix B

Demographics

1. How old are you? _____
2. What gender do you identify as? _____
3. Do you have a faith or spiritual affiliation?
    - Yes
    - No
    - Prefer not to say
4. What best describes your religious or spiritual affiliation?
    - Atheist
    - Agnostic
    - Christian
    - Hindu
    - Buddhist
    - Muslim
    - Wiccan
    - New Age
    - Other: _____
    - Prefer not to say
5. What best describes your ethnicity?
    - European Heritage/White
    - African American/Black
    - American Indian or Alaska Native
    - Southeast Asian/Pacific Islander
    - Biracial
    - Multiracial
    - Prefer not to say
6. What is your marital status?
    - Single
    - Married
    - Divorced
    - Widowed
    - Separated
    - Domestic Partnership
    - Prefer not to say
7. What is your highest level of education?
    - Some high school
    - High school degree or equivalent (e.g. GED)
    - Some college but no degree
    - Associate Degree

- Bachelor's Degree
- Graduate Degree
- Prefer not to say

8. What is your annual household income?
    - $0 – $9,999
    - $10,000 – $19,999
    - $20,000 – $29,999
    - $30,000 – $39,999
    - $40,000 – $49,999
    - $50,000 – $59,999
    - $60,000 – $69,999
    - $70,000 – $79,999
    - $80,000 – $89,999
    - $90,000 – $99,999
    - $100,000 or more
    - Prefer not to say
9. Which of the following categories best describes your employment status?
    - Employed full-time
    - Employed part-time
    - Not employed, looking for work
    - Not employed, not looking for work
    - Retired
    - Disabled, unable to work
    - Prefer not to say

Appendix C

DSES

	Many Times a Day	Everyd ay	Most Days	Some Days	Once in a While	Never or Almost Never
I feel God's presence						
I experience a connection all life						
During worship, or at other times when connecting with God, I feel joy, which lifts me out of my daily concerns						
I find strength in my religion or spirituality						
I find comfort in my religion or spirituality						
I feel deep inner peace or harmony						
I ask for God's help in the midst of daily activities						
I feel God's love for me directly						
I feel God's love for me through others						
I am spiritually touched by the beauty of creation						
I feel thankful for my blessings						
I feel a selfless caring for others						
I accept others even when they do things that I think are wrong						
I desire to be closer to God or in union with Him						

	Not Close at All	Somewhat Close	Very Close	As Close as Possible
In general, how close do you feel to God?				

Appendix D

PHQ-9

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

Appendix E

Sexual Risk Behavior Scale

1. Have you ever had sexual intercourse?
    a. Yes
    b. No
2. How old were you when you had sexual intercourse for the first time?
    a. I have never had sexual intercourse
    b. Less than 12 years old
    c. 12 years old
    d. 13 years old
    e. 14 years old
    f. 15 years old
    g. 16 years old
    h. 17 years or more old
3. During your life, with how many people have you had sexual intercourse?
    a. I have never had sexual intercourse
    b. 1 person
    c. 2 people
    d. 3 people
    e. 4 people
    f. 5 people
    g. 6 or more people
4. During the past 3 months, with how many people did you have sexual intercourse?
    a. I have never had sexual intercourse
    b. I have had sexual intercourse, but not during the past 3 months
    c. 1 person
    d. 2 people
    e. 3 people
    f. 4 people
    g. 5 people
    h. 6 or more people
5. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
    a. I have never had sexual intercourse
    b. Yes
    c. No
6. The last time you had sexual intercourse, did you or your partner use a condom?
    a. I have never had sexual intercourse
    b. Yes
    c. No
7. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response)
    a. I have never had sexual intercourse

   b. No method was used to prevent pregnancy
   c. Birth control pills
   d. Condoms
   e. An IUD (such as Mirena or ParaGard) or implant (such as Implanon or Nexplanon)
   f. A short (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing)
   g. Withdrawal
   h. Some other method
   i. Not sure
8. How many times have you been pregnant or gotten someone pregnant?
   a. 0 times
   b. 1 time
   c. 2 or more times
   d. Not sure
9. During your life, with whom have you had sexual contact?
   a. I have never had sexual contact
   b. Females
   c. Males
   d. Females and Males
   e. Transgender individuals
10. Which of the following best describes?
   a. Heterosexual
   b. Gay or lesbian
   c. Bisexual
   d. Other
   e. Not sure

Appendix F

Healthcare Access Scale

Question Text	Response Options
Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Serivce?	-Yes -No -Don't Know/Not Sure -Refused
Do you have one person you think of as your personal doctor or health care provider?	-Yes, only one -More than one -No -Don't know/Not Sure -Refused
Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?	-Yes -No -Don't Know/Not Sure -Refused
About how long has it been since you last visited a doctor for a routine checkup?	-Within the past year (anytime less than 12 months ago) -Within the past 2 years (1 year but less than 2 years ago) -Within the past 5 years (2 years but less than 5 years ago) -5 or more years ago -Don't know/Not sure -Refused

Appendix G

Sexual Health in Recovery

INSTRUCTIONS: Below is a list of situations, attitudes, behaviors, and concerns that people with drug and alcohol problems sometimes experience. Some items discuss drug and alcohol use combined with sex. Sex is defined as any combination of intercourse (vaginal and/or anal,) oral (vaginal, penile, anal), and mutual, partnered, or solo masturbation.

Please read each item carefully and then circle the number at the right that best describes how often you have felt, thought, or behaved in this way in the past 3 months. Mark only one number for each item. Do not skip any items.
1 = Never, 2 = Rarely, 3 = Some of the time, 4 = Frequently, 5 = Almost Constantly

Experienced problems with sexual interest, desire, or functioning because of drinking and using drugs	1	2	3	4	5
Wondered if I have sexual problems caused by drinking or using drugs	1	2	3	4	5
Felt more free to be sexual when high on drugs and alcohol	1	2	3	4	5
More likely to take risks during sex when high on drugs and alcohol	1	2	3	4	5
Less likely to use a condom for sex when high on drugs and alcohol	1	2	3	4	5
Less likely to use contraception to prevent pregnancy when I am high on drugs and alcohol	1	2	3	4	5
Thinking I will be sexually healthier if I stop drinking or using drugs	1	2	3	4	5
I worry that sex while sober is not as satisfying as it is when I am high or drinking	1	2	3	4	5
I used drugs and alcohol to experience a specific sex act or have kinky sex	1	2	3	4	5

Appendix H

Curriculum Vitae

Joanna Crowl

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Newberg, OR 97132
Email: jcrowl16@georgefox.edu
Phone: (402) 216-8183

EDUCATION

2016-Present	Doctor of Psychology Candidate George Fox University Graduate School of Clinical Psychology: APA accredited GPA: 3.9
2008-2012	Bachelor of Arts in Psychology University of Nebraska-Lincoln (UNL) Minors: English, History GPA: 3.883

PRACTICUM II THERAPY EXPERIENCE

Oregon Health and Science University **June 2018-Present**
Primary Supervisor: Joan Fleishman, Psy.D., June 2019-Present

Preinternship Therapist, Second Rotation

- 50% neuropsychological assessment, and 50% providing behavioral health interventions and long-term therapy to patients.
- Experience with individual psychotherapy and neuropsychological assessment throughout the lifespan
- Focused on an acceptance and commitment approach with exposure to attachment theory
- Common assessment referral questions consultations include attention-deficit/hyperactivity disorder, dyslexia, traumatic brain injury, and neurocognitive difficulties such as memory problems and aphasia
- Typical length of behavioral health visits ranged from 15-30 minutes, with average number of visits 6-8
- Co-located psychotherapy appointments typically last 1 hour, with the total number of visits lasting between 15-26
- Video supervision with supervisors

Practicum II Therapist, First Rotation
Primary Supervisors: Chloe Ackerman, Psy.D., June 2018-October 2018; Sarah Owens, LCSW, November 2018-June 2019

- Provided behavioral health interventions and long-term therapy to patients, including initial consults, warm handoffs, behavior-focused psychotherapy services, and co-located long-term therapy
- Provided occasional neuropsychological and cognitive assessments to individuals on the clinic waitlist for attention-deficit/hyperactivity disorder and neurocognitive concerns
- Collaborated with medical providers to respond therapeutically to warm hand-offs and coordinate services for medically complex patients
- Focused on an acceptance and commitment approach with exposure to attachment theory
- Experience with individual psychotherapy, short-term solution focused therapy, and brief interventions lasting 15-30 minutes
- Typical length of behavioral health visits ranged from 15-30 minutes, with average number of visits 6-8
- Typical presenting problems include anxiety, depression, sleep difficulties, chronic pain, grief and bereavement, and neurocognitive difficulties such as memory problems with individuals of all ages
- Co-located psychotherapy appointments typically last 1 hour, with the total number of visits lasting between 15-26
- Video supervision with supervisors

PRACTICUM I THERAPY EXPERIENCE

Santiam Memorial Hospital **August 2017- June 2018**
Primary Supervisor: Jennifer Felker, Psy.D.

Practicum I Therapist

- Provided behavior-focused psychotherapy services to individuals in a primary care setting
- Consulted with medical providers to respond therapeutically to initial consults and warm handoffs
- Focused on a cognitive-behavioral and acceptance and commitment approach
- Typical length of behavioral health visits ranged from 30-40 minutes, with typical number of visits lasting between 8-10
- Typical presenting problems included anxiety, depression, sleep difficulties, chronic pain, weight loss, grief and bereavement, and substance use cessation with individuals of all ages
- Experience with individual psychotherapy, couples, and groups
- In-session supervision with supervisors

PRE-PRACTICUM THERAPY EXPERIENCE

George Fox University **January 2017- April 2017**
Primary Supervisor: Zeke Saunders, MA; Glena Andrews, Ph.D., ABPP
Pre-Practicum Therapist

- Provided outpatient counseling services to college students including clinical interview, diagnosis, and individual psychotherapy

- Typical presenting problems consisted of adjustment disorders, relationship and identity distress
- Focused on a person-centered approach
- Experience with individual psychotherapy
- Videotape review

SUPPLEMENTAL PRACTICUM EXPERIENCE

Behavioral Health Crisis Consultation Team **January 2018-Present**
Primary Supervisor: Mary Peterson, Ph.D., June 2018-June 2019; Bill Buhrow, Psy.D., June 2019-Present
Consultation Team Coordinator

- June 2018-Present
- Communicate procedural changes to team members
- Collaborate with coordinators and faculty supervisors to address concerns regarding hospital systems and interpersonal training needs
- Assist in program development regarding training procedures, workflows, and implementing new professional practices, as well as communicating these to all team members

Behavioral Health Crisis Consultant

- Provided on-call crisis consultation to hospitals in Yamhill County, including initial risk assessment screens and recommendations for discharge or hospitalization
- Complete risk assessments for suicidality, homicidality, and inability to care for self in the emergency room
- Typical presenting with acute psychiatric distress include suicidal ideation, psychosis, substance abuse, and homicidal ideation
- Experience consulting with medical providers and coordinating care as part of an interdisciplinary team
- In-session supervision with supervisors

The Assessment Clinic at the Behavioral Health Clinic **March 2019-Present**
Primary Supervisor: Glena Andrews, Ph.D., ABPP
Supplemental Assessment Student

- Provided comprehensive and neuropsychological assessments to adults and children in a community mental health setting in Yamhill County
- Conduct neuropsychological and comprehensive examinations for individuals within the community
- Typical presenting problems include attention deficit/hyperactivity disorder, learning disabilities, and neurocognitive decline
- Provide feedback and relevant recommendations to assist with treatment

Oregon City Pediatric Clinic **May 2019- August 2019**
Primary Supervisor: Timofey Galuza, Psy.D.
Behavioral Health Consultant

- Provided comprehensive assessments to children in an integrated care setting

- Conduct comprehensive assessment batteries including the for children within the community in a pediatric primary care setting
- Typical presenting problems include attention deficit/hyperactivity disorder, learning disabilities, conduct problems, anxiety, and depression
- Provide feedback and relevant recommendations to assist with treatment

RESEARCH EXPERIENCE

Research Assistant
Graduate Department of Clinical Psychology
George Fox University
August 2018-December 2018

Completed six sessions of group therapy with undergraduate students covering acceptance and commitment therapy (ACT) principles in support of a doctoral candidate's dissertation on ACT as an intervention to reduce feelings of white privilege. Checked that weekly assignments for the group were completed and facilitated discussions regarding concepts such as fusion, acceptance, self-as-context, values, contact with the present moment, and committed action.

Research Assistant
Graduate Department of Clinical Psychology
George Fox University
September 2017-May 2018

Completed six performance improvement sessions with student athletes focused on visualization and mindfulness in support of a doctoral candidate's dissertation regarding short-term solution focused interventions with athletes.

Research Assistant
Graduate Department of Clinical Psychology
George Fox University
November 2016-Present

As part of the Prayer and Trauma study, administered an electroencephalogram (EEG), galvanic skin response (GSR) test, and an electrocardiogram (EKG). Administered and ran participants through the study protocol, recorded data, and coordinated with other students to ensure standardization of test administration protocol.

PUBLICATIONS

Napier, L., **Crowl, J**., & Colunga-Marin, A. (2019). Assessing provider satisfaction with behavioral health services at six diverse primary care clinics. Poster presented at the Oregon Psychological Association 2019 Annual Conference, Eugene, OR.

Fringer, L., Gallup, S., & **Crowl, J**. (2018). Does attending a faith-based university protect anxious and depressed students from negative academic outcomes? Poster presented at the Christian Association for Psychological Studies 2018 Annual Conference, Norfolk, VA.

PROFESSIONAL TRAINING

October 2019	Intercultural Prerequisites for Effective Diversity Work Cheryl Forster, Psy.D. George Fox University
September 2019	Promoting Forgiveness Everett L. Worthington, Jr., Ph.D. George Fox University
March 2019	Foundations of Relationships Therapy—The Gottman Model Douglas Marlow, Ph.D. George Fox University
February 2019	Opportunities in Forensic Psychology Diomaris Safi, Psy.D. and Alex Millkey, Psy.D. George Fox University
October 2018	Old Pain in New Brains Scott Pengelly, Ph.D. George Fox University
September 2018	Spiritual Formation and the Life of a Psychologist: Looking Closer at Soul-Care Lisa Graham McMinn, Ph.D. and Mark McMinn, Ph.D.
March 2018	Integration and Ekklesia Mike Vogel, Psy.D. George Fox University
February 2018	The History and Application of Interpersonal Psychotherapy Carlos Taloyo, Ph.D. George Fox University
November 2017	Telehealth Jeff Sordahl, Psy.D. George Fox University
October 2017	Using Community Based Participatory Research (CBPR) to Promote Mental Health in American Indian/Alaska Native (AI/AN) Children, Youth, and Families Eleanor Gil-Kashiwabara, Psy.D. George Fox University
February 2017	Domestic Violence: Victims and Perpetrators Patricia Warford, Psy.D. and Sgt. Todd Baltzell George Fox University

February 2017	Native Self-Actualization: Its Assessment and Application in Therapy Sydney Brown, Psy.D. George Fox University
November 2016	When Divorce Hits the Family: Helping Parents and Children Navigate Wendy Bourg, Ph.D. George Fox University
October 2016	Sacredness, Healing, and Naming: Lanterns Along the Way Brooke Kuhnhausen, Ph.D. George Fox University

SUPERVISION EXPERIENCE

Clinical Foundations Teaching Assistant
George Fox University
June 2019-Present

Assisted teaching first year doctoral students fundamental therapy skills, such as empathy, unconditional positive regard, and authenticity. Facilitated an hour and a half-long weekly group supervision lab where we reviewed video from sessions, discussed therapeutic concepts such as diagnosis, interventions, and conceptualization, and provided formative and summative feedback to students to assist in developing as clinicians.

UNIVERSITY INVOLVEMENT

Student Editing Coordinator, June 2019-Present
Student Editor, August 2017-June 2019
George Fox University

Managed and coordinated the Student Editing Team. The team was responsible for providing constructive feedback on organization, APA formatting, and grammar. Organized the trainings for oncoming team members, communicated editing expectations regarding assignments and submissions, monitored the submission portal to ensure all papers were addressed, and provided additional support to team members as needed during busy submission periods.

Clinical Foundations Teaching Assistant
George Fox University
June 2019-Present

Participated as a member of the teaching assistant team to provide supervision and education to students learning essential therapy skills. Duties include leading weekly lab groups, grading assignments, providing individual constructive feedback and one-on-one teaching as needed, reviewing videos of pseudo-therapy sessions, and attending weekly supervision with the course instructor.

Student Council Co-President, May 2019-Present
Student Council Cohort Representative, April 2018-May 2019
George Fox University

As Co-President, led and organized student council meetings throughout the year for the purpose of addressing student body concerns. Created the agenda for the meetings, solicited and addressed concerns from the student body, organized and delegated responsibilities to other council members as needed, and met with the Chairperson for the Graduate School of Clinical Psychology to collaborate on problem solving student requests.

Represent my cohort on a panel of students across the program to address relevant concerns for the student body. Duties include attending monthly student council meetings, soliciting opinions from cohort members and listening to concerns to bring to the council, and acting as a liaison between students and faculty.

Cognitive Assessment Teaching Assistant
George Fox University
July 2018-December 2018

Facilitated a weekly lab group with five second-year students taking the cognitive assessment course to explain concepts, practice administering subtests, and answer questions as needed. Provided supervision and instruction to students learning cognitive assessment administration and scoring and also participated in a weekly supervision with the course instructor. Spent 20-25 hours a week grading assignments, reviewing videos of assessment administrations, and providing individualized constructive feedback. Also collaborated with other teaching assistants to develop and implement a grading guide for the purpose of standardizing grading among future teaching assistants in the course.

TEACHING EXPERIENCE

Behavioral Health Crisis Consultation Team One-Day Rapid Onboarding
George Fox University
August 2019

Developed a one-day training program to onboard new team members. Concepts covered include risk assessment, utilization of the Columbia-Suicide Severity Rating Scale (C-SSRS), role of behavioral health consultants in the emergency department, and coordinating care in outpatient, respite, and acute psychiatric settings.

Behavioral Health Crisis Consultation Team, Clinical Writing Didactic
George Fox University
May 2019

Led a 30-minute didactic on principles of clinical writing for crisis assessment forms, including the purpose of these forms, necessary and important information to include, and how to write professionally in a non-pathologizing and objective manner.

Guest Lecture, Health and Human Flourishing: Stress
George Fox University
October 2018

Lectured on stress, the impact of stress on physical health, adverse childhood experiences, trauma, and the minority stress model for an Introduction to Psychology class.

RELEVANT COURSES

Psychopathology
Ethics for Psychologists
Lifespan Development
Family Therapy
Psychometrics
Social Psychology
Selected Topics: Integrated Primary Care

Cognitive-Behavioral Therapy
Cognitive Assessment
Psychodynamic Psychotherapy

Neuropsychological Assessment and Interpretation
Consultation, Education, and Program Development
Statistics
Biological Basis of Behavior

Professional Issues
Supervision and Management

Theories of Personality and Psychotherapy
Clinical Foundations I, II
Personality Assessment
Integrative Approaches to Psychology and Psychotherapy
Learning, Cognition, and Emotion

Bible Survey for Psychologists
Research Design
Multicultural Psychology
History and Systems of Psychology

Spiritual and Religious Diversity in Professional Psychology
Substance Abuse
Christian History and Theology Survey
Child and Adolescent Assessment

Spiritual and Religious Issues in Psychology

PROFESSIONAL AFFILIATIONS

August 2016-Present American Psychological Association, Student Member

October 2017-Present Association for Contextual Behavioral Science, Student Member

August 2018-Present Division 35: Society for the Psychology of Women

August 2018-Present Division 38: Society for Health Psychology

August 2018-Present Division 44: Society for the Psychology of Sexual Orientation and Gender

August 2018-Present	Division 56: Trauma Psychology

SELECTED EXTENDED EDUCATION

September 2019	Acceptance and Commitment Therapy: 2-Day Intensive ACT Training Melissa Farrell, Psy.D. Portland, Oregon
August 2019	Integrating ACT, Schemas, and Nonviolent Communication to Treat Victims of Narcissistic Abuse Avigail Lev, Psy.D., and Robyn Walser, Ph.D. Bay Area CBT Center
April 2019	Transgender Healthcare Chloe Ackerman, Psy.D. Student Interest Group Presentation Graduate School of Clinical Psychology George Fox University Newberg, Oregon
October 2018	Affirming Care for Bisexual Individuals Christopher Davids, Ph.D., LP Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity American Psychological Association
October 2017	ACT II Workshop Steve Hayes, Ph.D. Seattle, Washington
September 2017	Leadership Development Training Deborah Dunn, Ph.D. George Fox University

REFERENCES

William Buhrow, Jr., Psy.D.
Dean of Student Services
Director, Health and Counseling Services
503-554-2340
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Glena Andrews, Ph.D., ABPP
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Professor of Clinical Psychology
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Chloe Ackerman, Psy.D.
Licensed Clinical Psychologist
971-352-1601
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ASSESSMENTS ADMINISTERED

Cognitive
Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V)
Woodcock Johnson Test of Achievement (WJ-IV)
Comprehensive Test of Nonverbal Intelligence, Second Edition (CTONI-2)
Test of Premorbid Functioning (TOPF)

Memory
Wechsler Memory Scale, Fourth Edition (WMS-IV)
Children's Memory Scale
California Verbal Learning Test, Second Edition (CVLT-II)
California Verbal Learning Test, Children Version (CVLT-C)
The Rey Complex Figure Test (RCFT)

Aphasia/Dyslexia/Language
Boston Naming Test (BNT)
Boston Diagnostic Aphasia Examination (BDAE)
The Jordan Left-Right Reversal Test
Gray Oral Reading Test, Fifth Edition (GORT-5)
Comprehensive Test of Phonological Processing, Second Edition (CTOPP-2)

Executive Functioning
Behavior Rating Inventory of Executive Function, Second Edition (BRIEF-2)
Behavior Rating Inventory of Executive Function, Adult Form (BRIEF-A)
Trails A and B
Delis Kaplan Executive Function System (D-KEFS), Verbal Fluency; Trail Making

Behavior and Adaptive Functioning
Texas Functional Living Scale (TFLS)
Behavior Assessment System for Children, Third Edition (BASC-3)
Adaptive Behavior Assessment System, Third Edition (ABAS-III)
NEPSY-II Comprehension of Instructions
Child Behavior Checklist (CBCL)
Vineland-3 Comprehensive Interview Form

Attention
Conners' Adult ADHD Rating Scales (CAARS)
Conners' Continuous Performance Test, Third Edition (CPT-3)
NEPSY-II Auditory Attention and Response Set (AARS)

Personality
Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)

Effort
Dot Counting Test (DCT)
Test of Memory Malingering (TOMM)

Personality Assessment Inventory (PAI)
Personality Inventory for Children, Second Edition (PIC-2)

Visuospatial Processing
NEPSY-II Route Finding

Developmental
Fetal Alcohol Spectrum Disorder Behavior Screening Tool (FASD BeST)